Queensland Mental Health Commission

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Service Integration and Referral Mapping for Mental Health and Alcohol and Other Drugs

Regional Report 2015

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Preface

In 2015, Queensland Mental Health Commission (the Commission) engaged CheckUP to lead a service integration and referral mapping project.

CheckUP in partnership with the Commission conducted a survey and consultation process to map the integration of the service system across Queensland's North West, Central West and South West Hospital and Health Service (HHS) regions. This process included:

- a review of available existing information and data;
- conducting a comprehensive survey with local agencies; and
- conducting complementary focus groups.

The findings from this project will:

- provide evidence of the extent of integration between services;
- identify the supports and barriers for agencies in the use of inter-agency referrals to support the holistic needs of people living with mental illness, mental health difficulties and problematic substance use;
- provide perceptions of the current levels of service for mental health and alcohol and other drugs; and
- identify areas where good practice is occurring.

Key partners invited to participate in this process included, but were not limited to, Queensland Health public specialists, visiting specialists, general practice, allied health providers, Department of Veterans Affairs, community controlled health services, non-clinical support services (including local human service non-government organisations), domestic violence services, early childhood development and schools, housing and family support services.

The information and data obtained through the survey and consultation process has been compiled into this report. A regional report has been developed for Queensland's North West, Central West and South West HHS regions.

The Commission will use the information in this report to inform implementation of the Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019 and the Plan's 'Shared Commitments to Action', including development of a rural and remote action plan and moving toward better integrated and effective government services.

Contents

1.0 Background and context

It is estimated that approximately 897,000 Queenslanders experienced a mental or substance use disorder in 2011-2012. Just 49 percent of these people received treatment. The Australian Institute of Health and Welfare suggests that it is statistics like this that are forcing health care policy and decision makers to plan coordinated mental health care services that keep people well, rather than just respond to need as people are hospitalised.[1]

It is essential to support people living with mental health difficulties or problem substance use to access an integrated service system, receive the right type of support when it is needed and as close to home as is safe. Evidence suggests that integrated and coordinated care which acknowledges the multiple, and often complex, needs of individuals living with mental illness or problem substance use delivers better quality services and outcomes. Individuals are often involved with multiple services or agencies and there is a need to ensure that their health and social care needs are integrated and coordinated. This includes smooth referral pathways when moving between services. The range of care and support needs may or may not be directly related to the individual's mental health or substance use but might relate to their general healthcare and/or social welfare for example housing, employment, education, finances, family violence and/or child safety.

The Queensland Mental Health Commission (the Commission) recognises that access to services in rural and remote areas can be very difficult.[2] For mental health, alcohol and drug issues the limited availability of specialist services and local providers can make access to care challenging. This makes the need for a joint approach from a range of locally based, trusted non-government and government agencies very important. Where agencies and services collaborate effectively, the desired outcomes for clients are more likely to be met.

The Commission was established to drive ongoing reform towards a more integrated, evidence–based and recovery–orientated mental health and drug and alcohol system. As part of its role the Commission has developed, and will facilitate, the implementation of a whole–of–government strategic plan — the Queensland Mental Health, Drug and Alcohol Strategic Plan 2014 - 2019 (the Plan).

The Plan aims to improve mental health and wellbeing. It seeks to achieve this by focusing on better services, awareness, prevention and early intervention and engagement and collaboration. Taking a holistic approach to providing support and treatment is a key principle outlined in the Plan.

The Plan sets out eight Shared Commitments to Action that will require the involvement of government, business, industry, the community and individuals to move towards a population with good mental health and wellbeing, reduce avoidable ham attributed to problem substance use, improve the physical and oral health as well as the life expectancy of people living with mental illness. More integrated and effective services (both clinical and non-clinical) is a key priority under the Plan.

The Commission intends to utilise the findings from this project to inform the Shared Commitments to Action in the Plan. These include:

- Shared Commitment 2: awareness, prevention and early intervention — people receiving the right type of support, as early as possible, to start well, develop well, work well, live well and age well.
- Shared Commitment to Action 3 stage one priorities: the wellbeing of people living in rural and remote communities; the wellbeing of Aboriginal and Torres Strait Islander peoples; suicide

[1] Australian Institute of Health and Welfare (2014) *Australia's health 2014 in brief*: http://www.bing.com/search?q=australia's+health+2014+in+brief&src=IE-TopResult&FORM=IE11TR&conversationid=

[2] See the Commission's rural and remote work outlined at http://www.qmhc.qld.gov.au/work/promotion-awareness/rural-remote-access/

prevention; and actions to prevent and reduce the adverse impacts of alcohol and drugs on the health and wellbeing of Queenslanders.
- Shared Commitment to Action 4: A responsive and sustainable community sector
- Shared Commitment to Action 5: Integrated and effective government services.

Mental Health and Alcohol or Other Drugs in Rural and Remote Queensland

The 2010 and 2013 National Drug Strategy Household Surveys found that people living in rural and remote regions smoked, drank alcohol at risky levels, and used cannabis and meth/amphetamines than those living in urban areas.

The prevalence of people presenting with co-occurring alcohol and other drug use and mental illness (dual diagnosis) in rural and remote Queensland is high in both mental health and drug and alcohol treatment settings.[3]

For young people with a dual diagnosis, particularly in rural and regional areas in Queensland, there are significant barriers to the provision of optimal care including lack of communication between mental health, drug and alcohol services and consumers resulting in an inadequate provision of treatment for young people.[3]

Dual diagnosis is a particular problem in Aboriginal and Torres Strait Islander communities with higher rates of substance use than the general population, particularly alcohol and cannabis abuse, and have high rates of associated mental health problems, including self-harm and attempted suicide. [3]

In addition to harm to the individual, dual diagnosis has a significant negative impact on the community at large, for example, increased criminal activity, domestic violence and family breakdown. [3]

Suicide Rates in Rural and Remote Areas

Geographical location also has an impact on suicide rates with the male suicide rate in remote areas was found to be 33.6 per 100,000, in comparison to 23.9 in rural areas and 18.6 in urban areas. For females this was 12.0, 7.4 and 6.8 per 100,000 respectively.[4]

In comparison to suicides within urban locations, relationship conflict, alcohol use disorder as well as income and work problems have also been found to be more significant in rural localities.[5]

Geographical location may also affect service provision with people residing in rural and remote areas less likely to seek, or receive, treatment or support, in part because of a lack of accessible, quality services.[6]

[3] A framework for mental health service delivery in rural and remote Queensland: A literature review analysing models and treatment options, Centre for Rural and Remote Mental Health QLD, May 2011.
[4] Kolves, K., Potts, B. & De Leo D. (2015) Suicides in Queensland 2002-11 Australian Institute of Suicide Research and Prevention. Brisbane
[5] Kolves, K., Milnes, A., McKay, K. & De Leo (eds). (2012) Suicide in rural and remote areas of Australia. Australian Institute for Suicide Research and Prevention, Brisbane.
[6] Kolves, k., Mckay, K. & De Leo, D. (2012) Individual-level factors related to suicide in rural and remote areas of Queensland in Kolves, K., Milnes, A., McKay, K. & De Leo (eds).(2012) Suicide in rural and remote areas of Australia. Australian Institute for Suicide Research and Prevention, Brisbane.

2.0 Project Aims and Objectives

Aim

The aim of this project is to produce a clear understanding of the integration of non-government and government services and referrals to mental health and alcohol and other drugs (MH & AOD) services in Queensland's North West, Central West and South West HHS regions (based on the geographical boundaries for North West, Central West and South West Hospital and Health Service regions) by conducting a service integration and referral mapping analysis, resulting in three regional briefing documents.

Objectives

The objectives of this project include the following:

- Engage non-government and government services in North West, Central West and South West HHS regions to participate in a comprehensive mapping analysis[7];
- Develop and implement service integration and referral mapping analysis within agreed project timeframe;
- Analyse key findings to identify service integration and referral pathways, gaps and needs to inform the Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019 Shared Commitments to Action; and
- Develop and submit service integration and referral mapping analysis reports for the North West, Central West and South West HHS regions.

Expected Outcomes

The findings from this project will:

- provide evidence of the extent of integration between services.
- identify the supports and barriers for agencies in the use of inter-agency referrals to support the holistic needs of people living with mental illness, mental health difficulties and problematic substance use.
- provide perceptions of the current levels of service for mental health and alcohol and other drugs.
- identify areas where good practice is occurring.

[7] These services include, but are not limited to, Queensland Health public specialists, visiting specialists, general practice, allied health providers, Department of Veterans Affairs, community controlled health services, non-clinical support services (including local human service non-government organisations), domestic violence services, early childhood development and schools, housing and family support services.

3.0 Methodology

CheckUP in partnership with the Commission conducted a survey and consultation process to map the integration of the mental health and alcohol and other drug service system across Queensland's North West, Central West and South West HHS regions. This process included:

- a review of available existing information and data;
- consultation with a range of relevant stakeholders in the design (specifically the survey questions) and distribution of a comprehensive survey;
- engagement with data specialists to build the survey and undertake data analysis to ensure maximum impact of the survey;
- consultation and engagement with Regional Coordinators (Outreach Services) to support promotion of the project and ensure maximum of uptake within the communities;
- engagement and consultation with local community members through complementary focus groups with local service providers in Roma, Charleville, Mt Isa and Longreach; and
- undertaking a comprehensive data synthesis and analysis process for both the survey and focus groups.

The Commission will use the regional briefs to inform implementation of the Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019 and the Plan's 'Shared Commitments to Action', including development of a rural and remote action plan and moving toward better integrated government services.

4.0 Key Findings Across All Regions

Respondents Profile

- A total of 91 participants completed the service integration and referral mapping survey from across three regions in Queensland (North West, Central West and South West). Of these, 48 represented the North West HHS region, 18 represented the Central West and the remaining 25 represented the South West HHS region.
- Just under one half (47.2%) represented non-government agencies. A further 36.3% represented non-government agencies. The remaining 15.4% represented private organisations (12.1%) and registered charities (4.4%).
- Just over one-third (35.3%) of respondents were from service delivery / service providers roles. Slightly more (40.7%) were from middle / regional management positions.
- Just under two-thirds (64.7%) of respondents were female and just over one-third (35.3%) were male.
- The majority (47.2%) of respondents were aged between 35 and 64 years.

The Service System

Services Provided

- 78% of agencies surveyed provide services for mental health and/or alcohol and other drugs. Of these, 40.6% provided services for only mental health and 7.7% provided services for only alcohol and other drugs.
- The majority (27.5%) indicated their agency's primary focus to be mental health service provision. This was closely followed by 16.5% whose primary service delivery focus was primary health care.
- 41.8% provide mental health as a secondary service. This was closely followed by just over one-third (35.2%) who provide alcohol and other drugs as a secondary service.
- Just under three-quarters (72.2%) of respondents indicated that their service always or most of the time provides direct intervention or support clients at risk of suicide. In addition, over one-third (38.9%) suggested that they refer these clients to another agency.
- The majority of agencies provide services that specifically target Aboriginal and Torres Strait Islander people.

Types of Services

- The main types of mental health services provided include suicide risk detection and management, care coordination for mental health and recovery support.
- The main types of alcohol and other drugs services provided include counselling, brief intervention, assessment and support and case management.

Service Demand

- Just under two-thirds (61.1%) indicated that the current level of mental health service provision meets demand for the region from not at all to only some extent.
- Just under three-quarters (70.4%) suggested that the current level of alcohol and other drug service provision meets demand for the region from not at all to only some extent.
- Two-thirds (66.7%) indicated the current level of suicide prevention or postvention service provision met demand for the region from not at all to only some extent.
- Overall these results imply that the current level of service provision for mental health, alcohol and other drugs and suicide prevention may not adequately meet demand across all three regions.
- Further to this, a significant proportion of respondents indicated that mental health and alcohol and other drug service demand for people from a culturally and linguistically diverse background as well as lesbian, gay, bisexual, transgender and intersex people was unknown. This might suggest service demand for these populations groups are unclear to service providers in the region.

Networking and Interagency Groups

- Respondents engaged with a large variety organisations, networks or interagency groups.
- A greater proportion (43.6%) indicated that interagency collaboration supports service provision to clients with mental health needs from a moderate to large extent. Whereas, a smaller percentage (23.6%) suggested that that interagency collaboration supports service provision to clients with problematic substance use from a moderate to large extent. Thus implying that interagency collaboration best supports service provision for people with mental health needs.
- More networking opportunities and specific meetings were the most common suggestions to enhance interagency collaboration in the region.

Service Integration

Strategies Implemented by Services

- When a client is identified with mental health difficulties and/or problematic substance use, the most common strategies implemented were as follows:
    - refer to another agency for mental health services (68.5%);
    - work with other services for aspects of the mental health care/support needs (65.8%);
    - refer to another agency for alcohol and other drug services (64.5%).

Ease of Integration with Other Services

- Just under one-third (28.9%) indicated the ease of coordinating care for a client was harder or much harder than expected and just under one-half (48.7%) suggested it was as expected. Only a small percentage (14.5%) felt the ease of coordinating care was easier or much easier than expected.

Supports for Integration

- Strong individual relationships between workers, a dedicated case coordinator or care coordination model and clear internal policies practices were identified as the most effective supports in assisting coordinated care / support for clients.

Barriers to Integration

- Across all regions the following were identified as the most significant barriers on an agency's ability to coordinate care / support successfully:
    - Lack of access to services due to distance or cost to client;
    - lack of access to specialist services;
    - lack of services to refer to; and
    - client reluctance or ability to take up referral.

Strategies to Manage Barriers to Integration

- Across all regions the following were identified as the most effective strategies to address barriers to successful coordinated care:
    - building relationships;
    - interagency forums or regular meetings with key agencies;
    - promoting own agency's role and function; and
    - delivering training and / or resources.

Referrals

Referrals to Other Services

- Clients were most commonly referred to allied health, mental health, alcohol and other drugs, housing support and community health.
- Warm referrals and supported referrals where the most common types of referrals made. The majority (70.1%) of referrals were always and often within the scope of services the agency delivers.
- Just under two-thirds of agencies (65.2%) keep a central record of referrals and just over half (54.4%) always or often monitor the effectiveness of referrals.

Supports for Referrals

- Strong individual relationships between workers, a dedicated case coordinator or care coordination model and clear internal policies practices were identified as the most effective supports in assisting referral processes. This are identical to the most effective support identified in assisting coordinate care / support for clients.

Barriers to Referrals

- Across all regions the following were identified as the most significant barriers on an agency's ability refer successfully:
    - lack of access to specialist services;
    - Lack of access to services due to distance or cost to client;
    - lack of services to refer to; and
    - client reluctance or ability to take up referral.
- The above barriers are identical to the most significant barriers on an agency's ability to coordinate care / support successfully.

Strategies to Manage Barriers to Referrals

- Across all regions the following were identified as the most effective strategies to address barriers to successful coordinated care:
    - building relationships;
    - promoting own agency's role and function;
    - interagency forums or regular meetings with key agencies; and
    - shared resources.

Focus Group Discussion

- Focus group feedback varied between regions however a number of common strategies were identified to build better service integration in the regions including:
    - ongoing interagency meetings and networking opportunities;
    - the development of a localised tool or system which providers can access comprehensive information about other services including referral pathways into and out of these services; and
    - the development of a range of local and shared resources.

5.0 North West HHS Region

North West HHS Region at a Glance

The North West Hospital and Health Service (HHS) region covers an area of over 300,000 square kilometres and services the rural and remote communities within North Western Queensland and the Gulf of Carpentaria. The region includes the City of Mount Isa and the towns and areas of Burketown, Camooweal, Cloncurry, Dajarra, Doomadgee, Julia Creek, Karumba, Normanton and Mornington Island.

Figure 1: North West HHS Region Map

Population Demographics

As of 30 June 2013, the Australian Bureau of Statistics' estimated the resident population of the North West HHS region was 32,654 which accounts for approximately 0.7% of the total population of Queensland. Of these, 24.9% of people in the region are in the most disadvantaged group.

According to the 2011 Census, the Indigenous population accounts for 23.1% (7,037) of the total population of the North West with Doomadgee Shire having the largest percentage of Indigenous people (92%).

In comparison to Queensland, the North West HHS region has:

- A higher proportion of children.
- A higher proportion of males.
- A higher proportion of Indigenous people.
- A remote location.

Demand for health services in the North West continues to be influenced by the mining sector and the impact of 'fly-in, fly-out' workers, a mature pastoral industry and a developing tourism industry.

The 2011 Census also indicates that 12% of people living in the North West HHS region in 2011 were born overseas with 2.6% of these people reporting that they did not speak English well. The top five non-English languages spoken at home in the North West HHS region in 2011 were:

1. Southeast Asian Austronesian
2. Australian Indigenous languages
3. Indo Aryan
4. Italian
5. Chinese

Reference: North West Hospital and Health Service Annual Report 2013–2014.

Key Health Conditions

The major health diseases and conditions experienced by people living in the North West HHS Region include:

- coronary heart disease
- stroke
- mental illnesses
- chronic lung disease
- diabetes
- renal failure
- asthma

Health determinants of significant impact for people living in the North West HHS region include smoking, poor nutrition, harmful alcohol consumption, overweight and obesity, physical inactivity, and risk and protective factors for mental health.

The major causes of death and illness for Aboriginal and Torres Strait Islander peoples in the North West includes but is not limited to:

- Stroke
- Coronary heart disease
- Diabetes
- Suicide
- Unintentional Injury
- Mental illness

Health determinants of significant impact for Aboriginal and Torres Strait Islander peoples in the North West HHS region include: poor diabetes management, overweight and obesity, poor nutrition, alcohol related disease, physical inactivity, high blood pressure, poor cholesterol management, smoking and family violence.

Reference: North West Hospital and Health Service Annual Report 2013–2014.

Survey Respondent Profile

Of the respondents (91) who completed the overall service integration and referral mapping survey, 25 (27.5%) were based in the North West HHS region.

Just under half (11; 44%) of respondents represented non-government agencies with the remaining representing 32% government (8), 20% private (5) and 4% registered charity (1) agencies. This suggests an adequate representation of agencies surveyed within the North West HHS region.

Of the respondents (17) who indicated their level of position within their organisation, the majority (7; 41.2%) were from middle/regional management positions followed closely by service delivery / provider positions (6; 35.3%). The remaining respondents were from upper management (2; 11.8%) and administrative (2; 11.8%) positions.

Of those who indicated their sex (15), 66.7% (10) were female and 5 (33.3%) were male. Of those respondents (15) who indicated their age, the majority (9; 60%) were aged between 45 and 64 years.

In addition to this, four service providers from across three agencies (Central and North West Queensland Medicare Local, **headspace** and North West Queensland Indigenous Catholic Social Services) participated in a focus group held in Mt Isa to complement the survey results.

5.0 North West HHS Region

Key Findings

The Service System

Services Provided

- 68% of agencies surveyed provide services for mental health and/or alcohol and other drugs.
- The majority (40%) indicated their agency's primary focus to be either primary health care service delivery or allied health service provision.
- Just under half provide mental health and/or primary health care as a secondary service delivery focus.
- Three-quarters of respondents indicated that their service always or most of the time provides direct intervention or support clients at risk of suicide. In addition, over one-third suggested that they refer these clients to another agency.
- The majority of agencies provide services that specifically target Aboriginal and Torres Strait Islander people.

Types of Services

- The main types of mental health services provided include suicide risk detection and management, care coordination for mental health, mental health information and primary care for mental health.
- The main types of alcohol and other drugs services provided include counselling, brief intervention and assessment.

Service Demand

- Just under three-quarters indicated that the current level of mental health service provision meets demand for the region from not at all to only some extent.
- Over three-quarters suggested that the current level of alcohol and other drug service provision meets demand for the region from a small to only some extent.
- Over half indicated the current level of suicide prevention or postvention service provision met demand for the region from not at all to only some extent.
- Overall these results imply that the current level of service provision for mental health, alcohol and other drugs and suicide prevention may not adequately meet demand for the region.

Networking and Interagency Groups

- Respondents engaged with a large variety of networks or interagency groups with just under three-quarters suggesting they were involved with adult mental health services and/or networks. Just over half indicated they were involved with ATODS/rehabilitation and child and youth services.
- A greater proportion (41.2%) indicated that interagency collaboration supports service provision to clients with mental health needs from a moderate to large extent. Whereas, a smaller percentage (29.4%) suggested that that interagency collaboration supports service provision to clients with problematic substance use from a moderate to large extent. Thus implying that interagency collaboration best supports service provision for people with mental health needs.
- More interagency support, financial support, open communication, information sharing and better knowledge of services and needs of clients were the most common suggestions to enhance interagency collaboration in the region.

Service Integration

Strategies Implemented by Services

- Over 60% of agencies work with other services for aspects of mental health or problematic substance use needs.
- When a client is identified with mental health difficulties and/or problematic substance use, the most common strategies implemented were as follows:
    - work with other services for aspects of the mental health care/support needs (65%);
    - refer to another agency for mental health services (65%);
    - work with other services for aspects of problematic substance use needs (60%); and/or
    - refer to another agency for alcohol and other drug services (60%).

Ease of Integration with Other Services

- One-third indicated the ease of coordinating care for a client was harder or much harder than expected and under one-third suggested it was as expected. A small percentage (20%) felt the ease of coordinating care was easier or much easier than expected.

Supports for Integration

- Strong individual relationships between workers and a dedicated case coordinator or care coordination model were identified as the most effective supports in assisting coordinated care for clients.

Barriers to Integration

- Lack of access to specialists and services due to distance or cost to clients and client reluctance or ability to take up referral were the most significant barriers to coordinate care successfully.

Strategies to Manage Barriers to Integration

- Built relationships and requesting and providing feedback to/from other agencies were the most effective strategies to address barriers to successful coordinated care.

Referrals

Referrals to Other Services

- The majority of agencies (72.2%) referred clients to alcohol and other drugs and/or allied health services. In addition, 55.6% of agencies referred to disability services. Just under 30% of agencies referred 90 to 100% of their clients to mental health services.
- Warm referrals and supported referrals where the most common types of referrals made. The majority (82.4%) of referrals were always and often within the scope of services the agency delivers.
- The majority of agencies (77.8%) keep a central record of referrals and 76.5% always or often monitor the effectiveness of referrals.

Supports for Referrals

- Strong individual relationships between workers followed by a dedicated case coordinator or care coordination model was identified as the most effective supports in assisting referral processes.

Barriers to Referrals

- Lack of access to specialists and services due to cost or distance were identified as the most significant barriers to refer successfully.

Strategies to Manage Barriers to Referrals

- Respondents suggested that built relationships was the most effective strategy to address barriers to successful referrals.

Focus Group Discussion

- Service providers feel service integration is not working well in the region. There is limited attendance at interagency meetings and a lack of awareness of service providers and their function in the region.
- Service providers feel referrals do not occur well in the region due limited awareness of services, referral processes and criteria, lack of private practitioner workforce and limited knowledge about mental health.
- There are limited specialists, detoxification centres and inpatient services in the region.
- Service providers feel there are gaps in services for people with dual diagnosis, those requiring home services, high risk mental health patients and those requiring after hours services.
- A number of key actions were identified to build better service integration in the region including a dedicated service integration coordinator, an interactive database outlining services and referral pathways, funded interagency meetings, flexibility of funding and community education about recognising the signs of mental health and alcohol and other drug issues.

