Primary Health Networks Primary Mental Health Care Funding

- Annual Mental Health Activity Work Plan 2016-2017

**Northern Queensland Primary Health Network**

When submitting this Mental Health Activity Work Plan (referred to as the Regional Operational Mental Health and Suicide Prevention Plan in the 2015-16 Schedule for Operational Mental Health and Suicide Prevention, and Drug and Alcohol Activities) to the Department of Health, the Primary Health Network (PHN) must ensure that all internal clearances have been obtained and has been endorsed by the CEO.

Additional planning and reporting requirements including documentation, data collection and evaluation activities for those PHNs selected as lead sites will be managed separately.

The Mental Health Activity Work Plan must be lodged to <name of Grant Officer> via email <email address> on or before 6 May 2016.
Introduction

Overview

In the 2015-16 financial year, PHNs are required (through the recent mental health Schedule which provided operational funding to PHNs this financial year) to prepare a Mental Health Activity Work Plan by May 2016. This Plan is to cover activities funded under two sources:

- the Primary Mental Health Care flexible funding pool (which will provide PHNs with approximately $1.030 billion (GST exclusive) over three years commencing in 2016-17); and
- Indigenous Australians’ Health Programme - an additional $28.25 million (GST exclusive) will be available annually under this programme and further quarantined to specifically support Objective 6 (detailed below): Enhance and better integrate Aboriginal and Torres Strait Islander mental health.

This is to be distinguished from the Regional Mental Health and Suicide Prevention Plan to be developed in consultation with Local Hospital Networks (LHNs) and other regional stakeholders which is due in 2017 (see Mental Health PHN Circular 2/2016).

Objectives

The objectives of the PHN mental health funding are to:

- improve targeting of psychological interventions to most appropriately support people with or at risk of mild mental illness at the local level through the development and/or commissioning of low intensity mental health services;
- support region-specific, cross sectoral approaches to early intervention for children and young people with, or at risk of mental illness (including those with severe mental illness who are being managed in primary care) and implementation of an equitable and integrated approach to primary mental health services for this population group;
- address service gaps in the provision of psychological therapies for people in rural and remote areas and other under-serviced and/or hard to reach populations, making optimal use of the available service infrastructure and workforce;
- commission primary mental health care services for people with severe mental illness being managed in primary care, including clinical care coordination for people with severe and complex mental illness who are being managed in primary care including through the phased implementation of primary mental health care packages and the use of mental health nurses;
- encourage and promote a systems based regional approach to suicide prevention including community based activities and liaising with Local Hospital Networks (LHNs) and other providers to help ensure appropriate follow-up and support arrangements are in place at a regional level for individuals after a suicide attempt and for other people at high risk of suicide, including Aboriginal and Torres Strait Islander people; and
- enhance access to and better integrate Aboriginal and Torres Strait Islander mental health services at a local level facilitating a joined up approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol and other drug services. For this Objective, both the Primary Health Networks Grant Programme Guidelines – Annexure A1 - Primary Mental Health Care and the Indigenous Australians’ Health Programme – Programme Guidelines apply.

Objectives 1-6 will be underpinned by:

- evidence based regional mental health and suicide prevention plans and service mapping to identify needs and gaps, reduce duplication, remove inefficiencies and encourage integration; and
• a continuum of primary mental health services within a person-centred **stepped care approach** so that a range of service types, making the best use of available workforce and technology, are available within local regions to better match with individual and local population need.

**Activities eligible for funding**

• commission evidence-based clinical primary mental health care services in line with a best practice stepped care approach;

• develop and commission cost effective low intensity psychological interventions for people with mild mental illness, making optimal use of the available workforce and technology;

• the phased implementation of approaches to provide primary mental health care to people with severe and complex mental illness which offer clinical support and care coordination, including services provided by mental health nurses;

• establish joined up assessment processes and referral pathways to enable people with mental illness, particularly those people with severe and complex mental illness, to receive the clinical and other related services they need. This will include provision of support to GPs in undertaking assessment to ensure people are referred to the service which best targets their need;

• develop and commission region-specific services, utilising existing providers, as necessary, to provide early intervention to support children and young people with, or at risk of, mental illness. This should include support for young people with mild to moderate forms of common mental illness as well as early intervention support for young people with moderate to severe mental illness, including emerging psychosis and severe forms of other types of mental illness;

• develop and commission strategies to target the needs of people living in rural and remote areas and other under-serviced populations; and

• develop evidence based regional suicide prevention plans and commission activity consistent with the plans to facilitate a planned and agile approach to suicide prevention. This should include liaison with LHNs and other organisations to ensure arrangements are in place to provide follow-up care to people after a suicide attempt.

Each PHN must make informed choices about how best to use its resources to address the objectives of the PHN mental health funding.

**This document, the Mental Health Activity Work Plan template, captures the approach to those activities outlined above.**

The Mental Health Activity Work Plan will help guide activity to June 2016 and outline the planned mental health services to be commissioned for the period from 1 July 2016 to 30 June 2017, although activities can be proposed in the Plan beyond this period. The Department of Health will require an update in relation to these activities in the Annual Mental Health Activity Work Plan for 2017-18.

The Mental Health Activity Work Plan template includes:

1) The Annual Mental Health Activity Work Plan for 2016-2017, which will be linked to and consistent with the broader PHN Activity Work Plan, and provide:
   a) The Strategic Vision on the approach to addressing the mental health and suicide prevention priorities of each PHN.
b) A description of planned activities funded under the Primary Mental Health Care Schedule which incorporates:
   i) Primary Mental Health Care funding (PHN: Mental Health and Suicide Prevention Operational and Flexible Activity); and
   ii) Indigenous Australians’ Health Programme funding (quarantined to support Objective 6 – see pages 2-3) (PHN: Indigenous Mental Health Flexible Activity).

**Mental Health Activity Work Plan 2016-2017**

The template for the Plan requires PHNs to outline activities against each and every one of the six priorities for mental health and suicide prevention. The Plan should also lay the foundation for regional planning and implementation of a broader stepped care model in the PHN region. This Plan recognises that 2016-17 is a transition year and full flexibility in programme design and delivery will not occur until 2018-19.

The Plan should:

a) Outline the planned mental health services to be commissioned from 1 July 2016, consistent with the grant funding guidelines.

b) Outline the approach to be undertaken by the PHN in leading the development with regional stakeholders including LHNs of a longer term, more substantial *Regional Mental Health and Suicide Prevention plan* (which is aligned with the Australian Government Response to the Review of Mental Health Programmes and Services (available on the Department’s website). This will include an outline of the approach to be undertaken by the PHN to seek agreement to the longer term *regional mental health and suicide prevention plan* from the relevant organisational signatories in the region, including LHNs.

c) Outline the approach to be taken to integrating and linking programmes transitioning to PHNs (such as headspace, and the Mental Health Nurse Incentive Programme services) into broader primary care activities, and to supporting links between mental health and drug and alcohol service delivery.

d) Have a particular focus on the approach to new or significantly reformed areas of activity – particularly Aboriginal and Torres Strait Islander mental health, suicide prevention activity, and early activity in relation to supporting young people presenting with severe mental illness.

In addition, PHNs will be expected to provide advice in their Mental Health Activity Work Plan on how they are going to approach the following specific areas of activity in 2016-17 to support these areas of activity:

- Develop and implement clinical governance and quality assurance arrangements to guide the primary mental health care activity undertaken by the PHN, in a way which is consistent with section 1.3 of the *Primary Health Networks Grant Programme Guidelines* available on the PHN website at [http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines](http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Program_Guidelines), and which is consistent with the National Standards for Mental Health Services and National Practice Standards for the Mental Health Workforce.

- Ensure appropriate data collection and reporting systems are in place for all commissioned services to inform service planning and facilitate ongoing performance monitoring and evaluation at the regional and national level, utilising existing infrastructure where possible and appropriate.

- Develop and implement systems to support sharing of consumer clinical information between service providers and consumers, with appropriate consent and building on the foundation provided by My Health Record.
• Establish and maintain appropriate consumer feedback procedures, including complaint handling procedures, in relation to services commissioned under the activity.

Value for money in relation to the cost and outcomes of commissioned services needs to be considered within this planning process.

**Activity Planning**

This initial Mental Health Activity Work Plan will be informed by a specific mental health needs assessment developed by PHNs (as a complement to the broader PHN needs assessment) which should explore mental health and suicide prevention priorities against those six areas of activity which the Government has articulated for PHNs, and in consultation with key stakeholders (refer to pages 2-6, for Objectives and Activities eligible for funding, and other requirements to be reflected in the Plan).

**Measuring Improvements**

Each mental health priority area has one or more mandatory performance indicators. In addition to the mandatory performance indicators, PHNs may select a local performance indicator. These will be reported on in accordance with the Primary Mental Health Care Schedule.

**Mental Health Activity Work Plan Reporting Period and Public Accessibility**

The Mental Health Activity Work Plan will help guide activity to June 2016 and outline the planned mental health services to be commissioned for the period from 1 July 2016 to 30 June 2017.

A mental health focussed activity work plan is to be provided to the Department annually. This mental health activity plan will complement the broader PHN Activity Plan as part of the annual reporting mechanism and will build on the initial Mental Health Activity Work Plan delivered in 2016.

Once approved, the Annual Mental Health Activity Work Plan component (Section 1(b) of this document) must be made available by the PHN on their website as soon as practicable. The Annual Mental Health Activity Work Plan component will also be made available on the Department of Health’s website (under the PHN website). Sensitive content identified by the PHN will be excluded, subject to the agreement of the Department.

