

# 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 **2018 – 2023**



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

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Development of this Plan has been sponsored through a partnership between Brisbane North PHN and Metro North HHS. 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 experience, and those who care for them, who contributed their valuable insights and perspectives through consultation.
- The Peer Participation in Mental Health Services Network and delegates who led and conducted specific consultations with consumers and carers.
- Staff from Brisbane North PHN and Metro North HHS 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



Professor Brett Emmerson AM



Abbe Anderson

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.<sup>1</sup>

Preparing a regional plan focusing on the critical healthcare areas of mental health, suicide prevention and alcohol and other drug treatment services, 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 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 HHS have sponsored development of this Plan and have developed it in partnership with other healthcare providers and practitioners, people with a lived experience 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, and has been endorsed by the Strategic Coordination Group, tasked with overarching governance of the Plan.<sup>1</sup>

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, 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 preparation of 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 *Planning for wellbeing*. We look forward to working with you to realise future directions in mental health, suicide prevention and alcohol and other drug treatment services.

**Abbe Anderson**  
Chief Executive Officer  
Brisbane North PHN

**Professor Brett Emmerson AM**  
Executive Director  
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<sup>1</sup> See chapter 13 for information about the Strategic Coordination Group's role and membership.

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## List of abbreviations and acronyms

List of abbreviations and acronyms used in this Plan	
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
Emergency Departments	EDs
Full-time equivalent	FTE
Health needs assessment	HNA
Lesbian, gay, bisexual, transgender, intersex, and/or questioning people	LGBTIQ+ people
Medical Benefits Schedule	MBS
Metro North Hospital and Health Service	the HHS
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
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.<sup>ii</sup> At the same time, design and roll out of the 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.<sup>iii</sup> In 2017, the *National Drug Strategy* was released, outlining a national framework identifying priorities relating to alcohol, tobacco and other drugs.<sup>iv</sup>

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.<sup>v</sup> This Regional 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 HHS (the HHS) is committed, through the Queensland Government's commitment to the Fifth Plan, to the production of this Plan. As Australia's largest health service, the HHS works to lead development of responsive, accessible, innovative health services<sup>vi</sup> 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 Regional 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<sup>vii</sup> 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.<sup>viii</sup>

This Plan is also established within the context of Queensland Health's *Connecting care to recovery 2016–2021 (Connecting care to recovery)*, a plan for Queensland Government funded mental health, alcohol and other drug services,<sup>ix</sup> which has been established within the common purpose and investment strategy outlined in Queensland Health's *My health, Queensland's future: Advancing health 2026*.<sup>x</sup> *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.<sup>xi</sup>

## 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 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 also outlines opportunities for expanding, diversifying and extending service delivery. The Plan makes no commitment to future funding for these additional services. Instead, in chapter four on commissioning services, we commit to development of a regional resourcing 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 the HHS 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 HHS have sponsored development of this Plan and have developed it in partnership with other healthcare providers and practitioners, people with a lived experience 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. A comprehensive consultation process has informed the Plan's development, with over 90 consultation events involving many attendees from across Brisbane North, with over 50 per cent of attendees estimated as people with a lived experience or those who care for them.

## 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 for. 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 experience 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.



Healthcare area	Consultation feedback	Shared objectives
<p><b>People with a lived experience leading change.</b> (page 27)</p>	<ul style="list-style-type: none"> <li>• ‘nothing about us, without us’</li> <li>• strengthen the collective voice of people with a lived experience</li> <li>• make it easier for people with a lived experience to be active partners in planning, co-designing, delivering and evaluating services</li> <li>• make services accountable to people with a lived experience</li> <li>• must support each other and be informed</li> <li>• need stronger participation and collaboration mechanisms</li> <li>• strengthen participation by people with a lived experience in the workforce, both in peer work and in broader roles</li> </ul>	<ul style="list-style-type: none"> <li>• strengthen and diversify the collective voice of people with a lived experience to drive service improvements</li> <li>• make available training and capacity building for people with a lived experience</li> <li>• establish better opportunities for participating in planning, delivery and evaluation of services</li> <li>• establish and sustain a consistent region-wide approach to participation in services</li> <li>• advocate for an expanded and more diverse regional lived experience workforce, across all levels of employment</li> </ul>
<p><b>Supporting families and carers.</b> (page 30)</p>	<ul style="list-style-type: none"> <li>• carers are not included, supported and welcomed by service providers</li> <li>• communication between service providers and carers is lacking</li> <li>• financial hardship experienced as a result of caring role</li> <li>• carers are not clear on benefits those they care for are entitled to</li> </ul>	<ul style="list-style-type: none"> <li>• provide information, resources and skills building to support carers</li> <li>• better care for families and carers</li> <li>• families and carers are listened to and involved in services</li> <li>• services are more responsive to the needs of people and carers</li> </ul>
<p><b>Sustaining good mental health.</b> (page 32)</p>	<ul style="list-style-type: none"> <li>• building people’s resilience is critical</li> <li>• insufficient investment in mental health promotion and prevention activities and no one driver</li> <li>• prevention is important, but services are not funded to do it</li> </ul>	<ul style="list-style-type: none"> <li>• build the resilience of individuals, families and communities</li> <li>• prevent stigma associated with poor mental health</li> <li>• use existing resources to promote mental health</li> </ul>
<p><b>Commissioning services.</b> (page 34)</p>	<ul style="list-style-type: none"> <li>• commissioning approaches vary between funding bodies</li> <li>• need better funding outcomes and stronger consumer outcomes</li> <li>• move to integrated delivery, reporting and evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• align commissioning approaches between funding bodies</li> <li>• improve commissioning approaches</li> </ul>
<p><b>Delivering integrated services.</b> (page 37)</p>	<ul style="list-style-type: none"> <li>• new and different services are needed</li> <li>• new thinking must support our stepped care framework</li> <li>• better alignment between services is needed</li> <li>• need to support our workforce to deliver great services, including our peer workforce</li> </ul>	<ul style="list-style-type: none"> <li>• expand, diversify and better target services</li> <li>• improve our service delivery</li> <li>• align and integrate existing services</li> <li>• skill up and diversify our workforce</li> </ul>

Healthcare area	Consultation feedback	Shared objectives
<b>Responding to diversity.</b> (page 40)	<ul style="list-style-type: none"> <li>• respect people from different backgrounds and respond to their specific needs</li> <li>• improve access by all to services</li> <li>• deliver high quality services to people from different backgrounds</li> <li>• address stigma and discrimination</li> </ul>	<ul style="list-style-type: none"> <li>• improve access to services for people from culturally and linguistically diverse backgrounds</li> <li>• ensure services are inclusive of lesbian, gay, bisexual, transgender, intersex and/or questioning (LGBTIQ+) people and respond effectively to their needs</li> <li>• expand and diversify mental health services for older people</li> </ul>

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 experience 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
<b>Aboriginal and Torres Strait Islander (Indigenous) social and emotional wellbeing.</b> (page 47)	<ul style="list-style-type: none"> <li>• good mental health for Indigenous people is about a 'whole of life view' considering relationships, kin and community</li> <li>• holistic care led by Indigenous people is critical</li> <li>• reconciliation and addressing the negative impact of racism improves mental health</li> <li>• Indigenous people experience access barriers and service gaps</li> </ul>	<ul style="list-style-type: none"> <li>• foster Indigenous leadership and engagement in planning, delivery and evaluation of services</li> <li>• increase cultural responsiveness</li> <li>• improve access to mental health services</li> <li>• strengthen integration between services</li> <li>• proactively support reconciliation</li> <li>• recognise that racism impacts on healthcare</li> <li>• respond to service gaps</li> <li>• invest in an evidence base for services</li> </ul>
<b>Alcohol and other drug treatment services.</b> (page 51)	<ul style="list-style-type: none"> <li>• greater collaboration between alcohol and other drug treatment services is needed</li> <li>• people using alcohol and other drugs experience stigma that prevents them from accessing services</li> <li>• workers are addressing complex service consumer needs</li> <li>• increased number of mental health diagnoses, alongside problematic use of alcohol and other drugs</li> </ul>	<ul style="list-style-type: none"> <li>• improve collaboration between alcohol and other drug treatment services</li> <li>• challenge stigmatising and discriminatory practices</li> <li>• skill up our workforce</li> <li>• support effective alcohol and other drug service delivery responses</li> <li>• improve services for at risk groups</li> </ul>

Focus area	Consultation feedback	Shared objectives
<b>Infants, children, young people and families.</b> (page 55)	<ul style="list-style-type: none"> <li>• support early in life is critical – through pregnancy, infancy and early childhood</li> <li>• quality needs assessment is important to infants, children and their families</li> <li>• better treatment and support is needed for parents during the perinatal period</li> <li>• mental health support is fragmented</li> <li>• services do not always respond as needed to vulnerable young people</li> <li>• there are barriers to locating services in schools</li> </ul>	<ul style="list-style-type: none"> <li>• deliver better infant and perinatal support, including responses to service gaps</li> <li>• deliver more effective services to infants, children, young people and their families</li> <li>• improve outcomes for vulnerable young people</li> <li>• make more school-based services available</li> </ul>
<b>Psychological therapies.</b> (page 57)	<ul style="list-style-type: none"> <li>• little is known about consumer preferences</li> <li>• more effective responses are needed for people in disadvantaged circumstances</li> <li>• limited information on outcomes is available</li> <li>• greater service integration is needed</li> <li>• geographic access to services is inequitable</li> </ul>	<ul style="list-style-type: none"> <li>• better align services with consumer preferences and needs and with our stepped care framework</li> <li>• improve integration with other services</li> <li>• increase services in high need areas</li> <li>• improve evidence base</li> </ul>
<b>Severe and complex mental illness.</b> (page 59)	<ul style="list-style-type: none"> <li>• greater integration of responses to physical health needs is required</li> <li>• transition to the NDIS impacting on service consumers and service providers</li> <li>• people often have difficulty in obtaining and sustaining safe, secure and affordable housing</li> <li>• people are experiencing social and economic isolation</li> <li>• better services needed for people experiencing borderline personality disorder</li> </ul>	<ul style="list-style-type: none"> <li>• improve the physical health of people experiencing severe and complex mental illness</li> <li>• assist people to access and sustain safe, secure and affordable housing</li> <li>• support successful transition to the NDIS</li> <li>• foster community connections by people experiencing severe and complex mental illness</li> <li>• establish alternatives to hospital Emergency Departments (EDs)</li> <li>• improve the experience of people transitioning between hospital and community</li> <li>• improve services for people experiencing borderline personality disorder</li> </ul>
<b>Suicide prevention.</b> (page 62)	<ul style="list-style-type: none"> <li>• no clear pathways to care for people experiencing a suicidal crisis or who have been bereaved by suicide</li> <li>• changes are needed to ED responses for people who have attempted suicide</li> <li>• inadequate follow up care after suicide attempts</li> <li>• better suicide prevention services are needed</li> </ul>	<ul style="list-style-type: none"> <li>• improve and integrate suicide prevention responses</li> <li>• improve care and follow up at EDs and after hospital discharge</li> <li>• establish new suicide prevention models</li> <li>• increase accessibility of care after a suicide attempt for vulnerable population groups</li> <li>• increase community knowledge about suicide prevention</li> <li>• better equip GPs and other professionals to identify and support people at risk of suicide</li> <li>• ensure delivery of school-based suicide prevention programs for young people</li> </ul>

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.



# 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.<sup>xii</sup> 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.<sup>xiii</sup> 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.<sup>xiv</sup>

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.<sup>xv</sup>

Our 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, with – improving 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.

In addition, Metro North HHS (the HHS) is committed, through the Queensland Government's commitment to the Fifth Plan, to production of this Plan. As Australia's largest health service, the HHS works to realise the opportunity to lead development of responsive, accessible, innovative health services<sup>xvi</sup> 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 Regional 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.<sup>xvii</sup> Since then, the Commission's strategic plan, *Improving mental health and wellbeing: Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019* 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.<sup>xviii</sup>

Within the context of this national and statewide reform, Queensland Health's *Connecting care to recovery*, a plan for Queensland Government funded mental health, alcohol and other drug services,<sup>xix</sup> 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*.<sup>xx</sup> 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.<sup>xxi</sup>

## 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 HHS have sponsored development of this Plan and have developed it in partnership with other healthcare providers and practitioners, people with a lived experience 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 experience 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 also outlines opportunities for expanding, diversifying and extending service delivery that have been proposed in consultation. The Plan makes no commitment to future funding for these additional services. Instead, in chapter four on commissioning services, we commit to development of a regional resourcing plan that will consider new and extended services proposed in the Plan, in conjunction with data from planning tools that project future demand for services.

## A Plan for Brisbane North

The catchment area for both the HHS 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 980,000 people,<sup>xxii</sup> 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.<sup>xxiii</sup>

## How we developed this Plan

A comprehensive consultation process has informed development of this Plan, with over 90 consultation events, ensuring that we have had the opportunity to hear and understand the perspectives of people across Brisbane North. We have used a range of consultation methods to enable diverse stakeholders to share their views including public symposia, surveys, focus groups allowing specialised input and workshops enabling stakeholders to identify and prioritise issues and options for the future.

