Primary Mental Health Care

Activity Work Plan 2025/26 - 2028/29

phn
DARLING DOWNS AND WEST MORETON
An Australian Government Initiative

Local Integrated Primary Health Care

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1. Mental Health Multidisciplinary Services Program

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Mental Health Priority Area 4: Mental health services for people with severe and complex mental illness including care packages

AIM OF ACTIVITY

The aim of this activity is to enhance access to appropriate mental health support for people with severe and complex mental health needs in primary care settings.

This activity prioritises people with severe and complex mental health needs in four underserviced, rural communities within the PHN region and will increase access to care, reduce delivery fragmentation, prevent avoidable hospital admissions, and improve mental health outcomes for these people located in these areas.

DESCRIPTION OF ACTIVITY

CountryCare Connect is a GP-led Hub-and-Spoke model, with GPs at the centre of care coordination for severe and complex mental health patients. The Hubs will service MMM 4 and 5 areas namely Western Downs, Somerset, Goondiwindi, and Lockyer Valley Local Government Areas, where healthcare access is limited and communities are dependent on visiting health professionals or travelling significant distances to access appropriate services.

The GP clinics will act as Hubs and hold the clinical governance for the program, with support from a team of multidisciplinary Allied Health Professionals (AHP) and Specialist Telehealth Psychiatry. The spokes include outreach clinics and the availability of home visits to reach rural and isolated patients, which will offer both individual and group services aligned to the patient's care plans.

Four GP-led, rural place-based multidisciplinary Hubs will deliver enhanced access to support for individuals utilising a coordinated stepped-care approach that allows patients to step down to lower-intensity Mental Health supports through the PHN's Integrated Mental Health Hubs, or step-up to acute hospital care.

Being led by the patient's GP, regular multidisciplinary case conferencing will be a key component of this collaborative model ensuring holistic treatment, reduced hospitalisations and coordinated care is delivered, ensuring the patient's physical, psychological and social care needs are addressed.

Consultation with key stakeholders to determine referral pathways and integration and interfaces with existing services and programs will be central to the Hub's design and establishment.

Capacity Building and Training:

The AHP team workforce will be supported through an integrated approach with each General Practice Hub via regular Communities of Practice, professional development opportunities, and professional supervision via the Hospital and Health Service (HHS) Mental Health Service in each region.

The commissioned GP Practices will support these AHPs Team members by defining roles, providing resources, fostering collaboration, ensuring clinical governance, facilitating case conferencing, and supporting care coordination.

GP's will be supported via the commissioned Telehealth Psychiatry service, who will provide specialist advice and guidance on individual care plans and treatment where required. In addition, GPs will have the opportunity to access advice and resources through the commissioned HHS Mental Health service.

Service Workforce:

The CountryCare Connect workforce will aim to include a Mental Health Worker (Psychologist, Mental Health Occupational Therapist or Mental Health Nurse), a Social Worker, and Telehealth Psychiatry. The opportunity to add an additional third FTE allied health professional has arisen with the delay in funding being provided for 2025/26. The

composition of the disciplines of each AHP Team will be determined according to the identified needs with each Hub and subject to workforce availability.

These workers will provide therapeutic support, psychosocial interventions, and telehealth psychiatric consultations which will include:

- Assessment, diagnosis and treatment of psychological problems
- Psychotherapy, Counselling and Therapy
- Delivery of person-centred and evidence-based clinical and non-clinical interventions
- Advocacy, clinical care and resource coordination, case management
- Recovery planning that includes education to support patients and carers to understand their mental illness.

Patient turnover will support the management of caseloads and adjust care intensity.

Governance:

Clinical Governance will be managed by the GP practice and Psychiatry service and supported by Professional Supervision provided by the HHS in each region. The PHN will collaborate with the local HHS to ensure efficient decision-making and alignment with the Program's goals.

Program Governance will be managed by the PHN Program Coordinator and the Directors of Primary Care and Mental Health, which will include regular provider meetings and performance monitoring which will ensure key performance indicators are being met.

CountryCare Connect Hubs will also align their activities with actions outlined in the PHN's Joint Regional Mental Health and Suicide Prevention Plan, Healthy Minds, Healthy Lives.

Data Reporting Requirements:

Service activity data will be collected through the PHN's Client Management System, refeRHEALTH. This tool will collect both aggregate and disaggregated data as required by the Department. System training and ongoing support for users will be provided.

MDT providers will use refeRHEALTH to collect patient data for reporting, with compliance, performance and monitoring managed by the PHN Program Coordinator.

The outcome tools to be utilised beyond K5/K10 will be a QoL Patient Reported Outcome Measure (PROM) to be determined by the PHN, a Patient Reported Experience Measure (PREM) Your Experience of Service (YES) survey, along with a Workforce Satisfaction Outcome Measure to be determined by the PHN.

Evaluation Arrangements:

The PHN will commission an external evaluator to develop a structured evaluation framework for the CountryCare Connect Program. This framework and tools will assess the program's effectiveness and impact, including data collection methods, patient-reported outcome and experience measures, and evaluation timeframes. The PHN will oversee the evaluation process, facilitate data collection, and ensure collaboration with key stakeholders.

The PHN will also ensure the evaluation is aligned with the national-level program evaluation as this is developed.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Mental health and problematic substance use

ACTIVITY CONSULTATION AND COLLABORATION

Consultation

Consultation with the commissioned Hub locations and local stakeholders will be undertaken to map the needs of the community, including priority populations and referral pathways.