It is important to note that while planning may continue following submission of the Mental Health Activity Work Plan, PHNs must not commit or spend any part of the funding related to this Activity Work Plan until it is approved by the Department.

**Further information**

The following may assist in the preparation of your Mental Health Activity Work Plan:

- The requirements detailed in the Primary Mental Health Care Schedule;
- PHN Needs Assessment Guide;
- Mental Health PHN Circulars;
- Primary Health Networks Grant Programme Guidelines – Annexure A1 – Primary Mental Health Care; and

Please contact your Grants Officer if you are having any difficulties completing this document.
1. (a) Strategic Vision

**Overarching comment:** To develop a comprehensive approach to mental health planning within the region and engage all the stakeholders and communities, it is important to allow the time engage and consult in a meaningful way. In relation to Aboriginal and Torres Strait Islander communities in particular, this process around developing relationships can take time.

NQPHN is working in a range of ways to engage and develop relationships. There are some activities identified in the activity plan that will be progressed concurrently with the development of the framework including broader consultations. This will include building on existing programs that are being commissioned. These programs will be reviewed within the initial two month period so will be ready for enhancement, expansion if appropriate.

NQPHN will review its identified actions and work within the Primary Health Network Grant Programme Guidelines. This activity was identified in relation to service coordination and collaboration across the system for clients accessing services. This is a key area for NQPHN particularly in relation to rural and remote areas and further specific strategies will be identified in the initial three-month planning phase.

The conventional definition of mental health is that of the WHO: “a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” [1]. Mental illness refers to: “suffering, disability or morbidity due to mental, neurological and substance use disorders, which can arise due to the genetic, biological and psychological make-up of individuals, as well as adverse social conditions and environmental factors”, with the goal of mental health investment being both the “promotion and protection of mental health [and] the prevention and treatment of mental illness or disorders” [2].

Regardless of setting, this goal demands a mix of activities across a range of sectors and players – from specialist clinical activities to social policy addressing individual and community capacity and agency, as presented schematically below (Figure 1) - with primary care being centrally located both in terms of the pathway to care, but also, as from a consumer perspective: “integrating mental health into primary care facilitates person-centred and holistic services” [3].
Primary care services can influence across the spectrum of needs, but have greatest responsibility and opportunity within that primary care service area and, relatively, less in terms of specialist interventions and supporting community agency. Further, even within the primary care service setting, there are different conceptual models incorporating mental health care (Figure 2) [4]. Reviewing those models with consideration of effectiveness, efficiency, access and equity, Bower and Gilbody note differences relating to both client and service factors – different strokes for different folks.

They raise two key issues particularly relevant to collaborative care models:

**TASK SHIFTING** – the reallocation of roles to efficiently use expertise [5], and

**STEPPED CARE** – a system of delivering and monitoring treatments so that the most effective yet least resource-intensive treatment is delivered to patients first.
The population served by and the area across which Northern Queensland Primary Health Network operates is diverse and challenging, with a large number of remote and socially disadvantaged communities—some of which are very small. While mental health and social and emotional wellbeing need is universal, service options across the region are not. Responding to these challenges, in 2016-17 NQPHN will clearly articulate a theoretical framework of action allowing adaptation to local population and service factors that will ultimately ensure that all needs are met—which may be by different means in different circumstances. That demands a clear understanding of where the real capacities to influence through primary care lie, as well as an understanding of where better outcomes can be leveraged through support of other services and sectors. That may be understood schematically through a reconfiguration of the WHO pyramid.

**Figure 3: Primary care responsibility and capacity to influence**

![Diagram showing primary care responsibility and capacity to influence](image)

WHO: Idealised suite of activities  
Primary care responsibility and capacity to influence

In defining its core activities and in support of mental health system strengthening in the region across mental health and suicide prevention, NQPHN will plan carefully on the basis of a clear understanding of needs across **priority populations** and the **lifecourse**. The WHO schema provides a model against which to check that all populations in the region have their full ranges of needs addressed. That will require three strategic approaches (Figure 4). The first is to define on the basis of the comprehensive needs assessment the range of **ACTIVITIES** for which NQPHN can take primary responsibility. The second is to identify through the service mapping and analysis a **COMMUNICATION AND COLLABORATION** framework through which to support capacity across the range of needs. The third strategic approach is to identify the **WORKFORCE AND RESOURCE** requirements informed by this model and its local adaptations (for instance in relation to refinement of stepped care and approaches to task shifting in particular settings).
This detailed planning will occur in 2016-17 and NQPHN, in collaboration with its partners, will facilitate the development of an overarching Regional Mental Health and Suicide Prevention Plan incorporating communication and collaboration, as well as the workforce and resource needs that will guide the future service development required in North Queensland. NQPHN will base its approach on the above theory, translated into a context-informed regional plan.

NQPHN clinical governance and quality assurance arrangements to guide the primary mental health care activity undertaken is currently being further developed to include an expert mental health advisory panel, which comprises representatives from the mental health sector including Hospital and Health Services (HHSs), GPs, General Practice Liaison Officers (GPLOs), remote area services, alcohol and other drugs, youth, community-managed mental health services, Indigenous services, allied health networks, consumers, and carers.

All activities identified within this Mental Health Activity Work Plan link directly to addressing five of the six local health priority areas identified in the 2016 Health Needs Assessment:

1) Access to health care in rural and remote areas
2) Access to mental health services especially for rural and remote areas
3) Health workforce expansion and sustainability
4) Improve Aboriginal and Torres Strait Islander health
5) Improve childhood and maternal health.

REFERENCES


1. (b) Planned activities funded under the Primary Mental Health Care Schedule

PHNs must use the table below to outline the activities proposed to be undertaken in the 2016-17 financial year. These activities will be funded under the Primary Mental Health Care Schedule (PHN: Mental Health and Suicide Prevention Operational and Flexible Activity; and the PHN: Indigenous Mental Health Flexible Activity).

Note 1: Indicate within the duration section of the table if the activity relates to a period beyond 2016-17.

Note 2: PHNs must complete activities under every priority area in the tables below.

Note 3: All activities identified articulate with the other priority areas in the plan. To avoid duplication they have just been listed in one section. The activities outlined in this section may be reviewed and/or modified following further developmental work including the collection of additional information as part of the comprehensive mental health and suicide prevention needs assessment, and the development of the NQPHN Regional Mental Health and Suicide Prevention Plan.

<table>
<thead>
<tr>
<th>Proposed Activity</th>
<th>Priority Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low intensity mental health services</td>
<td>1. Low intensity mental health services</td>
</tr>
<tr>
<td>Establish workforce development needs and up skilling options for primary health care staff</td>
<td>1.1 Establish workforce development needs and up skilling options for primary health care staff</td>
</tr>
<tr>
<td>Education for community members</td>
<td>1.2 Education for community members</td>
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<tr>
<td>Self-management options</td>
<td>1.3 Self-management options</td>
</tr>
<tr>
<td>Implementation of the redesigned ATAPS program (links with activity 3.1)</td>
<td>1.4 Implementation of the redesigned ATAPS program (links with activity 3.1)</td>
</tr>
</tbody>
</table>

As identified in NQPHN’s Health Needs Assessment, there is a lack of access to low intensity services for people from rural and remote populations, as well as for Aboriginal and Torres Straits Islander people. These activities align with local priorities; access to mental health services especially for rural and remote areas; health workforce expansion and sustainability; and improving Aboriginal and Torres Strait Islander health.

1.1 A consistent and comprehensive map of the mental health workforce across the PHN catchment is needed to identify gaps in existing workforce, and particular skills required to meet mental health priority areas. This will include scoping the existing...
training provided and skills of the primary health care workforce around providing low intensity services to deliver evidence-based mental health services, but not at the level required for recognition as a mental health professional such as the completion of recognised training in delivery of cognitive behaviour therapy, narrative therapy etc.

1.2 Consider options and partnerships to commence educating community members and service providers on available low intensity services, including referral pathways and service parameters.

1.3 Further scope activities currently being provided within the North Queensland region, as well as additional evidence-based activities/services that support self-management of people who are mentally distressed, or with mild or moderate high prevalence needs, and provide people with a first option to access alternatives to medical and pharmaceutical treatments such as on-line self-help, childhood and youth education and support, and family and community resilience building. As access to internet is limited in many of the rural and remote communities within NQPHN’s footprint, due to limited availability and high cost, additional options and viability of many on-line self-help options will be explored further.

1.4 In early 2016, NQPHN redesigned the existing Access to Allied Psychological Services (ATAPS) program into People in Mind (PiM) for implementation in July 2016. Key elements of PiM include:

- Funding psychological support sessions for people unable to access other services
- Being modelled on the ATAPS operational guidelines, as consistent with the transitional nature of this activity.

PiM is considered to be a transitional program, while consideration is given to the best way of delivering services to this group within a region-wide stepped care model. This region-wide model will be developed by the end 2016 (Activity 8.1). A remodelling of PiM will see:

- Redress of the current maldistribution of services for people with mild to moderate illness
- Expansion of alternative service modalities such as telehealth and internet-delivered self-help resources
- Foundational work for the establishment of a locally sustainable peer mental health workforce
- Introduction of innovative services that will be both appropriate and sustainable in rural, remote and Indigenous communities.