Most importantly, our consultation has invited people with a lived experience in Brisbane North who access mental health, suicide prevention and alcohol and other drug treatment services, and those who care for service consumers, to have authentic opportunities to share their experiences, perspectives and vision for future services. We estimate that over 50 per cent of attendees at consultation events were people with a lived experience or those who care for them. Consultation with people with a lived experience and those who care for them, was led by the Peer Participation in Mental Health Services (PPIMS) Network, enabling people with a lived experience to contribute their valuable insights to assist us in developing this Plan.

The results of this widespread and multi-faceted consultation underpin the entire Plan. However, we have endeavoured to keep the Plan succinct and readable and to focus on future directions rather than to provide a detailed report on the results of consultation. An overview of the consultation process for the Plan is provided in Appendix Two.

## Linkages to other Brisbane North planning tools

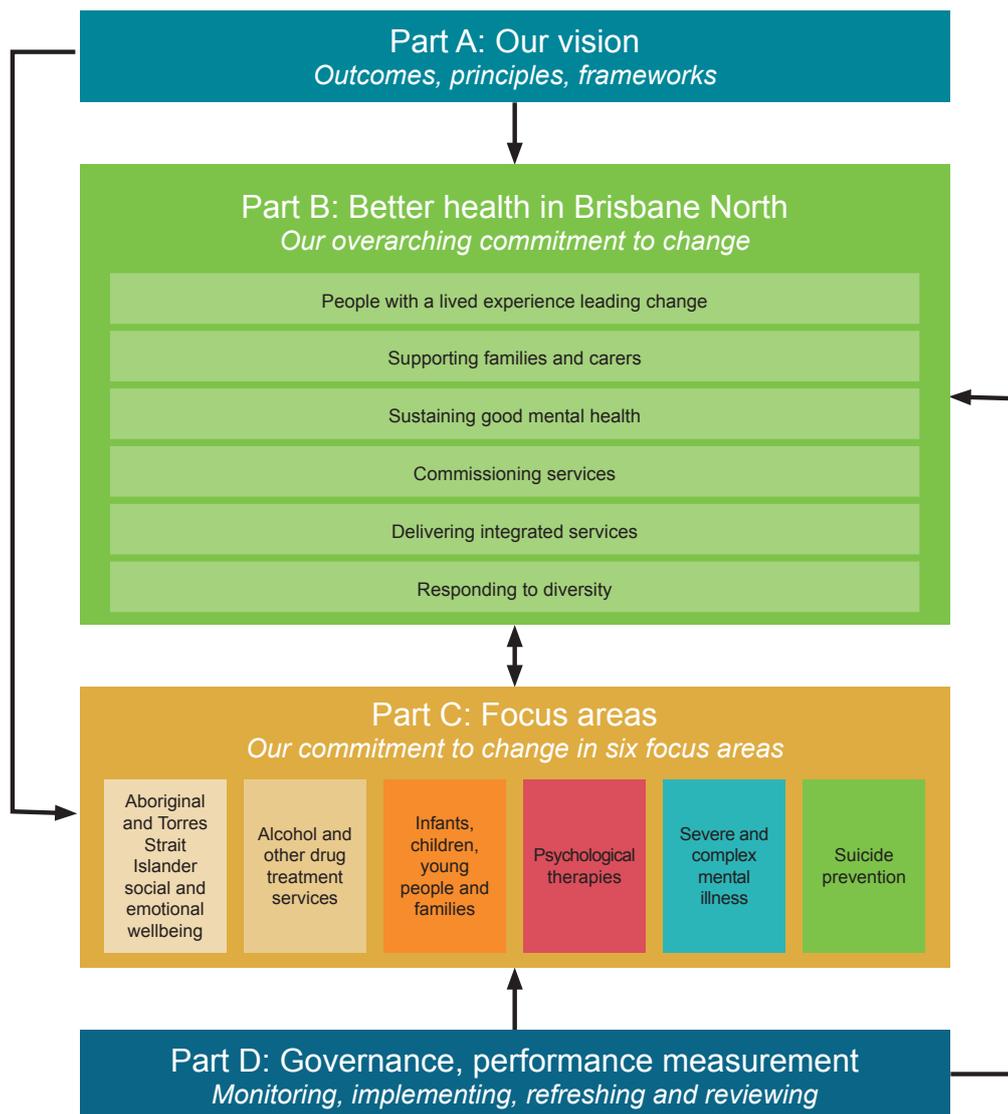
This Plan must be seen in connection with other planning tools that have been developed to shape and drive healthcare nationally, across Queensland and within Brisbane North. A brief overview of key national and statewide strategic drivers and plans is included in Appendix One. Regional plans and planning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

Brisbane North – regional planning tools		
Organisation	Planning resource	Overview
Metro North HHS	<i>Connecting for Health: Strategy for inclusive engagement, involvement and partnerships 2016-18</i> <sup>xxiv</sup>	Outlines a roadmap for engagement with consumers and communities to ensure care is person-centred, integrated and respectful.
	<i>Health Service Strategy 2015–2020: 2017 Refresh</i> <sup>xxv</sup>	Establishes overarching priorities and a forward strategy for providing healthcare services in Brisbane North.
	<i>Mental Health Clinical Services Plan 2018-2023</i> <sup>xxvi</sup>	Describes the HHS's commitment to delivering care through public mental health and alcohol and other drug services, in line with the HHS's overarching regional direction.

Brisbane North – regional planning tools		
Organisation	Planning resource	Overview
Brisbane North PHN	<i>Needs Assessment Report, 2017</i> <sup>xxvii</sup>	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 HHS and Brisbane North PHN	<i>A five year health care plan for older people who live in Brisbane North: 2017-22</i> <sup>xxviii</sup>	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

  
**980,000**

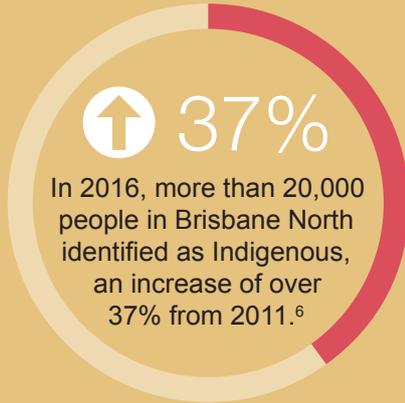
Brisbane North is home to over 980,000 people<sup>1</sup> and this is projected to increase to over 1,200,000 people by 2036.<sup>2</sup>

*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.<sup>3</sup>*



People who were born overseas represent almost 1/4 of Brisbane North's population.<sup>4</sup>

.....  
10% of Brisbane North residents speak a first language other than English.<sup>5</sup>

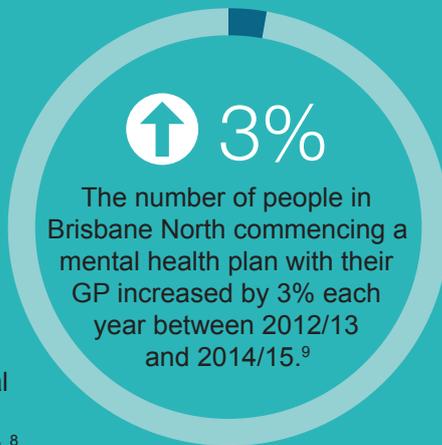


## Mental health in Brisbane North

**70,513**

Between 2011 and 2013, there were an estimated 70,513 adults in Brisbane North with high or very high psychological distress.<sup>7</sup>

.....  
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.<sup>8</sup>



The prevalence of mental health issues in Brisbane North has increased over the last 5 years, particularly among younger people.<sup>10</sup>

## Suicide prevention

**25-59 YEARS**

The number of suicide deaths in Brisbane North is higher in people aged between 25 and 59 years.<sup>11</sup>

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

.....  
*The highest numbers of suicides in Brisbane North suburbs were in Caboolture, Deception Bay, New Farm, Morayfield, Redcliffe and Burpengary.<sup>13</sup>*



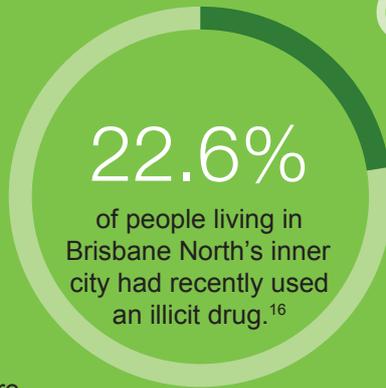
## Use of alcohol and other drugs



5% of adults in Brisbane North consume alcohol at levels of high risk.<sup>14</sup>



An estimated 16.4% of adults in Brisbane North smoke, with Indigenous adults 2.7 times more likely to smoke compared to non-Indigenous adults.<sup>15</sup>



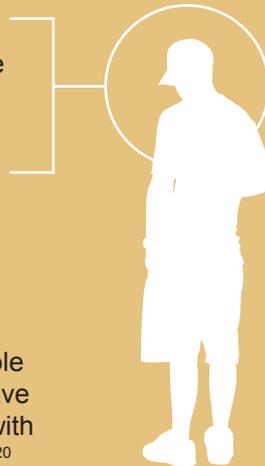
Data from Brisbane North GPs indicates that 54.7% of patients diagnosed with a drug related issue also had a mental health condition.<sup>17</sup>

7%  
Indigenous

Between 2012/13 and 2015/16, 7% of people in Brisbane North who received treatment for alcohol or other drug use identified as Indigenous.<sup>18</sup>

## 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.<sup>19</sup>



**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.<sup>20</sup>



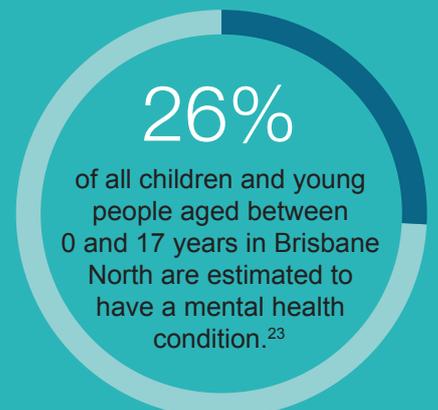
**5.2%**  
mental health  
presentations

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

## Children and young people

**5,000** people  
0-17 years

In 2018, an estimated 5,129 children and young people 0-17 years are expected to experience severe mental illness and require treatment.<sup>22</sup>





## 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 for. 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.*<sup>xxix</sup>

## Outcomes

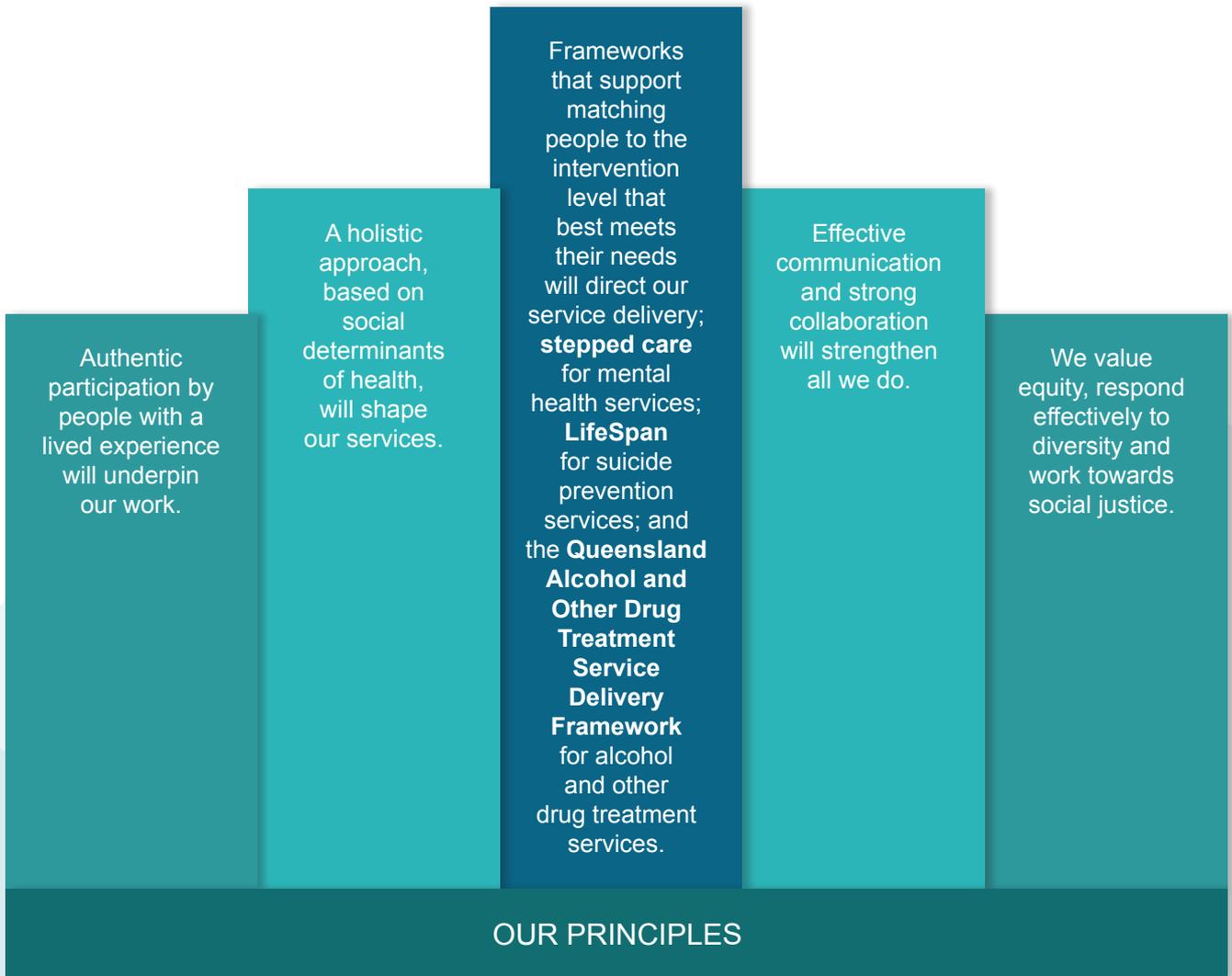
In consultation with stakeholders, the PHN and HHS have identified ten long-term outcomes that we will work towards in our community in response to the challenges posed by mental illness and the prevalence and impacts of suicide and problematic use of alcohol and other drugs. These outcomes will help 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 With a lived experience are actively involved in all levels of policy, planning, delivery and evaluation.
- 9 With a lived experience contribute their 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.