This consultation will identify gaps and barriers to mental health primary care services, determine referral pathways and integration/interfaces with existing services and programs.

Stakeholders engaged include but are not limited to:

- Darling Downs Hospital and Health Service
- West Moreton Hospital and Health Service
- CountryCare Connect General Practices and Allied Health Professionals
- Commissioned Telehealth Psychiatry service
- Local referring GP Practices and ACHHOs
- PHN Commissioned service providers
- Local community organisations
- People with a lived experience of severe and complex mental health issues.

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2. Medicare Mental Health - Intake and Assessment Phone Service

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Mental Health Priority Area 7: Stepped care approach

AIM OF ACTIVITY

The aim of this activity is to support the operations of the Medicare Mental health Phone Service as an entry point for adults to access mental health services for the Darling Downs and West Moreton region.

DESCRIPTION OF ACTIVITY

The PHN engages a lead agency to operate the service within the funding provided for this activity and in accordance with the service model and guidance documents provided by the Department.

The Medicare Mental Health Phone Service includes the following core service elements:

- operate under the single national phone number specified in the service model (1800 595 212);
- provide a central point to connect people to other services in our region, including offering information and advice about mental health and alcohol and other drug use
- provide a holistic assessment of needs delivered by a trained professional using the Commonwealth's Initial Assessment and Referral (IAR) tool
- connect people seamlessly to the most appropriate local service to meet their identified needs; and
- collect and report data to the PMHC MDS, in accordance with the national service model for the intake and assessment phone service

The Medicare Mental Health Phone Service adopts the national branding, data collection and reporting requirements as directed by the Department and works with the commissioned lead agency on relevant matters including service delivery, data, communications and branding.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Mental health and problematic substance use
Enablers

ACTIVITY CONSULTATION AND COLLABORATION

Consultation

The following key stakeholder groups will be engaged and consulted during the activity:

- Darling Downs and West Moreton Hospital and Health Service;
- Community Working Group/s;
- PHN Clinical Council;
- GP / Health Service Provider Advisory Groups;
- Aboriginal Community Controlled Health Services;
- Non-Government and community organisations including consumer and carer representative groups or lived experience representatives.

3. Initial Assessment and Referral

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Mental Health Priority Area 7: Stepped care approach

AIM OF ACTIVITY

This activity aims to support General Practitioners (GPs), clinicians and relevant commissioned service providers in the primary care setting, using the stepped care model to select the least intensive level of care, for a person presenting for mental health assistance by using the Initial Assessment and Referral (IAR) tool. This will contribute to achieving nationally consistent levels of care for persons presenting with similar conditions.

DESCRIPTION OF ACTIVITY

A plan for disseminating and implementing the National IAR Guidelines locally has been developed. The plan implements strategies to encourage local adoption and implementation, forecasting any anticipated challenges and developing strategies to address these challenges.

The PHN has trained several Primary Care Liaison Officers (PCLOs) to become IAR Training and Support Officers, to support GPs and clinicians in learning and implementing the IAR into clinical practice and workflow.

By training multiple PCLO's, the PHN will be able to leverage established relationships with GP's to improve uptake of training and future proof the program by building redundancy via multiple trained parties who can continue to educate into the future.

The PCLO's will continue to:

- Participate in required training including 'train the trainer' education delivered by the Program's National Project Manager, to build capability and confidence in using the IAR, facilitating training and supporting GPs to implement the IAR;
- Deliver training to build relationships with, and provide ongoing support to GPs, clinicians and relevant commissioned service providers in Adult Mental Health Centres, general practices, Aboriginal Medical Services within the PHN region via monthly scheduled webinars and practice specific face to face training;
- Deliver training to build relationships with, and provide ongoing support to GPs and clinicians in Kids Mental Health Centres and Residential Aged Care Facilities as the IAR is adapted for specific vulnerable cohorts and as required by the Department, as well as in Local Hospital Networks/Districts as jurisdictions in our region adopt the IAR via monthly scheduled webinars and facility specific face to face training;
- Meet the GP training target and maintain records to support the GP attendance and remuneration. Payment to GPs who attend and complete the full IAR training will be made available once evaluation forms have been completed. PCLO's will keep records of GP attendance throughout each training session, ensure the training and evaluation forms are completed, and provide informal updates to the Department at monthly meetings. IAR TSOs will provide quarterly reports to the Department with details on how many GPs have been trained and remunerated and how many GPs are booked in for future training;
- Build strong relationships across the TSO network and with other key stakeholders to explore opportunities for cross-boundary learning and collaboration;
- Undertake targeted implementation improvement and planning activities for the Initial Assessment and Referral for Mental Healthcare Decision Support Tool to optimise effectiveness and enhance mental healthcare accessibility
- Meet with the Department and National Project Manager, as required, to report on training numbers for all staff trained, share enablers and discuss any barriers;

- Work with the Department to promote integration of clinical software solutions, once developed, with clinical practices and practice managers within the PHN region
- Collect data and report on GP and other clinician training as detailed in the Program Guidance for Primary Health Network Initial Assessment and Referral Training and Support Officers.