Collaboration

NQPHN will utilise a systems-thinking approach to these planning activities to ensure that there is full engagement with all relevant parties. Building on the information from the needs assessment, specific collaboration will occur with service providers in rural and remote communities to identify appropriate service models. Existing service providers, GPs, and a wide range of private providers of mental health services will be included in NQPHN’s collaborative approach. The HHSs, Aboriginal Community Controlled Health Sector (ACCHS), and Royal Flying Doctor Service are key partners in this activity, as in most cases they are the only existing providers in many of the remote communities in the region.
NQPHN has adopted the International Association for Public Participation - IAP2 model, with overlap utilising specific protocols for different population groups (e.g. Aboriginal, Torres Strait Islander and South Sea Islander populations) to guide all engagement and consultation processes.

The contractual terms for transitioning providers will obligate them to participate in regional systems re-design consultations and workshops.

**Link with systems strengthening and reform activities in Priority Area 8.**

<table>
<thead>
<tr>
<th>Duration</th>
<th>It is anticipated that the activities outlines above will be completed in July 2016-17, with new services commissioned between September and December 2016.</th>
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<tbody>
<tr>
<td>Coverage</td>
<td>These activities will cover the entire NQPHN region. There will however be more intense focus on new activity in the LGAs with a higher Aboriginal and Torres Strait Islander population.</td>
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</tbody>
</table>
| Commissioning approach | For existing programs and services, NQPHN will directly contract these services as directed by the Department of Health in line with approved transitional arrangements.  
New activities for commissioning outlined in the Regional Mental Health and Suicide Prevention Plan when developed will involve an approach to market in the first instance.  
NQPHN will seek to engage with the market in a competitive dialogue, or interactive procurement approach, to ensure that the service solution purchased and implemented meets the needs of the community. This process will be particularly valuable in enabling innovation. This approach will the completed with the release of a competitive approach to market resulting a contract execution.  
Monitoring of performance will be conducted based on factors such as the level of risk, value, and impact of the contract. This will be assessed, and will determine the level and frequency of reporting. Specific contract managers within the organisation will be identified and will meet regularly with the provider to understand any barriers, opportunities or improvements. |
| Performance Indicator | The mandatory performance indicators for this priority are:  
- Proportion of regional population receiving PHN-commissioned mental health services – low intensity services.  
- Average cost per PHN-commissioned mental health service – low intensity services.  
- Clinical outcomes for people receiving PHN-commissioned low intensity mental health services. |
<p>| Local Performance Indicator target (where possible) | Performance targets will be generally based on pre-existing arrangements as consistent with the transitional requirements of the Department. |
| Local Performance Indicator Data source | To be determined once we have assessed current service delivery. |</p>
<table>
<thead>
<tr>
<th>Proposed Activity</th>
<th>Priority Area</th>
<th>2: Youth mental health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity Title / Reference</td>
<td>2.1 headspace services in Cairns, Townsville and Mackay</td>
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<tr>
<td></td>
<td>2.2 Mental health professionals integrated with maternal and child health services</td>
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<td></td>
<td>2.3 Holistic youth services for rural and remote communities</td>
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<td></td>
<td>2.4 Mental health professionals integrated into youth services, with a particular focus on homeless young people and in schools</td>
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<tr>
<td></td>
<td>2.5 Redesign the existing Access to Allied Psychological Services (ATAPS) program into People in Mind (PiM) for implementation in July 2016.</td>
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</table>

**Description of Activity**

**Objective of the PHN mental health funding:** support region-specific, cross-sectoral approaches to early intervention for children and young people with, or at risk of, mental illness (including those with severe mental illness who are being managed in primary care), and implementation of an equitable and integrated approach to primary mental health services for this population group.

Improving childhood and maternal health, as well as mental health, are two of the six priority areas identified in the NQPHN needs assessment. NQPHN will take the central role in ensuring that the appropriate mix of services to address mental health and wellbeing needs are available across the lifespan. This is informed by appreciation of the importance of physical health, social determinants, and life-course natural history, and consistent with the principle of holistic care, specifically that:

1) Population general health clinical needs are greatest in early life (childhood communicable diseases, developmental disorders), and with advancing age past mid-adulthood (chronic, degenerative and neoplastic diseases).

2) Population mental health clinical needs rise rapidly from adolescence, peaking in young to middle adulthood and falling in older age.

3) Most of the significant mental health disorders have their onset or prodrome in childhood and young adulthood (psychotic, anxiety, affective and substance use disorders), which also applies to key later-life physical conditions (cardiovascular, metabolic and smoking-related respiratory disorders). There are important synergies in the life-style approaches (diet, exercise, stress management), and the opportunities for general health and mental health early detection and intervention are greatest in childhood in which the key social ‘agencies’ are family, school and primary care health services.
4) The same applies in relation to prevention. The greatest opportunity for effective and efficient preventive interventions – for both mental and physical disorders – is at the beginning of life, focusing on the physical, family and social contexts of the perinatal period. This is equally important for late life chronic diseases (metabolic, cardiovascular) and mental health conditions (anxiety disorders, attachment disorders, substance use disorders). This is the arena in which primary care providers, through maternal-child services, have privileged opportunities.

The emphasis in terms of service mix must be informed by an understanding of life-course need at the population level, such as that above, while also acknowledging that mental health promotion and prevention activities continue throughout life and are important regardless of ongoing mental health disorders.

A significant amount of activity in these areas will prioritise Aboriginal and Torres Strait Islander people.

During 2016-17, NQPHN will further explore these concepts and further identify specific activities that address the needs for the region. This will be documented as part of the Regional Mental Health and Suicide Plan, however some initial work will be commenced in the following key areas:

2.1 Work with headspace services in Cairns, Mackay and Townsville which will transition to NQPHN on 1 July 2016. This will include the NQPHN Mental Health Coordinators developing effective relationships with new service providers, refinement of performance data and other reporting arrangements, establishment of linkages between associated services to promote integration care, support for digital enablement including adoption and use of My Health Record, and consultation around service re-modelling to facilitate a region-wide move to stepped care.

2.2 Develop model to employ mental health nurses/mental health professionals as part of the maternal and child health teams/programs across the region to take early and effective action when children and families are experiencing risk factors, poor mental health and mental illness. Priority to be given to Aboriginal and Torres Strait Islander communities, as well as rural and remote, and align if possible with the further expansion of the Australian Nurse Family Partnership program with the Aboriginal Community Controlled Sector to promote additional sites to be allocated in North Queensland.

2.3 Work with headspace services, the youth sector and young people to develop models of service that can be delivered to rural and remote communities, particularly to address the needs of Aboriginal and Torres Strait Islander people.

2.4 Scope a service model that builds on the principles and activities of the school based youth health nurse program funded by Queensland Health, with the addition of a mental health/alcohol and other drugs professional position. This model would be piloted in rural and remote communities where access to mental health services is limited for young people. This model would also support early detection and intervention with mental health problems and illness in young people, as well as focus on further building the capacity of the school community to promote good mental health and wellbeing. This program may include the delivery of evidence-based programs that build resilience and promote positive mental health in teenagers, such as the Resourceful Adolescent Program (RAP). This scoping will also include models of engagement with young people to improve
access to services, including the employment of creative therapists and collaboration mechanisms to facilitate better links between child and youth services and mental health services, to increase relationships, and the ability for providers and young people to navigate the mental health system across the region.

2.5 In early 2016, NQPHN redesigned the existing Access to Allied Psychological Services (ATAPS) program into People in Mind (PiM) for implementation in July 2016. Key elements of PiM include:

- Funding psychological support sessions for people unable to access other services
- Being modelled on the ATAPS operational guidelines, as consistent with the transitional nature of this activity.

PiM is considered to be a transitional program, while consideration is given to the best way of delivering services to this group within a region-wide stepped care model. This region-wide model will be developed by the end 2016 (Activity 8.1). A remodelling of PiM will see:

- Redress of the current maldistribution of services for people with mild to moderate illness
- Expansion of alternative service modalities such as telehealth and internet-delivered self-help resources
- Foundational work for the establishment of a locally sustainable peer mental health workforce

Introduction of innovative services that will be both appropriate and sustainable in rural, remote and Indigenous communities.

<table>
<thead>
<tr>
<th>Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>For the activities that focus on specific stages in the lifespan, NQPHN will focus specific attention on engaging and consulting with people with lived experience from that life stage, as well as communities and service providers including GPs:</td>
</tr>
<tr>
<td>- Establish regular community forums/activities that target the specific interests of young people. Incorporate into all these activities focus groups/feedback mechanisms on key issues and services provided</td>
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<tr>
<td>- Strengthen community structures that can be used as a consultation mechanism</td>
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<tr>
<td>- Involve people with lived experience, their families and other support people in all areas</td>
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<tr>
<td>- Promote and create supportive environments for the community to be engaged</td>
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<tr>
<td>- Consider and address barriers to participation in any community engagement, participation and consultation activities that NQPHN undertakes</td>
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<tr>
<td>- Commit to monitoring and evaluating each engagement activity to ensure ongoing improvement, and provide information on outcomes to the community.</td>
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</tbody>
</table>