Overall Service Delivery

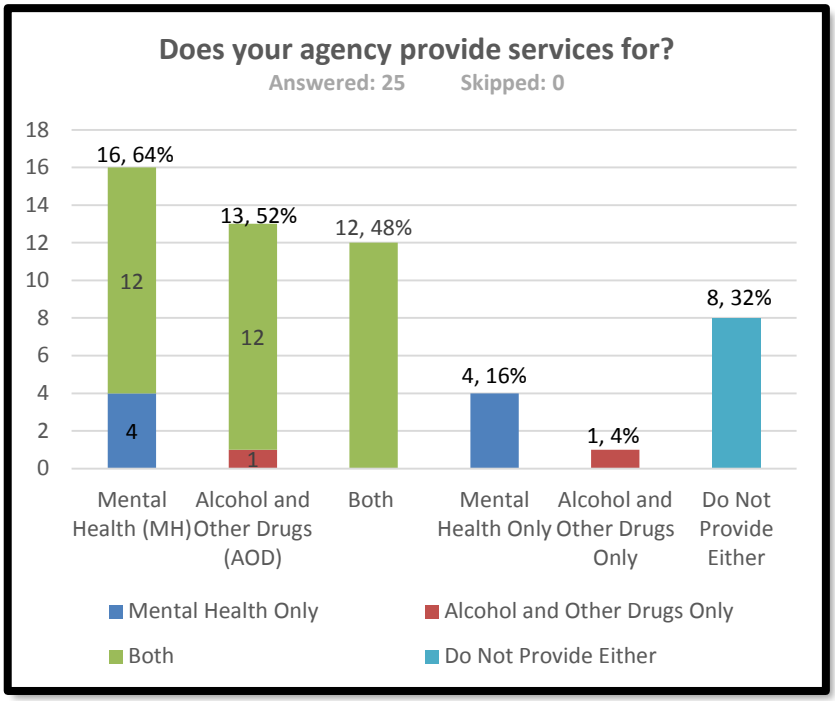
Services Provided

Of those who responded (25) just under half (12; 48%) provided services for both mental health and alcohol and other drugs. In addition, 4 (16%) respondents provided services for only mental health and 1 (4%) provided services for only alcohol and other drugs.

When looking overall at those who provided services for mental health or alcohol and other drugs, 16 (64%) provided services for mental health and 13 (52%) provided services for alcohol and other drugs.

Of the 25 who responded, 8 (32%) did not provide any mental health or alcohol and other drug services.

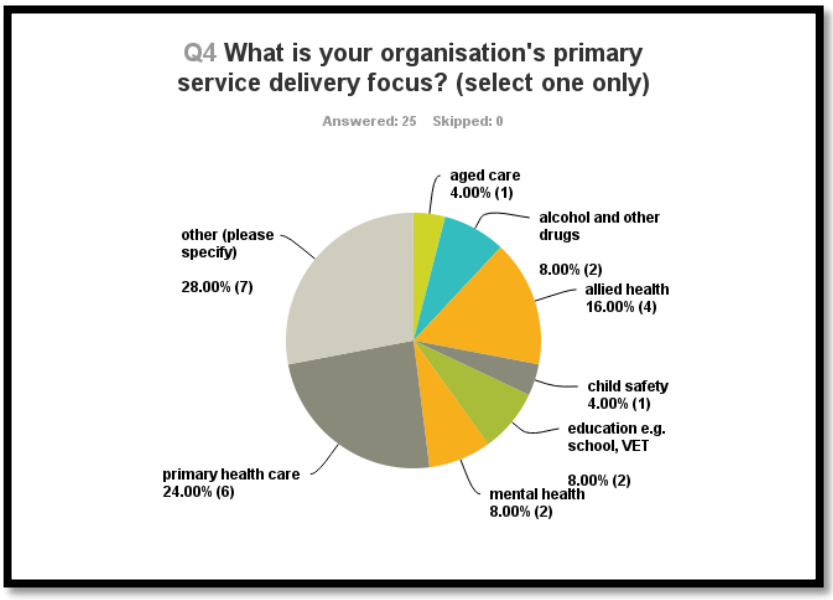
Graph 1: Service provided



Primary Focus of All Services

For all agencies (25), just under one-quarter (6; 24%) indicated their organisation's primary focus to be primary health care service delivery followed closely by allied health service provision (4; 16%). Only a small number of respondents indicated their primary service delivery focus to be alcohol and other drugs (2; 8%) or mental health (2; 8%).

Graph 2: Primary service delivery focus of all services



Although 28% (7) of respondents selected an "other" primary focus, the responses were quite varied (see table 1).

Table 1: Primary service delivery focus – other responses

Other (n=7)
AICCHS Support
Aged Care and Housing Support
Justices Examination Orders; QLD Housing Applications; Birth, Deaths & Marriages; Help completing and lodging domestic violence applications
Diversionary Rest and Recovery
Acute Care
Individual community support services and referral
Social and emotional wellbeing

Secondary Focus of All Services

Across all agencies (25), just under half provide mental health (12; 48%) and/or primary health care (11; 44%) as a secondary service delivery focus.

This was followed closely by aged care (9; 36%), family support (9; 36%) and alcohol and other drugs (8; 32%) as a secondary service delivery focus.

Four agencies (16%) indicated that they provided "other" secondary services (see Table 2).

Graph 3: Secondary service delivery focusses of all services

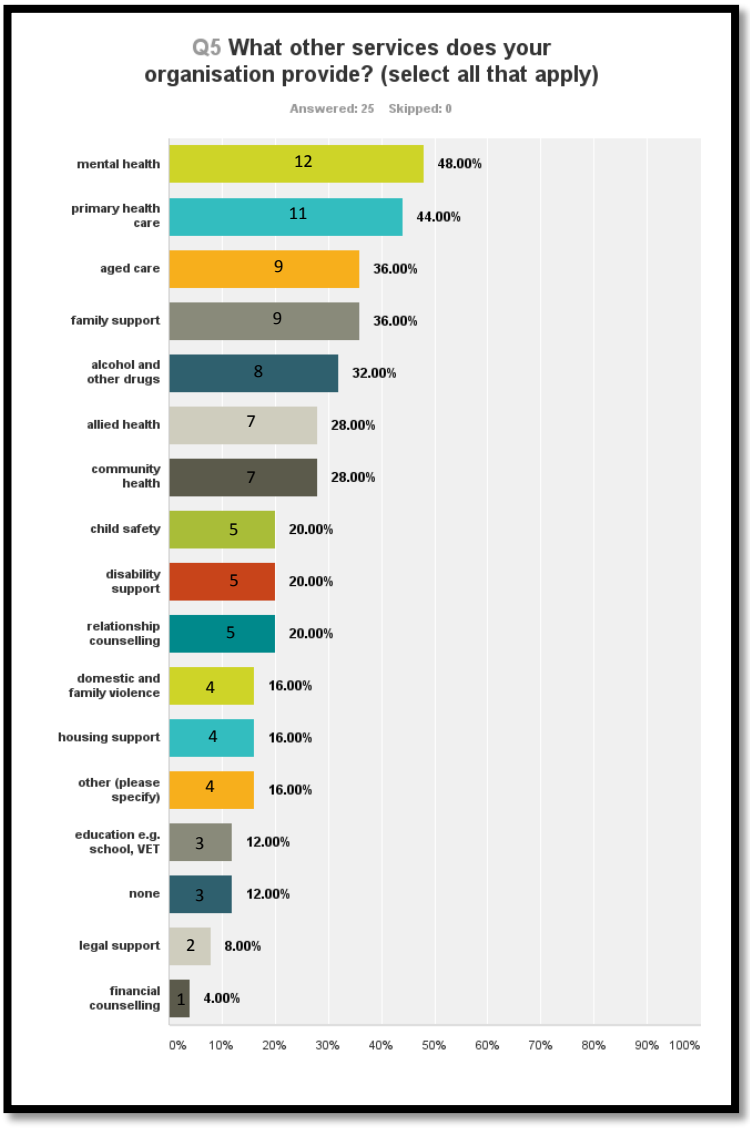


Table 2: Secondary service delivery focus – other responses

Other (n=4)
AICCHS Support
Referral and Access to all services
Social work, podiatry, occupational therapy, dietitians, nursing, physiotherapy
Access to specialist services

Primary Focus of Mental Health Services

Of those agencies who indicated they provide mental health services (16), the majority (6; 37.5%) indicated their organisation's primary focus to be primary health care service delivery followed closely by 4 (25%) who indicated their primary focus to be allied health service provision. Only two agencies suggested mental health as their primary service delivery focus. The "other" services as indicated by two agencies included acute care and social and emotional wellbeing.

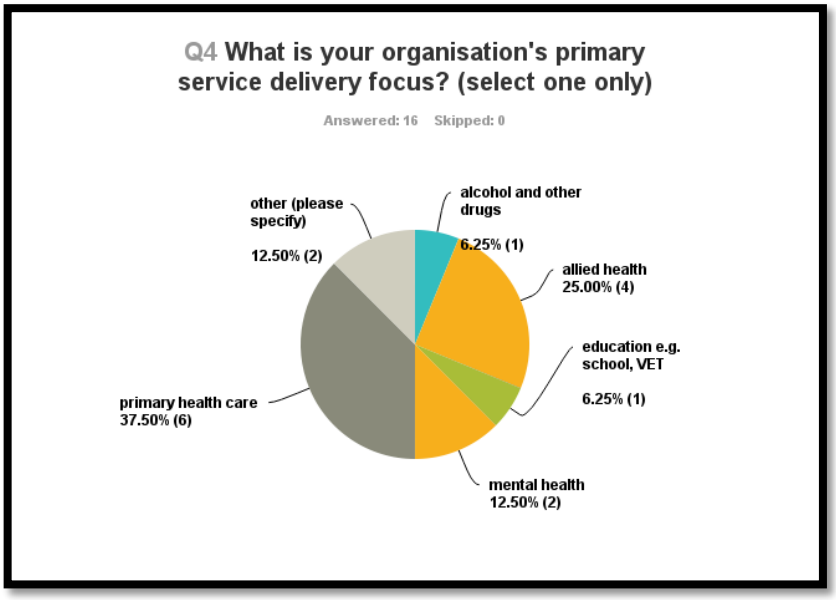
Secondary Focus of Mental Health Services

Of those agencies who indicated they provide mental health services (16), the majority (11; 68.8%) provided primary health care and mental health as a secondary service delivery focus. Seven (43.8%) agencies provided alcohol and other drugs as a secondary service delivery focus.

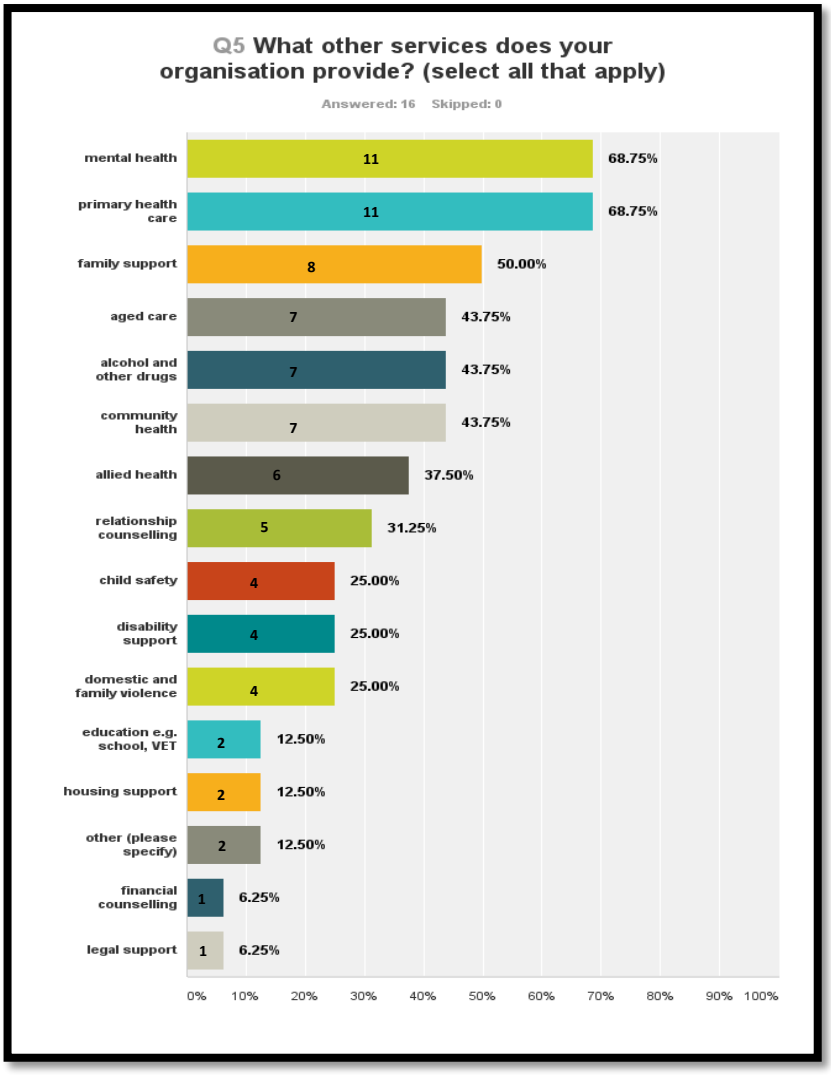
The following comments were provided by those who indicated "other":

- social work, podiatry, occupational therapy, dietitians, nursing, physiotherapy.
- access to specialist services.

Graph 4: Primary focus of mental health services



Graph 5: secondary focus of mental health services

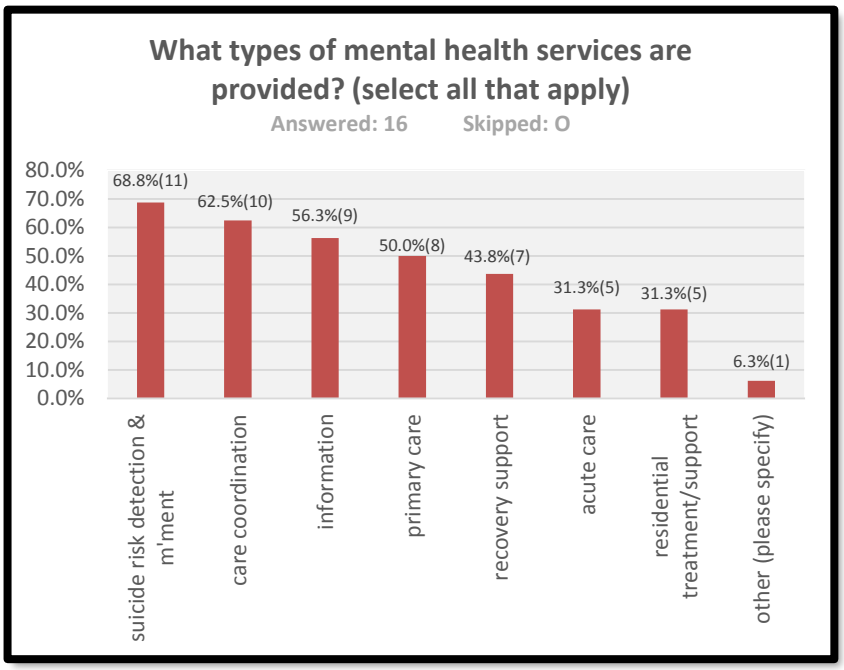


Types of Mental Health Services Provided

Of those who agencies who indicated they provide mental health services (16), the majority (11; 68.8%) of agencies provided services to address suicide risk detection and management. In addition, over half of the agencies provided care coordination for mental health (10; 62.5%), mental health information (9; 56.3%) and primary care for mental health (8; 50%).

One respondent indicated their service provides an "other" service of psychological therapy.

Graph 6: Types of mental health services provided

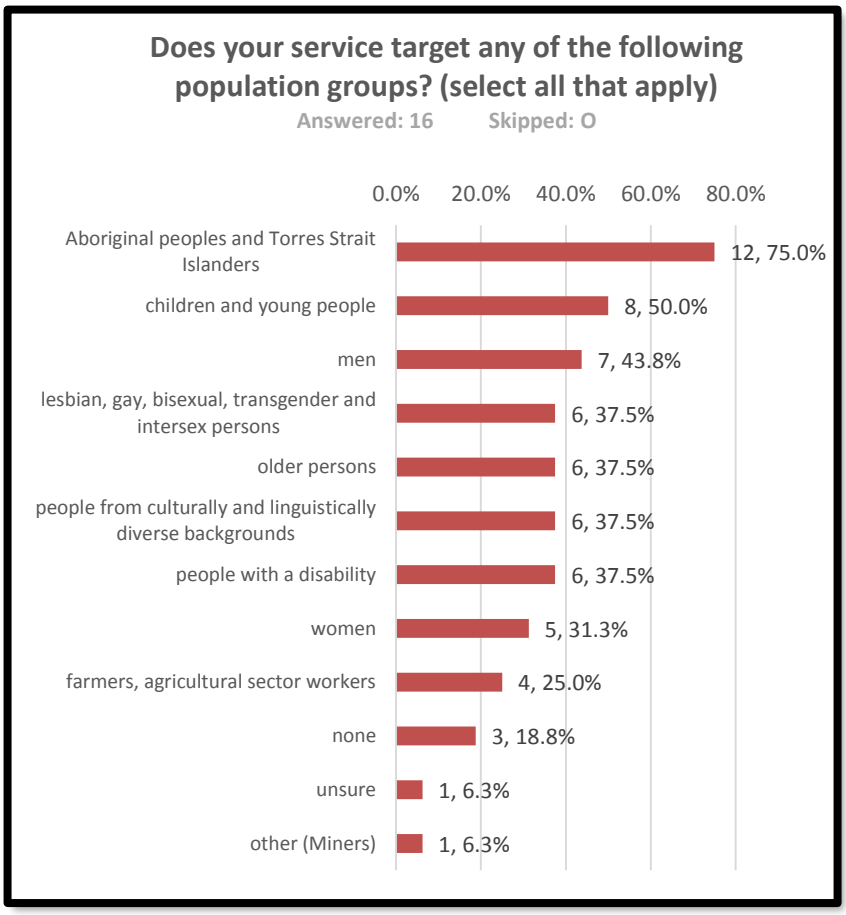


Population Groups Targeted by Mental Health Services

Of those who indicated they provide mental health services (16), 75% (12) provide services that specifically target Aboriginal and Torres Strait Islander peoples. In addition, 50% (8) of these agencies specifically target children and young people.

Three agencies indicated they did not target any specific population groups.

Graph 7: Population groups targeted by mental health services



Funding Sources for Mental Health Activities

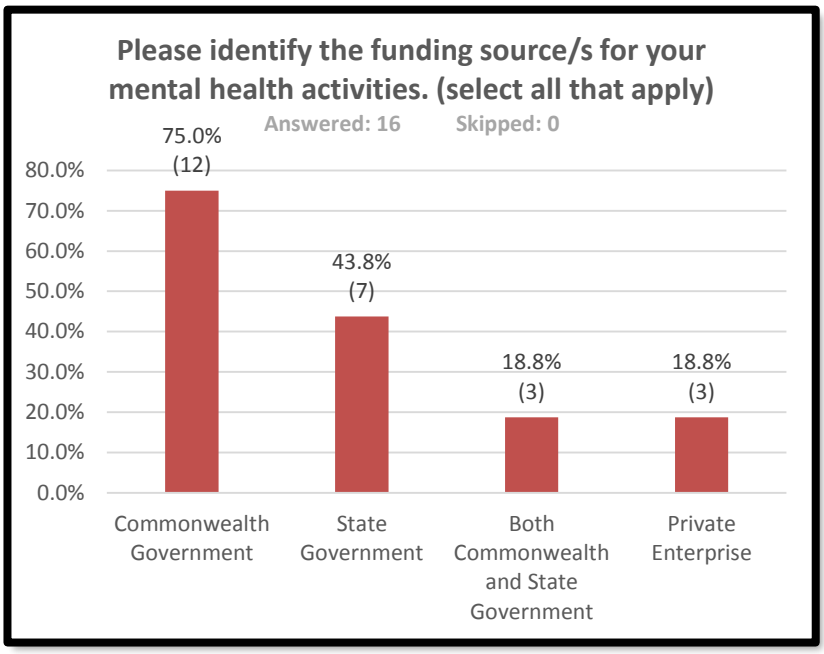
The majority (12; 75%) of agencies who indicated they provide provided mental health services (16) received funding for mental health activities from Commonwealth Government sources. Just under half (7; 43.8%) received funding from State Government for mental health activities. Of these, three (18.8%) received funding from both State and Commonwealth Government Sources.

Three (18.8%) services received funding from private enterprise. No services received funding from local government sources.

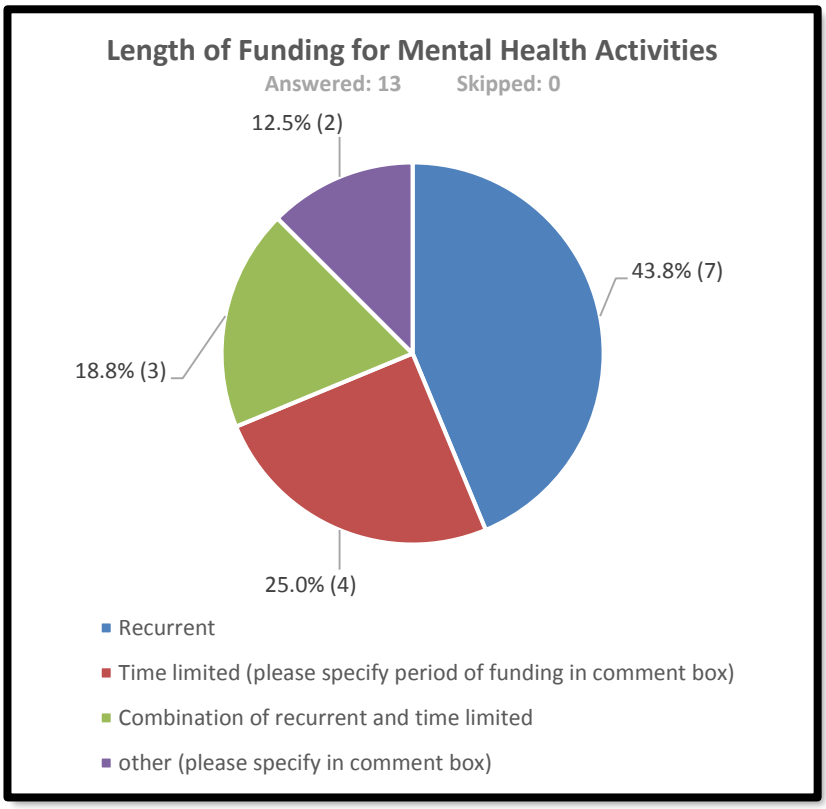
Length of Funding for Mental Health Activities

Of those agencies who indicated they provide provided mental health services (16), just under half (7; 43.8%) received recurrent funding for mental health activities. This was followed by time-limited funding (4; 25%) and a combination of recurrent and time-limited funding (3; 18.8%).

Graph 8: Funding sources for mental health activities



Graph 9: Length of funding for mental health activities



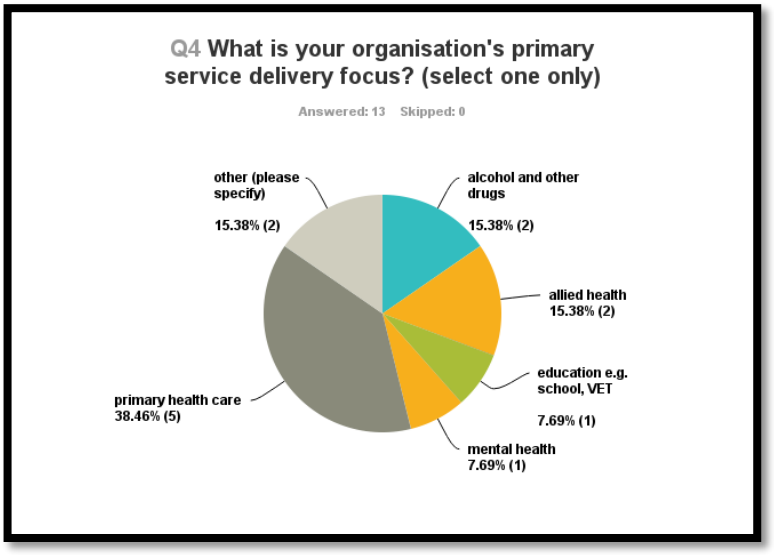
Primary Focus of Alcohol and Other Drug Services

Of those agencies who indicated they provide alcohol and other drugs services (13), just over one-third (5; 38.5%) indicated their organisation's primary focus to be primary health care service delivery.