NEEDS ASSESSMENT PRIORITY

Live Health Needs Assessment 2022/24

PRIORITY
Increasing access and coordination or care
Providing primary mental health care

ACTIVITY CONSULTATION AND COLLABORATION

Consultation

The following key stakeholder groups will be engaged and consulted during the activity:

- PHN Clinical Council
- Consumer Groups
- Local Networks
- GP / Health Service Provider Advisory Groups.

4. Psychological Treatment Services for People with Mental Illness in RACH

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Mental Health Priority Area 3: Psychological therapies for rural and remote, under-serviced and / or hard to reach groups.

AIM OF ACTIVITY

This Activity aims to provide services for residents in collaboration with residential aged care homes (RACH), in a way which respects RACH roles, responsibilities and operational issues. This includes provision of appropriate referral and assessment processes to ensure services target residents with or at risk of mental health conditions.

DESCRIPTION OF ACTIVITY

Darling Downs and West Moreton PHN will continue the provision of mental health services to deliver mental health care that complements personal care and accommodation services provided by RACHs, dementia services and broader physical health and social supports.

Services are provided on location in RACHs, targeting residents with a diagnosed mental health condition or who are assessed as at risk if they do not receive support. A stepped care approach is utilised with appropriate referrals to mental health support, including time-limited psychological therapies for older people with mild to moderate mental illness and low intensity group and individual services.

Ongoing consultation throughout this activity assists in determining the longer-term mental health care delivery models for older people living in RACHs.

Under this activity, deidentified service delivery data that is in scope for inclusion in the PMHC-MDS will be submitted by commissioned services providers via the PHN's Data Reporting Management Tool and uploaded to the Logicly MDS portal..

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Care across the lifespan
Mental health and problematic substance use

5. Targeted Regional Initiatives for Suicide Prevention

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Mental Health Priority Area 5: Community based suicide prevention activities.

AIM OF ACTIVITY

This activity aims to adopt a community-led and systems-based approach to suicide prevention targeting populations identified at risk of suicide or suicidal distress.

DESCRIPTION OF ACTIVITY

- Our PHN will work with the Department and key stakeholders to:
- Improve care coordination and service pathways for people at risk of or bereaved by suicide;
- Commission and/or adapt services, activities and training packages for at-risk cohorts in the community to identify and respond early to distress;
- In partnership with community leaders and people with lived experience, commission services that offer support via multiple channels including online, telephone, videoconference and face to face to meet community needs;
- Build the capacity and capability of the local workforce to respond to suicide and distress and link people with appropriate supports and services;
- Commission peer support and mentorship programs for people at risk or impacted by suicide;
- Submit data on activities to the Primary Mental Health Care Minimum Data Set;
- Undertake data analytics and research using data in the Suicide and Self Harm Monitoring System and make the analysis available for use by planners and service providers.

Our PHN's Suicide Prevention Regional Response Coordinator takes primary responsibility for engagement, coordination and integration of early intervention and suicide prevention activities across regional stakeholders and service providers. This includes establishing governance groups, developing local action plans and establishing suicide response protocols.

The Suicide Prevention Regional Response Coordinator also:

- Acts as a key contact for the National Aboriginal Community Controlled Health Organisation's Culture Care Connect Program, which is a first of its kind Aboriginal and Torres Strait Islander community-controlled approach to suicide prevention service coordination, aftercare services and training in alignment with the National Agreement on Closing the Gap;
- engage with the Suicide Prevention Network and community of practice events, and participate in the suicide prevention capacity building program, which provides expert research, evidence, and implementation support to communities across Australia.

In addition to the above the PHN will commission a Distress Brief Support Trial site in Toowoomba funded by underspend held within this activity and the Regional Approach to Suicide Prevention activity.

Under the Distress Brief Service activity, the Darling Downs and West Moreton PHN (the PHN) will deliver a trial site in the Toowoomba LGA, with an intention to establish outreach to other high needs areas of Darling Downs. The PHN will commission the service provider to:

- Partner with and support community engagement points, which are places in the community outside the health system, that people may present to when in distress, but which lack internal capacity to respond to distress. The service will provide training to workers within these Community Engagement Points to identify people in distress and provide supportive conversations to help people manage their distress, as an initial layer of service

support. The number of community engagement points will be determined as implementation progresses, are subject to co-design, interest, and emergent demand and capacity.

- Identify, engage, support and coordinate short-term non-clinical supports for adults experiencing distress who require support beyond that provided through Community Engagement Points, particularly those who would otherwise be unlikely to seek help.
- Employ a strengths-based approach that empowers the person to cope with their distress by promoting positive help-seeking behaviours.
- Establish connections to longer-term supports that addresses the drivers of the person's distress if required.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Mental health and problematic substance use

ACTIVITY CONSULTATION AND COLLABORATION

Consultation

The following key stakeholder groups will be engaged and consulted during the activity:

• PHN Clinical Council
• Consumer Groups
• Local Networks
• GP / Health Service Provider Advisory Groups.

6. Aboriginal and Torres Strait Islander People Mental Health Service

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Aboriginal and Torres Strait Islander Health

AIM OF ACTIVITY

This Activity aims to:

- Establish linkages between commissioned and existing services to facilitate an integrated approach to the provision of mental health services for Aboriginal and Torres Strait Islander people. This includes social and emotional wellbeing, suicide prevention and alcohol and other drug services to enhance and better integrate mental health services
- Support providers to develop and maintain culturally appropriate and safe services that holistically meet the needs of clients and their families
- Ensure referral pathways are in place to enable and support clients to seamlessly transition between services as their needs change
- Improve access to culturally appropriate services.