While this activity is a whole of region planning process, specific attention will be paid to the needs of Aboriginal and Torres Strait Islander people within the region, and will involve culturally appropriate forums on location in these communities, developed in collaboration with the Community Controlled Health Sector and the HHSs.
<table>
<thead>
<tr>
<th>Duration</th>
<th>A significant amount of planning will occur between July 2016 and December 2016. It is anticipated that any additional services that are required to be commissioned will occur in early 2017.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage</td>
<td>These activities will cover the entire NQPHN region. There will however be more intense activity in the LGAs with a higher Aboriginal and Torres Strait Islander population.</td>
</tr>
<tr>
<td>Commissioning approach</td>
<td>Within 2016-17, the existing programs that are being commissioned or transitioned from the Department of Health to NQPHN will be continued for a further 12 months. NQPHN will directly contract these services as directed by the Department of Health in line with approved transitional arrangements. During this period of time, NQPHN will review each of the programs against the criteria identified in the performance evaluation framework being developed, as well as the new service models being scoped. Following the review, NQPHN will work with the commissioned services to identify service improvements and potential collaborations/partnerships that may enhance program outcomes. Any new activities for commissioning outlined in the Regional Mental Health and Suicide Prevention Plan will involve an approach to market in the first instance. To achieve this, NQPHN will seek to engage with the market in a competitive dialogue, or interactive procurement approach, to ensure that the service solution purchased and implemented meets the needs of the community. This process will be particularly valuable in enabling innovation. This approach will be completed with the release of a competitive approach to market resulting a contract execution. Monitoring of performance will be conducted based on factors such as the level of risk, value, and impact of the contract. This will be assessed, and will determine the level and frequency of reporting. Specific contract managers within the organisation will be identified and meet regularly with the provider to understand any barriers, opportunities or improvements.</td>
</tr>
<tr>
<td>Performance Indicator</td>
<td>The mandatory performance indicator for this priority is:</td>
</tr>
<tr>
<td></td>
<td>• Proportion of regional youth population receiving youth-specific PHN-commissioned mental health services.</td>
</tr>
<tr>
<td>Local Performance Indicator target (where possible)</td>
<td>Performance targets will be generally based on pre-existing arrangements as consistent with the transitional requirements of the Department.</td>
</tr>
<tr>
<td>Local Performance Indicator Data source</td>
<td>To be determined once NQPHN has assessed current service delivery.</td>
</tr>
</tbody>
</table>
Objective of the PHN mental health funding: address service gaps in the provision of psychological therapies for people in rural and remote areas and other under-serviced and/or hard to reach populations, making optimal use of the available service infrastructure and workforce.

The region serviced through NQPHN contains the most decentralised population in Australia. Within this are subpopulations characterised by elevated risk of negative mental health outcomes that are priority groups in NQPHN planning. As identified through the needs assessment, priority groups in NQPHN planning are identifiable either by features of identity and personal characteristics (e.g. Aboriginal and/or Torres Strait Islander peoples, lesbian, gay, bisexual, trans, and/or intersex (LGBTI), migrant/refugee) or as a consequence of social settings and circumstances (rural and remote, homeless, detained populations).

The elevated risk to wellbeing and mental health of these groups may relate to processes/issues associated with that identity (for example, racism and stigma impacting Aboriginal and Torres Strait Islander people, migrant/refugee groups and LGBTI) or to social settings (homeless, rural and remote residents and detained populations). There is, of course, overlapping and compounding risk (for example, remote Indigenous populations) and some groups are at elevated risk in part because these groups concentrate people with mental disorders as a consequence of poor mental health and wellbeing (detained populations, homeless).

NQPHN’s commitment to ensuring comprehensive coverage of needs across the WHO pyramid for each of the priority groups requires both group and setting-specific strategies informed by a commitment to efficiency, effectiveness, access and equity, as well as making sure that the services are appropriate and effective in the real world(s) in which that group lives, and are available when needed regardless of social or group circumstances. To address need, there will be different degrees of focus by NQPHN across the WHO service sectors.

Due to the geography and population characteristics of the region, several of the NQPHN strategies that address rural and remote communities are identified in other, such as young people and Aboriginal and Torres Strait Islander people.

During 2016-17, NQPHN will further explore these concepts above and identify specific activities that address the needs for the region. This will be documented as part of the Regional Mental Health and Suicide Prevention Plan, however some initial work will be commenced in the following key areas:

<table>
<thead>
<tr>
<th>Proposed Activity</th>
<th>3: Psychological therapies for rural and remote, under-serviced and/or hard to reach groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area</td>
<td>3.1 Implement redesign of ATAPS program into People in Mind (PIM).</td>
</tr>
<tr>
<td></td>
<td>3.2 Commission new services as identified following redesign, with a particular focus on rural and remote access to services.</td>
</tr>
<tr>
<td></td>
<td>3.3 Recommission existing ATAPS contractors for a period of six months.</td>
</tr>
<tr>
<td></td>
<td>3.4 Improve access to services for the homeless population.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity Title / Reference</th>
<th>Description of Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Implement redesign of ATAPS program into People in Mind (PIM).</td>
</tr>
<tr>
<td>3.2</td>
<td>Commission new services as identified following redesign, with a particular focus on rural and remote access to services.</td>
</tr>
<tr>
<td>3.3</td>
<td>Recommission existing ATAPS contractors for a period of six months.</td>
</tr>
<tr>
<td>3.4</td>
<td>Improve access to services for the homeless population.</td>
</tr>
</tbody>
</table>
### 3.1 Implementation of redesigned ATAPS program into the People in Mind (PiM) program

NQPHN will maintain existing activity across the region, however additional activity will be focused in areas that have not previously received services, such as Cape York Peninsula and the Torres Strait. To enable access to services in rural and remote communities, service models will be explored that commission existing providers and programs to ensure cost effective delivery. This may include enhancement of existing programs to cover a wider geographical area of increased eligibility criteria for existing programs (links with activity 1.4).

### 3.2 Identification of additional activities/services, as part of the development of the Regional Mental Health and Suicide Prevention Plan

Commissioning of these services will commence in early 2017.

### 3.3 Continuation of existing contracts for a 3-6 month period during the transition to PiM to ensure continuity of service provision

### 3.4 Scoping of service models for the homeless population, marginalised from family and services that attend to the base levels of the WHO pyramid – self-care, informal care and access to primary care (which may involve groups like headspace, Indigenous community controlled services, and issue specific non-government organisations).

### Collaboration

NQPHN will utilise a broad consultation and collaboration approach to ensure that there is full engagement with all relevant parties. NQPHN will focus on further developing its consultation mechanisms to regularly engage and consult with people with lived experience, as well as seldom-heard groups. This will include exploring non-traditional consultation processes through activities such as music, sport and social media.

These include:
- Specific collaboration structures with the Aboriginal Community Controlled Health Sector
- Involving people with lived experience, their families, and other support people in all areas
- Reaching out to include those whose voices are seldom heard, including those in the criminal justice system or who do not access GPs or mainstream services, homeless people, and other disenfranchised groups
- Engaging with a broad range of community support services such as emergency relief organisations
- The contractual terms for transitioning providers will obligate them to participate in regional systems re-design consultations and workshops.

### Duration

A significant amount of planning will occur from July 2016–December 2016. It is anticipated that any additional services that are required to be commissioned will occur in early 2017.

### Coverage

These activities will cover the entire NQPHN region. There will however be more intense activity in the LGAs with a higher Aboriginal and Torres Strait Islander population.
| Commissioning approach | Within 2016-17, the existing programs that are being commissioned or transitioned from the Department of Health to NQPHN will be continued for a further 6-12 months. NQPHN will directly contract these services as directed by the Department of Health in line with approved transitional arrangements. During this period of time, NQPHN will review each of the programs against the criteria identified in the performance evaluation framework being developed, as well as the new service models being scoped. Following the review, NQPHN will work with the commissioned services to identify service improvements and potential collaborations/partnerships that may enhance program outcomes. NQPHN will seek to engage with the market in a competitive dialogue, or interactive procurement approach, to ensure that the service solution purchased and implemented meets the needs of the community. This process will be particularly valuable in enabling innovation. This approach will the completed with the release of a competitive approach to market resulting a contract execution. Monitoring of performance will be conducted based on factors such as the level of risk, value, and impact of the contract. This will be assessed, and will determine the level and frequency of reporting. Specific contract managers within the organisation will be identified and meet regularly with the provider to understand any barriers, opportunities or improvements. |
| Performance Indicator | The mandatory performance indicators for this priority are:  
- Proportion of regional population receiving PHN-commissioned mental health services – psychological therapies delivered by mental health professionals  
- Average cost per PHN-commissioned mental health service – psychological therapies delivered by mental health professionals  
- Clinical outcomes for people receiving PHN-commissioned – psychological therapies delivered by mental health professionals. |
<p>| Local Performance Indicator target (where possible) | Performance targets will in general be based on pre-existing arrangements as consistent with the transitional requirements of the Department. |
| Local Performance Indicator Data source | To be determined once we have assessed current service delivery. |</p>
<table>
<thead>
<tr>
<th>Proposed Activity</th>
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<tbody>
<tr>
<td>Priority Area</td>
</tr>
<tr>
<td>4: Mental health services for people with severe and complex mental illness including care packages</td>
</tr>
<tr>
<td>Activity Title / Reference</td>
</tr>
<tr>
<td>4.1 MHNIP continuation</td>
</tr>
<tr>
<td>4.2 Mental Health Nurses and Care Coordination in rural and remote communities</td>
</tr>
<tr>
<td>4.3 Service coordination and navigation</td>
</tr>
<tr>
<td>4.4 Recommission existing ATAPS contractors for a period of six months and redevelop future model</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description of Activity</th>
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<tbody>
<tr>
<td><strong>Objective of the PHN mental health funding:</strong> commission primary mental health care services for people with severe mental illness being managed in primary care, including clinical care coordination for people with <strong>severe and complex mental illness</strong> who are being managed in primary care, including through the phased implementation of primary mental health care packages and the use of mental health nurses.</td>
</tr>
<tr>
<td>NQPHN’s Health Needs Assessment highlighted the inadequate and often difficult to access mental health services, in particular for rural and remote populations. The Mental Health Nurse Incentive Program (MHNIP) coverage is limited across the NQPHN region, and care coordination is made difficult with the transient population.</td>
</tr>
<tr>
<td>During 2016-17, NQPHN will further explore these concepts above and identify specific activities that address the needs for the region. This will be documented as part of the Regional Mental Health and Suicide Prevention Plan, however some initial work will be commenced in the following key areas:</td>
</tr>
<tr>
<td>4.1 Continue with the commissioning of existing providers under the MHNIP</td>
</tr>
<tr>
<td>4.2 Scope the option of expanding the number of sites within the region that can access the MHNIP to employ mental health nurses, enabling individuals with severe and persistent mental illnesses to receive coordinated clinical care. This may include providing an additional start up grant to enable rural and remote services/organisations to be able to participate in this program. Also, develop a specific model for mental health care coordination and integration of services around an individual’s needs in collaboration with the HHSs, ACCHS, RFDS and other providers, with a focus on remote Aboriginal and Torres Strait Islander people. This model may also be based on the principles of the MHNIP.</td>
</tr>
<tr>
<td>4.3 Work with the HHSs around developing systems to help people with mental ill-health and their families and carers find and navigate services, as well as further developing systems of support for GPs and National Disability Insurance Scheme (NDIS) service providers to support the needs of people with severe and complex mental illness who are principally managed in primary health care. Also work with people with severe mental illness who cannot be appropriately managed in the primary care setting to ensure</td>
</tr>
<tr>
<td><strong>Collaboration</strong></td>
</tr>
<tr>
<td><strong>Duration</strong></td>
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<tr>
<td><strong>Coverage</strong></td>
</tr>
<tr>
<td><strong>Commissioning approach</strong></td>
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<tr>
<td><strong>Commissioning approach</strong></td>
</tr>
</tbody>
</table>
NQPHN will seek to engage with the market in a competitive dialogue, or interactive procurement approach, to ensure that the service solution purchased and implemented meets the needs of the community. This process will be particularly valuable in enabling innovation. This approach will be completed with the release of a competitive approach to market resulting in a contract execution.