One agency who provided alcohol and other drugs services indicated their primary service delivery focus to be mental health.

Two agencies suggested they provide an "other" primary services (acute care; social and emotional wellbeing).

Graph 10: Primary focus of alcohol and other drug services



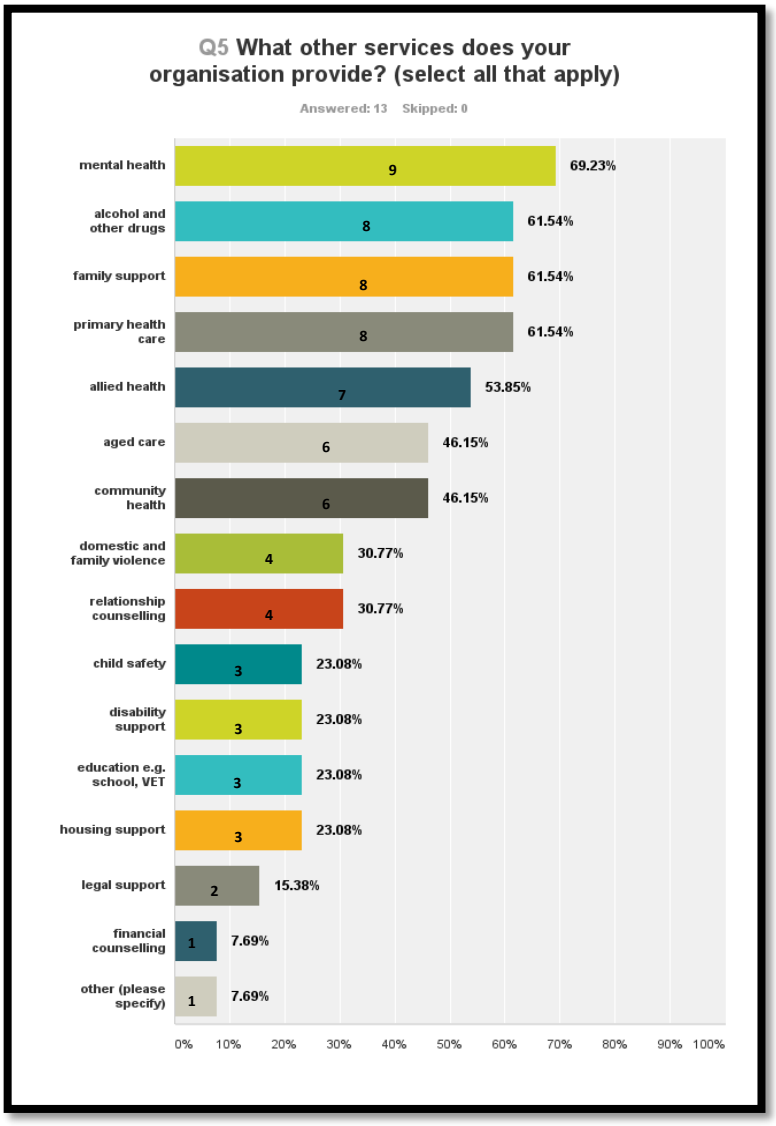
Secondary Focus of Alcohol and Other Drug Service

Of those agencies who indicated they provide alcohol and other drugs services (13), just over two-thirds (9; 69.2%) provide mental health as a secondary service delivery focus.

This was followed closely by 61.5% (8) who provide family support, alcohol and other drugs and/or primary health care as a secondary service delivery focus.

One respondent (other category) indicated their agency provides access to specialist care as a secondary service.

Graph 11: Secondary focus of alcohol and other drug services



Types of Alcohol and Other Drug Services

Of those agencies who indicated they provide alcohol and other drug services (13), the main types of alcohol and other drug services provided included counselling (11; 84.6%), brief intervention (11; 84.6%) and assessment (10; 76.9%).

Just over half of these agencies (7; 53.8%) provided support and case management for alcohol and other drug issues.

Residential rehabilitation and sobering up/ intoxication/ diversion centre services were only provided by a small number of agencies.

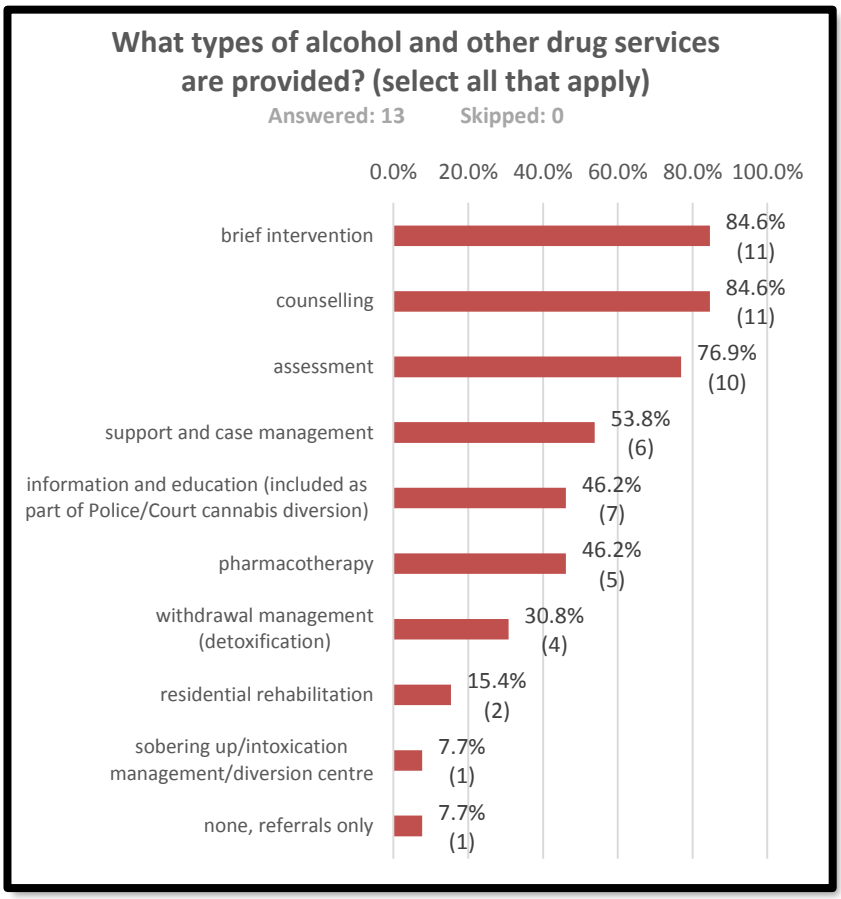
Population Groups Targeted by Alcohol and Other Drug Services

Of those who indicated they provide alcohol and other drugs services (13), 84.6% (11) provide services that specifically target Aboriginal and Torres Strait Islander people.

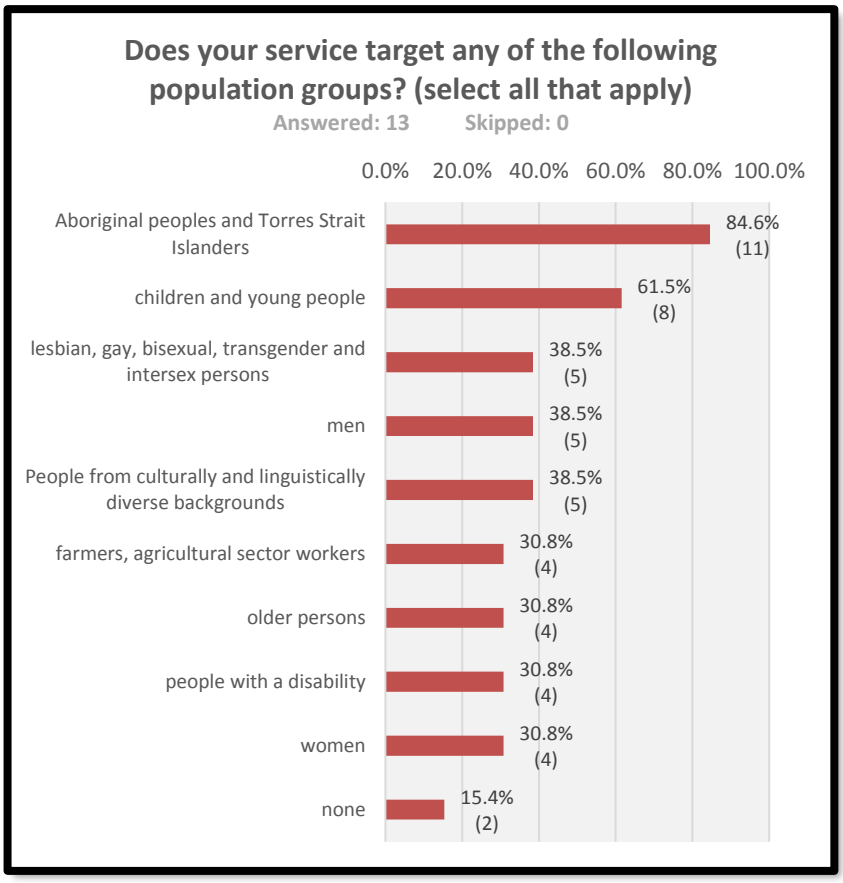
In addition, 61.5% (8) of these agencies specifically target children and young people.

Two agencies indicated they did not target any specific population groups.

Graph 12: Types of alcohol and other drug services provided



Graph 13: Population groups targeted by alcohol and other drug services

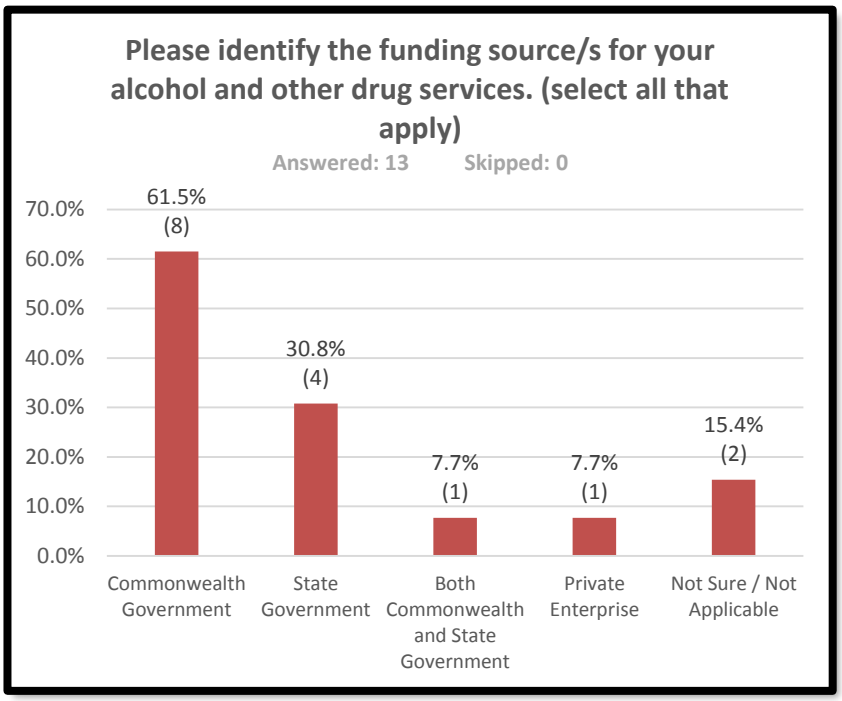


Funding Sources for Alcohol and Other Drug Activities

Just under two-thirds (8; 61.5%) of agencies who indicated they provided alcohol and other drug services (13) received funding for alcohol and other drug activities from Commonwealth Government sources. Just under one-thirds (4; 30.8%) received funding from State Government sources. Of these, only one agency received funding from both State and Commonwealth Government sources.

One service received funding from private enterprise while services received funding from local government sources.

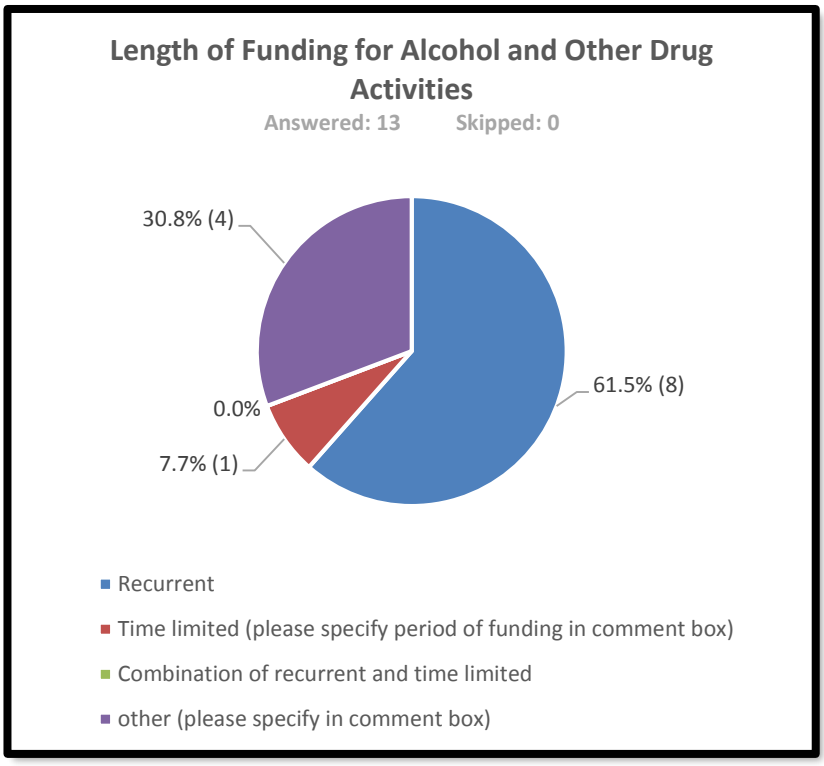
Graph 14: Funding sources for alcohol and other drug activities



Length of Funding for Alcohol and Other Drug Activities

The majority (8; 61.5%) of agencies who indicated they provided alcohol and other drug services (13) received recurrent funding for alcohol and other drug activities.
Just under one-third (4; 30.8%) indicated they received other sources of funding for alcohol and other drug activities.

Graph 15: Length of funding for alcohol and other drug activities



Suicide Policies and Procedures

Respondents were ask if their agency had policies or procedures in place to assist the identification and management of clients who present at risk of suicide. Although the majority (13; 76.5%) indicated their agency did have policies and procedures in place, a significant proportion (4; 23.5%) suggested they did not.

One respondent commented:

- Use of IRIS risk assessment on ongoing basis. Training for staff i.e. Mental Health First Aid and others on a semi regular basis.

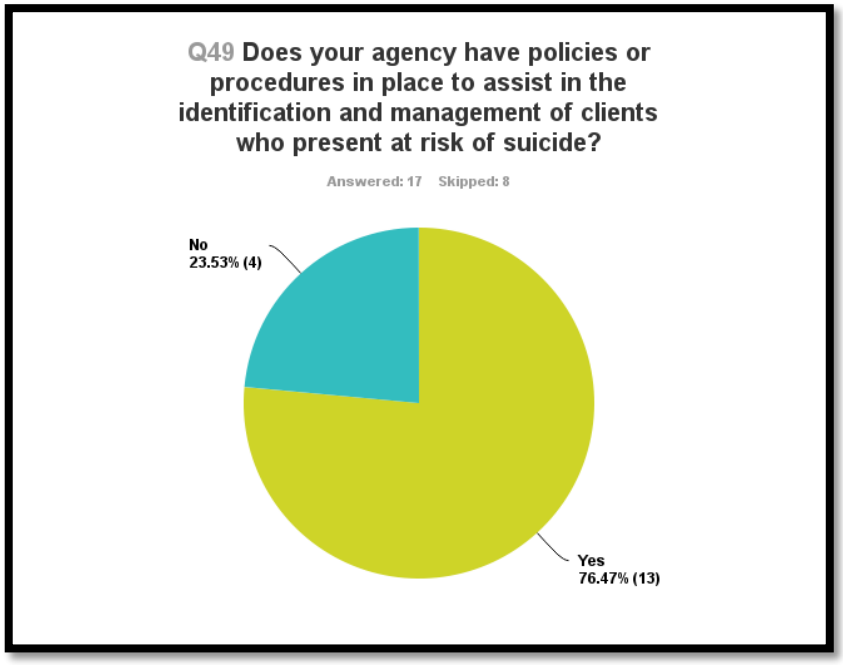
Strategies for Clients at Risk of Suicide

Respondents were asked what approach their organisation takes when they identify that a client may be at risk of suicide. Of those who responded (17), the majority (13; 75.5%) indicated that their service always or most of the time provides direct intervention or support. In addition, 35.3% (6) suggested that they refer these clients to another agency.

One respondent commented:

- We are not an acute service. If at high risk would refer onto Hospital. If only low-moderate would be assessed by Mental Health Professionals and then referred on if necessary.

Graph 16: Suicide policies and procedures



Graph 17: Approach when a client is identified at risk of suicide

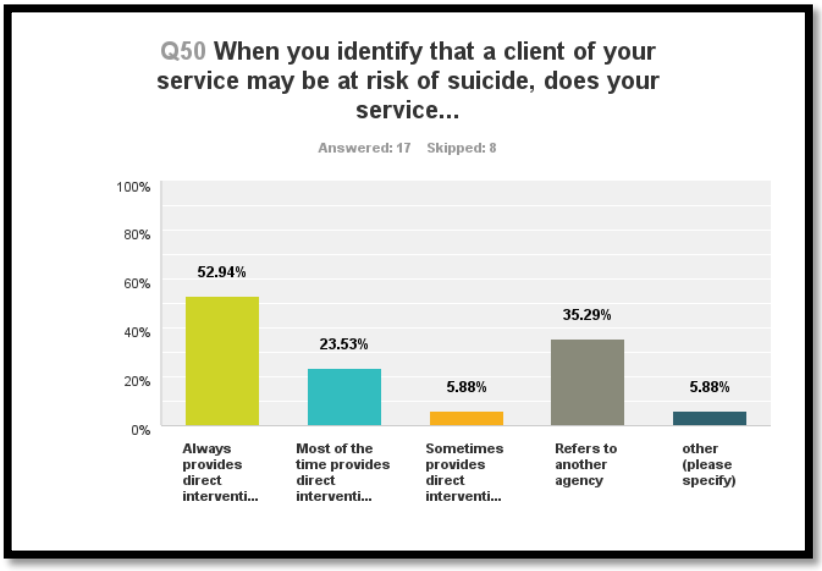


Table 3: Approach when a client is identified at risk of suicide

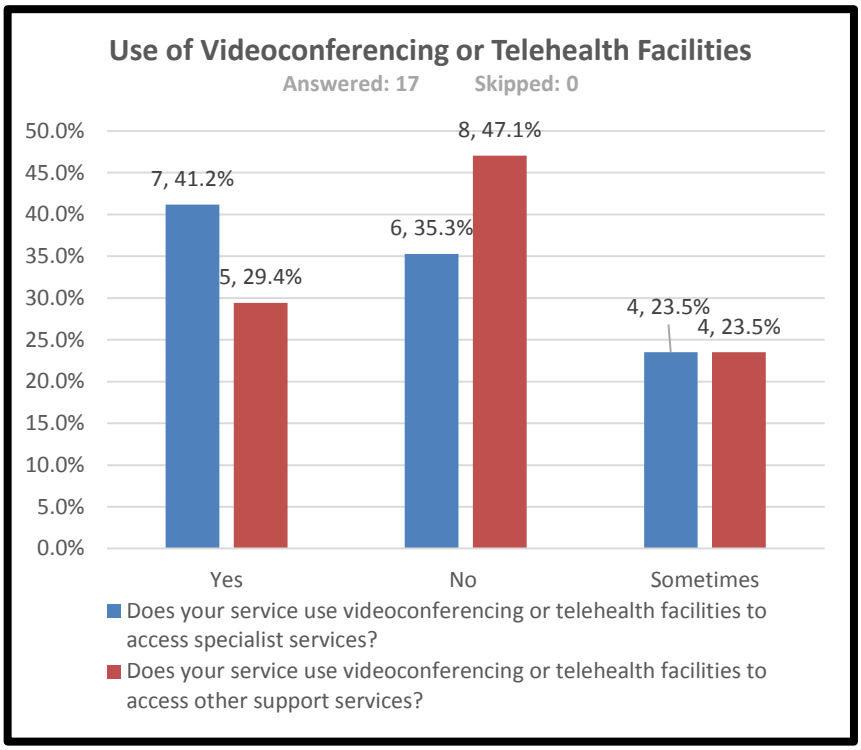
Answer Choices	Count	%
Always provides direct intervention or support	9	52.94%
Most of the time provides direct intervention or support	4	23.53%
Sometimes provides direct intervention or support	1	5.88%
Refers to another agency	6	35.29%
other (see comment to left)	1	5.88%

Use of Videoconferencing and Telehealth facilities

A greater percentage indicated they use videoconferencing and telehealth facilities to access specialist services (11; 64.7%) than other general support services (9; 54.9%). A large proportion (8; 47.1%) suggested that they do not use any videoconferencing or telehealth facilities to access other support services.

Overall, the majority do use videoconferencing and telehealth facilities however most utilise these facilities to access specialist services.

Graph 18: Use of videoconferencing and telehealth facilities



Mt Isa Lookout, The Gap, Mt Isa

Mental Health Service Demand

Of those who responded (17), just under three-quarters (12; 70.5%) indicated that the current level of mental health service provision meets demand for the region from not at all to only some extent. Only a small proportion (3; 17.6%) felt the current level mental health service provision meets demand for the region from a moderate to a large extent. These results suggest that the current level of service provision for mental health may not be adequately meeting demand for the region.

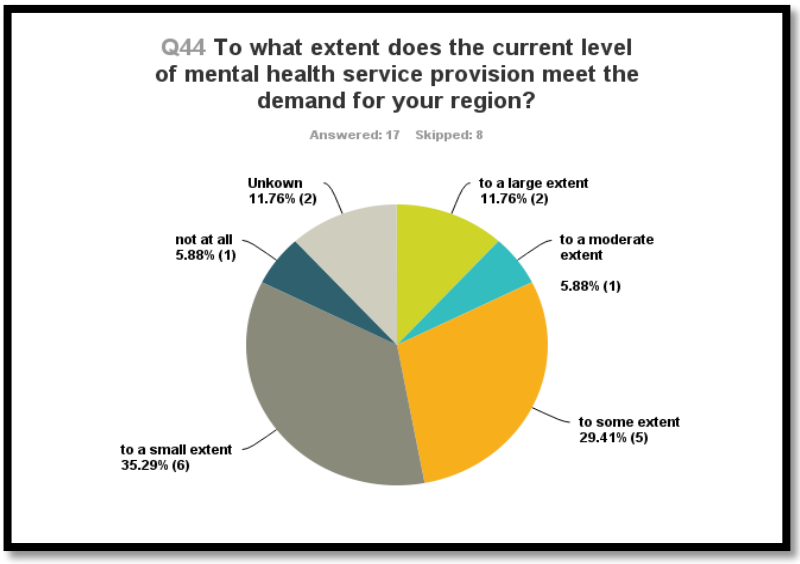
Mental Health Service Demand for Population Groups

Based on a weighted average, mental health service provision met demand for Aboriginal and Torres Strait Islander peoples to the largest extent. This was closely followed by men, people with a disability and women.

Conversely, mental health service provision met demand for people from culturally and linguistically diverse backgrounds to the least extent.

Further to this, just under one-third (5; 29.4%) indicated mental health service demand for lesbian, gay, bisexual, transgender and intersex people was unknown.