DESCRIPTION OF ACTIVITY

This Activity provides a continuum of primary mental health services for Aboriginal and Torres Strait Islander people within a person-centred, stepped care approach providing a range of services to meet local needs. This includes access to services for low intensity interventions, hard to reach populations, severe mental health conditions, child and youth, and suicide prevention ensuring commissioning includes providers of social and emotional wellbeing, suicide prevention and alcohol and other drug services.

Service models holistically meet the Social and Emotional needs of each patient, including providing support for affected families and communities through implementing team-based approaches within local communities to deliver efficient and coordinated mental health services.

The PHN will support Aboriginal & Torres Strait Islander Community Controlled Health Organisations / Aboriginal Community Controlled Health Organisations (ATSICCHOs / ACCHOs) and Aboriginal Medical Service (AMS) providers to deliver high quality services that meet the needs of people and their community.

Under this activity, deidentified service delivery data that is in scope for inclusion in the PMHC-MDS will be submitted by commissioned services providers via the PHN's Data Reporting Management Tool and uploaded to the Logicly MDS portal.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Priority populations
Mental health and problematic substance use

7. Regional approach to suicide prevention

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Mental Health Priority Area 5: Community based suicide prevention activities

AIM OF ACTIVITY

This Activity aims to:

This activity aims to deliver community-based suicide prevention services, through an integrated and systems-based approach in partnership with Hospital and Health Services and other local organisations. This involves ensuring agreement within the region, including Hospital and Health Services, about the need to support person-centred follow-up care to individuals who are at risk of suicide, have self-harmed or attempted suicide, and that there is no ambiguity in the responsibility for provision of this care.

DESCRIPTION OF ACTIVITY

Under the Distress Brief Support activity, the Darling Downs and West Moreton PHN (the PHN) will deliver a trial site in the Toowoomba Local Government Area, with an intention to establish outreach to other high needs areas of Darling Downs. This program is funded by underspend held within this activity and the Targeted Regional Initiatives for Suicide Prevention activity. The PHN will commission the service provider to:

- Partner with and support community engagement points, which are places in the community outside the health system, that people may present to when in distress, but which lack internal capacity to respond to distress. The service will provide training to workers within these Community Engagement Points to identify people in distress and provide supportive conversations to help people manage their distress, as an initial layer of service support. The number of community engagement points will be determined as implementation progresses, are subject to co-design, interest, and emergent demand and capacity.
- Identify, engage, support and coordinate short-term non-clinical supports for adults experiencing distress who require support beyond that provided through Community Engagement Points, particularly those who would otherwise be unlikely to seek help.
- Employ a strengths-based approach that empowers the person to cope with their distress by promoting positive help-seeking behaviours.
- Establish connections to longer-term supports that addresses the drivers of the person's distress if required.
- Further activities delivered will:
- Aim to reduce the risk of escalation and the need for hospitalisation by reaching people in distress earlier, with provision of supports to help address individual concerns and risk factors in the short term.
- Support connections to the broader mental health (including psychosocial) services system as relevant.
- Continue to develop of referral pathways and protocols.
- Continue to coordinate and mobilise resources locally in the context of postvention supports, to reduce the impacts of suicide within our communities.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Mental health and problematic substance use

8. Child and Youth Mental Health Services - headspace

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Mental Health Priority Area 2: Child and youth mental health services

AIM OF ACTIVITY

This activity aims to deliver services in line with the existing headspace model. headspace centres aim to improve mental health outcomes for young people aged 12-25 years with, or at risk of, mild to moderate mental illness.

DESCRIPTION OF ACTIVITY

Darling Downs and West Moreton PHN will maintain service delivery within headspace centres, in line with the existing headspace service delivery model (hMIF). This Activity will establish improved integration of headspace centres with broader primary mental health care services; physical health services; drug and alcohol services and social and vocational support services.

The Activity provides for the continuation of funding headspace Toowoomba, Warwick and Ipswich which addresses mental health needs of children, young people and young adults aged 12- 25 by offering a range of flexible clinical and non-clinical services. Additionally, the funding is utilised as needed to address ongoing targeted psychosocial, individual and group intervention and community supports to young people.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Mental health and problematic substance use

9. Primary Mental Health Service Navigation

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Mental Health Priority Area 7: Stepped care approach

AIM OF ACTIVITY

This activity aims to:

- Drive projects that seek to reduce the complexity of accessing local services through navigation of stepped care ensuring consumers receive the right care in the right place at the right time.
- Increase General Practitioner knowledge and ability to provide appropriate referrals by utilising an integrated, stepped care approach.
- Increase accessibility to appropriate services within appropriate timeframes.

DESCRIPTION OF ACTIVITY

The PHN is currently undertaking a broad Mental Health, Suicide Prevention, and Alcohol and Other Drugs (MHSPAOD) commissioning refresh, which is focussed on the establishment of integrated mental health hubs/networks and Medicare Mental Health Centres (MMHCs) across the region. This initiative seeks to ensure that people residing in each Local Government Area in our region have access to well-integrated MHSPAOD supports that are co-designed to be tailored to the context of place and are underpinned by an equitable approach to the distribution of funding.