Monitoring of performance will be conducted based on factors such as the level of risk, value, and impact of the contract. This will be assessed, and will determine the level and frequency of reporting. Specific contract managers within the organisation will be identified and meet regularly with the provider to understand any barriers, opportunities or improvements.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>The mandatory performance indicators for this priority are:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Proportion of regional population receiving PHN-commissioned mental health services – clinical care coordination for people with severe and complex mental illness (including clinical care coordination by mental health nurses).</td>
</tr>
<tr>
<td></td>
<td>- Average cost per PHN-commissioned mental health service – clinical care coordination for people with severe and complex mental illness.</td>
</tr>
</tbody>
</table>

<p>| Local Performance Indicator target (where possible) | Performance targets will generally be based on pre-existing arrangements as consistent with the transitional requirements of the Department. |
| Local Performance Indicator Data source | To be determined once NQPHN has assessed current service delivery. |</p>
<table>
<thead>
<tr>
<th>Proposed Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority Area</strong></td>
</tr>
</tbody>
</table>
| **Activity Title / Reference** | 5.1 Define suicide prevention system across region  
5.2 Continue commissioning existing and transitioning programs  
5.3 Development of a toolkit for commissioned services  
5.4 Review existing commissioned services/enhancement  
5.5 Commence commissioning new services. |
| **Description of Activity** | **Objective of the PHN mental health funding:** encourage and promote a systems-based regional approach to **suicide prevention** including community-based activities and liaising with Local Hospital Networks (LHNs) and other providers to help ensure appropriate follow-up and support arrangements are in place at a regional level for individuals after a suicide attempt, and for other people at high risk of suicide, including Aboriginal and Torres Strait Islander people.  
While suicidal and other self-harmful behaviours do not necessarily indicate mental illness, it is reasonable to confidently assert that such behaviours are not consistent with positive mental health and wellbeing. Furthermore, certain mental disorders do confer significant risk of completed suicide, including major depression, bipolar disorder and schizophrenia, with that risk amplified by comorbid substance misuse. Data on completed suicides in Queensland reveal: 1) males are more vulnerable than females; 2) male risk peaks around the fourth decade and in later life; 3) female vulnerability peaks in the fourth and fifth decades; 4) remoteness confers additional vulnerability, particularly for younger persons; 5) Indigenous Queenslanders are at elevated risk, with peak risk at earlier ages, peaking in the second to third decade for females and the third to fourth decades for males.[7] The needs assessment data from the Queensland Mental Health Commission (QMHC) highlights that the high rates of suicide are worse in rural and remote areas, especially in Cape York Peninsula and the Torres Strait.  
The agreed approach to conceptualising the spectrum of activities related to suicide prevention and response nationally is the Living is For Everyone (LIFE) framework. It provides for universal, selective and indicated prevention, symptom identification, early treatment and standard treatment, and longer-term treatment and support, and ongoing care and support. A coordinated strategy balances investment across the three broad areas of prevention, intervention/treatment, and continuing care, investing effectively and efficiently in promoting resilience versus responding to identified needs. Self-care/mental health promotion is relevant to everyone regardless of their mental health status or service need.  
As preventing suicide is everybody’s business, the role of NQPHN will demand coordination and communication across sectors, and integration with programs that address risk of other negative outcomes with which the risk for self-harm co-varies (for example,
empowerment and resilience-based initiatives that are also relevant in relation to homelessness, substance misuse and domestic violence). NQPHN will ensure:

- Population-wide exposure to mental health literacy/suicide awareness building on national programs, and will contract and coordinate a mix of universal to indicated prevention programs across sectors (self-care and informal community care levels in the WHO pyramid)
- Setting-specific symptom identification and early treatment through schools, workplaces and primary care settings as a key activity area for system-based programs
- Longer-term treatment and ongoing care and support requiring collaboration with specialist services for those individuals whose ongoing risk status relates to mental illness, but, equally importantly, continuing to support engagement for all at risk through the primary care and informal community care sectors. Primary care will have a particularly important role in post intervention where the importance of existing community relationships and linkages across the range of services and sectors is critical
- Collaboration with existing national and local programs with identified expertise across all these activities but, particularly, in relation to post intervention (such as Standby Response Services, Lifeline, Beyond Blue, Kids HelpLine).

During 2016-17, NQPHN will further explore the above concepts and further identify specific activities that address the needs for the region. This will be documented as part of the Regional Mental Health and Suicide Prevention Plan, however some initial work will be commenced in the following key areas:

5.1 Define the suicide prevention and response service system which currently exists in NQPHN, and further work on the needs assessments and data systems that support this information to identify critical gaps with respect to high risks groups and communities (June 2016–October 2016). Based on this review, identify improvements to this system, in particular community-led long term responses in remote Aboriginal and Torres Strait islander communities.

5.2 Continue commissioning programs that are already funded by NQPHN or the Department of Health under suicide prevention funding for a further six months to 12 months.

5.3 Develop a toolkit for services that are being commissioned around suicide prevention. This will include evidence-based guidelines around developing local protocols including response times and collaborative practice with communities. For service responses in Aboriginal and Torres Strait Islander communities, additional guidelines will be provided that include community and cultural protocols.

5.4 Review the existing services that are funded by NQPHN against the criteria identified in the outcomes-focused performance evaluation framework being developed. If needed, work with the currently commissioned agencies to identify service improvements and potential collaborations/partnerships that may enhance program outcomes, and to ensure that a systemic, community-based approach to suicide prevention is delivered. This review may also identify opportunities for expansion of
existing programs, such as the option for additional intake in Certificate IV in Indigenous Mental Health (Suicide Prevention),

5.5 Commence commissioning of new community-based suicide prevention activities within the context of the Regional Mental Health and Suicide Prevention Plan (when developed).

Collaboration

The Queensland Mental Health Commission is establishing funding programs within the QPHN region. QPHN will develop strong collaborative arrangements with the QMHC to enable sharing of information and learnings on suicide prevention activities.

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These activities will be delivered through both commissioned agencies, as well as QPHN. QPHN will continue to develop its consultation mechanisms to regularly engage and consult with people with lived experience, communities, and service providers within the region. QPHN will ensure that the needs of the whole population, including high-risk and seldom heard groups, are considered in relation to suicide prevention.

- The already established mental health advisory panel, which comprises representatives from the mental health sector including HHSs, GPs, GPLOs, remote area services, alcohol and other drugs, youth, community-managed mental health services, Indigenous services, allied health networks, consumers, and carers. This group will also focus on suicide prevention.
- Strengthening community structures that can be used as a consultation mechanism, with a particular focus on Aboriginal and Torres Strait Islander communities and community leaders.
- Involving people with lived experience, their families, and other support people in all areas.
- Reaching out to include those whose voices are seldom heard, including those in the criminal justice system or who do not access GP or mainstream services, homeless people, and other disenfranchised groups.
- Engaging with community services and other services such as alcohol and other drugs, youth, community-managed mental health services, Indigenous services, allied health networks, and consumer and carers.
- Engaging with communities and community leaders to identify the specific mental health needs of Aboriginal and Torres Strait Islander people.
- Strengthening community structures that can be used as a consultation mechanism, with a particular focus on Aboriginal and Torres Strait Islander people.
- NQPHN convening a reference group, made up of a broad cross-section of Indigenous Elders and young people, to advise the Local Action Alliance to assist them to accomplish their brief.

Building feedback mechanisms into all QPHN activities. NQPHN involvement in the Townsville Suicide Prevention Network.