Graph 19: Extent current level of mental health service provision meets demand for the region



Two respondents provided additional comments:

- Not enough clinical practitioners available
- Absence of dedicated CYMHS in Lower Gulf – Major Service Gap

Table 4: Extent current mental health service provision meets demand for population groups

Population Group	to a large extent	to a mod extent	to some extent	to a small extent	not at all	Unkn-own	Weighted Average (excludes unknown)
Aboriginal and Torres Strait Islanders	17.7% 3	11.8% 2	23.5% 4	35.3% 6	0% 0	11.8% 2	3.13
Men	12.5% 2	12.5% 2	25% 4	18.8% 3	6.2% 1	25.0% 4	3.08
People with a disability	11.8% 2	11.8% 2	29.4% 5	17.6% 3	11.8% 2	17.6% 3	2.93
Women	12.5% 2	12.5% 2	18.8% 3	31.2% 5	6.2% 1	18.7% 3	2.92
Older persons	11.8% 2	5.9% 1	17.6% 3	35.3% 6	11.8% 2	17.6% 3	2.43
Children and young people*	5.9% 1	0% 0	23.5% 4	47.1% 8	5.9% 1	17.6% 3	2.43
Lesbian, Gay, Bisexual, Transgender and Intersex people	5.9% 1	11.8% 2	5.9% 1	29.4% 5	17.6% 3	29.4% 5	2.42
People from a culturally and linguistically diverse background	6.2% 1	12.5% 2	12.5% 2	31.2% 5	25.0% 4	12.5% 2	2.36

Alcohol and Other Drug Service Demand

Of those who responded (17), over three-quarters (13; 76.5%) suggested that the current level of alcohol and other drug service provision meets demand for the region from a small to only some extent. Only a small proportion (2; 11.8%) felt the current level alcohol and other drug service provision meets demand for the region to a large extent.

These results suggest that the current level of service provision for alcohol and other drugs may not be adequately meeting demand for the region.

Alcohol and Other Drug Service Demand for Population Groups

Based on a weighted average, alcohol and other drug service provision met demand for men to the largest extent. This was closely followed by women and Aboriginal and Torres Strait Islander peoples.

Conversely, alcohol and other drug service provision met demand for people from culturally and linguistically diverse (CALD) backgrounds and children and young people to the least extent. Further to this, approximately one-third felt alcohol and other drug service demand for lesbian, gay, bisexual, transgender and intersex people (6; 35.3%) and people from CALD backgrounds (5; 31.2%) was unknown.

Graph 20: Extent current level of alcohol and other drug service provision meets demand for the region

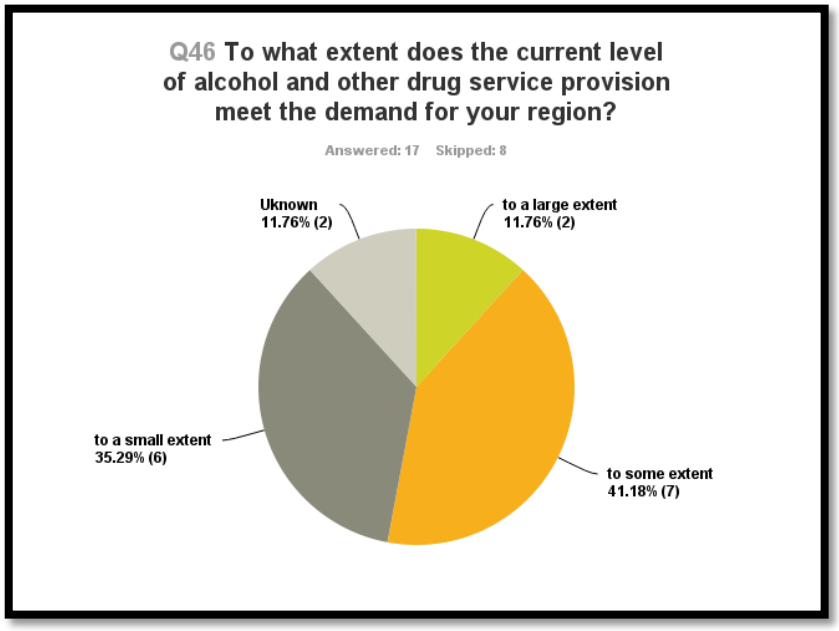


Table 5: Extent current alcohol and other drug service provision meets demand for population groups

Population Group	to a large extent	to a mod extent	to some extent	to a small extent	Not at all	Unkn-own	Weighted Average (excludes unknown)
Men	5.9% 1	11.8% 2	29.4% 5	29.4% 5	0% 0	23.5% 4	2.92
Women	5.9% 1	5.9% 1	29.4% 5	35.3% 6	0% 0	23.5% 4	2.76
Aboriginal peoples and Torres Strait Islanders*	17.6% 3	5.9% 1	23.5% 4	35.3% 6	5.9% 1	11.8% 2	2.67
People with a disability	11.8% 2	0% 0	23.5% 4	29.4% 5	11.8% 2	23.5% 4	2.61
Older persons	5.9% 1	0% 0	23.5% 4	41.2% 7	5.9% 1	23.5% 4	2.46
Lesbian, Gay, Bisexual, Transgender and Intersex people	5.9% 1	5.9% 1	11.8% 2	29.4% 5	11.8% 2	35.3% 6	2.45
Children and young people	0% 0	5.9% 1	23.5% 4	41.2% 7	11.8% 2	17.6% 3	2.29
People from a culturally and linguistically diverse background	0% 0	0% 0	18.7% 3	37.5% 6	12.5% 2	31.2% 5	2.09

***Comment**: For those living in DMG and ONG they still have to travel out of community to access rehab services. While there is a rehab in Normanton there are also 3 pubs which could be problematic for those who usually live in dry communities. This facility also does not support other family members/children

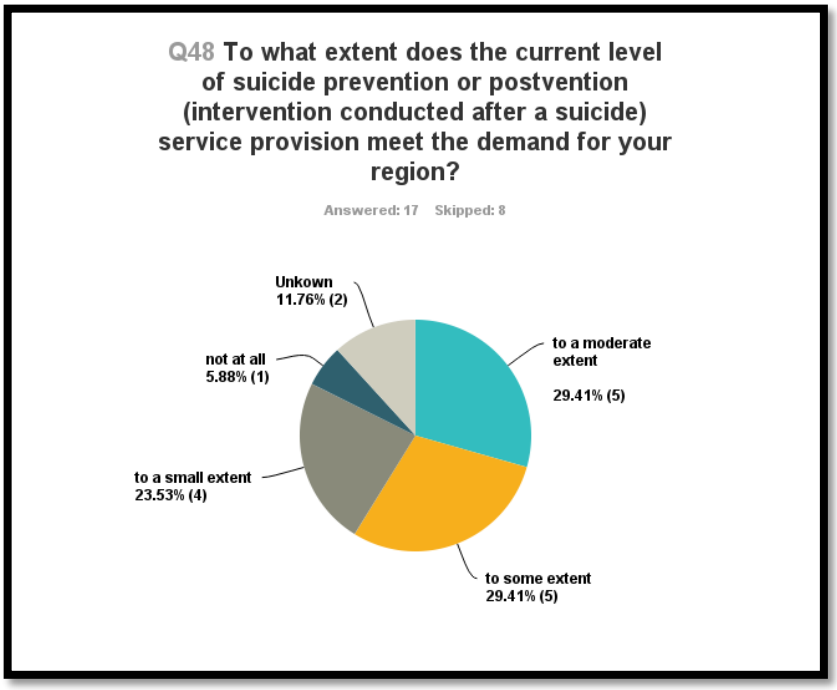
Suicide Prevention or Postvention Service Demand

Of those who responded (17), over half (10; 58.8%) indicated the current level of suicide prevention or postvention service provision met demand for the region from not at all to only some extent. Under one-third (5; 29.4%) suggested the current level of suicide service provision met demand to a moderate extent.

Two respondents commented:

- We need someone local in our community.
- Developing coordination of programs and actions.

Graph 21: Extent current suicide prevention or postvention meets demand for region



Cloncurry Health Precinct, Cloncurry, Queensland

Networks and Interagency Groups Engaged

Respondents were asked to list the networks or interagency groups they were involved with. Of those who responded (15), a large variety of networks or interagency groups that agencies were involved with were identified. Of these, the majority (11; 73.3%) of respondents indicated that they were involved with adult mental health services and/or networks. An equal proportion (8; 53.3%) of respondents indicated that they were involved with ATODS/ rehabilitation and child and youth services. The specific services respondents were involved with are outlined in the table to the right.

Table 6: Networks and interagency groups engaged

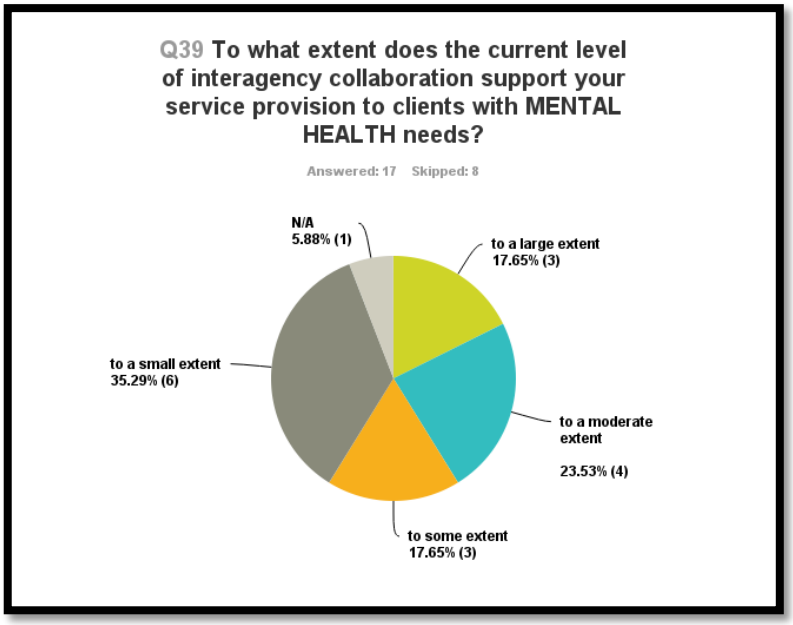
Networks/Interagency Groups	Count	%
Adult Mental Health Services and/or Networks (Queensland Health Mental Health, Mental Health Network, Mental Health Counsellor, Cairns Base Hospital Mental Health Unit, Social Workers Network, Commonwealth Mental Health Provider Meetings)	11	73.3%
ATODS and Rehabilitation Services	8	53.3%
Child and Youth Services (Child Safety, **headspace**, Child and Youth Mental Health, Save the Children, ACT for Kids, Department of Community Services)	8	53.3%
Disability and Community Services (Centacare, Blue Care, Anglicare, Community Health)	7	46.7%
Aboriginal and/or Torres Strait Islander Services (Wuchopperen AMS, Local AMS, Deadly Ears, All Mt Isa Indigenous Agencies, BYNOE)	5	33.3%
Police and Emergency Services (Queensland Police Service, Queensland Ambulance Service, Support Link)	4	26.7%
Legal and Criminal Justice Services (Youth Justice Service, Probation and Parole Service, Cloncurry Justice Group)	3	20.0%
Medicare Local	3	20.0%
General Practitioners (GPs, RFDS)	2	13.3%
Interagency Groups (Cloncurry Service Providers, Normanton Interagency)	2	13.3%
Dual Diagnosis Services	1	6.7%
Employment Services (Mission Australia)	1	6.7%
Local Councils (Carpentaria Shire Council Health Sub-Committee)	1	6.7%
North West Hospital and Health Service	1	6.7%
Other (PMC, PsylutionWorx, One Sight, Hearing Australia)	4	26.7%

Extent Collaboration Supports Clients with Mental Health Needs

Of those who responded (17), over half (9; 52.9%) indicated that interagency collaboration supports service provision to clients with mental health needs from a small to some extent.

A smaller percentage (7; 41.2%) suggested that interagency collaboration supports service provision to clients with problematic substance use from a moderate to large extent.

Graph 22: Extent interagency collaboration supports clients with mental health needs



Extent Collaboration Supports Clients with Problematic Substance Use

Just under two-thirds 11; 64.7%) suggested interagency collaboration supports alcohol and other drug service provision from not at all to only some extent. Only 29.4% (5) indicated interagency collaboration supports alcohol and other drug service provision from a moderate to a large extent.

Extent Collaboration Supports Service Provision - Weighted Average

Based on the weighted average, overall ratings from respondents indicate that the current interagency collaboration best supports service provision for people with mental health needs.

Enhancing Interagency Collaboration

Of those who provided suggestions (12) to enhance interagency collaboration to improve client outcomes, more interagency support and financial support was identified as the most common suggestion to enhance interagency collaboration. This was closely followed by open communication, information sharing and better knowledge of services and needs of clients in the region.

Graph 23: Extent collaboration supports clients with problematic substance use

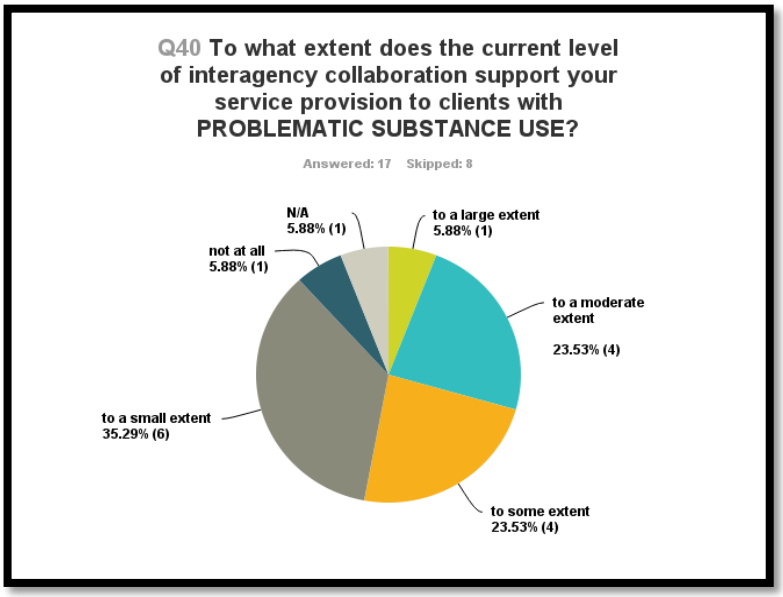


Table 7: Extent collaboration supports service provision – weighted average

	to a large extent	to a mod extent	to some extent	to a small extent	not at all	Weighted Average
Extent Collaboration Supports People with Problematic Substance Use	5.9% 1	23.5% 4	23.5% 4	35.3% 6	5.9% 1	2.88
Extent Collaboration Supports People with Mental Health Needs	17.6% 3	23.5% 4	17.6% 3	35.3% 6	0.0% 0	3.25

Enhancing Interagency Collaboration

Table 8: Suggestions for how to enhance interagency support in the region

Suggestions for how to enhance interagency collaboration in the region	Count	Percentage
More Interagency Support and Financial Support (financial assistance and fund holding to provide infrastructure and buy in relevant services)	3	25%
Open Communication and Information Sharing (including information sharing guidelines)	2	17%
Better knowledge of services and the needs of clients in the region	2	17%
Use of a Coordinated Care Manager/ Case Manager for clients with complex needs and long term strategic planning of visits of clinicians	1	8%
Consistent Referral Forms	1	8%
More Service Providers	1	8%
Other	2	17%
Total	**12**	**100%**

Strategies Implemented by Services for Clients

Of the agencies who responded (20), just under two-thirds (13; 65%) indicated that they work with other services for aspects of the mental health care/support needs and/or refer to another agency for mental health services.

This was closely followed by 60% (12) of agencies indicating that they work with other services for aspects of problematic substance use needs and/or refer to another agency for alcohol and other drug services.

Only a small number of agencies indicated that they provide all the needed mental health services (5; 25%) and/or all the needed problematic substance use services (3; 15%).

Graph 24: Strategies implemented by services

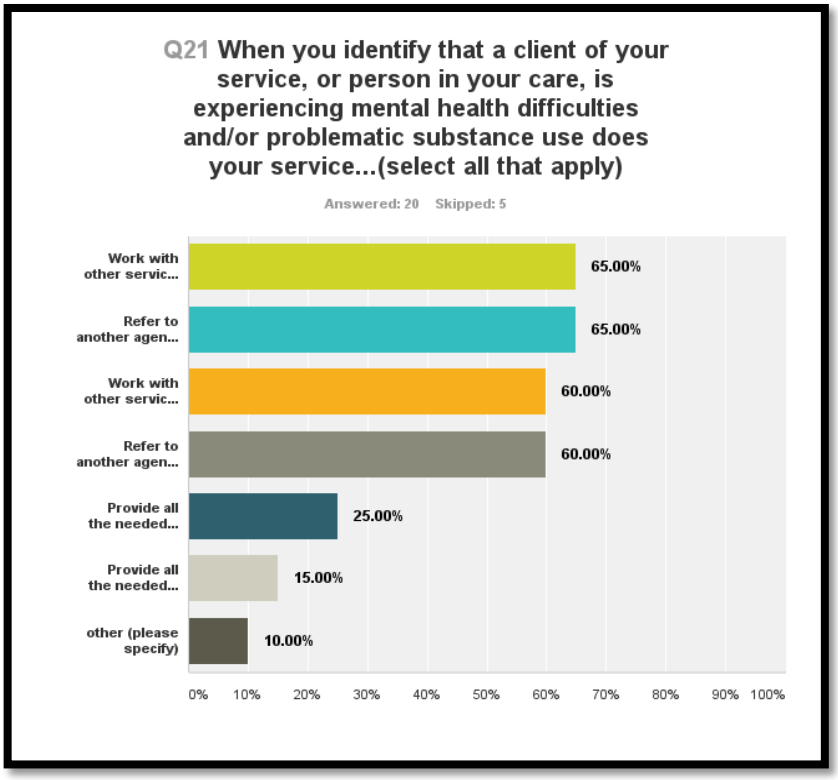


Table 9: Strategies implemented by services

Strategies	Responses
Work with other services for aspects of the mental health care/support needs (e.g. clinical, social)	65.00% 13
Refer to another agency for mental health services	65.00% 13
Work with other services for aspects of problematic substance use needs (e.g. clinical, social)	60.00% 12
Refer to another agency for alcohol and other drug services	60.00% 12
Provide all the needed mental health services	25.00% 5
Provide all the needed problematic substance use services	15.00% 3
other (please specify)	10.00% 2

"I think service integration works really well when clinicians sit together in the same building for example the super clinic. The whole ethos in a super clinic is to be a multidisciplinary centre. People are recognizing this approach works well."

Focus Group Participant Comment, North West HHS Region

Ease of Integration with other Agencies

Of the agencies that responded (20), just under one-third (7; 35%) indicated that coordinating care for a client was harder or much harder than expected. This was closely followed by 30% (6) who indicated that coordinating care for a client with other agencies was as expected. Only one agency suggested the ease of coordinating care for a client with other agencies was easier than expected.

Four respondents provided additional comments (see Table 10).

Graph 25: Ease of integration with other agencies

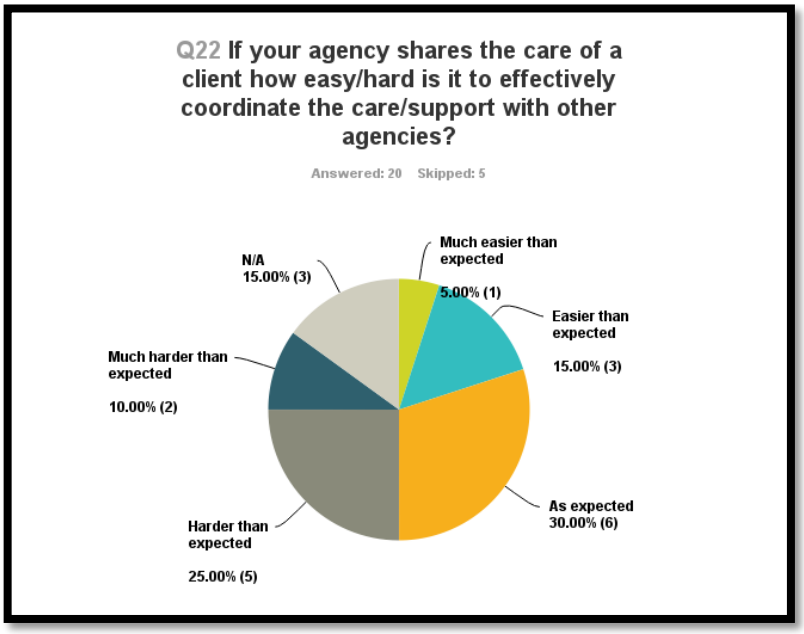


Table 10: Ease of integration with other agencies – additional comments

Additional Comments (n=4)
Much better since Dr has been the Mt Isa Psychiatrist
Distance of service providers
Client availability is unpredictable
Depends on agency and needs of client. For more complex cases we have had funding to set up a Coordinated Case management framework which has improved the coordination around complex case management.

Mechanisms Used to Coordinate Care/ Support

Of those agencies who responded (20), consultation and liaison (16; 80%) was the most common mechanism used to coordinate care/support for clients.

Over half (11; 55%) indicated that they used case management to coordinate care/support for their clients.

Four respondents provided additional mechanisms used (see Table 11).

Graph 26: Mechanisms used to coordinate care/support

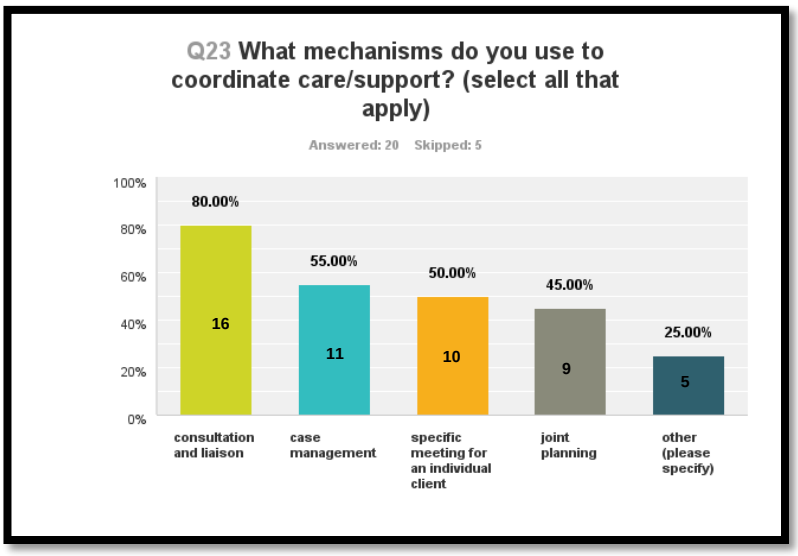


Table 11: Other mechanisms used to coordinate care/support

Other mechanisms used to coordinate care/support (n=4)
Referral
Referral and letter feedback
Coordinated visits of relevant services to access client through activity
Coordinated Case Management Framework

Supports for Integration

Based on a weighted average, strong individual relationships between workers was identified as the most effective support in assisting coordinated care for clients. This was closely followed by a dedicated case coordinator or care coordination model. A formal established mechanism between agencies was considered the least effective support in assisting coordinated care for clients.

Barriers to Integration

Based on a weighted average, lack of access to services due to distance or cost to clients had the greatest impact on an agency's ability to coordinate care successfully. This was closely followed by lack of access to specialist services and client reluctance or ability to take up referral.