This approach will ensure clients who are seeking support for their mental health concerns are provided with person centred, place based, seamless, integrated referral pathways enabling care to be delivered along the stepped continuum, to meet their needs on their path to wellness. It will reduce siloed service delivery, place the client at the centre of their care and create positive and transformative change within the mental health services system. These hubs will work in partnership with communities, local Hospital and Health Services, and the broader system to establish mental health care neighbourhoods around the MMHCs and integrated mental health hubs/networks, to drive initiatives to support better coordinated care at the system level.

Through this Activity, the DDWMPHN will continue:

- Delivery of community engagement and co-design activities to better understand community needs around models of integrated mental health.
- Supporting the implementation of integrated mental health models in the context of place.
- Delivery of assistance and education to consumers, carers, GPs, mental health professionals and other key services to drive the coordination of integrated services for people with or at risk of developing mental health conditions and complex support requirements from a person-centred approach;

Under this activity, deidentified service delivery data that is in scope for inclusion in the PMHC-MDS will be submitted by commissioned services providers via the PHN's Data Reporting Management Tool and uploaded to the Logicly MDS portal.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Enablers
Mental health and problematic substance use

ACTIVITY CONSULTATION AND COLLABORATION

Collaboration

The PHN will be co-designing the integrated mental health hubs with a range of key stakeholders, including people with a Lived or Living Experience, community members, GPs, Hospital and Health Service representatives, commissioned and non-commissioned mental health, suicide prevention, and alcohol and other drug service providers, community groups, and other providers of services that span key social determinants of health. By working in partnership with these stakeholders, we will design innovative and place-based responses that are aligned to the unique needs of communities across our PHN region.

10. Primary Mental Health Clinical Care Coordination for People with Severe Mental Illness

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Mental Health Priority Area 4: Mental health services for people with severe and complex mental illness including care packages

AIM OF ACTIVITY

This Activity aims to:

- Deliver clinical care coordination, including mental health nurse services to support the needs of people with severe and complex mental illness who are best managed in primary health care.
- Encourage GPs and other regional providers to address the physical health and other inequities of individuals with severe mental health conditions within the region.
- Promote improved integration of primary care services with community based private psychiatry services and state community managed mental health services for people with severe mental health conditions in the context of the development of the joint Regional Mental Health, Alcohol and Other Drugs plan.

DESCRIPTION OF ACTIVITY

This activity, previously referred to as 'Primary Mental Health Nurse Care for People with Severe Mental Illness' has been renamed to reflect clinical care coordination activities more broadly.

The PHN is currently undertaking a broad Mental Health, Suicide Prevention, and Alcohol and Other Drugs (MHSPAOD) commissioning refresh, which is focussed on the establishment of integrated mental health hubs/networks and Medicare Mental Health Centres (MMHCs) across the region. This initiative seeks to ensure that people residing in each Local Government Area in our region have access to well-integrated MHSPAOD supports that are co-designed to be tailored to the context of place and are underpinned by an equitable approach to the distribution of funding.

This approach will ensure clients who are seeking support for their mental health concerns are provided with person centred, place based, seamless, integrated referral pathways enabling care to be delivered along the stepped continuum, to meet their needs on their path to wellness. It will reduce siloed service delivery, place the client at the centre of their care and create positive and transformative change within the mental health services system. These hubs will work in partnership with communities, local Hospital and Health Services, and the broader system to establish mental health care neighbourhoods around the MMHCs and integrated mental health hubs/networks, to drive initiatives to support better coordinated care at the system level.

In FY2026/27, the PHN will continue to:

- Plan and deliver right-size Mental Health Clinical Care Coordination services, and more broadly, stepped care mental health investments in alignment with community need through the roll out and planning of place based LGA focussed responses through mental health and healthcare neighbourhood models • Partner with commissioned providers to drive an uplift in service performance, through stronger reach, impact, and value propositions.

Mental Health Clinical Care Coordination services are for people with severe mental illness being managed in primary care and commissioned by our PHN to be delivered by lead agencies across the region. In the Toowoomba Local Government Area, the local allocation of Mental Health Clinical Care Coordination services will be delivered primarily through the Toowoomba Integrated Mental Health Hub. Commissioned Mental Health Clinical Care Coordination services for people with severe mental illness will:

- Provide evidence-based intervention for people with severe mental illness who can be appropriately managed in the primary care setting as part of their overall treatment.

- Complement and enhance existing GP, psychiatrist and allied mental health professional services available through the Medicare Benefits Schedule (MBS).
- Offer the right frequency and volume of services to meet the needs of people with severe mental illness (e.g. The right number of occasions of service at the right time).
- Be provided by a suitably skilled and qualified workforce, working within their scope of practice, matched to the needs of those accessing the services. This includes, but is not limited to, mental health nurses.
- Be consistent with relevant standards and legislative/regulatory requirements and align with the standards articulated in the national standards for mental health services 2010.
- Promote recovery and align with the national framework for recovery oriented mental health services 2013 where relevant.
- Be coordinated with other health and support services already provided to people with severe mental illness and complex needs.

Provide links to other services within a stepped care approach to ensure people are matched to a service commensurate with their mental health need, and;

- Address the needs of young people with or at risk of severe mental illness.

The PHN will also support commissioned Mental Health Clinical Coordination services to collaborate with the Medicare Mental Health Phone Service and other commissioned mental health stepped care providers to help ensure that Mental Health Clinical Care Coordination services are delivered as part of an integrated stepped care continuum.