NQPHN development of a Local Action Alliance, consisting of members from health, education, child safety, corrections, QMHC, and Townsville Aboriginal and Islander Health Service (TAHIS), who will utilise a 'collective impact' approach towards building local solutions to mitigate Aboriginal and Torres Strait Islander youth suicide in the region.

NQPHN convening a reference group, made up of a broad cross-section of Indigenous Elders and young people, to advise the Local Action Alliance to assist them to accomplish their brief.

These include:

- Involving people with lived experience, their families, and other support people in all areas.
- Reaching out to include those whose voices are seldom heard, including those in the criminal justice system or who do not access GP or mainstream services, homeless people, and other disenfranchised groups.
- Engaging with community services and other services such as alcohol and other drugs, youth, community-managed mental health services, Indigenous services, allied health networks, consumers, and carers.
- Engaging with communities and community leaders to identify the specific mental health needs of Aboriginal and Torres Strait Islander people.
- Strengthening community structures that can be used as a consultation mechanism, with a particular focus on Aboriginal and Torres Strait Islander people.
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NQPHN convening a reference group, made up of a broad cross-section of Indigenous Elders and young people, to advise the Local Action Alliance to assist them to accomplish their brief.
| Duration | Existing and transitioning commissioning services will commence on 1 July 2016. A significant amount of planning will occur between July 2016 to December 2016. It is anticipated that any additional services that are required to be commissioned will occur in early 2017. |
| Coverage | These activities will cover the entire NQPHN region. There will however be more intense activity in the LGAs with a higher Aboriginal and Torres Strait Islander population. |
| Commissioning approach | Within 2016–17, the existing programs that are being commissioned will be continued for a further 6-12 months. NQPHN will directly contract these services as directed by the Department of Health in line with approved transitional arrangements. During this period of time, NQPHN will review each of the programs against the criteria identified in the performance evaluation framework being developed. Following the review, NQPHN will work with the commissioned services to identify service improvements and potential collaborations/partnerships that may enhance program outcomes. Any new activities for commissioning outlined in the Regional Mental Health and Suicide Prevention Plan will involve an approach to market in the first instance. NQPHN will seek to engage with the market in a competitive dialogue, or interactive procurement approach, to ensure that the service solution purchased and implemented meets the needs of the community. This process will be particularly valuable in enabling innovation. This approach will the completed with the release of a competitive approach to market resulting a contract execution. Monitoring of performance will be conducted based on factors such as the level of risk, value, and impact of the contract. This will be assessed, and will determine the level and frequency of reporting. Specific contract managers within the organisation will be identified and meet regularly with the provider to understand any barriers, opportunities or improvements. |
| Performance Indicator | The mandatory performance indicator for this priority is:  
  - Number of people who are followed up by PHN-commissioned services following a recent suicide attempt.  
  - Completion of a review of all suicide prevention programs that are commissioned by NQPHN against the outcomes — focused performance evaluation framework.  
  - Submission of all Department of Health requirements on time and of a high standard including:  
    a. Regional Mental Health and Suicide Prevention service plan (March 2017).  
    b. Comprehensive Mental Health and Suicide Prevention needs assessment (November 2016).  
  - Number of key stakeholders involved in the development process. |
While these indicators are process and output measures, the development of the monitoring and evaluation framework will inform the outcome measures that NQPHN will be working towards from 2017-18 onwards.

<p>| Local Performance Indicator target (where possible) | In general, performance targets will be based on pre-existing arrangements as consistent with the transitional requirements of the Department. |
| Local Performance Indicator Data source | To be determined once NQPHN has assessed current service delivery. |</p>
<table>
<thead>
<tr>
<th>Priority Area</th>
<th>6: Aboriginal and Torres Strait Islander mental health services</th>
</tr>
</thead>
</table>
| Activity Title / Reference | 6.1 Update protocols  
6.2 Social and emotional wellbeing embedded into primary health care  
6.3 Aboriginal Mental Health First Aid collaboration and coordination  
6.4 Innovative models  
6.5 Community planning/led activities  
6.6 Continue commissioning current ATAPS programs that are already funded by NQPHN or the Department of Health targeting Indigenous Australians for a further six months to 12 months. |

Improving services for Aboriginal and Torres Strait Islander people is a key priority for NQPHN. All activities within the Mental Health and Suicide Prevention activity plan will have a focus on Aboriginal and Torres Strait Islander people.

<table>
<thead>
<tr>
<th>Description of Activity</th>
<th>Objective of the PHN mental health funding: enhance access to and better integrate Aboriginal and Torres Strait Islander mental health services at a local level facilitating a joined up approach with other closely connected services including social and emotional wellbeing, suicide prevention and alcohol and other drug services. For this Objective, both the Primary Health Networks Grant Programme Guidelines - Annexure A1 - Primary Mental Health Care and the Indigenous Australians’ Health Programme – Programme Guidelines apply.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Within the NQPHN over the past 5 years there has been many staff across agencies trained as facilitators in Aboriginal Mental Health First Aid. In FNQ alone up to approx. 35 in the last 4 years. However completing the required sessions to maintain accreditation is a significant hurdle. Currently only approx. 4 of these trained have been able to maintain accreditation. This is a huge loss to the capacity of the Indigenous Workforce across the region. This proposal is not to fund the rollout of the training but as a workforce development strategy to support and coordinate the trainers of this program. With one dedicated part time position across the region we are able to provide a level of support, mentoring and shadow training with the Indigenous staff to support them in gaining reaccreditation as well as those to maintain accreditation after completing the course. This level of support is required at a local level to maximise the investment that the organisations have made in training staff as AMHFA facilitators and is not provided by any other funding in this PHN region.</td>
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<tr>
<td></td>
<td>The revising and circulation of the best practice guidelines for working with Aboriginal and Torres Straits Islander peoples around Mental Health and Social EWB is really important within the region. This supports both improved clinical outcomes, collaboration across the service providers and development of the workforce. Within this activity we have identified that guidelines do exist</td>
</tr>
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</table>
however were developed in 2009 and require a clinical review by an expert group to ensure that they are up to date. Again this activity will require minimal investment but with significant impact locally. It will also be available as a guide that could be accessed nationally for other organisations. This activity is currently not funded by any other source.

Improving Aboriginal and Torres Strait Islander health, as well as mental health are two of the six priority areas identified in NQPHN’s Health Needs Assessment. Aboriginal and Torres Strait Islander people are identified as a separate priority population, not only because of the universality of their disadvantage, but also its intransigence to significant change across the nation. Queensland is home to more than 155,000 people of Indigenous descent, of whom more than 79,000 live within the area serviced by NQPHN. This includes a disproportionate number of remote Indigenous communities, greater levels of socially disadvantaged Indigenous people, and a significant majority of the nation’s Torres Strait Islander population.

Although existing reliable information is wanting, existing community surveys demonstrate inequality between the mental health status of Indigenous Australians and the wider society [1], and that while data on prevalence rates are very limited, it is clear from available data that rates of major mental disorders are high [2]. Based on existing data sources (published and service activity collections) and expert input, the Australian Institute of Health and Welfare (AIHW) is currently generating prevalence rates for Indigenous mental health diagnoses based on estimated rate ratios by comparison to the national population for adult males and females respectively. Preliminary findings suggest that rates are nearly double for most major mental disorders, and substantially higher for substance use disorders (Australian Institute for Health and Welfare, Australian Burden of Disease Study: Technical methods report 2011, in press). Queensland research demonstrates extremely elevated rates of mental health disorders in the incarcerated population [3, 4] and of psychotic disorders in the remote Aboriginal communities in Cape York Peninsula [5]. There is also recent research demonstrating that the leading causes of non-fatal burden of disease in the Indigenous population, constituting some 27 per cent of the non-fatal burden, are from anxiety disorders and depression, and alcohol misuse [6]. Consistent with these higher rates of mental disorder, suicide rates are higher in Queensland’s Indigenous population, substantially greater in young adulthood, and dramatically higher for children under 15 [7]. As a developmental marker of mental health vulnerability, this should be regarded with alarm.

There is evidence for increased service use, not only in terms of public hospital admissions, but also of outpatient services such as Access to Allied Psychological Services (ATAPS) [8]. There is a dearth of reliable evidence for effective interventions – mainstream or culturally adapted – as demonstrated in a systematic review of interventions for Indigenous adults with mental and substance use disorders in Australia, Canada, New Zealand and the United States (Lesk, Harris et al, in press).

In relation to models of service consistent with the WHO service/needs approach, the higher level of social disadvantage (impacting, in particular on the non-formal sector and self-care) and the relative unavailability of specialist services in remote populations, emphasises the centrality of primary care for improving service delivery and effectiveness generally. Furthermore, the circumstances of Queensland’s Indigenous population suggests particular issues in relation to three identified issues in NQPHN’s...
vision: activities, communication, and workforce and resources. In relation to activities (and given the absolute dearth of an evidence-base for effective treatments), this should include an emphasis on the adaptation of evidence-based approaches from the mainstream, and ensuring effective evaluation of adapted and new approaches. In terms of communication, there must be an effective collaborative working relationship with the community-controlled sector and with the primary care providers through Queensland Health services in remote settings. This must also include developing working relationships with peak representative bodies for Indigenous populations (Queensland Aboriginal and Islander Health Council, Torres Strait Regional Authority, councils etc). In relation to workforce and resources, there is a need for sustained needs-based funding commensurate with the excess burden of disease and the challenges of access. Consideration of the cultural needs of the population will be central to recruitment, service processes and resources (clinical and non-clinical). To that end, equity in Indigenous representation across the spectrum of service roles should be sought for the health sector generally, and should be a competence-based affirmative action priority for NQPHN’s Indigenous populations.