Table 12: Effectiveness of supports in assisting coordinated care/support

Not at all effective	Slightly effective	Moderately effective	Very effective	Extremely effective	Weighted Average
strong individual relationships between workers					
0.0% 0	16.7% 3	11.1% 2	44.4% 8	27.8% 5	3.83
dedicated case coordinator or care coordination model					
6.2% 1	12.5% 2	31.3% 5	25.0% 4	25.0% 4	3.50
clear internal policies and practices					
0.0% 0	13.3% 2	40.0% 6	33.3% 5	13.3% 2	3.47
standardised referral forms between agencies					
0.0% 0	31.3% 5	18.7% 3	31.3% 5	18.7% 3	3.38
local structured formal network or governance structure					
0.0% 0	23.6% 4	41.2% 7	17.6% 3	17.6% 3	3.29
formal mechanism between agencies established					
6.7% 1	40.0% 6	26.7% 4	13.3% 2	13.3% 2	2.87
Other*					
0.0% 0	0.0% 0	66.7% 2	0.0% 0	33.3% 1	3.67

***Comments:** Collaborative management model; Chronic care model process only recently established so difficult to evaluate outcomes at this time

Table 13: Impact of barriers on agency's ability to coordinate care

No impact at all	Very little impact	Some impact	Moderate to high level of impact	Significant impact	Weighted Average
lack of access to services due to distance or cost to clients					
8.33% 1	0.00% 0	16.67% 2	16.67% 2	58.33% 7	4.17
lack of access to specialist services					
7.69% 1	0.00% 0	7.69% 1	38.46% 5	46.15% 6	4.15
client reluctance or ability to take up referral					
13.33% 2	0.00% 0	0.00% 0	40.00% 6	46.67% 7	4.07
lack of services to refer to					
14.29% 2	7.14% 1	21.43% 3	21.43% 3	35.71% 5	3.57
waiting times for appointments					
7.14% 1	21.43% 3	21.43% 3	21.43% 3	28.57% 4	3.43
inadequate staff training					
7.14% 1	7.14% 1	42.86% 6	21.43% 3	21.43% 3	3.43

Continued over page

No impact at all	Very little impact	Some impact	Moderate to high level of impact	Significant impact	Weighted Average
varying levels of cultural capability between services (affecting the ability to deliver consistent culturally appropriate services between agencies)					
7.69% 1	15.38% 2	23.08% 3	46.15% 6	7.69% 1	3.31
lack information and understanding about other agencies and their services (currency of service information, staff training/capability)					
7.14% 1	14.29% 2	28.57% 4	42.86% 6	7.14% 1	3.29
information sharing issues (data protection/ privacy/confidentiality/client consent)					
6.67% 1	13.33% 2	46.67% 7	33.33% 5	0.00% 0	3.07
lack of clarity about when referrals must be made and the reasons for doing so (no clear internal policies and practice)					
7.14% 1	21.43% 3	35.71% 5	35.71% 5	0.00% 0	3.00
eligibility criteria of other agencies					
15.38% 2	23.08% 3	23.08% 3	23.08% 3	15.38% 2	3.00
Other*					
33.33% 1	0.00% 0	33.33% 1	33.33% 1	0.00% 0	2.67

*Comment: Isolation

Effectiveness of Strategies to Manage Barriers to Integration

Based on a weighted average, respondents suggested that building relationships was the most effective strategy to address barriers to successful coordinated care. Requesting and providing feedback from other agencies was identified as the second most effective strategy. Conversely, providing financial support to clients was identified as the least effective strategy.

Table 14: Effectiveness of strategies to manage barriers to successful coordinated care

Not at all effective	Slightly effective	Moderately effective	Very effective	Extremely effective	Weighted Average
built relationships					
0.00% 0	0.00% 0	18.75% 3	37.50% 6	43.75% 7	4.25
sought and provided feedback (monitoring quality)					
0.00% 0	14.29% 2	28.57% 4	28.57% 4	28.57% 4	3.71
delivered training and/or resources					
0.00% 0	6.67% 1	46.67% 7	26.67% 4	20.00% 3	3.60
participated in interagency forums or held regular meeting with key agencies					
14.29% 2	14.29% 2	21.43% 3	21.43% 3	28.57% 4	3.36
shared resources					
0.00% 0	23.08% 3	30.77% 4	38.46% 5	7.69% 1	3.31
developed internal policies and referral procedures					
0.00% 0	26.67% 4	33.33% 5	26.67% 4	13.33% 2	3.27
promoted your own agency's role and function (e.g. newsletters, website)					
6.25% 1	25.00% 4	18.75% 3	37.50% 6	12.50% 2	3.25
provided practical assistance to clients (e.g. provided or subsidised transport)					
7.14% 1	21.43% 3	35.71% 5	28.57% 4	7.14% 1	3.07
provided financial support to client					
40.00% 2	40.00% 2	20.00% 1	0.00% 0	0.00% 0	1.80
Other					
0.00% 0	0.00% 0	66.67% 2	33.33% 1	0.00% 0	3.33

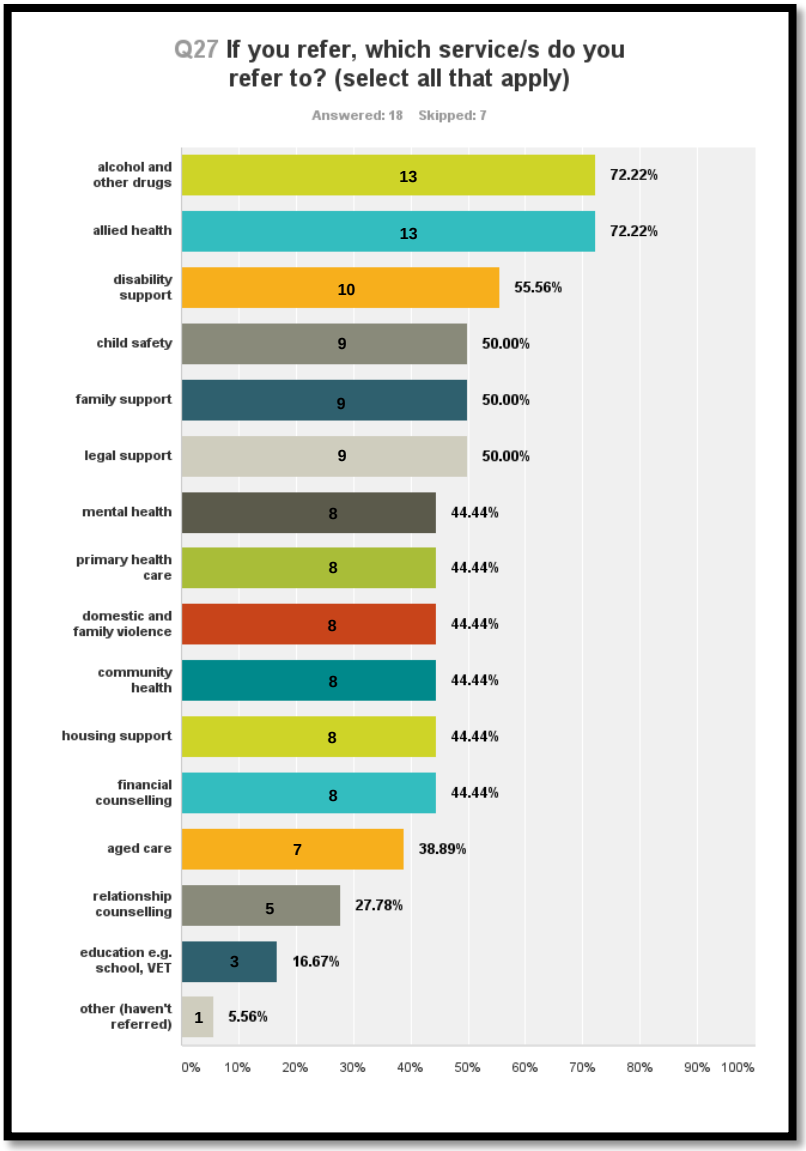
Referrals to Other Services

Of those who responded (18), 72.2% (13) of agencies referred to alcohol and other drugs and/or allied health services.

In addition, 55.6% of agencies referred to disability services.

Education (school or VET) was the least service referred to by the agencies that responded.

Graph 27: Referrals to other services

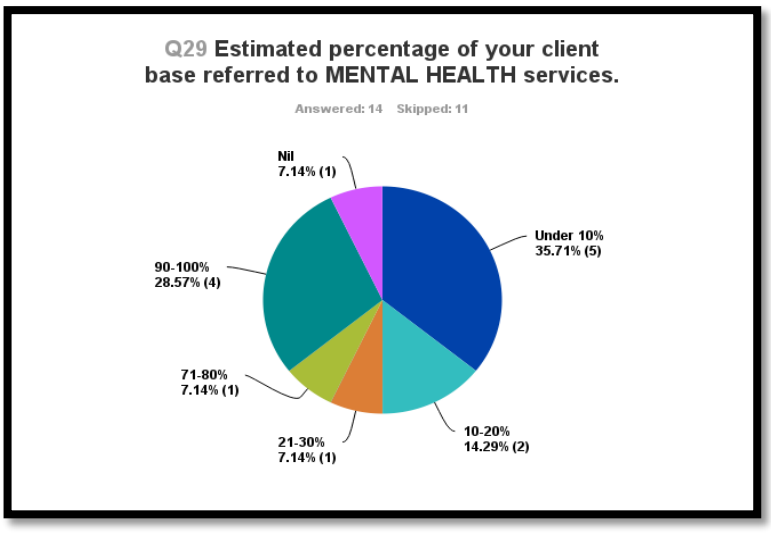


Percentage of Referrals to Mental Health Services

Of those agencies who responded (14), over one-third (5; 35.7%) of agencies referred over 71% of their clients to mental health services.

An equal proportion (5; 35.7%) referred under 10% of their clients to mental health services.

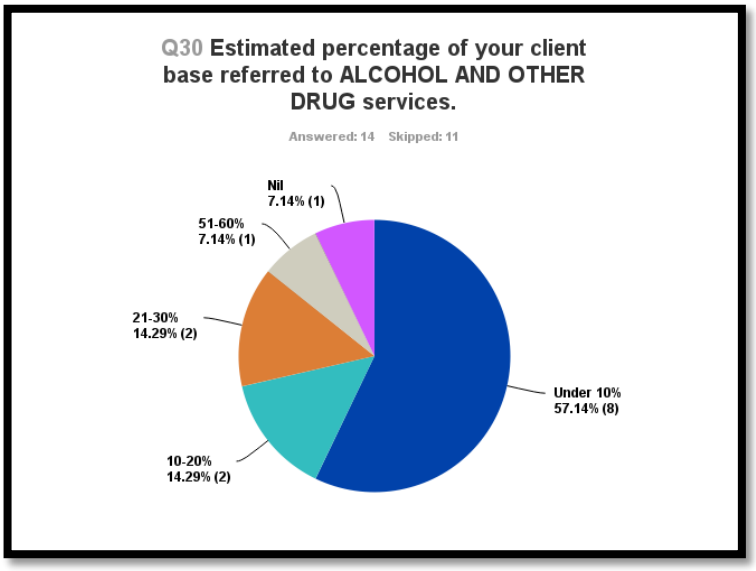
Graph 28: Percentage of referrals to mental health services



Percentage of Referrals to Alcohol and Other Drug Services

Of the 13 who referred to alcohol and other drugs services (as noted in graph 27), over half (8; 57.1%) referred under 10% of their clients to alcohol and other drug services.

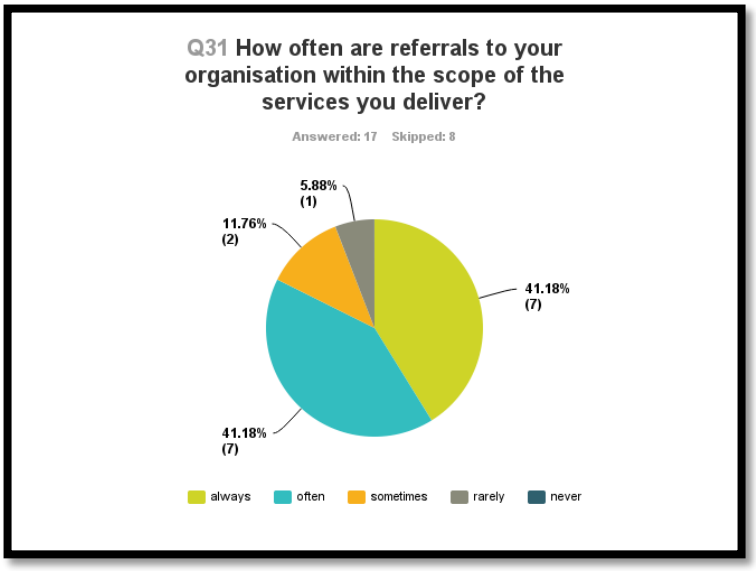
Graph 29: Percentage of referrals to alcohol and other drug services



Scope of Referrals

Of those who responded (17), the majority (14; 82.4%) indicated that referrals were always and often within the scope of services they deliver. Only a small percentage (1; 5.9%) suggested the referrals were rarely within the scope of services they deliver.

Graph 30: Scope of referrals



Mode of Referral Delivery

Of those who responded, warm referrals and supported referrals where the most often types of referrals made (see table 15 for definitions).

Referrals where the client is provided with the referral information (thus the client has responsibility for contacting other organisations) was not made as frequently.

Graph 31: Frequency of mode of referral delivery

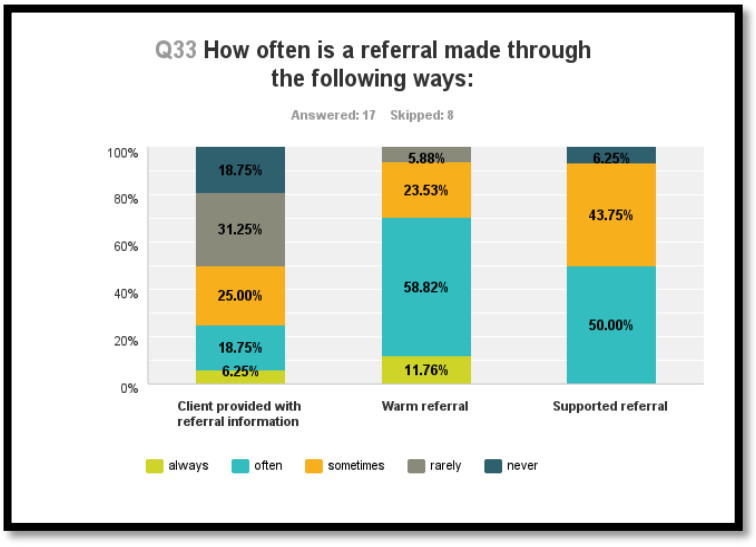


Table 15: Frequency of mode of referral delivery

Type of referral	always	often	sometimes	rarely	never	Total
Client provided with referral information	6.25% 1	18.75% 3	25.00% 4	31.25% 5	18.75% 3	16
Warm referral*	11.76% 2	58.82% 10	23.53% 4	5.88% 1	0.00% 0	17
Supported referral**	0.00% 0	50.00% 8	43.75% 7	0.00% 0	6.25% 1	16

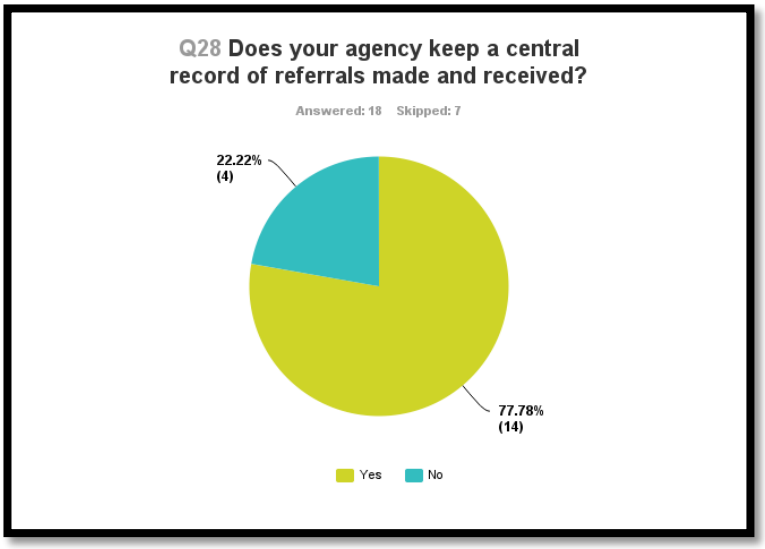
***Warm Referral**: the individual making the referral makes first contact on behalf of the client, and explains to the referral organisation the client's circumstances and the reason they believe the client would benefit from the referral.

****Supported Referral**: accompanying the client to the initial interview, assisting the client to attend the appointment by assisting with support needs such as arranging travel, providing an interpreter

Recording Referrals

Of those agencies who responded (18), 77.8% (14) keep a central record of referrals made and received. Only 4 indicated that their agency did not keep a central record of referrals.

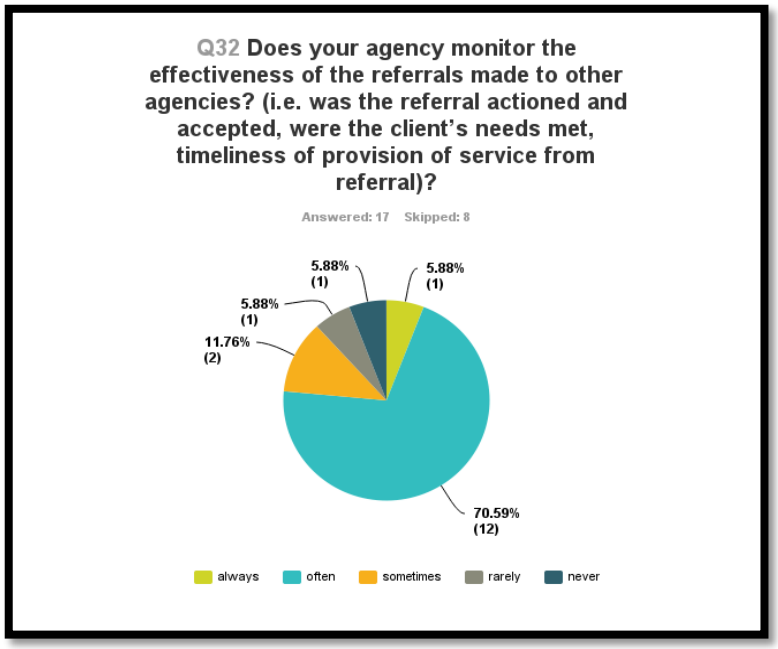
Graph 32: Central record of referrals



Monitoring Effectiveness of Referrals

Of those who responded (17), the majority (13; 76.5%) indicated that their agency always and often monitors the effectiveness of referrals made to other services. Only a small percentage (2; 11.8%) of respondents suggested their agency only sometimes or never monitors the effectiveness of referrals to other services.

Graph 33: Monitoring the effectiveness of referrals



Ongoing Partnership with Referred / Referring Agency

Of those who responded (17), just under three-quarters (12; 70.6%) always or often continued to work with their client in partnership with the referred/referring agency. No respondents indicated that they rarely or never work in partnership with the referred/referring agency.

Supports for Referrals

Based on a weighted average, strong individual relationships between workers was identified as the most effective support in assisting referral processes to other agencies. This was followed by a dedicated case coordinator or care coordination model. Formal mechanism between agencies established (e.g. service level agreement or memorandum of understanding) was identified as the least effective support strategy.

Further to this, the top three supports identified above in assisting referral processes re the same as the top three most effective supports in assisting coordinated care for clients. This is also the case for the support strategy identified as the least effective in assisting both referral processes and coordinated care for clients (see Table 12).

Graph 34: Ongoing partnership with referred/referring agency

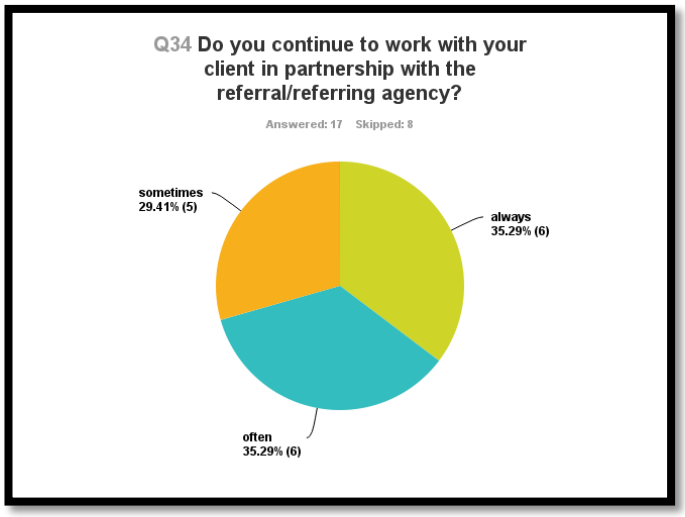


Table 16: Effectiveness of supports in assisting referral processes

Not at all effective	Slightly effective	Moderately effective	Very effective	Extremely effective	Weighted Average
strong individual relationships between workers					
0.00% 0	0.00% 0	13.33% 2	33.33% 5	53.33% 8	**4.40**
dedicated case coordinator or care coordination model					
0.00% 0	0.00% 0	41.67% 5	33.33% 4	25.00% 3	**3.83**
clear internal policies and practice e.g. referral flowchart available, training provided					
6.67% 1	6.67% 1	33.33% 5	40.00% 6	13.33% 2	**3.47**
standardised referral forms between agencies making and receiving the referral					
0.00% 0	28.57% 4	28.57% 4	21.43% 3	21.43% 3	**3.36**
local structured formal network or governance structure (may include a focus on how clients can be referred between agencies)					
6.67% 1	13.33% 2	40.00% 6	40.00% 6	0.00% 0	**3.13**
formal mechanism between agencies established (e.g. service level agreement or memorandum of understanding)					
6.67% 1	20.00% 3	40.00% 6	33.33% 5	0.00% 0	**3.00**
other					
0.00% 0	0.00% 0	50.00% 1	50.00% 1	0.00% 0	**3.50**

"If I know someone in that organisation and can trust them, I know I can pick up the phone and say, 'I've got this person do you think you could fit them in?', I'm a thousand times more likely to refer to them."

Focus Group Participant Comment, North West HHS Region

Barriers to Referrals

Based on a weighted average, lack of access to specialist services (weighted average of 4.36) and lack of access to services due to distance or cost (weighted average of 4.15) was identified as the barriers of most significant impact on an agency's ability to refer successfully. Client reluctance or ability to take up referral was also identified as a significant barrier impacting on an agency's ability to refer successfully.

Further to this, the top three barriers identified as having the greatest impact on successful referrals coincide with the top three barriers impacting on an agency's ability to coordinate care/support successfully (see Table 13).

Table 17: Impact of barriers on agency's ability to refer successfully

No impact at all	Very little impact	Some impact	Moderate to high level of impact	Significant impact	Weighted Average
lack of access to specialist services					
0.00% 0	0.00% 0	14.29% 2	35.71% 5	50.00% 7	**4.36**
lack of access to services due to distance or cost to clients					
0.00% 0	7.69% 1	15.38% 2	30.77% 4	46.15% 6	**4.15**
client reluctance or ability to take up referral					
0.00% 0	6.67% 1	13.33% 2	46.67% 7	33.33% 5	**4.00**
waiting times for appointments					
0.00% 0	6.67% 1	33.33% 5	20.00% 3	40.00% 6	**3.93**
lack of services to refer to					
14.29% 2	0.00% 0	28.57% 4	14.29% 2	42.86% 6	**3.71**
inadequate staff training					
0.00% 0	21.43% 3	21.43% 3	28.57% 4	28.57% 4	**3.64**
eligibility criteria of other agencies					
0.00% 0	6.67% 1	46.67% 7	26.67% 4	20.00% 3	**3.60**
information sharing issues (data protection/privacy/confidentiality/client consent)					
0.00% 0	6.67% 1	40.00% 6	46.67% 7	6.67% 1	**3.53**
lack information and understanding about other agencies and their services (currency of service information, staff training/capability)					
0.00% 0	7.14% 1	50.00% 7	28.57% 4	14.29% 2	**3.50**
varying levels of cultural capability between services (affecting the ability to deliver consistent culturally appropriate services between agencies)					
0.00% 0	23.08% 3	38.46% 5	15.38% 2	23.08% 3	**3.38**
lack of clarity about when referrals must be made and the reasons for doing so (no clear internal policies and practice)					
0.00% 0	21.43% 3	42.86% 6	21.43% 3	14.29% 2	**3.29**
other					
0.00% 0	0.00% 0	100.00% 2	0.00% 0	0.00% 0	**3.00**

Mt Isa, Queensland

Strategies to Address Barriers to Referrals

Based on a weighted average, respondents suggested that built relationships was the most effective strategy to address barriers to successful referrals. Requesting and providing feedback (monitoring quality) and delivering training and/or resources were equally identified as the second most effective strategy to address barriers. These results correlate with the most effective strategies to address barriers for successful coordinated care/support (see Table 14).