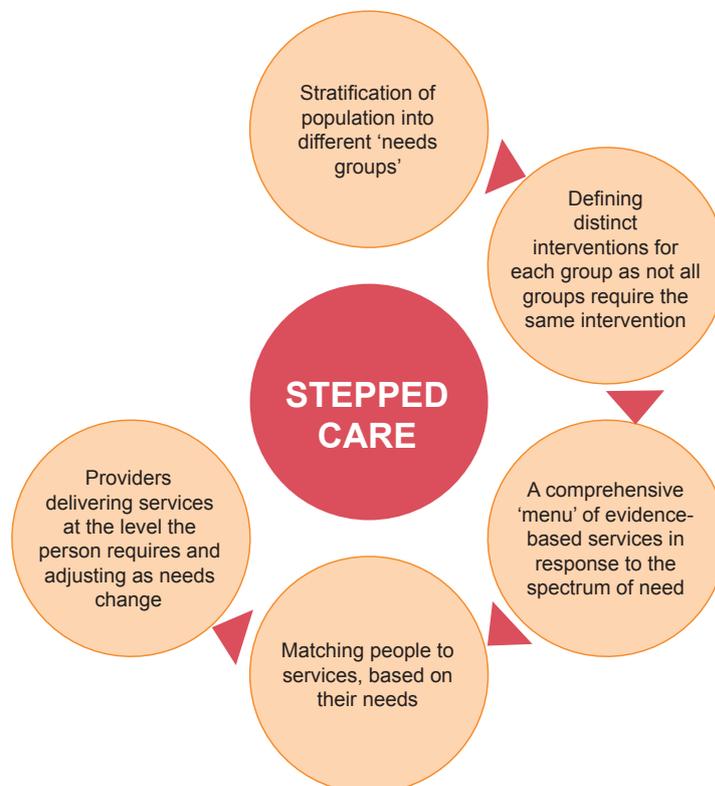


# Our stepped care framework for mental health services

## 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.<sup>xxx</sup> A stepped care approach seeks to:<sup>2</sup>

- 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.



<sup>2</sup> 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

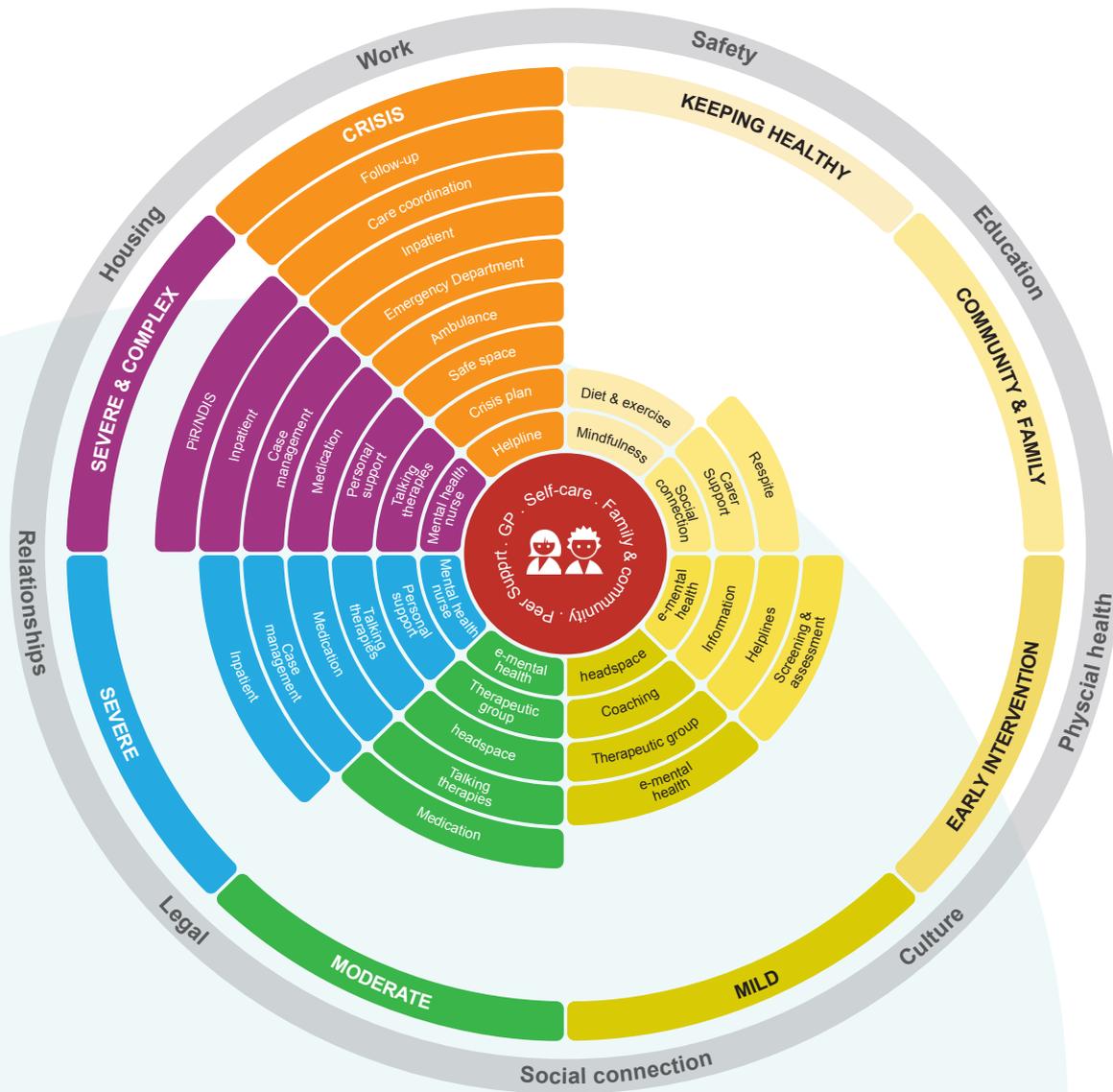
To help people to connect to the mental health service or services that are right for them as part of stepped care, we must understand their needs and circumstances through discussion, assessment tools and/or screening and triage processes. Based on the range of mental health needs and circumstances 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.<sup>xxxi</sup>
- 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.<sup>xxxi</sup>
- 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.<sup>xxxi</sup>
- 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.<sup>xxxi</sup>
- 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.<sup>xxxi</sup>
- 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, suicidal behaviour or harm to self or others.

## 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.
- The HHS, 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, the HHS'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 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:<sup>3</sup>

- **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.
- **Triage and referral tool.** A new 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. Based on demographic information, level of mental distress and other information, rediCASE will suggest programs and service providers that best match the person's needs. 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.

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<sup>3</sup> These strategies are also reflected as actions in appropriate chapters of this Plan.

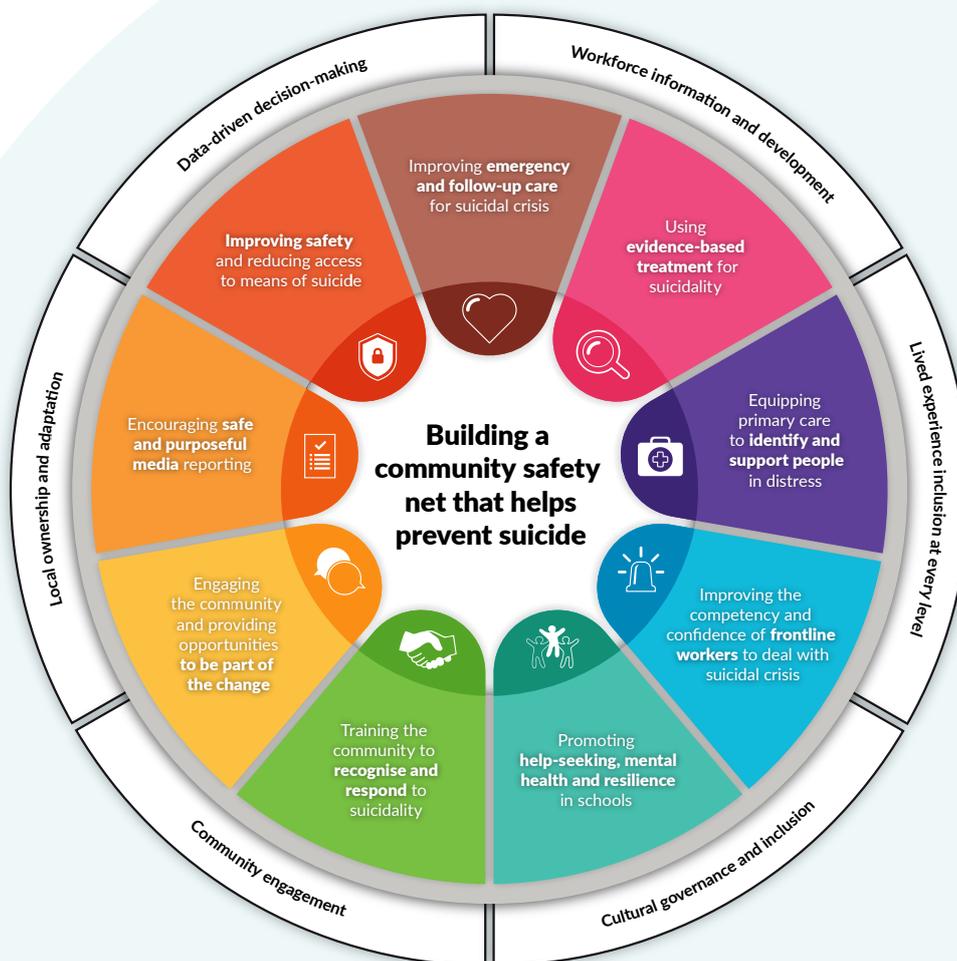
## Our systems approach to suicide prevention services

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.<sup>xxxii</sup> 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 experience. It is expected that implementation of LifeSpan 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 in the diagram opposite
- 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.<sup>xxxiii</sup>



The LifeSpan model 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. Indigenous people, LGBTIQ+ people and veterans).

## 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.<sup>xxxiv</sup> 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.

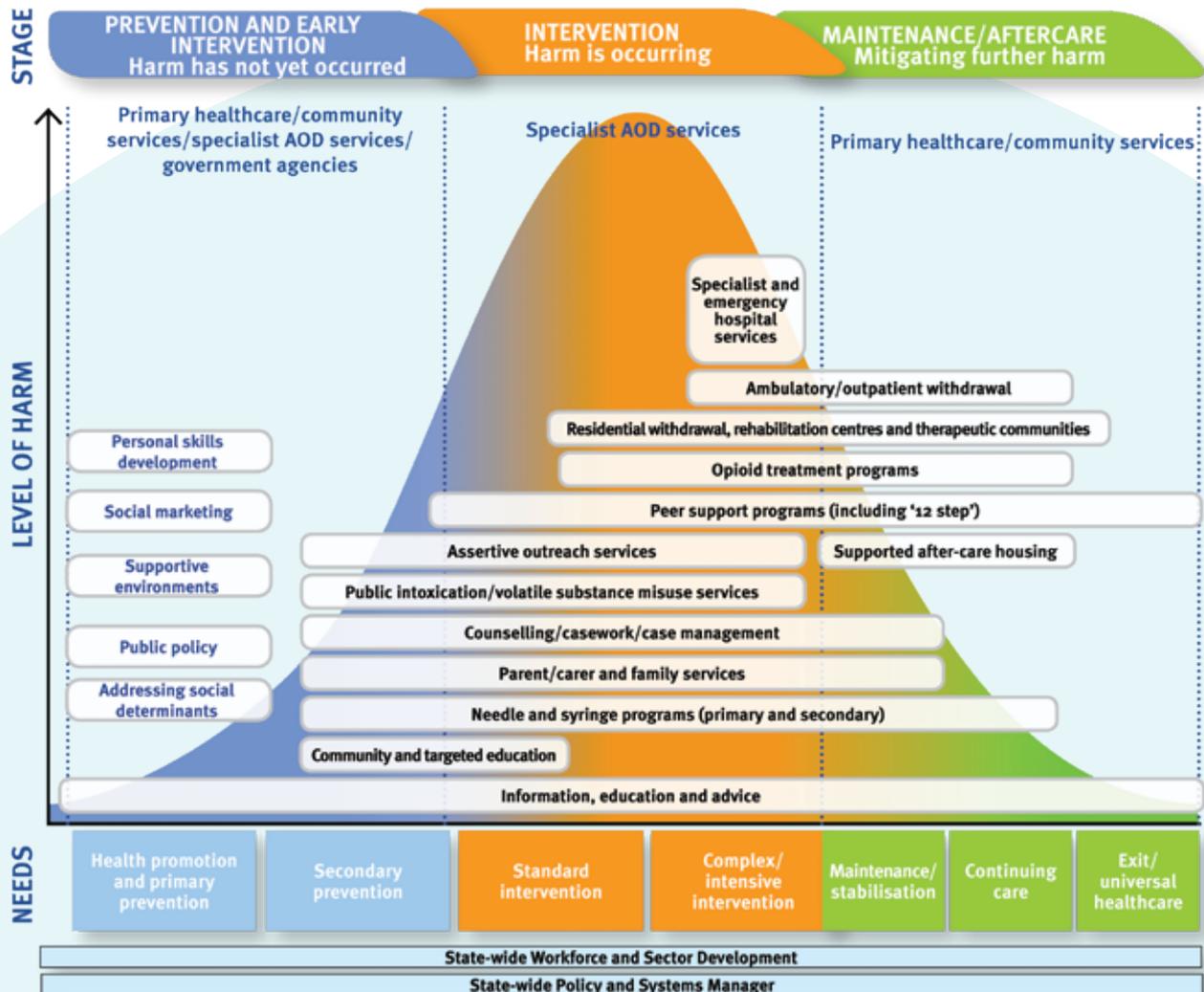
In Queensland, alcohol and other drug treatment services are provided by: public health Mental Health and Alcohol, Tobacco and Other Drug Services (MH-ATODS) and public hospitals; NGOs, including Aboriginal and Torres Strait Islander community-controlled organisations; and GPs and other private healthcare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

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.<sup>xxxvi</sup>

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.<sup>xxxvii</sup>







## 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 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 experience and carers working together to improve quality, coordination and integration.