6.1 Scope the work associated with updating the 2009 document, “Protocols for the Delivery of Social and Emotional Wellbeing Services in Indigenous Communities: Guidelines for Health worker, clinicians, consumers and carers”. These guidelines were developed in North Queensland for the local population and provide expert guidance for the primary health care sector on assessment, treatment, monitoring, and referral within Aboriginal and Torres Strait Islander populations. This will lead the establishment of mechanisms to ensure that both NQPHN contracted services and all mainstream services provide culturally responsive and accountable mental health services.

6.2 In collaboration with the Aboriginal Community Controlled Health Services (ACCHSs), scope the options for establishing integrated Mental Health and Social and Emotional Wellbeing (SEWB) teams in ACCHSs that aim to improve the journey of Aboriginal and Torres Strait Islander people into and through primary mental health care into specialist mental health services, as well as enhancing the primary care system capacity to better meet needs of people with complex and chronic mental health conditions, including enhanced nursing support and coordinated care. These activities will be connected to the redesigning of the ATAPS program into PiM, and enable access to services that have previously not been provided.

6.3 Scope the funding to an Aboriginal Community Controlled Health Service within the region to facilitate the coordination of the rollout of AMHFA programs, and support facilitators in the delivery of the program, as well as maintaining accreditation. Through a coordinated approach there can be a clear strategy to delivering the program across the region to service providers, as well as communities. While many people are initially trained as facilitators, it takes mentoring, support and coordination to ensure that all are able to maintain their registration.

6.4 In collaboration with Torres and Cape Hospital and Health Service, and the Torres Strait community, scope appropriate models for service delivery and commission if appropriate. Through the Cape York Peninsula SEWB team, collaboratively work with all the agencies to address the identified gaps and collaborate in the delivery of services to remote communities.

6.5 Through the development of the Regional Mental Health and Suicide Prevention Plan, actively engage Aboriginal and Torres Strait Islander communities to undertake planning of community-based suicide prevention activities for Aboriginal and Torres Strait Islander people, which is integrated with drug and alcohol services, mental health services, and social and emotional wellbeing services. Commence commissioning identified services by January 2017.

6.6 Implementation of redesigned ATAPS program into the People in Mind (PiM) program. NQPHN will maintain existing activity across the region. Service models will be explored that commission existing providers and programs to ensure cost effective delivery. This may include enhancement of existing programs to cover a wider geographical area of increased eligibility criteria for existing programs (links with activity 1.4).

### Collaboration

All activities outlined in this area will be developed in collaboration with the Aboriginal Community Controlled Sector and communities. Existing forums and groups will be used to enable collaborative approaches to be further developed.
<table>
<thead>
<tr>
<th><strong>The needs of Aboriginal and Torres Strait Islander people will be identified as a key priority within the Regional Plan, and system strengthening for Aboriginal and Torres Strait Islander communities will involve culturally-appropriate forums on location in these communities and be developed in collaboration with the Community Controlled Health Sector and the HHSs.</strong></th>
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<tbody>
<tr>
<td><strong>Duration</strong></td>
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<tr>
<td><strong>Coverage</strong></td>
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<tr>
<td><strong>Commissioning approach</strong></td>
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</table>
| **Performance Indicator** | The mandatory performance indicator for this priority is:  
  - Proportion of Indigenous population receiving PHN-commissioned mental health services where the services were culturally appropriate. |
<p>| <strong>Local Performance Indicator target (where possible)</strong> | Performance targets will in general be based on pre-existing arrangements as consistent with the transitional requirements of the Department. |
| <strong>Local Performance Indicator Data source</strong> | To be determined once NQPHN has assessed current service delivery. |</p>
<table>
<thead>
<tr>
<th>Proposed Activity</th>
<th>7: Stepped care approach</th>
</tr>
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<tbody>
<tr>
<td>Priority Area</td>
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<tr>
<td>Activity Title / Reference</td>
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<tr>
<td>7.1 Define a comprehensive ‘menu’ of evidence-based services</td>
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<tr>
<td>7.2 Develop a comprehensive map of the mental health workforce</td>
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<tr>
<td>7.3 Promote and support availability of self-help and digital mental health services as an alternative and/or adjunct to face-to-face services</td>
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<tr>
<td>7.4 Access to 24-hour support</td>
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**Objective of the PHN mental health funding:** a continuum of primary mental health services within a person-centred **stepped care approach**, so that a range of service types, making the best use of available workforce and technology, are available within local regions to better match with individual and local population need.

As identified in the needs assessment, NQPHN is actively working towards establishing a comprehensive stepped care approach to ensure that people get the right clinical service at the right level and at the right time, linked to other non-health services. In an area such as North Queensland, access to the full continuum of services is not always possible due to limited availability in rural and remote areas. This creates great challenges in establishing cost effective and efficient services to ensure a system of delivering and monitoring treatments, so that the most effective yet least resource-intensive treatment is delivered to individuals first. As identified in the needs assessment, the urban areas have reasonable access to a range of services whereas the remote areas are less well serviced. Access to internet for e-mental health services is also limited due to the limited availability and high cost of internet access. As discussed in the vision, the workforce capability is fundamental in a stepped care approach and will be a key focus area for NQPHN in the initial stages. This may include some task shifting or reallocation of roles to efficiently use expertise across the mental health continuum. While mental health service providers are familiar with the concepts around the stepped care model, detailed planning on a region-wide basis and use of the reform terminology may be new to many. Through the service strengthening and reform activities outlined in Priority Area 8, it will be essential to work through a shared vision in 2016-17, engaging and building capacity across providers and the community.

7.1 NQPHN will systematically review evidence-based services to identify a comprehensive ‘menu’ of evidence-based services required to respond to the spectrum of need that are appropriate for the local region. Feedback from local experts will also inform this menu. Again, this will not be done in isolation and will be informed by the development work completed in priority area 8. As with priority area 8, this activity aligns with all the objectives of PHN mental health funding and will form the foundation of the mental health systems reform in North Queensland.
7.2 Develop a comprehensive map of the mental health workforce across the PHN catchment to identify gaps in existing workforce, and particular skills required to meet mental health priority areas, in particular a focus on clinicians’ capacity around e-mental health and clinician-assisted digital mental health services.

7.3 Scope the preferred use of e-mental health solutions across the region in collaboration with service providers and the community. Based on the outcomes, work towards improving access to these services and promote e-mental health solutions to provide support to people as a front-line response to more common and less severe issues.

7.4 Scope the access to 24-hour culturally appropriate support needs for the NQPHN region.

| Collaboration | Some of the mechanisms in place or currently being progressed include:
| | - The already established mental health advisory panel, which comprises representatives from the mental health sector including HHSs, GPs, GPLOs, remote area services, alcohol and other drugs, youth, community-managed mental health services, Indigenous services, allied health networks, consumers and carers.
| | - Strengthening community structures that can be used as a consultation mechanism.
| | - Reaching out to include those whose voices are seldom heard, including those in the criminal justice system or who do not access GPs or mainstream services, homeless people, and other disenfranchised groups.
| | - Engaging with communities and community leaders to identify the specific mental health needs of Aboriginal, Torres Strait Islander and South Sea Islander people.
| | - Building feedback mechanisms into all NQPHN activities.

| Duration | It is anticipated that any additional services that are required to be commissioned will occur in early 2017.

| Coverage | These activities will cover the entire NQPHN region. There will however be more intense activity in the LGAs with a higher Aboriginal and Torres Strait Islander population.

| Commissioning approach (If applicable) | New activities for commissioning outlined in the Regional Mental Health and Suicide Prevention Plan will involve an approach to market in the first instance.
NQPHN will seek to engage with the market in a competitive dialogue, or interactive procurement approach, to ensure that the service solution purchased and implemented meets the needs of the community. This process will be particularly valuable in enabling innovation. This approach will be completed with the release of a competitive approach to market resulting in a contract execution.
Monitoring of performance will be conducted based on factors such as the level of risk, value, and impact of the contract. This will be assessed, and will determine the level and frequency of reporting. Specific contract managers within the organisation will be identified and meet regularly with the provider to understand any barriers, opportunities or improvements.