Conversely, providing financial support to clients was identified as the least effective strategy address barriers to successful referrals. This again coincides with the least effective strategy identified to address barrier for successful coordinated care/support (see Table 14).

Additional Comments

Two respondent provided additional open comments.

Table 18: Strategies to address barriers to refer successfully

Not at all effective	Slightly effective	Moderately effective	Very effective	Extremely effective	Weighted Average out of 5
built relationships					
0.00% 0	0.00% 0	18.75% 3	31.25% 5	50.00% 8	**4.31**
delivered training and/or resources					
0.00% 0	6.25% 1	37.50% 6	56.25% 9	0.00% 0	**3.50**
sought and provided feedback (monitoring quality)					
0.00% 0	7.14% 1	50.00% 7	28.57% 4	14.29% 2	**3.50**
participated in interagency forums or held regular meeting with key agencies					
6.67% 1	0.00% 0	46.67% 7	33.33% 5	13.33% 2	**3.47**
promoted your own agency's role and function (e.g. newsletters, website)					
0.00% 0	0.00% 0	60.00% 9	33.33% 5	6.67% 1	**3.47**
developed internal policies and referral procedures					
0.00% 0	7.69% 1	53.85% 7	30.77% 4	7.69% 1	**3.38**
shared resources					
0.00% 0	7.69% 1	61.54% 8	23.08% 3	7.69% 1	**3.31**
provided practical assistance to clients (e.g. provided or subsidised transport)					
13.33% 2	0.00% 0	40.00% 6	46.67% 7	0.00% 0	**3.20**
provided financial support to client					
50.00% 3	0.00% 0	33.33% 2	16.67% 1	0.00% 0	**2.17**
other					
0.00% 0	0.00% 0	50.00% 1	50.00% 1	0.00% 0	**3.50**

"When I go out to Cloncurry I work in the Cloncurry Health Precinct with the Centacare workers. When we work in the same building and they know your workload and how you work they are more comfortable to refer. It comes down to that ease of referral."

Focus Group Participant Comment, North West HHS Region

Additional Open Comments

Table 19: Additional comments

Additional Comments (n=2)
Services continue to develop within this context. With the complexity of issues and changeover of staff, it becomes difficult to significantly address what is becoming generational repetition of disadvantage.
We want more local control on funding of services. We believe that we can deliver much better value for money by buying in our own services and / or identifying local support who could be used to support local mental health services e.g. respected elders in the community who could do some mentoring and be paid for their services.

Focus Group Summary

Service providers from within the North West HHS region were invited to participate (face-to-face and teleconference) in a focus group and actively contribute to a number of key focus group questions to complement the survey results. Four service providers from across three agencies (Central and North West Queensland Medicare Local, **headspace** and North West Queensland Indigenous Catholic Social Services) participated in the focus group held in Mt Isa.

The discussion was audio recorded and a summary of key themes were identified and are provided below.

What does effective service integration mean?

Focus group participants felt effective service integration:

- is about working together and including mental health and alcohol and other drug issues are part of general service provision;
- is about relationships with other services providers which was identified as critical for effective service provision; and
- works very well when clinicians are co-located.

What does good service integration look like in the region?

Focus group participants commented that overall service integration is ineffective in the North West HHS region. There is limited attendance at interagency meetings and a lack of awareness of service providers and their function in the region. Compartmentalisation of services was identified as a key barrier to effective integration.

What does effective service integration mean?

Summary of Comments
Good integration is about including mental health and drug and alcohol issues as part of general health and wellbeing to reduce the stigma associated with it. Often people with mental health or alcohol or other drug issues will not seek out services themselves however they may be more receptive if these services were integrated into general health services.
Relationships with other services providers in region is critical for effective service integration. Having effective relationships means that referrals are more likely to occur.
Service integration works very well when clinicians (including GPs, dietitians, dentists, physiotherapists etc.) work together in the same building such as the Medicare Local, Gidgee Healing and super clinics. Clinicians get to know each other, the services they offer, how they work, their waiting lists and their referral processes. When clinicians are based in different organisations obtaining the relevant information is more difficult. Therefore ease of referral is very important.

What does good service integration look like in the region?

Summary of Comments
In the North West HHS region there are interagency meetings held, however no providers attend. Too many meetings with the same providers are held in the region. In addition, generally, government agencies attend whereas private providers will not attend as they are taken away from private practice during the day which results in lost income. Therefore networking with private providers never occurs.
In the North West HHS region there is limited awareness of the service providers in the region. Service providers do not know what other services are funded to do.
One of the barriers for service integration in the North West is the compartmentalisation of services. Providers become territorial as funding is so competitive which impacts on good integration and good service delivery.
Often good service integration occurs out of hours however organisations do not fund staff for this and therefore it becomes volunteered time.
There is consensus that Aboriginal and/or Torres Strait Islander people do not want segregation of Indigenous and Non-Indigenous services which continues to occur in the North West HHS region.

What do referral pathways look like in the region?

Overall, focus group participants felt that referrals do not occur well in the region due to a number of reasons including limited awareness of services and what they can offer, the referral process, lack of private practitioner workforce, referral criteria and limited knowledge about what mental health is.

A case manager role to support referral processes was identified as a strategy for the North West HHS region.

Types of supports that exist in the region

Focus group participants felt that although there are services that address mental health and alcohol and other drug issues, there is:

- limited specialists, detoxification centres and inpatient services. Often patients with severe alcohol and other drug problems are transferred to Brisbane or Townsville;
- shortage of skilled workforce;
- lack of community awareness of services; and
- some current strategies (e.g. health expos) do not reach people at an early intervention stage as people engage with services when needed.

What do referral pathways look like in the region?

Summary of Comments
Although there are good intentions and understanding of the importance of referring, service providers feel that referrals do not occur well in the North West HHS region.
There is not a large number of providers in the North West HHS region however there is also not a good directory of services.
As service providers have limited awareness of what other services can offer, most patients are generally referred to ATODS and Mental Health.
One of the biggest barriers to service integration in the North West HHS region is the referral process, especially in the case of youth and being able to access young people to make the referral.
Another barrier is the lack of private practitioner workforce. Private practitioners rely on MBS so without the referrals, private practitioners do not visit the region.
Referral criteria is often a barrier for some services. For example **headspace** are required to turn away clients who to do not meet the age criteria for the service due to funding restrictions.
Would be beneficial in the North West HHS region to have an organisation whose only role is to be case managers where they arrange appointments, get patients to the appointments and then the providers refer on.
For some community based services, there is a lack of knowledge about what mental health is and how to recognise the signs of a mental health issue to initiate referrals.

Types of supports that exist in the region for people (and their family and carers) with mental illness, mental health difficulties or problematic substance use.

Summary of Comments
Types of supports / services: • Mt Isa Recovery Centre • ATODS • Mental Health (Queensland Health) • Burke Street Shed which targets Indigenous patients/clients.
There are very few specialists in drug and alcohol and very few detox centres who will keep people until they sober up. The Mt Isa Recovery Centre is quite a specific funded service.
There is no inpatient, just ED so patients with severe drug and alcohol issues are transferred to Townsville or Brisbane.
For a lot of services, due to the workforce shortage they do not have people with the right skills in positions. Often they are just filling positions. There is a major issue with a shortage of skilled workers.
There is duplications of services in the region.
The community sometimes have no idea what services are available to them. The service providers have health expos however people don't turn up unless they need the service.

Groups of people whose needs are not being met.

Participants felt there were a number of service gaps targeting specific population groups including people with a dual diagnosis, those requiring home services, high risk mental health patients and those requiring after hours services.

Participants' suggested actions and strategies to build better service integration

Participants identified a number of key actions to build better service integration in the region. These include:

- A dedicated person in the community to bring all of the services together;
- An interactive database or tool containing comprehensive information about services available in the region and the referral pathways into and out of each service;
- Interagency meetings where workers on the ground are funded to attend;
- Flexible funding; and
- Community education about recognising the signs of mental health and alcohol and other drug issues.

Specific groups of people whose mental health and alcohol and other drug service needs are not being met for the region.

Summary of Comments
There is a big gap of services for people with dual diagnosis of mental health and alcohol and other drug issues. Mental Health cannot treat people with drug and alcohol issues and ATODS are not equipped to deal with people who have mental health problems. There are no specialists who are dual practitioners.
There are no services that actually go to the people in their own homes. In the past Aboriginal Health Workers would go and do home visits however this does not occur anymore.
There are limited services for high risk mental health patients. Mental Health deal with low to moderate mental health issues and once it becomes high risk they have to go to hospital.
More after hour services are needed.

Focus group participants' suggested actions and strategies to build better service integration in the region

Summary of Comments
There is a need for a dedicated person in the community to bring all the services and the people together. A lot of programs fall down when you do not have a dedicated person coordinating activities. This would also help to bridge the gap between government and private services.
An interactive database program or application (App) which maps entry and exit point into and out of local services would be beneficial. This would also include information about referral processes for these services where you would answer a series of questions or select options based on the client's needs which would provide you with a range of possible referral options (including service contact details and referral criteria). This type of program would need dedicated personnel to coordinate gathering the information, developing and updating the program. It is important that this program or App is free of charge to include information and also to utilise.
Meet and greets of ground workers where they are paid to attend (to ensure private practitioners are catered for) would be extremely beneficial.
Flexible funding so that agencies are able to provide flexible services to whatever the community needs at that point in time.
Education about recognising the signs of mental health and drug or alcohol problem both for the community and also for some local services is very important.

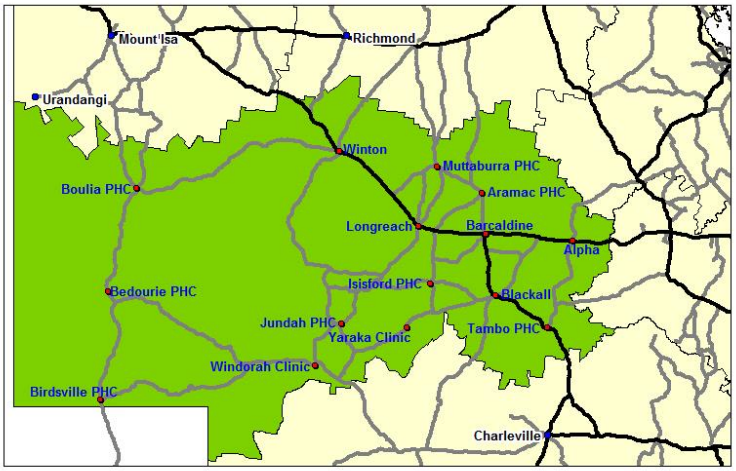
Cloncurry Health Precinct, Cloncurry

6.0 Central West HHS Region

Central West HHS Region at a Glance

The Central West HHS region covers an area of over 382,000 square kilometres which is 22 percent of the land mass of Queensland. Central West HHS region comprises of seven local government areas, all of which have a classification of 'very remote'. The Central West is one of the more isolated regions in Australia and distances that residents and services must sometimes travel can be extensive.

Figure 2: Central West HHS Region Map



Population Demographics

The estimated population of the Central West is 12,387 which accounts for approximately 0.3% of the total population of Queensland. According to the 2011 Census, the Indigenous population accounts for 8.3% (999 people) of the total population of the Central West HHS region which is twice the Queensland average.

Key Health Conditions

The burden of disease is 21% higher than the Queensland state average and the leading causes of death for people living in the Central West HHS region include:

- heart disease (e.g. heart attack)
- cerebrovascular diseases (e.g. stroke)
- lung cancer
- diabetes
- chronic lower respiratory diseases (e.g. bronchitis)

Although 91% of residents rate their quality of life 'good' or 'very good':

- 1 in 3 adults have high blood pressure
- 1 in 4 adults have high cholesterol
- 1 in 5 residents are 'daily smokers'
- 1 in 7 adults had risky levels of alcohol consumption
- 1 in 10 adults have diabetes/high blood sugar

References:

- *Central West Hospital and Health Service Annual Report 2013–2014.*
- *Health of the West: A single health plan for central west Queensland 2014–2024.*

Survey Respondent Profile

Of the respondents (91) who completed the overall service integration and referral mapping survey, 18 (19.8%) were based in the Central West HHS region. Half of respondents represented non-government agencies with the remaining half representing 32% government agencies.

Of the respondents (10) who indicated their level of position within their organisation, half (5; 50%) were from service delivery / service provider positions followed closely by middle / regional management positions (4; 40%). The remaining respondent was from an administrative position.

Of those who indicated their sex (10), 60% (6) were female and the remaining 40% (4) were male.

Half of the respondents were aged between 35 and 44 years.

In addition, seven service providers from across five agencies (Central and North West Queensland Medicare Local, Red Cross, Royal Flying Doctor Service, Queensland Health and Rural Financial Service) participated in the focus group held in Longreach to complement the survey results.

6.0 Central West HHS Region

Key Findings

The Service System

Services Provided

- 72% of agencies surveyed provide services for mental health and/or alcohol and other drugs.
- Just under 40% indicated their agency's primary focus to be mental health service provision. Just under half provide mental health as a secondary service delivery focus.
- The majority (60%) also indicated that their service always or most of the time provides direct intervention or support when they identify that a client may be at risk of suicide with half also suggesting that they refer these clients to another agency. In addition, 100% of agencies have policies and procedures in place to assist the identification and management of clients who present at risk of suicide.

Types of Services

- The main types of mental health services provided include suicide risk detection and management, care coordination for mental health and recovery support.
- The main types of alcohol and other drugs services provided include brief intervention, support and case management and counselling.

Service Demand

- Forty percent indicated that the current level of mental health service provision meets demand for the region to a large extent.
- In addition, 40% of respondents suggested that the current level of alcohol and other drug service provision meets demand for the region from a moderate to a large extent.
- Half of all agencies indicated the current level of suicide prevention or postvention service provision met demand for the region from some to a moderate extent.
- Respondents felt that the current level of mental health and alcohol and other drug service provision met demand for men, women, Aboriginal and Torres Strait Islanders, and older people to the largest extent. Conversely, service provision met demand for children and young people to the least extent.

Networking and Interagency Groups

- Respondents engaged with a large variety of networks or interagency groups with the majority (77.8%) suggesting they were involved with generic interagency groups / networks. An equal proportion (44.4%) of respondents said that they were involved with mental health services / networks and/or the Royal Flying Doctor Service.
- A large proportion (60%) indicated that interagency collaboration supports service provision to clients with mental health needs from a moderate to large extent. An equal proportion (60%) suggested that interagency collaboration supports service provision to clients with problematic substance use from only some to a small extent. Thus implying that interagency collaboration best supports service provision for people with mental health needs.
- Increasing case conferencing and use of technology and specific strategic meetings to discuss referral avenues and protocols were some suggestions to enhance interagency collaboration in the region.

Service Integration

Strategies Implemented by Services

- When a client is identified with mental health difficulties and/or problematic substance use, the most common strategies implemented were as follows:
    - refer to another agency for mental health services (68.75%);
    - refer to another agency for alcohol and other drug services (56.25%); and/or
    - work with other services for aspects of the mental health care/support needs (56.25%).

Ease of Integration with Other Services

- The majority (62.50%) indicated the ease of coordinating care for a client was as expected. Only three agencies (18.75%) suggested the ease of coordinating care was easier or much easier than expected.

Supports for Integration

- Joint planning (75%) and consultation and liaison (75%) were the most common mechanisms used to coordinate care/support for clients.
- Strong individual relationships between workers followed by a dedicated case coordinator or care coordination model were identified as the most effective supports in assisting coordinated care for clients.

Barriers to Integration

- Lack of access to services due to distance or cost and lack of access to specialist services were the most significant barriers to service integration.

Strategies to Manage Barriers to Integration

- Built relationships and shared resources were the most effective strategies to address barriers to service integration.

Referrals

Referrals to Other Services

- The majority of agencies referred clients to mental health (82.6%), community health (76.9%) and allied health (76.92%) services.
- Over 60% of all agencies referred 10 to 30 percent of their clients to mental health services. In addition, half referred 10 to 30 percent of their clients to alcohol and other drug services.
- Warm referrals and supported referrals where the most common types of referrals made. The majority (70%) of referrals were often within the scope of services the agency delivers.
- The majority of agencies (61.5%) keep a central record of referrals and 70% always or often monitors the effectiveness of referrals.

Supports for Referrals

- A dedicated case coordinator or care coordination model followed by strong individual relationships between workers was identified as the most effective supports in assisting referral processes.

Barriers to Referrals

- Lack of services to refer to, lack of access to specialists and lack of access to services due to cost or distance were identified as the most significant barriers to refer successfully.

Strategies to Manage Barriers to Referrals

- Respondents suggested that promoting own agency's role and function, built relationships and shared resources were the most effective strategy to address barriers to successful referrals.

Focus Group Discussion

- Service providers feel that providers generally work well together in the region. Communication is very good across the region and due to remoteness, providers often know one another. Two key barriers to service integration were identified including ownership of clients and recruiting and retaining good clinical staff.
- Providers predominantly rely on GPs for referrals. Most services have formal referral processes with some also using information referral processes. Patient consent to refer was identified as a barrier.
- There are a number of services in the region that are mostly based in Longreach and provide outreach services to the Central West.
- Service providers feel there are gaps in services for youth, people who require early psychosis services and residential rehabilitation. Lack of recruitment to specific positions due to lack of skilled workers was identified as a barrier to service provision.
- Key actions that were identified to build better service integration in the region included ongoing interagency meetings and an interactive database or tool outlining local services and referral pathways.

Services Provided

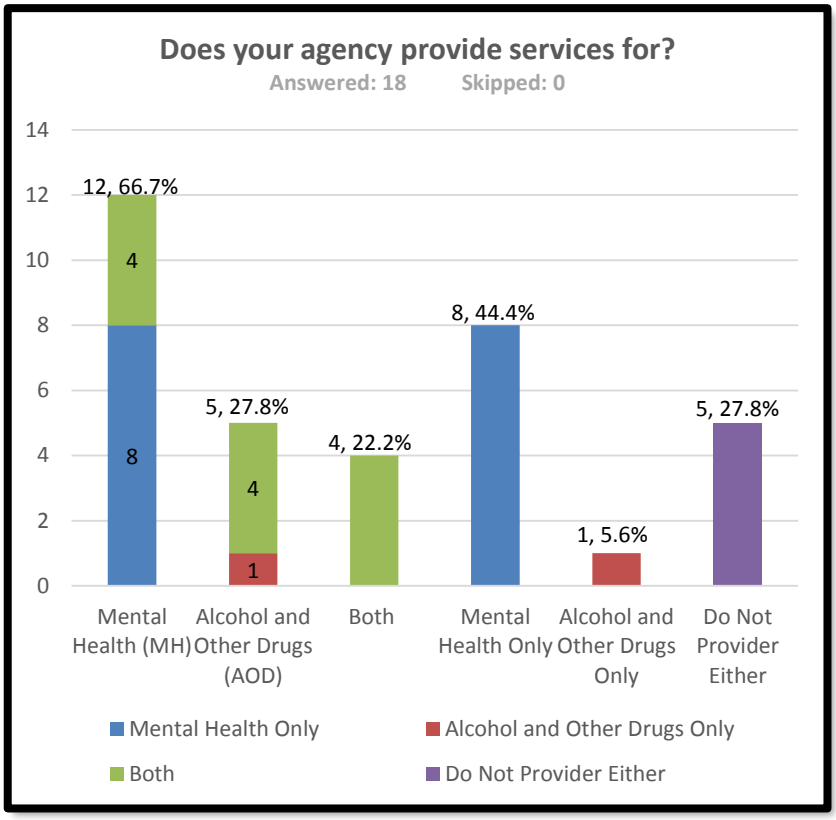
Just under half of respondents (8; 44.4%) provide services for only mental health. In addition, four (22.2%) respondents provide services for both mental health and alcohol and other drugs. Only one (5.6%) agency provide services for alcohol and other drugs alone. When looking overall at those who provide services for mental health or alcohol and other drugs, 12 (66.7%) provide services for mental health and only five (27.8%) provide services for alcohol and other drugs. Of the 18 who responded, five (27.8%) did not provide any mental health or alcohol and other drug services.

Primary Focus of All Services

Over one-third (7; 38.9%) of agencies indicated their primary focus to be mental health service delivery. This was closely followed by three agencies suggesting their primary service delivery focus to be financial counselling. The remaining eight responses were varied.

Overall Service Delivery

Graph 35: Service provided



Graph 36: Primary service delivery focus

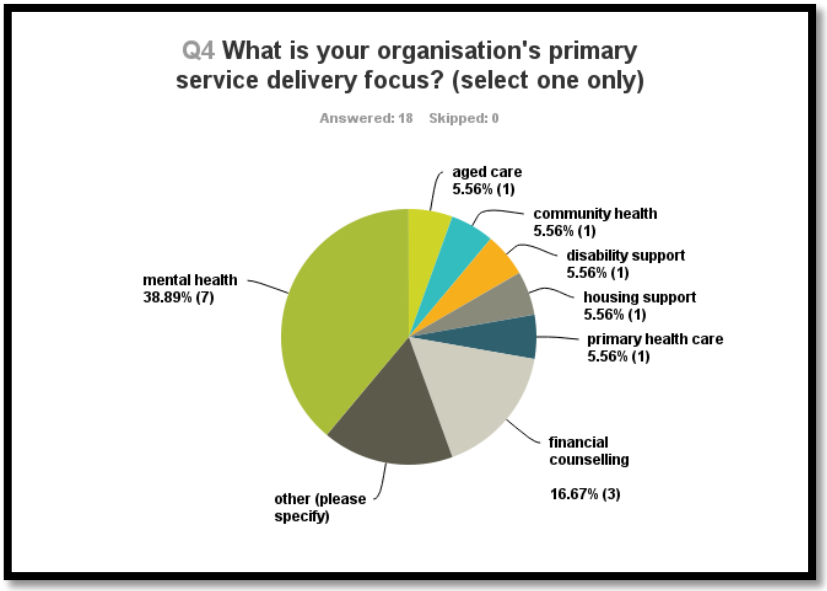


Table 20: Primary service delivery focus – other responses

Other (n=3)
Mixed and varied service delivery
Acute and Emergency Care
Emergency Care

Secondary Focus of All Services

Just under half (8; 44.4%) of all agencies indicated that they provide mental health as a secondary service delivery focus.

Just under one-third (5; 27.8%) provided aged care, alcohol and other drugs and family support as secondary services.

Three agencies suggested they provide 'other' secondary services (see table 21).