## 1. People with a lived experience leading change

*“As someone with a lived experience of the range of services available to those with a mental illness, it is very clear that many of these services have a lot of adapting to do in order to truly meet the needs of the community they aim to support. Peers must be consulted in order to successfully make these changes and those services who embrace peer participation will flourish as the community chooses how they wish to receive support.” Deb*

*“Hospitals can be a scary place especially if you are in there for a psychiatric condition. The nurses there are always busy and often don't have time to sit down and talk to their patients. This is where peer support is really needed, to sit down with a person who understands and just chat is really important.” Alex*

*“Peer support helped me regain my sense of community and it was the start of my re-connection with others... my peer worker gives me hope that I too can recover.” Brenda*

### Introduction

Authentic participation by, and collaboration with, people with a lived experience, both service consumers and their families or carers, enriches our work in planning and delivering mental health, suicide prevention and alcohol and other drug treatment services. This participation and collaboration needs to inform assessing needs, planning for the future, commissioning, co-designing and delivering services and evaluating the outcomes our services achieve. National and regional policy drivers reinforce the need to embed participation and collaboration in our work, including when we are commissioning services.<sup>xxxviii</sup>

While we have made progress in participation by people with a lived experience, consultation articulated clearly the need for sustaining participation mechanisms that are working well and strengthening participation and collaboration through a range of actions outlined below to ensure a stronger ‘collective voice.’

### 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 experience.

They also reinforced the need for a central, readily-accessible point for people with a lived 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 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 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 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 Indigenous people, 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 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, taking into account 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,<sup>xxxix</sup> 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
<p>1.1 Strengthen and diversify the collective voice of people with a lived experience in order to drive service improvements.</p>	<ul style="list-style-type: none"> <li>• continue to support the PPIMS Network to expand and build an independent and diverse voice</li> <li>• contribute to building a statewide and national network of people with a lived experience through peak body and advocacy work</li> <li>• actively recruit a diverse group of people with a lived experience to participate in planning, delivery and evaluation of services, including Indigenous people, young people, older people, LGBTIQ+ people and people experiencing problems related to the use of alcohol and other drugs</li> </ul>
<p>1.2 Make available training and capacity building for people with a lived experience.</p>	<ul style="list-style-type: none"> <li>• explore subsidies, funding and co-contributions to enable capacity building initiatives for people with a lived experience</li> <li>• investigate availability of Information, Liaison and Capacity Building funding for peer support groups</li> </ul>
<p>1.3 Establish more authentic opportunities for people with a lived experience to participate in planning, delivery and evaluation of mental health, suicide prevention and alcohol and other drug treatment services.</p>	<ul style="list-style-type: none"> <li>• develop a consumer and carer engagement strategy as part of the commissioning cycle</li> <li>• develop an online communications strategy to link a wider audience of people with a lived experience and services to promote participation and co-design opportunities</li> <li>• develop a register of people with a lived experience available as speakers, educators and trainers to support the service system and build the capacity of the broader workforce</li> <li>• ensure active participation by people with a lived experience in the NDIS readiness and implementation work</li> <li>• facilitate education and training led by people with a lived experience for the entire mental health, suicide prevention and alcohol and other drug treatment services workforce, including for frontline, managerial and executive staff</li> </ul>

Shared objectives	Actions over the next five years
<p>1.4 Establish and sustain a consistent region-wide approach to participation by people with a lived experience in mental health, suicide prevention and alcohol and other drug treatment services.</p>	<ul style="list-style-type: none"> <li>• research and develop a regional policy and engagement framework</li> <li>• develop a clearinghouse of best practice resources on engagement of people with a lived experience, service consumers and carers in the service system</li> <li>• sustain and strengthen existing peer participation and collaboration mechanisms through mentoring, supervision, peer reflection and self-care initiatives</li> <li>• continue involvement of people with a lived experience in PHN and HHS service planning, delivery and governance structures and extend this approach to other providers</li> </ul>
<p>1.5 Advocate for an expanded and more diverse regional lived experience workforce, across all levels of employment.</p>	<ul style="list-style-type: none"> <li>• undertake local research to better understand the existing profile of peer work and the peer workforce in the region</li> <li>• contribute to national and statewide initiatives to build the peer workforce</li> <li>• co-design and implement a Peer Workforce Development Strategy with relevant stakeholders and employers as part of the region's wider workforce needs assessment and development strategies (see chapter five)</li> <li>• identify and promote a comprehensive range of workplace roles for people with a lived experience in the mental health, suicide prevention and alcohol and other drug treatment services sectors</li> <li>• explore collaborative models for offering mentoring, supervision, peer reflection and self-care activities for the workforce of people with a lived experience</li> <li>• identify opportunities for peer workers to become service providers through the NDIS</li> </ul>

## 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 take into account service system impacts.

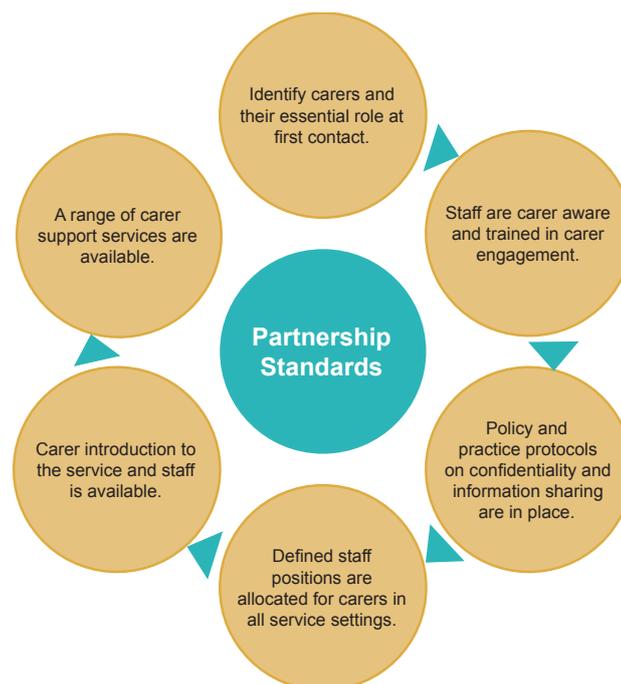


## 2. Supporting families and carers

### Introduction

Families 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, 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.

The carers support sector is currently going through significant reform, with the Australian Government proposing a new model of support for carers, the '*Integrated Carer Support Service*,'<sup>x1</sup> which has been developed in consultation with carers 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. From October 2018, carers will be able 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. From September 2019, the Australian Government will establish a new network of regional delivery partners to help carers 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 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 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.

Carers 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 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 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.	<ul style="list-style-type: none"> <li>• promote the Carer Gateway and regional Integrated Carer Support Service to carers locally</li> <li>• strengthen consumer and carer-centred practice, particularly at time of diagnosis, intake or admission to a service, by actively referring carers to support options and providing information for carers</li> <li>• ensure early involvement of carers in discharge and transition planning, working within privacy policies and procedures</li> </ul>
2.2 Better care for families and carers.	<ul style="list-style-type: none"> <li>• encourage providers to incorporate approaches such as the six partnership standards (see diagram on previous page) <sup>xii</sup> for working with carers and to undertake any associated self-assessment processes</li> <li>• develop a generic carer pathway for carers and review inclusion of carer information and supports in HealthPathways</li> <li>• encourage providers to nominate a named contact person for carers, such as a peer worker or carer liaison role</li> <li>• promote services and supports providing income and employment support to carers</li> </ul>
2.3 Families and carers are listened to and involved in services.	<ul style="list-style-type: none"> <li>• encourage providers to incorporate approaches such as the '<i>Triangle of Care</i>' <sup>xiii</sup> model where consumers, carers and providers work together as partners</li> <li>• inform the local development and roll out of the Integrated Carer Support Service, to ensure it meets the needs of carers of people experiencing mental illness, suicide risk and people experiencing problems related to the use of alcohol and other drugs</li> <li>• advocate for the full and effective involvement of carers in the NDIS, both at an individual and policy level</li> <li>• continue carer involvement in PHN and HHS service planning, delivery and governance structures and extend this approach to other providers</li> </ul>
2.4 Services are more responsive to the needs of people and carers.	<ul style="list-style-type: none"> <li>• provide education and training to providers on the perspectives of carers and on family-inclusive practice</li> <li>• improve service delivery so that practitioners have the requisite qualifications for their role and are matched to the level of need of the service consumer</li> <li>• facilitate improved access to mental health, suicide prevention and alcohol and other drug treatment services when and where service consumers need it</li> </ul>

## 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 take into account 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.<sup>4</sup>

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.<sup>xiii</sup> Prevention First defines promotion as “*enhancing social and emotional wellbeing and quality of life*” and prevention as “*reducing risk factors and enhancing protective factors.*”<sup>xliv</sup> The diagram below lists the components of promotion of wellbeing described in Prevention First.<sup>xlv</sup>



#### 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.

<sup>4</sup> 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.<sup>xlvi</sup> Many of these early deaths are due to physical diseases such as cardiovascular disease, cancer, diabetes and respiratory disease.<sup>xlvii</sup> 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.	<ul style="list-style-type: none"> <li>• support delivery of school-based programs that help young people to become more resilient</li> <li>• review evidence-informed resilience building interventions and promote effective options</li> <li>• promote beyondblue’s <a href="http://www.headsup.org.au">www.headsup.org.au</a> resource for workplaces</li> <li>• promote participation and collaboration in activities in the ‘<i>Prospectus: Mental Health Recovery and Clinical Programs</i>’</li> <li>• link people impacted on by domestic and family violence to mental health support as needed</li> </ul>
3.2 Prevent stigma.	<ul style="list-style-type: none"> <li>• work with statewide and national mental health organisations to implement their anti-stigma campaigns in Brisbane North</li> </ul>
3.3 Make better use of existing resources to promote mental health and prevent illness.	<ul style="list-style-type: none"> <li>• establish a regional mental health promotion and prevention action group</li> <li>• add value to implementation of statewide and national campaigns, through complementary regional work</li> <li>• organise and coordinate regional events for Mental Health Week</li> </ul>
3.4 Improve the physical health of people experiencing mental illness.	<ul style="list-style-type: none"> <li>• work with My Health for Life to enhance accessibility and suitability for people experiencing mental illness</li> <li>• encourage mental health services to develop a health promotion and prevention action plan, utilising the <i>Equally Well Consensus Statement</i><sup>xlviii</sup></li> </ul>
3.5 Support families and carers more effectively.	<ul style="list-style-type: none"> <li>• encourage family-inclusive practice in mental health, suicide prevention and alcohol and other drug treatment services</li> <li>• promote support services for families and carers widely, including via people with a lived experience</li> </ul>

## 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 take into account service system impacts.

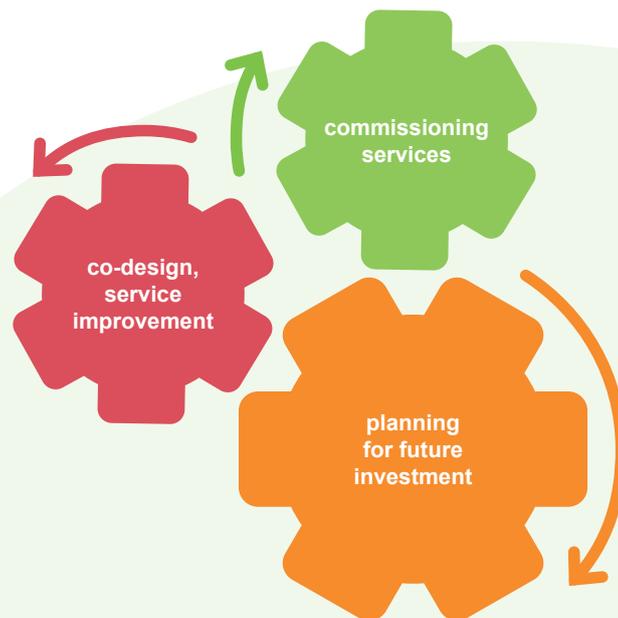


## 4. Commissioning services

### 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 the HHS); 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 stronger consumer 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 the HHS. Given this, there are some parts of the service system described above that we haven't 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 take into account 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 commit to development of a regional resourcing plan that will assess and prioritise these proposed new and extended services.