| Performance Indicator | The mandatory performance indicator for this priority is:  
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<tr>
<td></td>
<td>• Proportion of PHN flexible mental health funding allocated to low intensity services, psychological therapies, and clinical care coordination for those with severe and complex mental illness.</td>
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<thead>
<tr>
<th>Local Performance Indicator target (where possible)</th>
<th>To be determined.</th>
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<p>| Local Performance Indicator Data source | To be determined. |</p>
<table>
<thead>
<tr>
<th>Proposed Activity</th>
<th>8: Regional mental health and suicide prevention plan</th>
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<tbody>
<tr>
<td>Priority Area</td>
<td>8.1 Development of a Regional Mental Health and Suicide Prevention Plan. Incorporate within the plan:</td>
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<tr>
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<td>o A communication and collaboration framework</td>
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<td></td>
<td>o Identification of workforce and resource needs</td>
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<td></td>
<td>o An outcomes-focused performance evaluation framework.</td>
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<td>8.2 Development of an evaluation framework to review existing commissioned services</td>
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<td></td>
<td>8.3 Mental Health and Suicide Prevention service enhancement workshops</td>
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<td></td>
<td>8.4 Needs assessment and service mapping</td>
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<td></td>
<td>8.5 Commissioning principles</td>
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<td></td>
<td>8.6 My Health Record for individuals with mental health needs</td>
</tr>
<tr>
<td>Description of Activity</td>
<td>Objectives of the PHN mental health funding: evidence-based regional mental health and suicide prevention plans and service mapping to identify needs and gaps, reduce duplication, remove inefficiencies, and encourage integration.</td>
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<td></td>
<td>NQPHN will develop a shared evidence-based comprehensive Regional Mental Health and Suicide Prevention Plan that will be used by NQPHN to guide the strategic direction for North Queensland, in line with the national reform agenda, and be used for equitable planning and purchasing of place-based mental health, suicide prevention programs, services, and integrated care pathways across North Queensland.</td>
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<td>The framework will include key reform concepts such as the planning of mental health services around a stepped care approach, the integration of physical, mental, social and emotional health and wellbeing within primary health care, as well as applying a social determinants of health framework to the ongoing development of the Mental Health and Suicide Prevention service system, to address the interconnected behavioural and socio-economic factors.</td>
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<td></td>
<td>8.1 NQPHN, in collaboration with Abt JTA, will develop a Regional Mental Health and Suicide Prevention Plan. The implementation of a stepped care model locally will require a changed skills set and workforce to operate optimally. Therefore key considerations in the development of the plan will be communication and collaboration, as well as the identification of workforce and resource needs. As part of the process, a series of stakeholder consultations will be conducted initially across the NQPHN footprint, including service providers and consumers, to help evaluate the adequacy of the existing mental health service system response, including workforce. Within this planning period the planning team will focus on both collaborative care, as well as system and service collaboration with two main groups:</td>
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• With the specialist services (both mainstream and private) to facilitate joint planning to ensure that pathways to care function optimally, as is fundamental to a stepped care approach.
• With a wide range of community organisations and the primary health care sector to ensure that the broader social, occupational, accommodation, and general health care needs of those individuals who have a mental health disorder and/or problem are addressed.
• Involving people with lived experience, their families, and other support people is fundamental with both groups.

All consultations and engagement will following the International Association for Public Participation - IAP2 model, with overlap utilising specific protocols for different population groups – for example, Aboriginal, Torres Strait Islander and South Sea Islander populations.

As PHNs are responsible for identifying local indicators for each of their activities, Abt JTA will be contracted to develop an outcomes-focused performance evaluation framework for mental health and suicide prevention services, including collection and analysis of data on patients’ and consumers’ experiences with the mental health and suicide prevention/post intervention system; development of measures of service quality; and outcome-focused measures. This framework will be guided by the PHN Performance Framework (February 2016) and focus on local indicators that align with the PHN objectives, national priority areas, and national headline indicators. While some early work has been completed in this area, during the development of this activity plan further refinement and consultation will take place as part of the plan and incorporate:

• collection and analysis of data on patients’ and consumers’ experiences with the mental health and suicide prevention/post intervention system
• development of measures of service quality as part of further research into the mental health workforce
• development of an overarching performance framework based on outcome-focused measures, including indicators of:
  o Rates in repeat use of hospital mental health services
  o Rates of homelessness or increased accommodation security for mental health consumers
  o Uptake of employment services or employment opportunities by mental health consumers
  o Increased social inclusion and participation for people with a mental illness.

By engaging a contractor organisation, Abt JTA, who have expertise in mental health and alcohol and other drugs planning, as well as monitoring and evaluation, a broad range of capacity building will occur with NQPHN.

8.2 Based on the identified indicators above, Abt JTA will initially be used to review all mental health and suicide prevention services that are being commissioned through NQPHN. The service review information will inform potential program enhancements and expansion, as well as options for service collaboration and partnerships.
8.3 Using a systems-thinking approach, Abt JTA in partnership with NQPHN would conduct a range of service enhancement workshops across the region with service providers, communities, and people with a lived experience to decide how the service system can be improved for the full range of social contexts across the NQPHN footprint – coastal cities, rural, mining and remote Indigenous. These workshops will engage a broad range of people and enable discussion around the national mental health reform agenda and the NQPHN approach. It enables feedback to communities and individuals who participated in the consultations. It is through this process where we will seek agreement and ongoing collaboration for a coordinated mental health system across the region.

8.4 Further develop the comprehensive service mapping and needs assessment of mental health and suicide prevention and programmes and supports within the region to identify gaps in services for inclusion in the 2016-17 needs assessment.

8.5 Based on the Regional Mental Health and Suicide Prevention Plan and associated frameworks, develop key principles around commissioning mental health services. In addition to the NQPHN commissioning guidelines, these principles are specifically around ensuring that services are based on recovery principles such as humanity, dignity, respect and a strengths-based approach. Also included will be mechanisms to support individuals’ and families’ choice of provider where possible, and choice of interventions, treatments and therapies.

9 To maximise provider use and the value of the My Health Record for individuals with mental health needs, NQPHN will:

- Scope Northern Queensland mental health service providers who could sign up to use My Health Record
- Map the systems use of the service providers and identify compatible systems
- Promote, support and educate service providers to register to use My Health Record and upload mental health summaries for consenting clients.

Collaboration

NQPHN and Abt JTA will utilise a systems-thinking approach to these planning and system strengthening activities to ensure that there is full engagement with all relevant parties. NQPHN will continue to develop its consultation mechanisms to regularly engage and consult with people with lived experience, communities, and service providers within the region. NQPHN will ensure that the mental health needs of the whole population including seldom-heard groups are considered. NQPHN has adopted the International Association for Public Participation - IAP2 model, with overlap utilising specific protocols for different population groups – for example, Aboriginal, Torres Strait Islander and South Sea Islander populations to guide all engagement and consultation processes.

As part of the development of the Regional Mental Health and Suicide Prevention Plan, NQPHN will develop strategies around ongoing communication and collaboration with the mental health and associated sectors.

Some of the mechanisms in place or currently being progressed include:
- The already established mental health advisory panel, which comprises representatives from the mental health sector including HHSs, GPs, GPLOs, remote area services, alcohol and other drugs, youth, community-managed mental health services, Indigenous services, allied health networks, consumers and carers.
- Strengthening community structures that can be used as a consultation mechanism.
- Reaching out to include those whose voices are seldom heard, including those in the criminal justice system or who do not access GPs or mainstream services, homeless people, and other disenfranchised groups.
- Engaging with communities and community leaders to identify the specific mental health needs of Aboriginal, Torres Strait Islander and South Sea Islander people.
- Building feedback mechanisms into all NQPHN activities.

NQPHN will aim to further strengthen these systems and structures to enable the local community, service users, and carers to influence commissioning decisions. This could be achieved by strengthening relationships and jointly working with local groups and service users to assess the quality, performance, and outcomes of services and the effectiveness of care pathways, and to co-design innovative service models.

While this activity is a whole of region planning process, specific attention will be paid to the needs of Aboriginal and Torres Strait Islander people within the region. The needs of Aboriginal and Torres Strait Islander people will be identified as a priority within the Regional Plan.

System strengthening for remote Indigenous communities will involve culturally-appropriate forums on location in these communities, and will be developed in collaboration with the Community Controlled Health Sector and the HHSs.

<table>
<thead>
<tr>
<th>Duration</th>
<th>Commence June 2016 and deliverables completed by March 2017</th>
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<tr>
<td>Coverage</td>
<td>These activities will cover the entire NQPHN region. There will however be more intense activity in the LGAs with a higher Aboriginal and Torres Strait Islander population.</td>
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</table>

**Commissioning approach (if applicable)**

The range of activities outlined above will be a combination of commissioned services supported by the necessary internal planning and infrastructural enablement. NQPHN will directly engage Abt JTA to support the internal team in all the activities, including the framework development and facilitation of the systems strengthening workshops. Abt JTA has a wide range of health planning and evaluation experience and has assembled an expert mental health, alcohol and other drugs, Indigenous health and evaluation team to support NQPHN in the mental health service planning. Utilising this approach, capacity development will occur with NQPHN, particularly around mental health and suicide prevention reform, as well as evaluation.

Community engagement and consultation will be led by NQPHN, in collaboration with Abt JTA, to ensure that long-term relationships are being developed between the community stakeholders and NQPHN.
Ongoing feedback on the process will be sought from key stakeholders, as well as support and acceptance of the regional plan by all key stakeholders. Ongoing monitoring of these activities will be conducted by NQPHN, as it works alongside the Abt JTA consultant team.

Monitoring of performance will be conducted based on factors such as the level of risk, value, and impact of the contract. This will be assessed, and will determine the level and frequency of reporting. Specific contract managers within the organisation will be identified and meet regularly with the provider to understand any barriers, opportunities, or improvements.

The mandatory performance indicator for this priority is:

- Evidence of formalised partnerships with other regional service providers to support integrated regional planning and service delivery.

Local output indicators:
- An evidence-based regional mental health and suicide prevention service planning, communication, and collaboration framework that has been developed in collaboration will all key stakeholders.
- An outcomes-focused performance evaluation framework that will guide the commissioned service reporting against meaningful, measurable performance targets that aligns with national, state, and regional indicators.
- Submission of all Department of Health requirements on time and of a high standard including:
  - Regional Mental Health and Suicide Prevention service plan (March 2017)
  - Comprehensive Mental Health and Suicide Prevention needs assessment (November 2016)

Local process indicator:
- Number of key stakeholders involved in the planning process.

While these indicators are process and output measures, the development of the monitoring and evaluation framework will inform the outcome and impact measures that NQPHN will be working towards in 2017-18 onwards.

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>Local Performance Indicator target (where possible)</th>
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<td></td>
<td>To be determined once NQPHN’s planning framework is complete.</td>
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| Local Performance Indicator Data source | To be determined. |