Graph 37: Secondary focus of all services

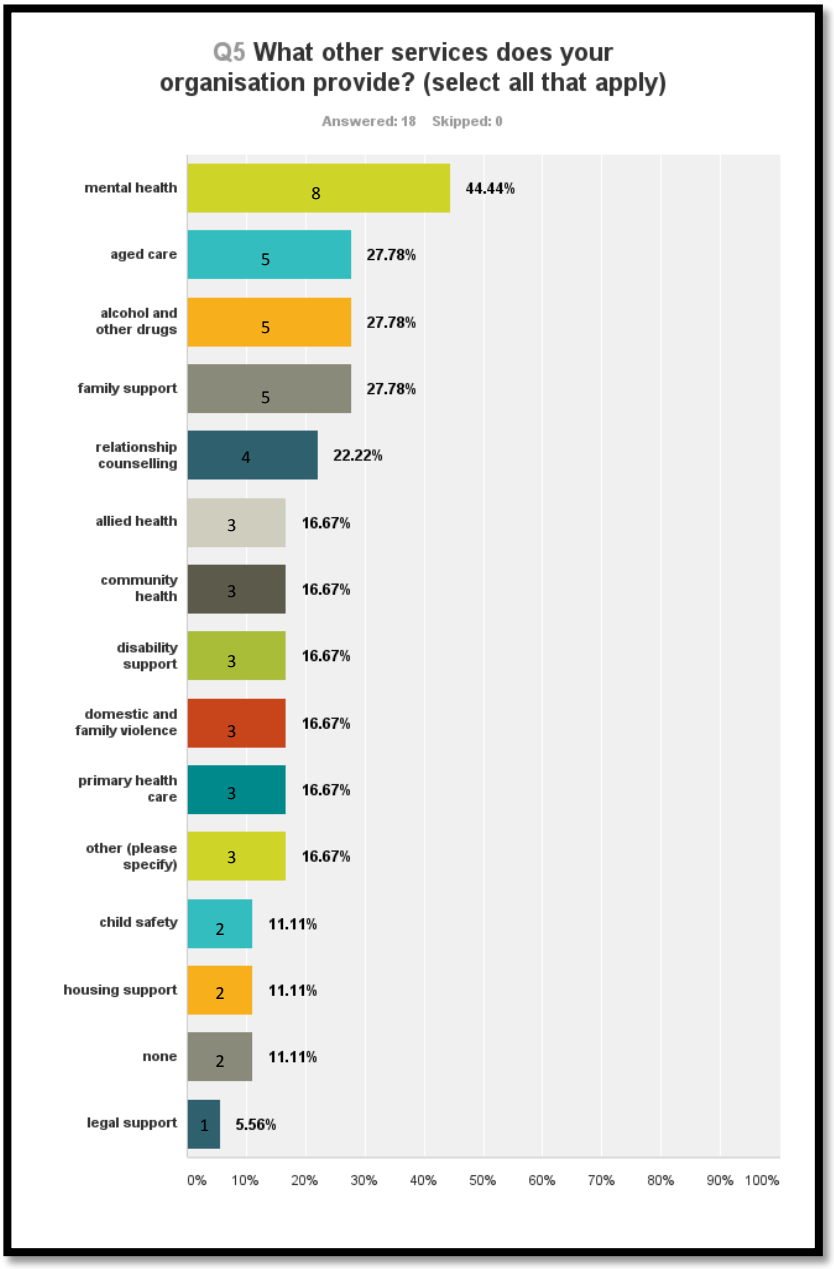


Table 21: Secondary focus of all services – other responses

Other (n=3)
Community Engagement, Community Linkages
Health Promotion
Referrals only to the above

Primary Focus of Mental Health Services

Of those who indicated they provided mental health services (12), half provided (6; 50%) mental health services as part of their primary service delivery focus.

Two indicated they provided "other" services (see table 22).

Graph 38: Primary focus of mental health services

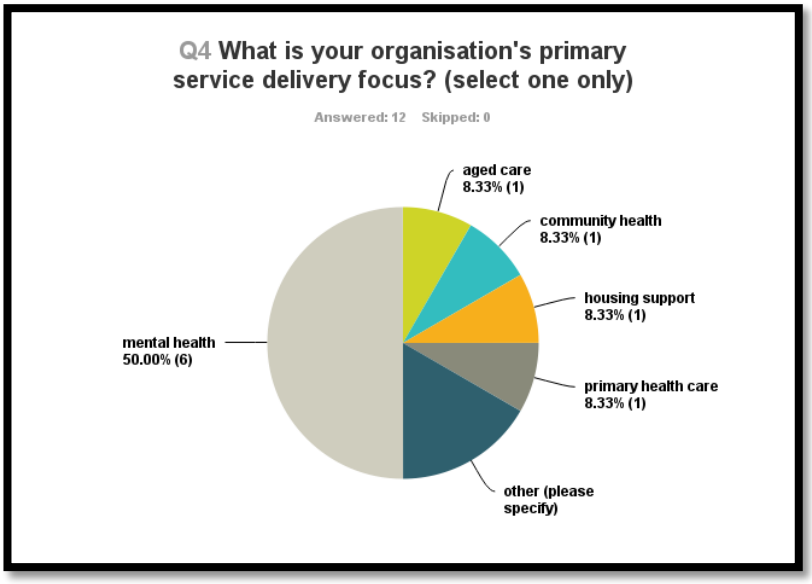


Table 22: Primary focus of mental health services – other responses

Other (n=2)
Mixed and varied service delivery
Emergency Care

Longreach Welcome Sign, Longreach, Queensland

Secondary Focus of Mental Health Services

Of those who indicated they provide mental health services (12), over half (7; 58.3%) provide mental health as a secondary service. This was closely followed by 41.7% (5) who provide family support as a secondary service. One-third provide alcohol and other drug services as a secondary focus.

Two respondents indicated that they provide "other" secondary services (see table 23).

Graph 39: Secondary focus of mental health services

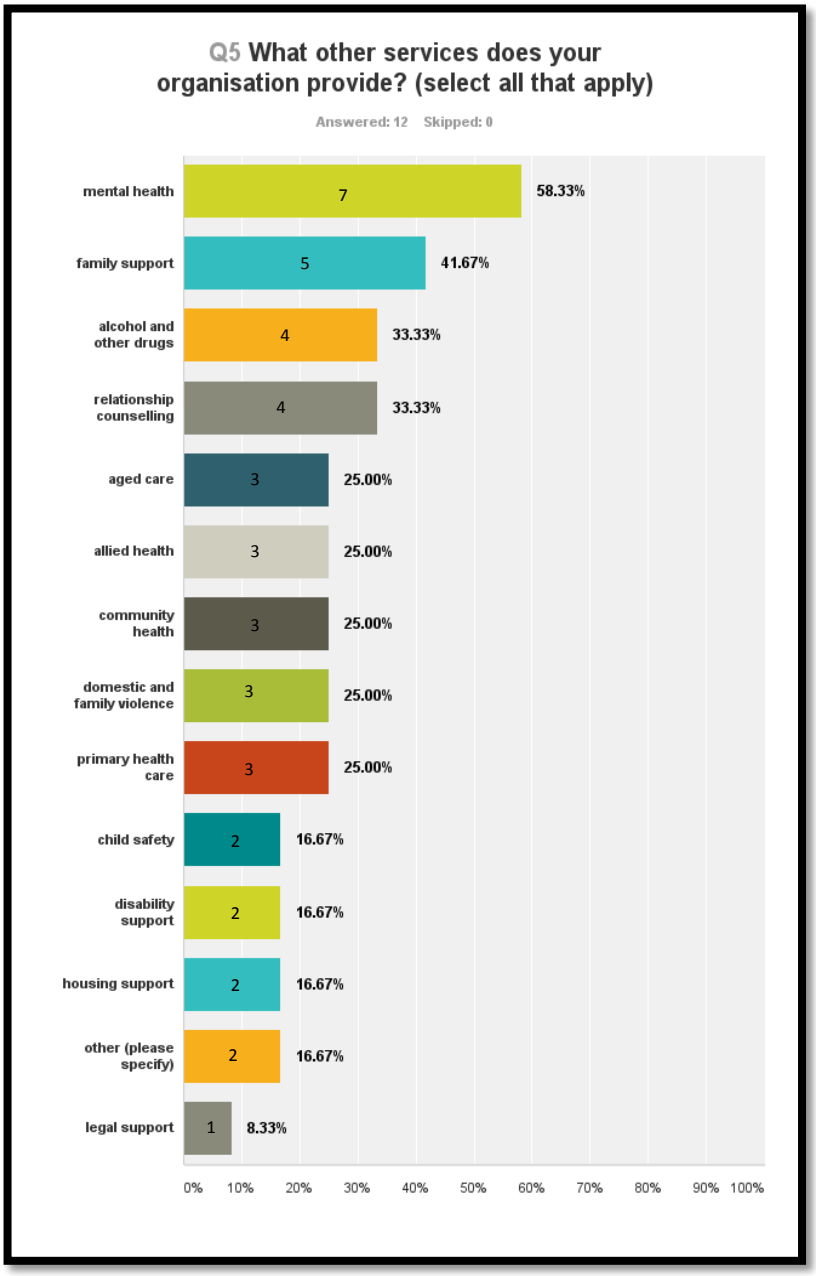


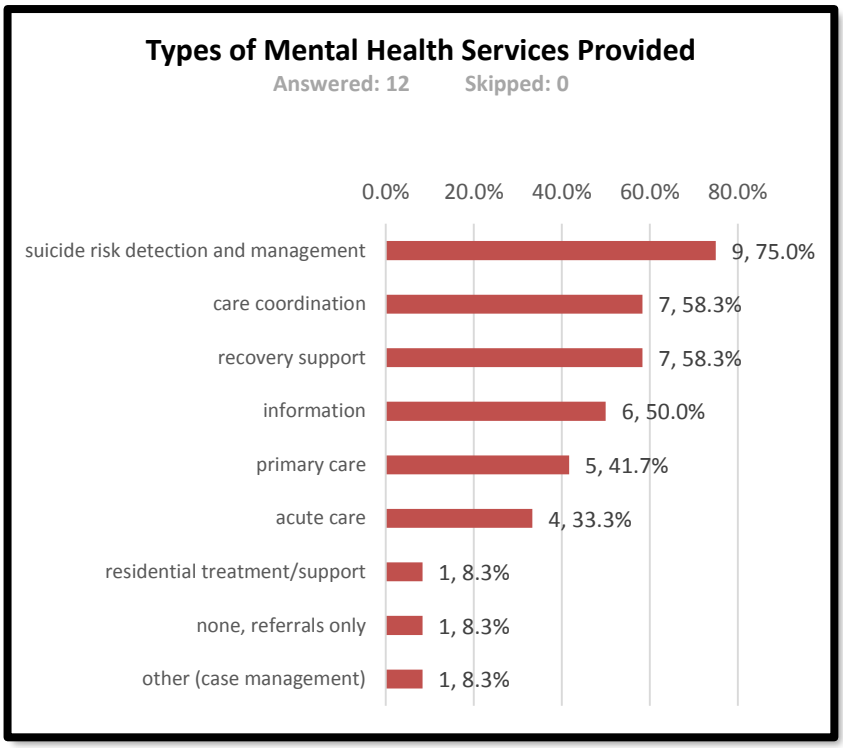
Table 23: Secondary focus of mental health services – other responses

Other (n=2)
Community Engagement, Community Linkages
Health Promotion

Types of Mental Health Services Provided

The most common type of mental health service provided was suicide risk detection and management (9; 75%). This was closely followed by care coordination (7; 58.3%) and recovery support (7; 58.3%). Only one agency indicated they provide residential treatment and support.

Graph 40: Types of mental health services provided



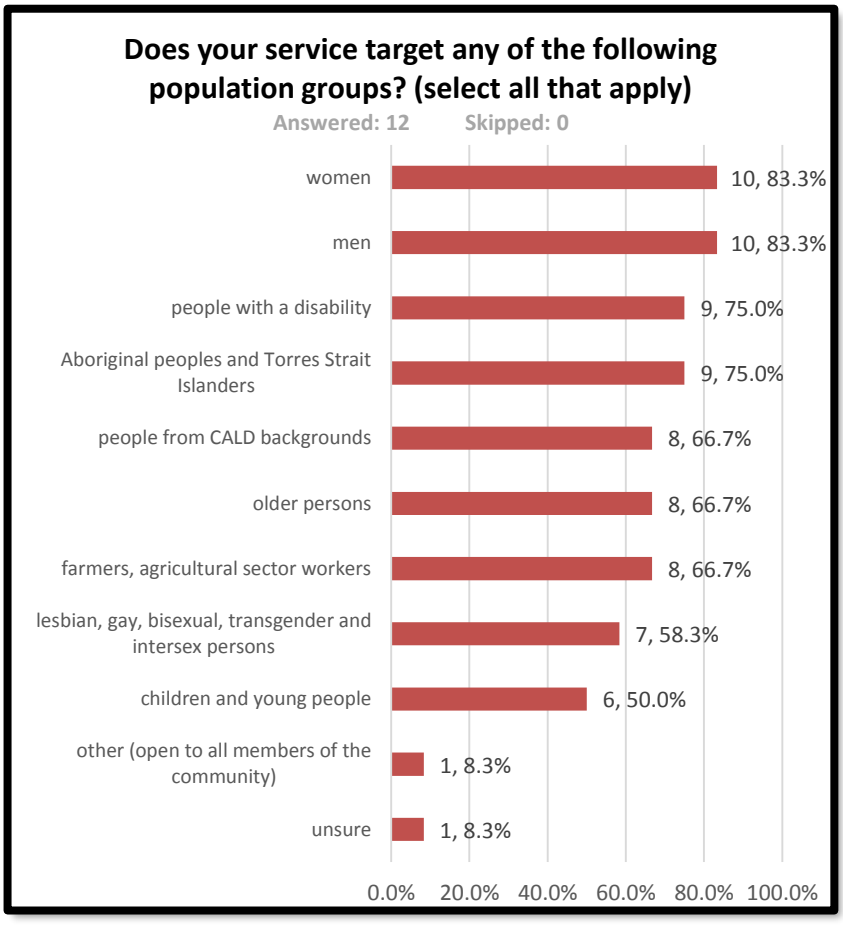
Population Groups Targeted by Mental Health Services

Of those who indicated they provide mental health services (12), almost all (10; 83.3%) provided services that target men and women. This was closely followed by people with a disability and Aboriginal and Torres Strait Islander peoples.

Half of all agencies who provide mental health services indicated they target all population groups listed.

Two additional open comments were provided suggesting their service is available to all members of the community.

Graph 41: Population groups targeted by mental health services



Funding Sources for Mental Health Activities

Of those who responded (11), the majority of agencies received funding for mental health activities from state government sources (7; 63.6%).

Just over one-third received funding for mental health activities from Commonwealth government sources.

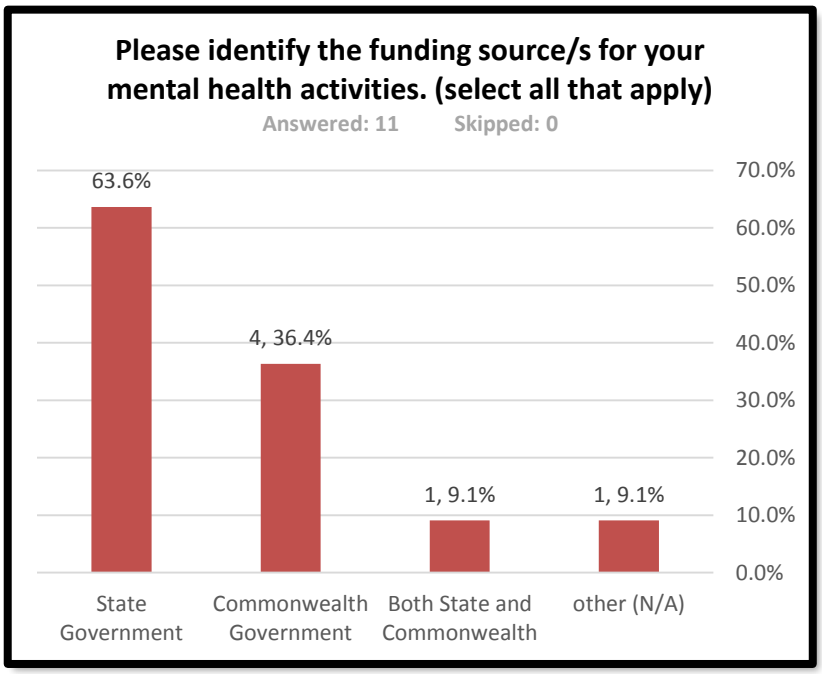
No agencies received funding for mental health activities from local government or private enterprise.

Length of Funding for Mental Health Activities

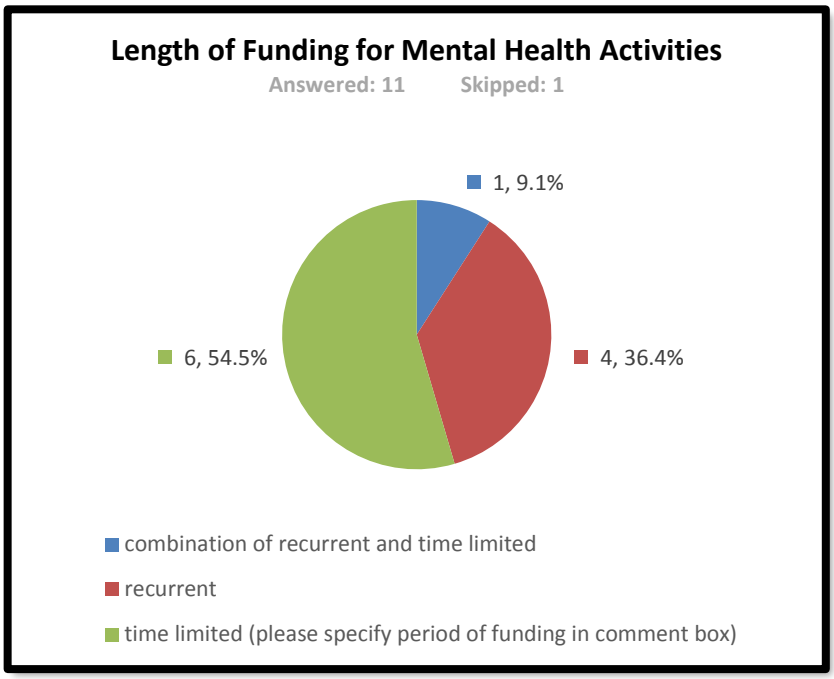
Of those who responded (11), over half (6; 54.5%) indicated they receive time limited funding for mental health activities.

Only 36.4% (4) of respondents suggested they received recurrent funding for mental health activities.

Graph 42: Funding sources for mental health activities



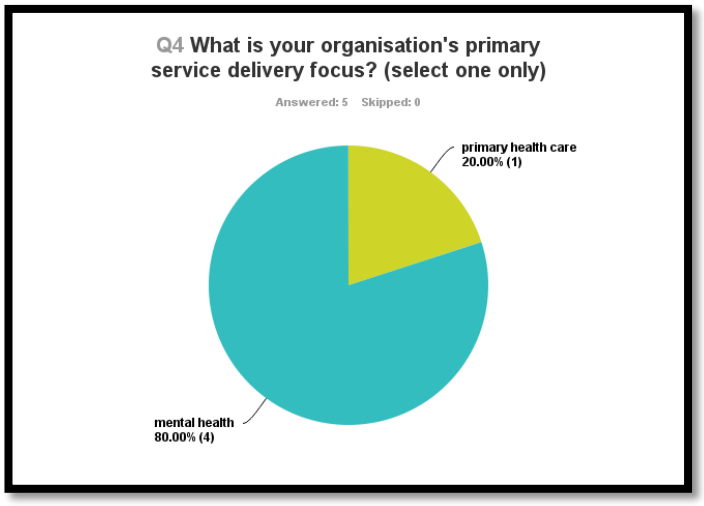
Graph 43: Length of funding for mental health activities



Primary Focus of Alcohol and Other Drug Services

Of those agencies who indicated they provide alcohol and other drug services (5), 80% provide mental health as a primary service delivery focus. The remaining one agency indicated that primary health care was their primary service delivery focus.

Graph 44: Primary focus of alcohol and other drug services

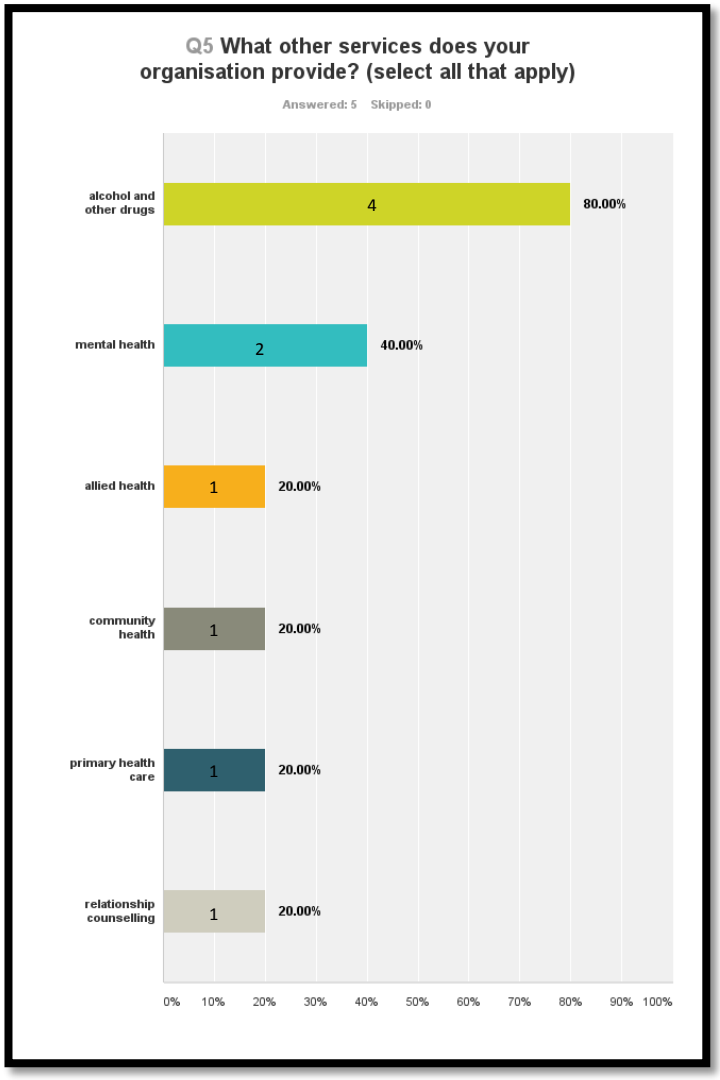


Secondary Focus of Alcohol and Other Drug Services

Of those agencies who indicated they provide alcohol and other drug services (5), almost all (4; 80%) provide alcohol and other drugs services as a secondary service.

In addition, two agencies indicated they provide mental health as a secondary focus.

Graph 45: Secondary focus of alcohol and other drug services

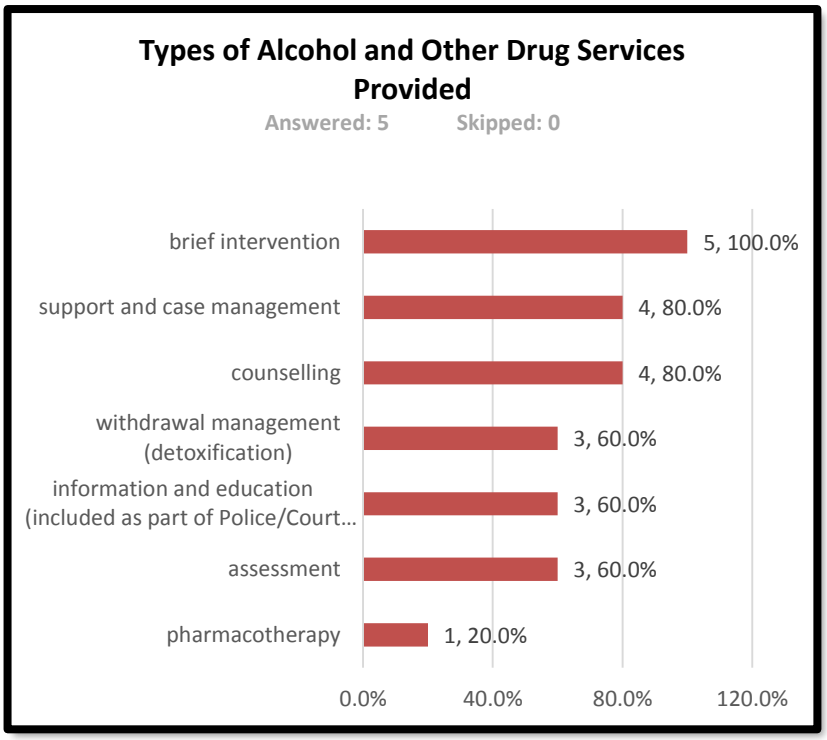


Types of Alcohol and Other Drugs Services Provided

The most common type of alcohol and other drug service provided was brief intervention with 100% of agencies providing this service. Almost all (80%) of agencies indicated they provide support and case management and counselling as part of their alcohol and other drug service.