In addition, the PHN will support commissioned Mental Health Clinical Care Coordination providers to collaborate with commissioned Commonwealth Psychosocial Support Program providers, to ensure that people with severe and complex mental health needs who require concurrent or consecutive psychosocial and Mental Health Clinical Care Coordination support experience appropriately integrated care.

Under this activity, deidentified service delivery data that is in scope for inclusion in the PMHC-MDS will be submitted by commissioned services providers via the PHN's Data Reporting Management Tool and uploaded to the Logicly MDS portal.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Mental health and problematic substance use

ACTIVITY CONSULTATION AND COLLABORATION

Consultation

The PHN will be co-designing the integrated mental health hubs with a range of key stakeholders, including people with a Lived or Living Experience, community members, GPs, Hospital and Health Service representatives, commissioned and non-commissioned mental health, suicide prevention, and alcohol and other drug service providers, community groups, and other providers of services that span key social determinants of health. By working in partnership with these stakeholders, we will design innovative and place-based responses that are aligned to the unique needs of communities across our PHN region.

11. Low intensity mental health services for Early Intervention

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Mental Health Priority Area 1: Low intensity mental health services

AIM OF ACTIVITY

This activity aims to appropriately support people with, or at risk of, mild mental illness at the local level through the provision of accessible low intensity mental health services.

DESCRIPTION OF ACTIVITY

The PHN is currently undertaking a broad Mental Health, Suicide Prevention, and Alcohol and Other Drugs (MHSPAOD) commissioning refresh, which is focussed on the establishment of integrated mental health hubs/networks and Medicare Mental Health Centres (MMHCs) across the region. This initiative seeks to ensure that people residing in each Local Government Area in our region have access to well-integrated MHSPAOD supports that are co-designed to be tailored to the context of place and are underpinned by an equitable approach to the distribution of funding.

This approach will ensure clients who are seeking support for their mental health concerns are provided with person centred, place based, seamless, integrated referral pathways enabling care to be delivered along the stepped continuum, to meet their needs on their path to wellness. It will reduce siloed service delivery, place the client at the centre of their care and create positive and transformative change within the mental health services system. These hubs will work in partnership with communities, local Hospital and Health Services, and the broader system to establish mental health care neighbourhoods around the MMHCs and integrated mental health hubs/networks, to drive initiatives to support better coordinated care at the system level. At a National level, the Medicare Mental Health Check In Service is being rolled out as a National digital entry point providing evidence-based, Low Intensity CBT and psychosocial support.

DDWMPHN will ensure residents across the Darling Downs and West Moreton region continue to have equitable access to early intervention mental health care, whether through digital platforms, Medicare Mental Health Centres (MMHCs), Integrated Mental Health Hubs or local service providers.

In FY26/27, the PHN will continue to:

- Plan and deliver right-size low-intensity, and more broadly, stepped care mental health investments in alignment with community need through the roll out and planning of place based LGA focussed responses through mental health and healthcare neighbourhood models.
- Partner with commissioned providers to drive an uplift in service performance, through stronger reach, impact, and value propositions.
- Support access and integration with the Medicare Mental Health Check In service.

Services are targeted to those with less severe mental health needs within stepped care and provide a key service platform.

Low-intensity mental health services commissioned by our PHN will be delivered by lead agencies across the region. In the Toowoomba LGA, the local Low Intensity Mental Health allocation will be delivered primarily through the Toowoomba Integrated Mental Health Hub.

While service models and service delivery modalities delivered by commissioned low-intensity mental health service providers may vary to enhance effectiveness in meeting the unique needs of communities within the PHN region, all models will be aligned to the Primary Health Networks (PHN) Primary Mental Health care Guidance – Low-intensity mental health service for early intervention.

Commissioned low-intensity mental health services will seek to provide access to value for money, low intensity supports, with uplifted commissioned service models expected to consider and/or include:

- evidence-based interventions providing flexible access to services regardless of referral source
- interventions offered in a variety of delivery formats (e.g. individual, group, telephone, web-based services and face-to-face)
- enhanced links to other services along the stepped care continuum to ensure people are matched to a service that meets their mental health needs
- mental health awareness raising activities

The PHN will support commissioned low-intensity mental health services to collaborate with the Medicare Mental Health Phone Service and other commissioned mental health stepped care providers to help ensure that low-intensity mental health services are delivered as part of an integrated stepped care continuum.

Under this activity, deidentified service delivery data that is in scope for inclusion in the PMHC-MDS will be submitted by commissioned services providers via the PHN's Data Reporting Management Tool and uploaded to the Logicly MDS portal.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Mental health and problematic substance use

ACTIVITY CONSULTATION AND COLLABORATION

Consultation

The PHN will be co-designing the integrated mental health hubs with a range of key stakeholders, including people with a Lived or Living Experience, community members, GPs, Hospital and Health Service representatives, commissioned and non-commissioned mental health, suicide prevention, and alcohol and other drug service providers, community groups, and other providers of services that span key social determinants of health. By working in partnership with these stakeholders, we will design innovative and place-based responses that are aligned to the unique needs of communities across our PHN region

12. Child and Youth Mental Health Services

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Mental Health Priority Area 2: Child and youth mental health services

AIM OF ACTIVITY

This activity aims to:

- Support the broader rollout of evidence-based early intervention services for children and young people with, or at risk of, severe mental health conditions.
- Promote local partnerships between primary mental health care services and the education sector.
- Work with Queensland Health and other regional organisations to ensure appropriate pathways for referral and support are available for children and young people in the context of implementation of the Regional Mental Health, Alcohol and Other Drugs Plan.