## 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 stronger consumer 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. Indigenous people), 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 Indigenous people, including through alignment with the Australian Government's *Social and Emotional Wellbeing Framework*.<sup>xlix</sup>

## 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 the HHS using a comprehensive process of data collation, analysis and stakeholder consultation.
- be developed through collaboration between Queensland Health, the PHN and the HHS and improve alignment of commissioning approaches between commissioning agencies.

Shared objectives	Actions over the next five years
<p>4.1 Align commissioning approaches between funding bodies.</p>	<ul style="list-style-type: none"> <li>• utilise the NMHSPF tools consistently across Brisbane North to help project demand for mental health services and required service configuration</li> <li>• use national and jurisdictional data sets for primary mental healthcare and alcohol and other drug treatment services, joint PHN and HHS needs assessments and other data, to collaboratively plan and co-design mental health, suicide prevention and alcohol and other drug treatment services</li> <li>• develop a joint regional resourcing plan between commissioning agencies that underpins and aligns commissioning</li> <li>• align funding approaches by key funding agencies, including scope, timing, service types, contract timeframes and reporting</li> <li>• explore the potential for coordinating commissioning between funding agencies</li> </ul>
<p>4.2 Improve commissioning approaches.</p>	<ul style="list-style-type: none"> <li>• develop funding approaches that focus on strengthening consumer outcomes</li> <li>• identify commissioning approaches that facilitate innovation and partner with people with a lived experience</li> <li>• explore options for providing funding for the full cost of service, including resources required for engagement and warm referral of all consumers accessing services</li> <li>• explore more flexible commissioning approaches that better fit the nature of services required, maximise collaboration and mitigate challenges associated with competitive tendering, including for Indigenous services</li> <li>• utilise funding agreements with providers to promote service improvements in the areas of lived experience participation, social determinants of health, recovery framework, family-inclusive practice, trauma-informed care, engagement, warm referral, service accessibility and evaluation</li> </ul>

## 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 take into account 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."* 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 (see page 17).

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 Indigenous service consumers, there needs to be greater representation of Indigenous people 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 experience.

Shared objectives	Actions over the next five years
5.1 Expand, diversify and better target services.	<ul style="list-style-type: none"> <li>• explore opportunities for expanding provision of community-managed mental health and alcohol and other drug treatment services</li> <li>• focus funding investment and service delivery on those groups in most need, including specific population groups, geographic communities and diagnosis groups</li> </ul>
5.2 Improve our service delivery.	<ul style="list-style-type: none"> <li>• identify options for establishing virtual and/or physical ‘hubs’ for people seeking mental health support and referral, including options incorporating peer service navigators</li> <li>• roll out a new electronic triage and referral tool for mental health called ‘rediCASE’ that will support GPs and service providers to connect people to the services that are right for them</li> <li>• using our stepped care framework, ensure regular review of needs of consumers accessing mental health services and connect consumers to services that best meet their changing needs and circumstances</li> <li>• strengthen our approaches to service delivery in the areas of recovery, harm minimisation and trauma-informed practice</li> <li>• explore approaches to shared clinical governance mechanisms to allow for agreed care pathways, referral mechanisms, quality processes and review of adverse events</li> </ul>

Shared objectives	Actions over the next five years
5.3 Align and integrate services.	<ul style="list-style-type: none"> <li>• review and align My Mental Health, and HealthPathways, in the context of Head to Health, to ensure services are well promoted and readily accessible</li> <li>• explore the development of an electronic shared record that can be accessed by service consumers, the HHS, primary healthcare practitioners and NGOs</li> <li>• review and further develop a clinical care pathway for people experiencing both mental illness and substance use issues</li> <li>• explore the need for establishing a care pathway for people experiencing mental illness and intellectual disability or autism</li> <li>• establish 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</li> <li>• 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</li> <li>• explore options for working with organisations delivering responses to eating disorders to inform and further develop regional service delivery models</li> </ul>
5.4 Skill up and diversify our workforce.	<ul style="list-style-type: none"> <li>• 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</li> <li>• develop and implement a strategy addressing the above workforce's identified needs</li> <li>• 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</li> <li>• create opportunities for the above workforce to network, build relationships, improve referral approaches and work in partnership</li> <li>• expand and develop the Indigenous workforce and peer workforce in mental health, suicide prevention and alcohol and other drug treatment services</li> <li>• 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)</li> </ul>

## 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 take into account service system impacts.



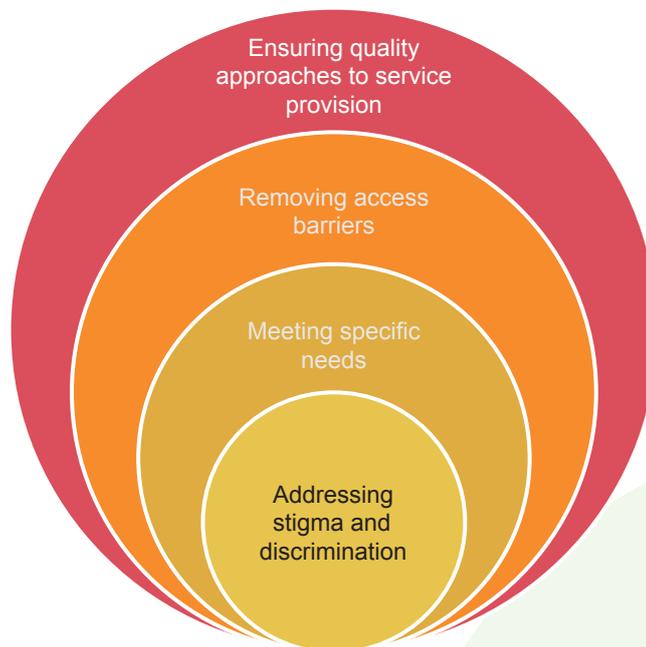
## 6. Responding to diversity

### Introduction

Brisbane North is a diverse community that is home to over 960,000 people.<sup>ii</sup> 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 Indigenous, 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.<sup>iii</sup> People who were born overseas represent almost one quarter of Brisbane North's population.<sup>iiii</sup> 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<sup>iv</sup> 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.<sup>lv</sup>

This chapter focuses on mental health and suicide prevention responses for these population groups, with the exception of responses meeting the needs of Indigenous people, 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.	<ul style="list-style-type: none"> <li>• develop and implement a strategy to address poor access to mental health services by people from culturally and linguistically diverse backgrounds</li> <li>• encourage providers across Brisbane North to adopt approaches such as the <i>Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery</i> <sup>lvi</sup></li> <li>• improve access to interpreter services by people from culturally and linguistically diverse backgrounds and their families and carers</li> </ul>
6.2 Facilitate better connections to healthcare for new arrivals.	<ul style="list-style-type: none"> <li>• empower culturally and linguistically diverse communities to develop community leaders who will support new arrivals to connect with mental health services</li> <li>• explore options for improving responses to mental health issues for new arrivals who have experienced trauma and/or torture</li> </ul>
6.3 Address affordability issues for those not eligible for healthcare through Medicare.	<ul style="list-style-type: none"> <li>• 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</li> </ul>
6.4 Improve the physical health of people from culturally and linguistically diverse backgrounds experiencing poor mental health.	<ul style="list-style-type: none"> <li>• encourage culturally and linguistically diverse service providers to promote physical health-related activities in the <i>'Prospectus: Mental Health Recovery and Clinical Programs'</i> <sup>lvii</sup></li> <li>• 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</li> </ul>

## 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.<sup>lviii</sup> 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 Ensure mental health and suicide prevention services are inclusive of LGBTIQ+ people and respond effectively to their needs.	<ul style="list-style-type: none"> <li>• develop web-based information that improves LGBTIQ+ people's access to mental health services</li> <li>• educate mental health services and healthcare practitioners about appropriate, inclusive, non-discriminatory approaches to working with LGBTIQ+ people</li> <li>• map LGBTIQ+ focused mental health and suicide prevention services and promote to GPs, psychologists and other healthcare providers</li> <li>• educate service providers and healthcare practitioners about mental health issues experienced by older HIV positive people who have been impacted on by early drug treatment regimes</li> </ul>
6.6 Build capacity of LGBTIQ+ services to adequately respond to needs.	<ul style="list-style-type: none"> <li>• assist LGBTIQ+ groups to enhance the quality and sustainability of supports they provide through improved linkages with mainstream services and GPs</li> </ul>
6.7 Prevent suicides amongst LGBTIQ+ people.	<ul style="list-style-type: none"> <li>• create timely, seamless referral pathways and warm referral processes between services for LGBTIQ+ people at risk of suicide and their carers</li> <li>• provide training on recognising and responding to suicidality to LGBTIQ+ people</li> <li>• as part of hospital admission and discharge planning, discuss connections to culturally appropriate services in the community, including community advocates</li> </ul>

## Older people: Improving responses for older people in Brisbane North

In 2017, the HHS and PHN developed 'A five year health care plan for older people who live in Brisbane North'<sup>lix</sup> 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 the HHS 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
<p>6.8 Expand and diversify mental health services for older people.</p>	<ul style="list-style-type: none"> <li>• obtain funding for and develop an evidence-based model of care to meet the sub-acute needs of psycho-geriatric consumers and clients as well as consumers and clients with challenging behaviours <sup>ix</sup></li> <li>• improve access to integrated specialist geriatric and psychiatric input for older people with mental illness <sup>ix</sup></li> <li>• support the provision of mental health services to older people with mental illness, including depression, living in residential aged care facilities</li> <li>• 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 <sup>ix</sup></li> </ul>
<p>6.9 Deliver high quality mental health and suicide prevention services for older people.</p>	<ul style="list-style-type: none"> <li>• develop a risk management approach for the detection of older people at risk of suicide <sup>ix</sup></li> <li>• educate GPs, service providers and carers on the relationship between mental health and physical health for older people and the need for more integrated services and responses across these two areas</li> <li>• 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</li> <li>• investigate establishment of 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 <sup>ix</sup></li> </ul>
<p>6.10 Support those caring for older people to sustain good mental health.</p>	<ul style="list-style-type: none"> <li>• implement strategies to better support carers, particularly ageing carers, using psychological services, peer support and other social supports</li> <li>• develop carers' skills in mental health and suicide prevention through targeted training</li> </ul>

## 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 take into account 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 experience and carers working together to improve quality, coordination and integration.





## 7. Aboriginal and Torres Strait Islander social and emotional wellbeing

### FACTS AND FIGURES

**30.1%** of Indigenous adults report high or very high levels of psychological distress, **nearly 3 times** the rate reported by other Australians.<sup>1</sup>

GPs report they are **2 to 3 times more likely** to manage mental health problems related to substance use in Indigenous patients than in other patients.<sup>2</sup>

The national suicide rate for Indigenous Australians is **twice** that of non-Indigenous Australians.<sup>3</sup>

For Indigenous Australians between 15 and 19 years of age, the suicide rate is **5 times higher** than for non-Indigenous Australians.<sup>4</sup>

Indigenous people with substance use, and/or mental health disorders, require a **greater number of episodes of care** to effectively treat their condition.<sup>5</sup>

### Introduction

The strategic context for delivering services supporting improved Aboriginal and Torres Strait Islander (Indigenous) 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 Indigenous peoples and provides a resource to support organisations delivering culturally and clinically appropriate mental health services for Indigenous people.<sup>lxi</sup>

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 Indigenous and non-Indigenous Queenslanders.<sup>lxii</sup> 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.<sup>lxiii</sup>

### What you told us<sup>5</sup>

Social and emotional wellbeing is the foundation for physical and mental health for Indigenous peoples. It is about a '*whole of life view*'<sup>lxiv</sup> 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 Indigenous people, 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.<sup>lxvi</sup> 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 Indigenous people and to provide care that spans medical, psycho-social and cultural support.

5 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

There has been insufficient attention to establishing an evidence base for Indigenous health programs and interventions focusing on social and emotional well-being.<sup>lxvii</sup> 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.<sup>lxviii</sup>

Reconciliation is about unity and respect between Indigenous and non-Indigenous Australians<sup>lxix</sup> and can be achieved through proactively building positive relationships, respect and trust. Racism has a negative effect on the social and emotional wellbeing of Indigenous people and is experienced by a significant proportion of Indigenous people in daily life.<sup>lxx</sup> Consultation highlighted that improving unity and respect between Indigenous and non-Indigenous Australians will help to address racism and improve health outcomes for Indigenous people.

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



Shared objectives	Actions over the next five years
7.1 Foster Indigenous leadership and engagement in planning, delivery and evaluation of services and programs.	<ul style="list-style-type: none"> <li>• ensure appropriate Indigenous representation on Brisbane North PHN's partnership and governance groups</li> <li>• establish additional avenues for input to services by people with a lived experience who are Indigenous and their carers</li> <li>• 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</li> </ul>
7.2 Increase cultural responsiveness amongst services and healthcare practitioners.	<ul style="list-style-type: none"> <li>• support the further development of social and emotional wellbeing teams <sup>lxxi</sup> within Aboriginal Community Controlled Health Services (ACCHSs), the HHS and NGOs</li> <li>• require PHN-commissioned services working with Indigenous people to embed the <i>Cultural Respect Framework</i> <sup>lxxii</sup> and <i>Social and Emotional Wellbeing Framework</i> <sup>lxxiii</sup> into their organisational systems and processes and encourage providers across the region to adopt these or similar approaches</li> <li>• provide cultural responsiveness training to GPs, other medical practitioners, mainstream service providers and healthcare practitioners working in forensic settings</li> <li>• identify and promote best practice case studies of cultural responsiveness</li> <li>• continue to develop Indigenous-specific mental health, suicide prevention and alcohol and other drug use care pathways in HealthPathways and ensure they are culturally responsive</li> </ul>
7.3 Improve accessibility of mental health services for Indigenous people.	<ul style="list-style-type: none"> <li>• work with relevant organisations and services to review and improve the NDIS's processes for Indigenous people</li> <li>• explore options for making 'soft entry' available through a greater number of mainstream mental health services, including through use of an Indigenous worker as first point of contact for Indigenous service consumers</li> <li>• strengthen partnerships between ACCHSs and general practices offering after hours care</li> <li>• review eligibility criteria for PHN-commissioned mental health services to identify and resolve any access barriers for Indigenous people</li> </ul>
7.4 Strengthen integration between services working with Indigenous people.	<ul style="list-style-type: none"> <li>• 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</li> <li>• establish linkages between ACCHSs and mainstream mental health services, including community mental health, alcohol and other drug treatment services, primary healthcare practitioners and psychiatrists</li> <li>• increase the range of primary healthcare services readily accessible by Indigenous people by improving provider partnerships</li> </ul>
7.5 Invest in an evidence base for Indigenous mental health, social and emotional wellbeing services and programs.	<ul style="list-style-type: none"> <li>• review the methodology for the regional population health survey to explore opportunities for culturally responsive data collection on mental health and wellbeing of Indigenous peoples</li> <li>• strengthen the focus on services delivered to Indigenous people by better harnessing available data on Indigenous health, including from the HHS's integrated health information system</li> <li>• ensure investments in new or existing Indigenous 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</li> </ul>

Shared objectives	Actions over the next five years
7.6 Reconciliation between Indigenous and non-Indigenous Australians.	<ul style="list-style-type: none"> <li>• require all PHN and Queensland Health funded mental health services to demonstrate effective strategies for improving cultural responsiveness and accessibility to services by Indigenous people</li> <li>• hold regular networking and best practice forums for Indigenous and non-Indigenous healthcare staff</li> <li>• establish an interchange program between mainstream and Indigenous health services</li> </ul>
7.7 Recognise that racism and discrimination are key social determinants of health for Indigenous people.	<ul style="list-style-type: none"> <li>• 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</li> <li>• use regional publications and newsletters to educate people about the effects of racism on healthcare for Indigenous people</li> </ul>
7.8 Respond to service gaps for Indigenous people.	<ul style="list-style-type: none"> <li>• identify options for culturally responsive residential rehabilitation services for Indigenous people experiencing substance abuse and for support to successfully transition people exiting these facilities into the community</li> <li>• explore the potential to extend existing outreach models delivered by mental health services to provide Indigenous people with support about living skills</li> <li>• investigate options for safe places for those living with people with alcohol and other drug dependence and/or mental health issues</li> <li>• assess national models for patient transport services and available existing local resources that assist with transport to improve access to healthcare</li> <li>• explore options for services that better respond to the needs of Indigenous children and young people experiencing mental health issues, and to their families</li> <li>• advocate for increased funding to improve and expand safe accommodation for homeless Indigenous people living with mental health and alcohol and other drug use issues</li> </ul>

## 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 take into account 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.<sup>1</sup>

People living in areas with higher levels of socioeconomic disadvantage are **more likely to smoke** than those living in areas with lower levels of socioeconomic disadvantage.<sup>2</sup>

**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.<sup>3</sup>

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

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.<sup>5</sup>

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

### Introduction

The strategic setting for alcohol and other drug treatment services varies from that for mental health and suicide prevention with national priorities drawn from the *National Drug Strategy 2017-2026*.<sup>lxxiv</sup> These specialist alcohol and other drug 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 *Improving mental health and wellbeing: Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019* provides the strategic setting for Queensland's alcohol and other drug treatment services alongside Queensland Health's *Connecting care to recovery*.<sup>lxxv</sup>

### 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.

Increased collaboration was also proposed between alcohol and other drug treatment services and other services to establish more integrated service responses for people requiring treatment, including enhanced referral pathways and warm referrals that assist service consumers to have their needs more appropriately met.

Stigma and discrimination create barriers for people experiencing problems related to their alcohol and other drug use that prevent them from seeking assistance. Consultation participants reported that this is particularly the case for people using illicit substances or whose alcohol and other drug use is exacerbated by other factors such as mental illness, domestic violence, homelessness or poverty. Consultation participants also highlighted that the impact of this stigma and discrimination is further compounded for LGBTIQ+ people, people from culturally and linguistically diverse backgrounds and Indigenous people. These discriminatory and stigmatising practices serve to hinder engagement in critical areas of life, such as employment and reconnection with community.

Consultation results indicated that a greater range of training and development opportunities to build worker capabilities and confidence is required to enable delivery of the diverse care needed to address broad-ranging and complex consumer needs. In addition, the significant growth in mental health diagnoses, alongside problematic alcohol and other drug use, requires specialised skills in both the alcohol and other drug treatment and mental health workforces. Consultation participants proposed that clinical staff need both alcohol and other drug and mental health knowledge and all staff with a consumer contact role in human services, irrespective of the role or field in which they are employed, should have basic knowledge about alcohol and other drug use so they can identify opportunities for early intervention.

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

Problematic substance use by people as a result 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.	<ul style="list-style-type: none"> <li>• 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</li> <li>• deliver an education campaign for GPs on the use of HealthPathways, and the Alcohol and Drug Information Service, in assisting them to support patients experiencing problems related to the use of alcohol and other drugs</li> </ul>
8.2 Build a region-wide commitment to challenging stigmatising and discriminatory practices.	<ul style="list-style-type: none"> <li>• develop and promote a best practice guide that educates service providers and the media on appropriate language when referring to people with alcohol and other drug issues</li> <li>• engage with media on use of inappropriate language in media coverage</li> <li>• 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</li> </ul>
8.3 Skill up our workforce.	<ul style="list-style-type: none"> <li>• 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</li> <li>• revive communities of practice for front-line alcohol and other drug treatment services' workers</li> <li>• increase investment in professional development that builds capability to respond to complex alcohol and other drug use and mental health issues</li> <li>• build capability of school staff to recognise and respond to alcohol and other drug issues for students and colleagues</li> </ul>

Shared objectives	Actions over the next five years
<p>8.4 Support effective alcohol and other drug service delivery responses.</p>	<ul style="list-style-type: none"> <li>• use service delivery data to increase understanding of consumer needs and improve service delivery</li> <li>• identify regional research priorities relating to problematic use of alcohol and other drugs</li> <li>• 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</li> <li>• support family inclusive approaches to delivery of alcohol and other drug treatment services</li> <li>• advocate for inclusion of gender identity and sexuality data in the <i>Alcohol and Other Drug Treatment Services National Minimum Data Set</i></li> </ul>
<p>8.5 Improve services for at risk groups.</p>	<ul style="list-style-type: none"> <li>• support integrated, culturally responsive alcohol and other drug services</li> <li>• support collaboration and referrals between the community controlled sector and mainstream alcohol and other drug treatment services</li> <li>• 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</li> <li>• promote use of 'throughcare' that links pre- and post-release programs for people leaving prison or youth detention, including for Indigenous people</li> <li>• 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</li> <li>• link youth and 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</li> <li>• provide LGBTIQ inclusion training to mainstream treatment providers and explore opportunities for LGBTIQ peer services</li> </ul>

## 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 take into account service system impacts.





## 9. Infants, children, young people and families

### FACTS AND FIGURES

In 2018, an estimated **5,129 children and young people** in Brisbane North are expected to experience severe mental illness and to require treatment for this.<sup>1</sup>

An estimated **30,007 children and young people** in Brisbane North are expected to experience moderate or mild mental illness in 2018.<sup>2</sup>

**80% of children and young people** experiencing moderate mental illness and 50% experiencing mild mental illness will require treatment.<sup>3</sup>

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.<sup>4</sup>

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.<sup>5</sup>

### Introduction

Increasingly, governments, policy makers and researchers recognise the importance of getting a good start in life and so focus on early intervention, making supporting and improving the wellbeing of infants, children, young people and their families a critical area. For example, the Queensland Mental Health Commission's *Early action: Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan 2015-2017* emphasises that 'starting well' and 'developing and learning well' in life, as well as intervening early, are critical.<sup>lxxvi</sup>

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 child care 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

A healthy early childhood is fundamentally linked to long-term health outcomes, making support for a range of needs, including mental health, vital early on in a mother's pregnancy and in a child's life. Consultation highlighted that the mental health needs of infants, children, young people and their families span healthcare, psycho-social and other fields and yet there is no well-integrated way for them to access the assistance they need. Healthcare has no formal links to psycho-social support and vice versa. Families are often sent in the wrong direction, for example to mental health services, when their primary concern is housing or to family support services when they require assistance with a mental health issue.

Consultation also emphasised that timely and effective assessment of the needs of infants, children and their families is critical. During early childhood, the overlap between different aspects of health (e.g. developmental disability and mental health conditions) may be more pronounced, making it difficult to identify appropriate assessment options. There are insufficient accessible, affordable assessment options and, at times, families experience varied and conflicting assessment outcomes depending on the assessor's background. In addition, incentives for specific assessment outcomes vary, sometimes perversely. For example, some assessment outcomes may result in differing levels of classroom resources for schools but not in appropriate or adequate treatment or support options for infants, children and their families.

Consultation participants also reported that perinatal mental illness is a significant factor impacting on infant, child and youth mental health. Access to treatment and support for those

experiencing perinatal mental illness, as well as to 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.

Young people may experience heightened vulnerability for many reasons including homelessness, domestic violence or family breakdown, feeling suicidal or undertaking self-harm, transitioning between different systems (e.g. from child to adult mental health services or out of the child safety system) or experiencing concurrent mental health and alcohol and other drug use issues. However, services and healthcare practitioners are not always able to readily respond to vulnerable young people with complex needs and their families.

Consultation participants indicated that schools are well placed to reach many children and young people requiring assistance, but also perceived that existing services are frequently disconnected from the school system. This points to the need for removal of barriers to delivering services in schools, allowing for more coordinated care and an integrated approach between services and sectors.

Shared objectives	Actions over the next five years
9.1 Deliver better infant and perinatal support.	<ul style="list-style-type: none"> <li>• identify service and workforce gaps and develop responses to them</li> <li>• strengthen assessment of infants and young children, including in Moreton Bay and for children in out of home care</li> <li>• identify and promote best practice approaches to perinatal mental health in primary health care</li> </ul>
9.2 Deliver more effective services to infants, children, young people and their families.	<ul style="list-style-type: none"> <li>• review configuration of child and youth mental health services and respond to findings</li> <li>• strengthen referral pathways between GPs and Intensive Family Support and Family and Child Connect Services</li> <li>• improve services for vulnerable infants, children and families, including Indigenous families and families from culturally and linguistically diverse backgrounds</li> <li>• coordinate existing services more effectively</li> <li>• enhance planning and collaboration mechanisms</li> </ul>
9.3 Improve outcomes for vulnerable young people.	<ul style="list-style-type: none"> <li>• establish better suicide prevention responses for young people</li> <li>• enhance delivery of existing youth services</li> <li>• improve service responses for diverse groups of vulnerable young people including those young people who identify as Indigenous, come from culturally and linguistically diverse backgrounds and are LGBTIQ+</li> </ul>
9.4 Make more school-based services available.	<ul style="list-style-type: none"> <li>• develop protocols enabling delivery of services in schools by private healthcare practitioners and NGOs</li> <li>• identify existing private healthcare practitioners and NGOs able to deliver services in schools</li> <li>• support the Australian Government funded <i>National Education Initiative</i> and reconfigure services and activities in the context of the Initiative</li> </ul>

## 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 take into account service system impacts.



## 10. Psychological therapies

### FACTS AND FIGURES

An estimated **22,000 adults** (18 to 65 years of age) in Brisbane North are expected to experience severe mental illness in 2018, all of whom are expected to require treatment.<sup>1</sup>

An estimated **93,000 adults** in Brisbane North are expected to experience moderate or mild mental illness in 2018, with 25,000 adults expected to require treatment for moderate illness and 31,000 for mild mental illness.<sup>2</sup>

**15,600 adults over 65 years of age** in Brisbane North are expected to experience moderate or mild mental illness in 2018, with 4,500 expected to require treatment for moderate mental illness and 5,000 for mild mental illness.<sup>3</sup>

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 subsidised GP mental health services.<sup>4</sup>

### 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 consumers using psychological therapies in Brisbane North, including about the modality or type of practitioner consumers 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 consumers' needs and expectations.