DESCRIPTION OF ACTIVITY

Darling Downs and West Moreton PHN will continue to develop flexible and responsive models in line with evidence-based best practice, which make use of a broader range of workforce, including vocational support, links to education, allied health providers, and case managers, as well as offering additional psychological therapy. Models will consider integrated approaches to provision of services to young people with or at risk of severe mental health conditions and comorbid substance use.

Services include wrap-around care-coordination support for children and young people with complex/severe mental health conditions. The service engages with other child and youth services and providers of education and vocational support to build opportunities for re-engagement and reduce social and familial isolation.

Psychological therapies will be delivered minimising restriction to access, particularly for early intervention and urgent and priority referrals from general practice in the primary care setting. Under this activity, deidentified service delivery data that is in scope for inclusion in the PMHC-MDS will be submitted by commissioned services providers via the PHN's Data Reporting Management Tool and uploaded to the Logicly MDS portal.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Priority populations
Mental health and problematic substance use

ACTIVITY CONSULTATION AND COLLABORATION

Consultation

The PHN will be co-designing the integrated mental health hubs with a range of key stakeholders, including people with a Lived or Living Experience, community members, GPs, Hospital and Health Service representatives, commissioned and non-commissioned mental health, suicide prevention, and alcohol and other drug service providers, community groups, and other providers of services that span key social determinants of health. By working in partnership with these stakeholders, we will design innovative and place-based responses that are aligned to the unique needs of communities across our PHN region.

13. Regional Approach to suicide prevention – Aboriginal and Torres Strait Islander People

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Aboriginal and Torres Strait Islander Health

AIM OF ACTIVITY

This activity aims to address regional high levels of suicide and suicide behaviour among Aboriginal and Torres Strait Islander people through encouraging and promoting a culturally sensitive and appropriate approach to suicide prevention. Community based activities include the provision of support and appropriate intervention for Aboriginal and Torres Strait Islander people after a recent suicide attempt and for people at high risk.

DESCRIPTION OF ACTIVITY

The Darling Downs and West Moreton PHN will identify and work with Aboriginal and Torres Strait Islander communities within the region that are at heightened risk of suicide to support the implementation of culturally based suicide prevention activities guided by the goals and actions of the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

This activity has specific focus on suicide prevention for Aboriginal and Torres Strait Islander people, delivered in an integrated manner as a combined model of service delivery with the Aboriginal and Torres Strait Islander Mental Health Service activity under the Primary Mental Health Care Schedule This is expected to increase access to culturally sensitive, integrated, mental health services for Aboriginal and Torres Strait Islander people and communities.

Aboriginal & Torres Strait Islander Community Controlled Health Organisations / Aboriginal Community Controlled Health Organisations (ATSICCHOs / ACCHOs) and Aboriginal Medical Service (AMS) providers will provide culturally based, community-led initiatives, to support Aboriginal and Torres Strait communities that are at high risk of suicide.

Under this activity, deidentified service delivery data that is in scope for inclusion in the PMHC-MDS will be submitted by commissioned services providers via the PHN's Data Reporting Management Tool and uploaded to the Logicly MDS portal.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Priority populations
Mental health and problematic substance use

ACTIVITY CONSULTATION AND COLLABORATION

Consultation

The following key stakeholder groups will be engaged and consulted during the activity:

- PHN Clinical Council.
- Consumer Groups.
- Local Networks.
- GP / Health Service Provider Advisory Groups.

ACCHOS and AMS

14. Psychological Therapies provided by Mental Health Professionals to Underserviced Groups

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Mental Health Priority Area 3: Psychological therapies for rural and remote, under-serviced and / or hard to reach groups

AIM OF ACTIVITY

The aim of this activity is to continue to provide evidence based, structured short term, low or medium intensity psychological intervention to people with a diagnosable mild, moderate, or severe mental illness for people in under-serviced and/ or hard to reach populations aligned with primary mental health care guidelines.

Services will offer evidence based psychological interventions for people who have attempted, or are at risk of, suicide or self-harm and where access to other services is not available or appropriate.

DESCRIPTION OF ACTIVITY

The PHN is currently undertaking a broad Mental Health, Suicide Prevention, and Alcohol and Other Drugs (MHSPAOD) commissioning refresh, which is focused on the establishment of integrated mental health hubs/networks and Medicare Mental Health Centres (MMHCs) across the region. This initiative seeks to ensure that people residing in each Local Government Area in our region have access to well-integrated MHSPAOD supports that are co-designed to be tailored to the context of place and are underpinned by an equitable approach to the distribution of funding.

This approach will ensure clients who are seeking support for their mental health concerns are provided with person centred, place based, seamless, integrated referral pathways enabling care to be delivered along the stepped continuum, to meet their needs on their path to wellness. It will reduce siloed service delivery, place the client at the centre of their care and create positive and transformative change within the mental health services system. These hubs will work in partnership with communities, local Hospital and Health Services, and the broader system to establish mental health care neighbourhoods around the MMHCs and integrated mental health hubs/networks, to drive initiatives to support better coordinated care at the system level.

In FY2026/27, the PHN will continue to:

- Plan and deliver right-sized psychological therapies responses, and more broadly, stepped care mental health investments in alignment with community need through the roll out and planning of place based LGA focussed responses through mental health and healthcare neighbourhood models.
- Partner with commissioned providers to drive an uplift in service performance, through stronger reach, impact, and value propositions.