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: Indigenous people; 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.<sup>lxxvii</sup> 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*.'<sup>lxxviii</sup>

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
<p>10.1 Better align psychological therapies with consumer preferences and needs, including for specific population groups that cannot access appropriate options.</p>	<ul style="list-style-type: none"> <li>• research consumer preferences and needs and promote findings of this research</li> <li>• align existing and newly-commissioned services with:               <ul style="list-style-type: none"> <li>– consumer preferences and needs on modality of delivery, access hours and type of practitioner</li> <li>– the needs of specific population groups that cannot access appropriate options</li> </ul> </li> <li>• develop, trial and evaluate an incentivised community-based service delivery model for specific population groups in Moreton Bay North</li> </ul>
<p>10.2 Align with our stepped care framework through improved integration between psychological therapies and community services.</p>	<ul style="list-style-type: none"> <li>• develop an education strategy for GPs, other healthcare practitioners and NGOs on psychological therapies, including low intensity psychological therapies</li> <li>• identify options for improving integration between community services and psychological therapies</li> <li>• promote examples enhancing integration between community services and psychological services</li> <li>• commission outcomes-focused practice models that achieve greater integration between psychological and community support services</li> </ul>
<p>10.3 Develop, diversify and geographically redistribute the workforce delivering psychological therapies.</p>	<ul style="list-style-type: none"> <li>• increase delivery of psychological therapies in high need geographic areas by improving workforce distribution</li> <li>• improve use of e- and tele-mental health services in high need areas</li> <li>• increase the number of skilled peers and students delivering low intensity psychological services for hard to reach population groups</li> </ul>
<p>10.4 Improve evidence base for effective psychological therapies.</p>	<ul style="list-style-type: none"> <li>• 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)</li> <li>• publish and share findings about effective use of psychological therapies as part of stepped care framework</li> </ul>
<p>10.5 Facilitate promotion and use of evidence-informed approaches addressing stigma associated with accessing psychological therapies</p>	<ul style="list-style-type: none"> <li>• identify low cost methods of effectively promoting evidence-informed approaches to reducing stigma across the community, including to different population groups</li> </ul>

## 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 take into account 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.<sup>1</sup>

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.<sup>2</sup>

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

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.<sup>4</sup>

### 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 the HHS's 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 the HHS'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*.<sup>lxxix</sup>

### 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.<sup>lxxxi</sup> 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 urgently needed to plan for, and maximise, successful transition to the NDIS for both potential NDIS participants<sup>6</sup> and NGO service providers.

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.

<sup>6</sup> The NDIS uses the term 'participant' to describe people utilising services and supports funded through the NDIS.

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.'*<sup>1bxxxii</sup>

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 as 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.	<ul style="list-style-type: none"> <li>• develop an action plan to address the physical health needs of people with severe and complex mental illness in our region</li> <li>• promote the use of <i>My Health Record</i> to people with severe and complex mental illness, and to service providers, to improve information sharing between services and healthcare practitioners on physical health</li> <li>• promote physical health related activities on <i>My Mental Health</i> and through other avenues</li> <li>• revise HealthPathways Tool for mental illness to include information about physical health</li> </ul>
11.2 Assist people experiencing severe and complex mental illness to access and sustain safe, secure and affordable housing.	<ul style="list-style-type: none"> <li>• establish linkages with the housing and homelessness sectors and the NDIS either through existing networks or establishment of a Housing Working Group</li> </ul>
11.3 Support successful transition to the NDIS in Brisbane North.	<ul style="list-style-type: none"> <li>• develop a Brisbane North Action Plan that addresses issues relating to transition to the NDIS, including participant, service and workforce needs</li> <li>• ensure ongoing support for people with a psycho-social disability who are not eligible for the NDIS, including referrals to existing community mental health support programs</li> </ul>
11.4 Foster community connections by people experiencing severe and complex mental illness and assist them to lead a <i>'contributing life.'</i> <sup>1bxxxiii</sup>	<ul style="list-style-type: none"> <li>• review existing qualitative and quantitative research into the needs of people experiencing severe and complex mental illness for social and economic inclusion and identify need for any further local research</li> <li>• develop an action plan to address the social and economic needs of people with severe and complex mental illness as identified from the research's findings</li> <li>• encourage all services to use <i>My Mental Health</i> to advertise social and economic inclusion activities</li> </ul>

Shared objectives	Actions over the next five years
11.5 Establish alternatives to hospital EDs for people experiencing severe and complex mental illness who are distressed.	<ul style="list-style-type: none"> <li>• promote the use of safety planning tool for people who experience high levels of distress</li> <li>• establish a network of Safe Spaces, initially in the Moreton Bay region</li> <li>• secure further funding to design and establish Safe Space initiatives in our region</li> </ul>
11.6 Improve the experience of people transitioning between hospital and the community.	<ul style="list-style-type: none"> <li>• implement recommendations on improving admissions, hospital stays and discharge planning</li> <li>• connect patients with appropriate non-government services while in hospital</li> <li>• promote shared responsibility for supporting clients to gain skills for community living while inpatients are preparing for discharge (e.g. the HHS's clinical services, funded NGOs, NDIS supports)</li> </ul>
11.7 Improve services for people experiencing borderline personality disorder (BPD).	<ul style="list-style-type: none"> <li>• develop a best practice model to provide a full range of services across the continuum of care</li> </ul>

## 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 take into account service system impacts.





## 12. Suicide prevention

### FACTS AND FIGURES

Suicide remains the leading cause of death for Australians aged between **15 and 44 years**.<sup>1</sup>

Suicide rates among Indigenous Australians are **at least twice** that of non-Indigenous Australians.<sup>2</sup>

Suicide attempts are **3 times more likely** for LGBTI people than for the general population.<sup>3</sup>

The suicide attempt rate is **10.7% for women**, compared to **4.5% for men**.<sup>4</sup>

Men are **3 times more likely** to die as a result of suicide than women.<sup>5</sup>

**49.2% of Queenslanders** who died by suicide between 2002 and 2011 had at least **1 diagnosable mental illness** and **1 in 4 had consulted a health professional** about their mental health in the 3 months before they suicided.<sup>6</sup>

### Adopting a systems approach

The *Fifth National Mental Health and Suicide Prevention Plan* (the 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.<sup>lxxxvii</sup>

### What you told us

Consultation flagged 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 and so often people do not receive the right care in the right place at the right time. Consultation participants proposed a care pathway is developed that points people to the right options. People who have attempted suicide often present to hospital EDs. Consultation participants identified numerous issues about EDs and indicated the following changes are needed:

- 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 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.

Consultation also highlighted that people currently experiencing a suicidal crisis, or who have attempted suicide, are not receiving timely follow-up care. The first 24 hrs, first week and first few

months after a suicide attempt are considered to be the highest risk times. However, people at risk of suicide are reported as frequently needing to wait at least a few days, and up to a few weeks, before they can access counselling or support. Examples cited included that: the mental health system does not have sufficient follow up capacity; people must wait to access a GP for referral to a counsellor, who may also have a wait time; and services that can respond to factors that may be contributing to a suicide attempt, such as job loss, housing issues or relationship breakdowns, are not always readily available.

The need for much improved suicide prevention services offering more person-centred, comprehensive and coordinated care was also reported by consultation participants. That is, 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.

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 in responding to their circumstances and with 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')<sup>lxvii</sup>, 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.

Shared objectives	Actions over the next five years
12.1 Improve and integrate suicide prevention responses on a systems-wide basis in Brisbane North.	<ul style="list-style-type: none"> <li>• continue implementation, delivery, monitoring and evaluation of initiatives and services funded through the <i>Australian Government's National Suicide Prevention Trial 2017-2019</i><sup>7</sup></li> <li>• identify suicide hotspots and high risk suburbs and explore opportunities for strategic placement of help-seeking information</li> <li>• finalise a suicide prevention pathway in HealthPathways<sup>8</sup></li> <li>• develop, and promote to all Brisbane North organisations, a template for a suicide prevention and postvention plan that incorporates workplace wellness and postvention strategies</li> </ul>
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.	<ul style="list-style-type: none"> <li>• implement the <i>Zero Suicide in Healthcare Multi-site Collaborative</i><sup>9</sup></li> <li>• promote the new <i>Clinical practice guidelines for engaging with and responding to the needs of the suicidal person</i> among ED staff</li> <li>• continue the roll out of the <i>Suicide Risk Assessment and Management in an Emergency Department Setting (SRAM-ED)</i> training for ED staff across the region; continue current data collection; and improve local data collection methods</li> <li>• seek funding to test and evaluate evidence-informed approaches for involving people with a lived experience of suicide as a resource in EDs, including those approaches locating peer support workers in EDs</li> <li>• explore options to improve care pathways for people experiencing a suicidal crisis and who are currently arriving at ED by ambulance</li> <li>• 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)</li> </ul>

<sup>7</sup> Brisbane North is a trial site for the Australian Government's National Suicide Prevention Trial 2017-2019.

<sup>8</sup> This action aligns with the work of the Queensland Suicide Prevention Health Taskforce.

<sup>9</sup> 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
12.3 Establish innovative, assertive follow-up suicide prevention service delivery models that utilise lived experience.	<ul style="list-style-type: none"> <li>• identify and prioritise funding for additional assertive follow-up services and for services providing holistic support</li> <li>• expand capacity of existing providers of specialist suicide prevention services to provide, and make referrals to, person-centred, comprehensive and coordinated support</li> <li>• develop suicide prevention service delivery models utilising peer service navigators</li> </ul>
12.4 Increase accessibility of care after a suicide attempt for vulnerable population groups.	<ul style="list-style-type: none"> <li>• develop and deliver accessible services to vulnerable populations, such as homeless people and disadvantaged young people, through mobile suicide prevention outreach services</li> <li>• improve integration of, and connection between, existing services focusing holistically on social determinants of health and suicide prevention services</li> <li>• undertake service mapping to identify current suicide prevention support services and service gaps for veterans and their families</li> <li>• develop and fund specialised bereavement support groups for different cohorts, including for veterans and/or their families</li> <li>• explore strategies for how people experiencing relationship difficulties (i.e. the life event most frequently reported as associated with suicide) can be proactively supported</li> </ul>
12.5 Improve access to high quality local suicide prevention services, information and resources.	<ul style="list-style-type: none"> <li>• enhance, and make more accessible, support for families and carers of people who are suicidal, and others bereaved by suicide</li> <li>• adjust service models to enable suicide prevention services to provide after hours and weekend services</li> <li>• develop a register of professionals who have successfully completed advanced suicide prevention training</li> </ul>
12.6 Increase community knowledge about, and skills in, recognising and responding to suicidality.	<ul style="list-style-type: none"> <li>• explore and develop a strategy to better support people who are engaged with the Family Court and have child custody issues</li> <li>• explore opportunities to deliver community education on recognising, and responding to, someone who may be at risk of suicide</li> <li>• raise awareness of frontline workers, including Family Court staff, about training in recognising and responding to suicidality</li> <li>• increase opportunities for community members to be involved in suicide prevention efforts by safely sharing their lived experience</li> </ul>
12.7 Better equip GPs and other professionals to identify and support people at risk of suicide.	<ul style="list-style-type: none"> <li>• facilitate opportunities for GPs to be informed of, and knowledgeable about, the new <i>Clinical practice guidelines for engaging with and responding to the needs of the suicidal person</i> used in hospital EDs</li> <li>• encourage GPs to utilise rediCASE (see pages 20 and 36) and the planned HealthPathways referral pathway to assist them to better match people at risk of suicide with the right services</li> <li>• increase the suicide prevention knowledge and skills of GPs and other professionals in the region, to enable more effective and efficient responses to people experiencing suicidality and appropriate on-referral</li> </ul>

Shared objectives	Actions over the next five years
12.8 Ensure delivery of school-based suicide prevention programs for young people.	<ul style="list-style-type: none"> <li>• deliver evidence-informed suicide prevention programs in schools where these programs are not currently available</li> <li>• support the roll out of the National Education Initiative and identify training opportunities for school staff through the Initiative</li> </ul>

## 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 take into account service system impacts.

## Part D

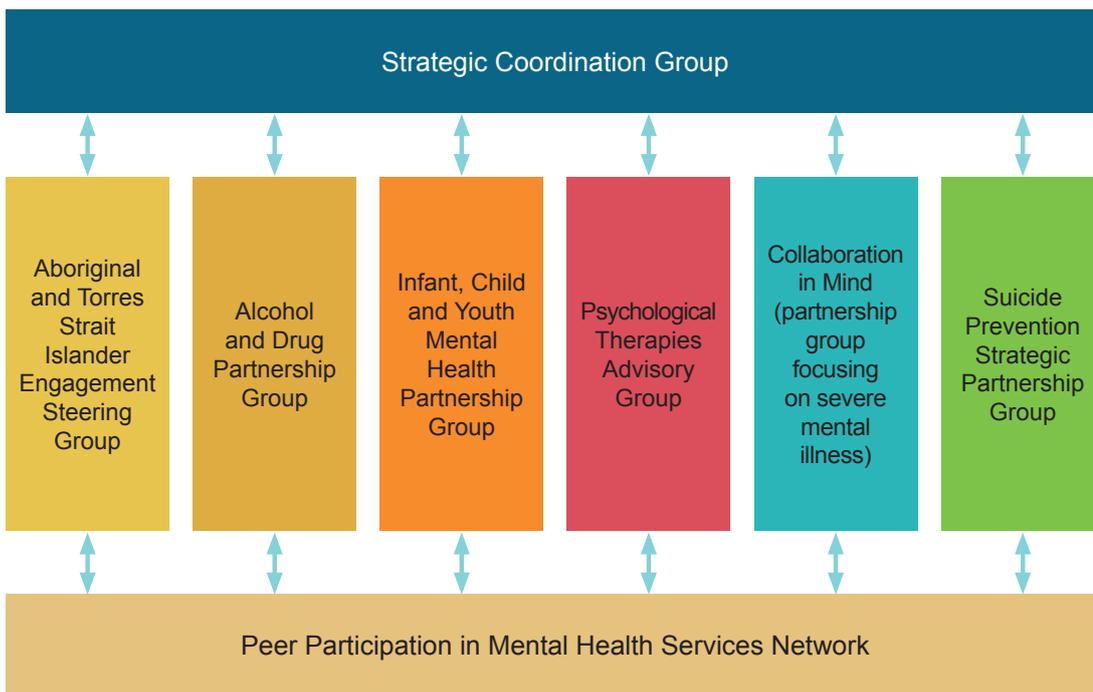
# MEASURING, MONITORING, REPORTING

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 HHS, 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 experience, Brisbane North PHN, the HHS, 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.	<ul style="list-style-type: none"> <li>• establish a Strategic Coordination Group as the overarching governance structure</li> <li>• ensure that governance structures for the Plan provide authentic opportunities for participation of, and collaboration with, people with a lived experience</li> <li>• establish and sustain multi-sector partnership groups in six key focus areas outlined above</li> </ul>

## 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 Three). 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

This Plan has been developed as a five year Plan. Over this time, healthcare needs in Brisbane North and our policy and service delivery environment will change, and progress on implementing the Plan's objectives will also be made. Given this, the Strategic Coordination Group will identify opportunities for updating and refreshing the Plan, as well as commit to a mid-term review of the Plan.

Shared objectives	Actions over the next five years
14.1 Measure and report on our progress against the Plan.	<ul style="list-style-type: none"> <li>• develop success and outcome measures and measure progress against the Plan</li> <li>• establish a reporting approach, using Implementation Plans, to support governance groups to monitor performance against the Plan</li> </ul>
14.2 Strengthen our outcomes approach.	<ul style="list-style-type: none"> <li>• develop impact and outcome evaluation indicators for mental health at the individual, service and system levels</li> <li>• implement the Queensland alcohol and other drug outcomes framework</li> </ul>
14.3 Drive service and system improvement through better use of data and evaluation.	<ul style="list-style-type: none"> <li>• develop a process to collaboratively utilise data and evaluation to drive service and system improvement</li> <li>• identify and implement a common consumer experience tool across the HHS, the PHN and community managed services</li> </ul>
14.4 Refresh and review the Plan.	<ul style="list-style-type: none"> <li>• identify and realise opportunities to 'refresh' and update the Plan</li> <li>• undertake a mid-term review of the Plan</li> </ul>



# 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	<i>National Mental Health Commission, Contributing lives, thriving communities: Report of the National Review of Mental Health Programmes and Services (Vol. 1).</i>	<ul style="list-style-type: none"> <li>• The mental health service system has fundamental structural shortcomings.</li> <li>• The impact of this poorly planned and badly integrated system is a drain on people’s wellbeing and participation in community.</li> <li>• 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).</li> <li>• Funds for people with severe and persistent mental health problems must be repackaged to become integrated packages of services.</li> <li>• The system needs to move to one which is easily navigable; involves people with a lived experience, and their carers, in decisions; focuses on outcomes; responds to whole-of-life needs; and is proactive and strategically aligned.<sup>lxxxix</sup></li> </ul>
	<i>Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Services and Programs.</i>	<ul style="list-style-type: none"> <li>• Points to “<i>fragmentation, inefficiency, duplication and a lack of planning and coordination at a local level</i>” in the mental health service system.</li> <li>• 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.</li> <li>• Outlines nine interconnected areas of reform:               <ol style="list-style-type: none"> <li>1. Locally planned and commissioned mental health services through PHNs.</li> <li>2. A new digital mental health gateway.</li> <li>3. Refocusing primary mental health services to support a stepped care model.</li> <li>4. Joined up support for child mental health.</li> <li>5. An integrated and equitable approach to youth mental health.</li> <li>6. Integrating Indigenous mental health and social and emotional wellbeing services.</li> <li>7. A renewed approach to suicide intervention.</li> <li>8. Improving services and coordination of care for people with severe and complex mental illness.</li> <li>9. National leadership in mental health reform.<sup>xc</sup></li> </ol> </li> </ul>

### Summary of strategy and policy drivers

Source	Policy/strategy document	Examples of key messages
	<p><i>The Fifth National Mental Health and Suicide Prevention Plan.</i></p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• The Plan establishes eight priorities:               <ol style="list-style-type: none"> <li>1. Achieving integrated regional planning and service delivery.</li> <li>2. Effective suicide prevention.</li> <li>3. Coordinating treatment and supports for people with severe and complex mental illness.</li> <li>4. Improving Indigenous mental health and suicide prevention.</li> <li>5. Improving the physical health of people living with mental illness and reducing early mortality.</li> <li>6. Reducing stigma and discrimination.</li> <li>7. Making safety and quality central to mental health service delivery.</li> <li>8. Ensuring that the enablers of effective system performance and system improvement are in place.<sup>xci</sup></li> </ol> </li> </ul>
	<p><i>National Drug Strategy 2017-2026.</i></p>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• The Plan proposes a balanced approach across the three pillars of harm minimisation: demand reduction; supply reduction; and harm reduction.</li> <li>• Priority actions are to:               <ol style="list-style-type: none"> <li>1. Enhance access to evidence-informed, effective and affordable treatment.</li> <li>2. Develop and share data and research, measure performance and outcomes.</li> <li>3. Develop new and innovative responses to prevent uptake, delay first use and reduce alcohol, tobacco and other drug problems.</li> <li>4. Increase participatory processes.</li> <li>5. Reduce adverse consequences.</li> <li>6. Restrict and/or regulate availability.</li> <li>7. Improve national coordination.</li> </ol> </li> <li>• People with mental health conditions are one of the priority populations identified by the Strategy.<sup>xcii</sup></li> </ul>

## Summary of strategy and policy drivers

Source	Policy/strategy document	Examples of key messages
Queensland Government	<i>Improving mental health and wellbeing: Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019.</i>	<ul style="list-style-type: none"> <li>• 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.”</li> <li>• The Plan establishes four pillars of reform:               <ol style="list-style-type: none"> <li>1. Better services for those who need them, when and where they need them.</li> <li>2. Better awareness, prevention and early intervention to reduce the incidence, severity and duration of problems.</li> <li>3. Better engagement and collaboration to improve responsiveness to individual and community needs.</li> <li>4. Better transparency and accountability to ensure the system is working as intended and in the most effective, efficient way possible.</li> </ol> </li> <li>• Eight shared commitments are also established to address immediate priorities:               <ol style="list-style-type: none"> <li>1. Engagement and leadership priorities for individuals, families and carers.</li> <li>2. Awareness, prevention and early intervention.</li> <li>3. Targeted responses in priority areas.</li> <li>4. A responsive and sustainable community sector.</li> <li>5. Integrated and effective government responses.</li> <li>6. More integrated health service delivery.</li> <li>7. Mental Health, Drug and Alcohol Services Plan.</li> <li>8. Indicators to measure progress towards improving mental health and wellbeing.<sup>xciii</sup></li> </ol> </li> </ul>
	Queensland Health, <i>My health, Queensland's future: Advancing health 2026.</i>	<ul style="list-style-type: none"> <li>• <i>My health, Queensland's future: Advancing health 2026 (My health)</i> 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.</li> <li>• 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.</li> <li>• My health establishes four directions:               <ol style="list-style-type: none"> <li>1. Promoting wellbeing.</li> <li>2. Delivering healthcare.</li> <li>3. Connecting healthcare.</li> <li>4. Pursuing innovation.</li> </ol> </li> <li>• For each of these four directions, focus areas are established as well as headline success measures.<sup>xciv</sup></li> </ul>

### Summary of strategy and policy drivers

Source	Policy/strategy document	Examples of key messages
	<p><i>Connecting care to recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services.</i></p>	<ul style="list-style-type: none"> <li>• Through <i>Connecting care to recovery</i>, Queensland Health aims to embed the directions outlined in <i>My health, Queensland's future: Advancing health 2026</i> and continue building more person-centred and recovery-oriented services in the mental health and alcohol and other drug services system by:               <ul style="list-style-type: none"> <li>» promoting wellbeing</li> <li>» delivering health care</li> <li>» connecting healthcare</li> <li>» pursuing innovation.</li> </ul> </li> <li>• <i>Connecting care to recovery</i> 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 <i>My health, Queensland's future: Advancing health 2026</i> by focusing effort across five priority areas:               <ul style="list-style-type: none"> <li>» access to appropriate services as close to home as practicable and at the optimal time</li> <li>» workforce development and optimisation of skills and scope.</li> <li>» better use of ICT to enhance clinical practice, information sharing, data collection and performance reporting</li> <li>» early identification and intervention in response to suicide risk.</li> </ul> </li> </ul> <p>strengthening patient's rights under the <i>Mental Health Act 2016</i>.<sup>xcv</sup></p>

## Appendix Two: 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, HHS, government organisations, service providers, healthcare practitioners, carer and consumer representatives.
Consumer and Carer 'Blue Sky' Symposia	50	50	Consumers, 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, carers, peer workers.
PHN consumer and carer meeting	15	15	Consumers, carers.
Workforce development framework meeting	5	5	Deloitte, PHN, HHS, Brook RED.
Peer Participation Network meeting	45	45	Consumers, carers, peer workers.
Lived Experience Forum	50	50	Queensland Mental Health Commission, consumers, carers.
Health Consumers Queensland Annual Forum	200	Estimated as 180	Range of stakeholders.
Measuring Performance of System Peer Symposia	45	45	Consumers, carers, peer workers.
Workshop	10	10	Peer work students.
Priorities and actions workshop @ Peer Participation Network meeting	45	45	Consumers, carers, peer workers.
Consumer and carer engagement recommendations workshop @ Peer Participation Network meeting	45	45	Consumers, carers, peer workers.
Child and Youth Partnership Advisory Group meeting	125	10	Government agencies, consumers, carers, service providers, healthcare practitioners.
Workshop at Peer Participation meeting	45	45	Consumers, carers, peer workers.
Focus Group with Headspace Youth Reference Group	Unknown		Headspace Youth Reference Group.

Consultation event	Number of attendees		Stakeholders participating
	Total no.	Est. no. of attendees with a lived experience	
North Coast Regional Child and Family Committee	Unknown		Government agencies, NGOs.
Suicide Prevention Forums	102	28	PHN, HHS, state government agencies, NGOs, service providers, healthcare practitioners, carers, people with a lived experience.
Suicide Prevention Strategic Partnership Group meetings 7 x meetings	140	14	PHN, HHS, 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 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, carers, parents, service delivery agencies.
Severe Mental Illness Regional Planning Working Group 6 x meetings	90	12	PHN, HHS, NGOs, GP representative, consumer and carer representatives.
Group consultation meeting	50	50	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, HHS, Department of Health, NGOs, alcohol and other drug peak body, consumers, carers.
20 x Kitchen Table Yarns	31	31	Indigenous community members.
2 x Yarning Circles	13	13	Indigenous workforce.

Consultation event	Number of attendees		Stakeholders participating
	Total no.	Est. no. of attendees with a lived experience	
1 x Yarning Circle	12	12	Indigenous integrated care patients.
2 x community surveys	55	55	Indigenous community members.
1 x clinic satisfaction survey	200	200	Indigenous 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 Indigenous suicide prevention community consultations	29	Unknown	Indigenous community members, Indigenous Elders, NGOs, government agencies.
Keeping Healthy Workshop	18	Unknown	NGOs, consumers, carers.
Culturally and linguistically diverse groups workshop	6	1	NGOs, consumers, carers.
LGBTIQ+ workshop	19	16	NGOs, consumers, carers.
LGBTIQ+ suicide prevention community consultation	19	6	NGOs, people with a lived experience of suicide, LGBTIQ+ people.
Older people's workshop	3	0	NGOs, carers.
Perinatal workshop	12	Unknown	NGOs, consumers, carers.

## Appendix Three: National and state indicators

### The Fifth National Mental Health and Suicide Prevention Plan <sup>xcvi</sup>

#### 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

**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

**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

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 Four: 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 Indigenous people. <sup>xcviii</sup>
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 <a href="http://www.mhima.org.au/framework/mhima-website">http://www.mhima.org.au/framework/mhima-website</a> <sup>xcix</sup>
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. <sup>c</sup>
Triangle of Care	Consumers, carers and service providers work together in a partnership model to provide care. <sup>ci</sup>

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