Psychological Therapies services commissioned by our PHN will be delivered by lead agencies across the region to underserviced populations who experiences significant barriers to accessing MBS based psychological interventions. In the Toowoomba LGA, the local allocation of Psychological Therapies services is being primarily delivered through the first Integrated Mental Health Hub.

All Commissioned Psychological Therapies services will seek to support priority populations in our region in accordance with local community needs, priorities, and service gaps.

The targeted demographic of this activity focuses on vulnerable cohorts including rural communities, children, people with a disability (dual diagnosis), perinatal women, CALD and refugee groups, people at risk of homelessness, people affected by the 2019/20 bushfires and people who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI) for whom stigma and lack of appropriate services may provide barriers to care.

The PHN will also support commissioned Psychological Therapies providers to collaborate with the Medicare Mental Health Phone Service and other commissioned mental health stepped care providers to help ensure that Psychological Therapies are delivered as part of an integrated stepped care continuum.

Under this activity, deidentified service delivery data that is in scope for inclusion in the PMHC-MDS will be submitted by commissioned services providers via the PHN's Data Reporting Management Tool and uploaded to the Logicly MDS portal.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Priority populations
Mental health and problematic substance use

ACTIVITY CONSULTATION AND COLLABORATION

Consultation

The PHN will be co-designing the integrated mental health hubs with a range of key stakeholders, including people with a Lived or Living Experience, community members, GPs, Hospital and Health Service representatives, commissioned and non-commissioned mental health, suicide prevention, and alcohol and other drug service providers, community groups, and other providers of services that span key social determinants of health. By working in partnership with these stakeholders, we will design innovative and place-based responses that are aligned to the unique needs of communities across our PHN region.

15. Medicare Mental Health Centres

ACTIVITY PRIORITIES AND DESCRIPTION

PROGRAM KEY PRIORITY AREA

Medicare Mental Health Centre

AIM OF ACTIVITY

The aim of this activity is to continue the operation of three Medicare Adult Mental Health Centres in the locations of Ipswich, Kingaroy and Warwick.

The Ipswich site was initially established under the full centre-scale funding envelope, and the Kingaroy and Warwick sites were established under the satellite-scale funding model. Identification of an opportunity to utilise underspend in the budget this year enabled the implementation of initiatives to uplift Kingaroy and Warwick satellite locations to alleviate a number of critical service pressures.

DESCRIPTION OF ACTIVITY

The Ipswich, Kingaroy and Warwick Medicare Mental Health Centres will provide the following core service elements:

- Respond to adults experiencing crisis or in significant distress.
- Provide a central point to connect people to other services in the region, including offering information and advice about mental health, service navigation and referral pathways for individuals and their carers and family.
- Provide in-house assessment using the Intake, Assessment and Referral (IAR) decisional support tool to connect people with the most appropriate services.
- Provide evidence-based and evidence-informed immediate and short to medium term episodes of care, including utilisation of digital mental health platforms.

To embed these service elements, all these centres, in partnership with the PHN, will ensure:

- Collaboration with the Darling Downs and West Moreton Hospital and Health Services to develop protocols for appropriate care integration and seamless transfer of patients when needed.
- Close liaison with key primary care services, public and private hospitals, General Practitioner clinics, Aboriginal Community Controlled Health Services and non-Government and community organisations including consumer and carer representative groups or lived experience representatives.
- Integration with the national Medicare Mental Health Phone Service.

All Centres will adopt the national branding, data collection and reporting requirements provided by the Department and work with the commissioned lead agency on relevant matters including service delivery, data, communications and branding.

Under this activity, deidentified service delivery data that is in scope for inclusion in the PMHC-MDS will be submitted by commissioned services providers via the PHN's Data Reporting Management Tool and uploaded to the Logicly MDS portal.

NEEDS ASSESSMENT PRIORITY

Joint Regional Needs Assessment 2025/28

PRIORITY
Mental health and problematic substance use

ACTIVITY CONSULTATION AND COLLABORATION

Consultation

In acknowledgement of the need for these Centres to be strongly embedded in local communities and service systems, our PHN undertakes robust consultation and co-design processes across three stages:

- Phase 1 - Initial Co-Design to inform tender
- Phase 2 - Co-Design with selected provider/s through service development and establishment
- Phase 3 - Ongoing Co-Design to inform service delivery (Consumer/Community Reference Group)

Co-design group membership across these three phases seeks to include key local stakeholders, including Hospital and Health Services, General Practitioners, service providers, community members, community groups, and people with a lived or living experience of mental health concerns. These co-design phases are undertaken as separate processes relating to the Ipswich Centre, Kingaroy Satellite and the Warwick Satellite location (bilaterally funded under the National Mental Health and Suicide Prevention Agreement and Bilateral PHN Program).

The established Ipswich and Kingaroy sites have progressed to co-design Phase 3. This will see continued engagement with Community Advisory Groups established for each service, inclusive of co-design participants from phases 1 and 2. These co-design activities will provide learnings crucial for the integration with the Medicare Mental Health Intake and Assessment Phone Service.

The Warwick Medicare Mental Health Centre is progressing from co-design Phase 2 to 3, through ongoing engagement with meaningful co-design to inform service delivery in a local context and help inform site establishment.

phn
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