No agencies provided residential rehabilitation or sobering up/intoxication management/diversion centre services.

Graph 46: Types of alcohol and other drug services provided

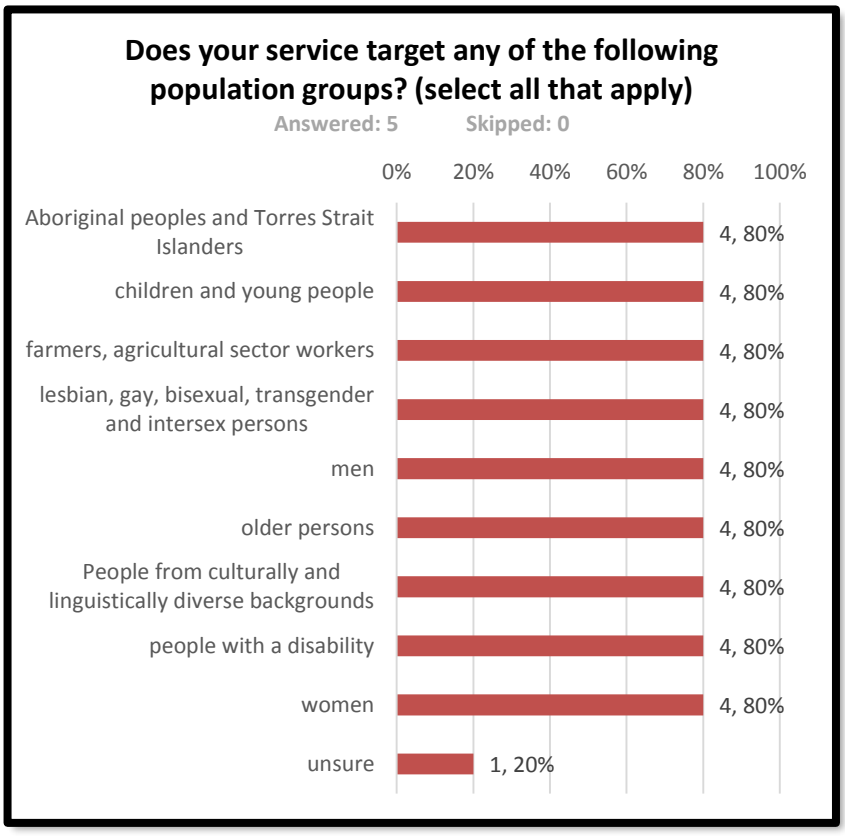


Population Groups Targeted by Alcohol and Other Drug Services

Almost all (4; 80%) agencies who provide alcohol and other drug services target all population groups with the exception of one who was unsure.

Two additional open comments were provided stating their service was available to all members of the community.

Graph 47: Population groups targeted by alcohol and other drug services



Funding Sources for Alcohol and Other Drug Activities

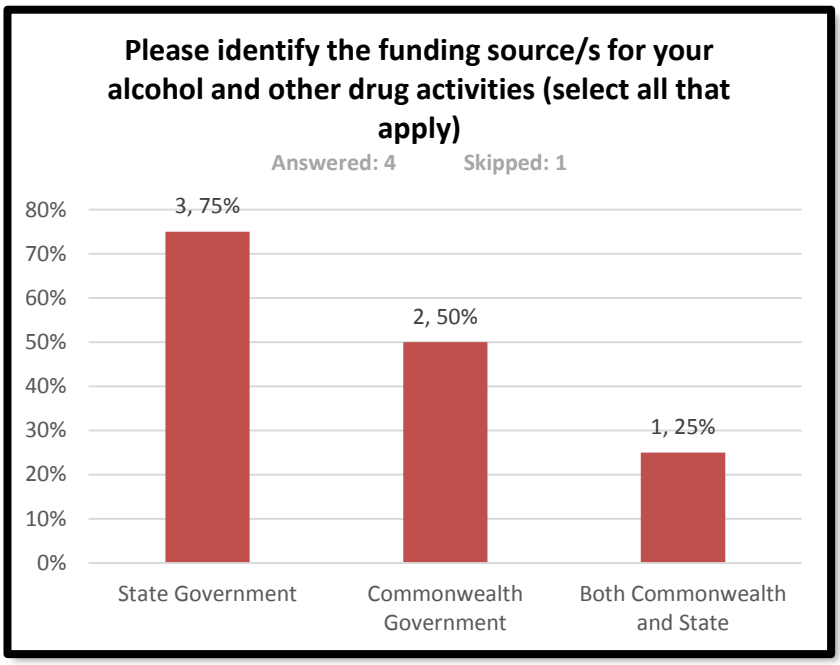
Of those who responded (4), almost all (3; 75%) received funding for alcohol and other drug activities from state government.

In additional two agencies (50%) received funding from commonwealth government sources.

Only one agency received funding from both state and commonwealth government sources.

No agencies received funding from local government or private enterprise for alcohol and other drug activities.

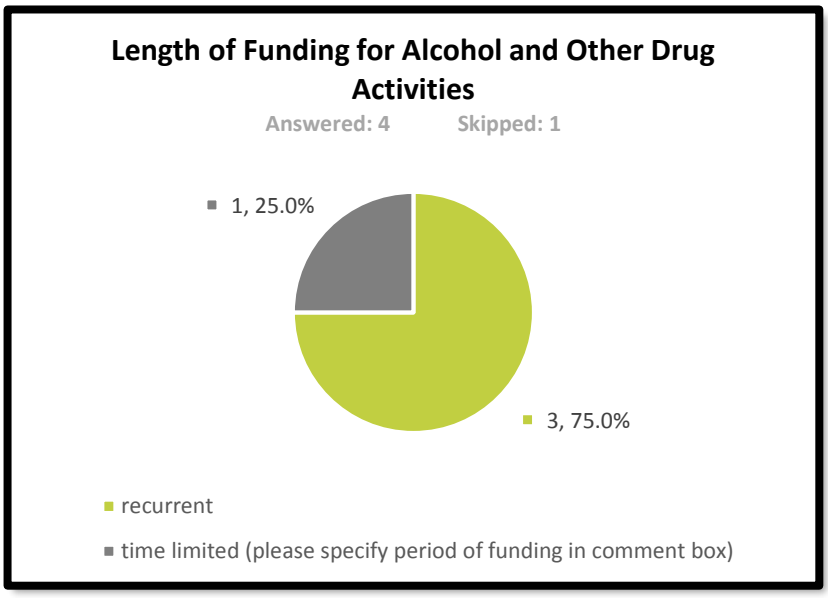
Graph 48: Funding sources for alcohol and other drug activities



Length of Funding for Alcohol and Other Drug Activities

Of those who responded (4), almost all (3; 75%) received recurrent funding for alcohol and other drug activities. Only one agency indicated that they received time-limited funding for alcohol and other drug activities.

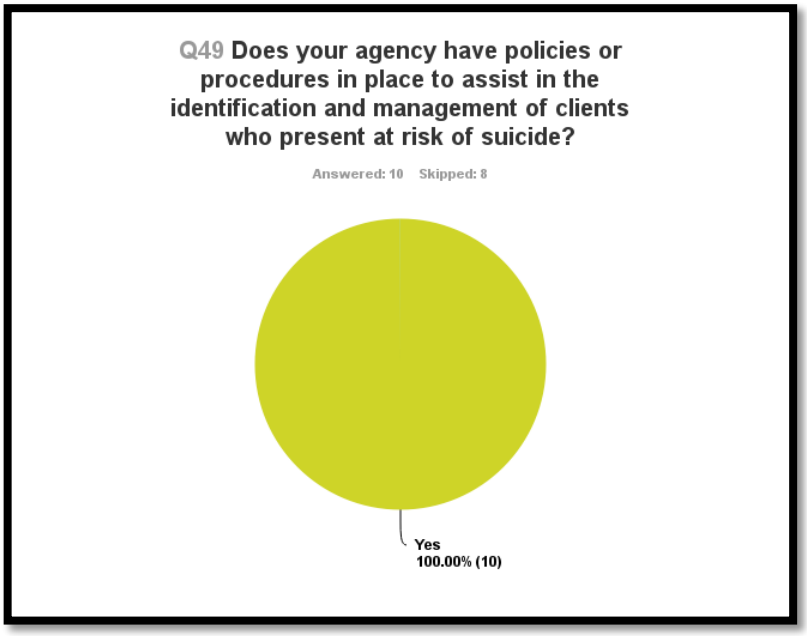
Graph 49: Length of funding for alcohol and other drug activities



Suicide Policies or Procedures

Of those who responded (10), 100% indicated that their agency has policies or procedures in place to assist with the identification of clients at risk of suicide.

Graph 50: Suicide policies or procedures



Strategies for Clients at Risk of Suicide

Of those who responded (10), when a client of their service is identified at risk of suicide, 60% indicated that they most of the time or always provide direct intervention or support.

In addition, half of all agencies refer to another agency when a client of their service is identified at risk of suicide.

A smaller percentage (30%) suggested they only sometimes provide direct intervention or support.

Graph 51: Approach when a client is identified at risk of suicide

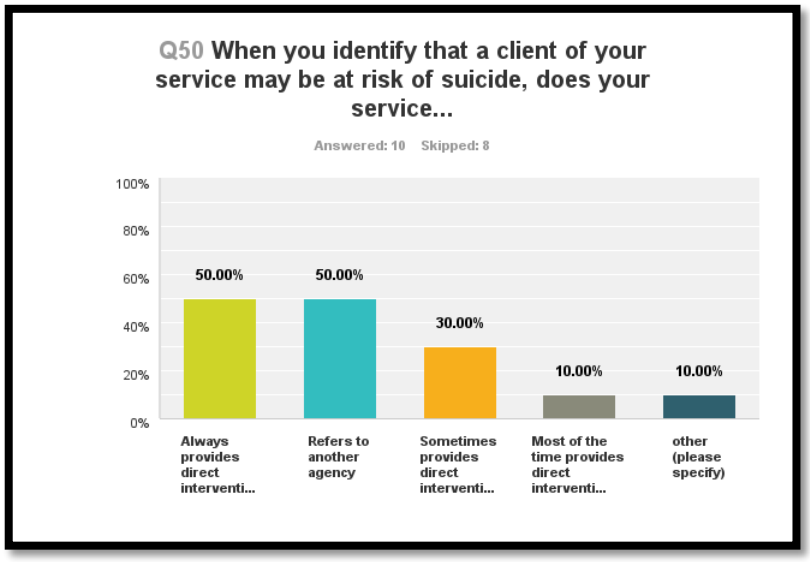


Table 24: Approach when a client is identified at risk of suicide

Answer Choices	Count	%
Always provides direct intervention or support	5	50%
Most of the time provides direct intervention or support	1	10%
Sometimes provides direct intervention or support	3	30%
Refers to another agency	5	50%
other (please specify)*	1	10%

*__Comment:__ I have not identified an at risk client however I would immediately involve a mental health professional and follow it through.

Use of Videoconferencing and Telehealth

A greater proportion indicated they use videoconferencing and telehealth facilities to access specialist services (8; 80%) than to access other general support services (6; 60%).

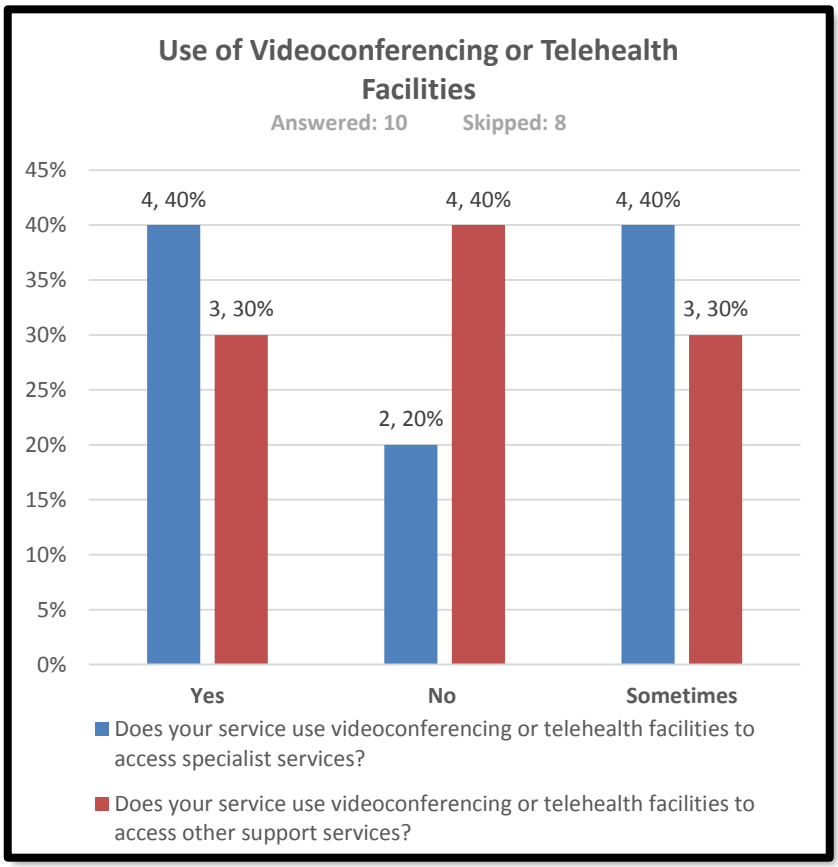
A significant proportion (4; 40%) suggested that they do not use any videoconferencing or telehealth facilities to access other support services.

Overall, the majority do use videoconferencing and telehealth facilities however most utilise these facilities to access specialist services.

Two additional comments were provided as follows:

- investigating improvement in video provided services
- but is available

Graph 52: Use of videoconferencing and telehealth facilities



Longreach Welcome Sign, Longreach, Queensland

Mental Health Service Demand

Of those who responded (10), 40% (4) indicated the current level of mental health service provision meets demand for the region to a large extent.

Only one respondent suggested the current level of mental health service provision meets demand to a small extent.

Two respondents provided addition comments (see table 25).

Mental Health Service Demand for Population Groups

Respondents were asked to rate the extent current mental health service provision meets demand in their region for particular population groups. Based on a weighted average, the current mental health service provision meets demand for men, women and Aboriginal and Torres Strait Islander peoples to the greatest extent.

Conversely, the current mental health service provision meets demand for Lesbian, Gay, Bisexual, Transgender, Intersex people and children and young people to the least extent.

Graph 53: Extent current level of mental health service provision meets demand for the region

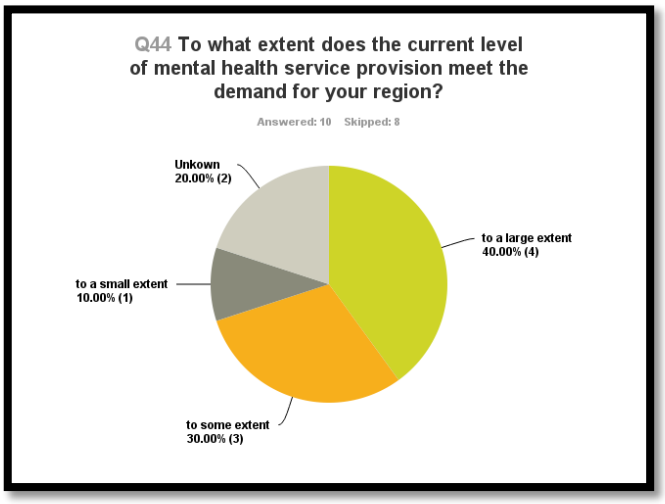


Table 25: Mental health service demand – additional comments

Other (n=2)
I have always been able to get assistance when required
There is a lack of services to individuals under 18 and for persons with less severe episodic mental health

Table 26: Extent current mental health service provision meets demand for population groups

Population Groups	to a large extent	to a mod extent	to some extent	to a small extent	not at all	Unkn-own	Weighted Average (excludes unknown)
Men	30% 3	20% 2	20% 2	10% 1	0% 0	20% 2	3.9
Women	30% 3	20% 2	30% 3	10% 1	0% 0	10% 1	3.8
Aboriginal peoples and Torres Strait Islanders	30% 3	20% 2	20% 2	20% 2	0% 0	10% 1	3.7
Older persons	30% 3	20% 2	10% 1	30% 3	0% 0	10% 1	3.6
People with a disability	20% 2	20% 2	10% 1	30% 3	0% 0	20% 2	3.4
People from culturally and linguistically diverse backgrounds	10% 1	30% 3	0% 0	40% 4	0% 0	20% 2	3.1
Lesbian, Gay, Bisexual, Transgender and Intersex people	10% 1	10% 1	20% 2	10% 1	10% 1	40% 4	3.0
Children and young people	20% 2	10% 1	20% 2	30% 3	10% 1	10% 1	3.0

Alcohol and Other Drug Service Demand

Of those who responded (10), half (5; 50%) indicated that the current level of alcohol and other drug service provision meets demand from some to a small extent.

In addition, 40% (4) suggested the current level of alcohol and other drug service provision meets demand from a moderate to a large extent. One respondent commented that it has been difficult to refer in the past.

Alcohol and Other Drug Service Demand for Population Groups

Respondents were asked to rate the extent alcohol and other drug service provision meets demand in their region for particular population groups. Based on a weighted average, the current level of alcohol and drug service provision in the region meets demand for men to the largest extent.

This is closely followed by women, Aboriginal and Torres Strait Islander peoples, older persons and Lesbian, Gay, Bisexual, Transgender and Intersex people.

Conversely, the current level of alcohol and other drug service provision in the region meets demand for children and young people to the least extent.

Graph 54: Extent current level of alcohol and other drug service provision meets demand for the region

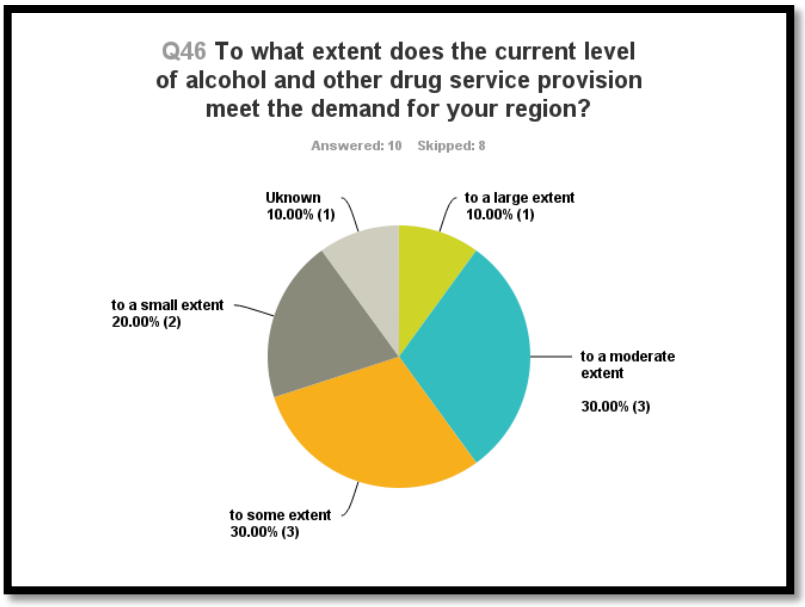


Table 27: Extent current alcohol and other drug service provision meets demand for population groups

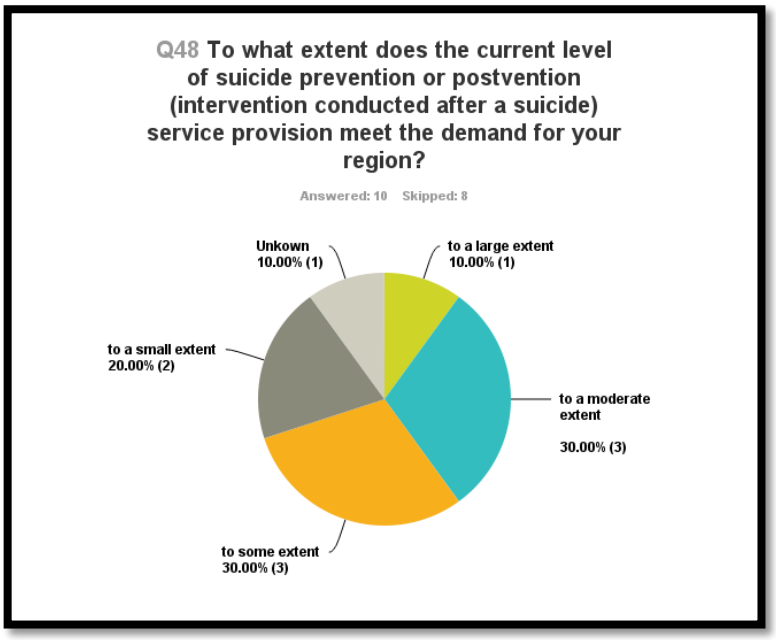
Population Groups	to a large extent	to a mod extent	to some extent	to a small extent	not at all	Unknown	Weighted Average (excluding unknown)
Men	20% 2	30% 3	30% 3	10% 1	0% 0	10% 1	3.7
Women	20% 2	20% 2	40% 4	10% 1	0% 0	10% 1	3.6
Aboriginal peoples and Torres Strait Islanders	10% 1	40% 4	30% 3	10% 1	0% 0	10% 1	3.6
Older persons	20% 2	20% 2	40% 4	10% 1	0% 0	10% 1	3.6
Lesbian, Gay, Bisexual, Transgender and Intersex people	10% 1	10% 1	30% 3	0% 0	0% 0	50% 5	3.6
People from culturally and linguistically diverse backgrounds	10% 1	20% 2	30% 3	10% 1	0% 0	30% 3	3.4
People with a disability	0% 0	33.3% 3	33.3% 3	11.1% 1	0% 0	22.3% 2	3.3
Children and young people	0% 0	30% 3	20% 2	30% 3	0% 0	20% 2	3.0

Suicide Prevention or Postvention Service Demand

Of those who responded (10), half (5; 50%) indicated that the current level of suicide prevention or postvention service provision meets demand from some to a small extent.

In addition, 40% (4) suggested the current level of suicide prevention or postvention service provision meets demand from a moderate to a large extent.

Graph 55: Extent current level of suicide prevention or postvention service provision meets demand for the region



"A lot of us are based in Longreach and provide outreach to the Central West. Some of the bigger towns like Blackall, Winton and Barcaldine are visited more regularly by the teams. Then you've got the far western corner that don't have the presence as regularly. Certain they have providers come but not as regularly."

Focus Group Participant Comment, Central West HHS Region

Networks and Interagency Groups Engaged

Respondents were asked to list the networks or interagency groups they were involved with. Of those who responded (9), over three-quarters (7; 77.8%) indicated they were involved with at least one generic interagency group within the region.

Just under half (4; 44.4%) also engaged with Mental Health Services / Networks and the Royal Flying Doctor Service.

One-third (3; 33.3%) indicated that they participated in drought response groups in the region.

Extent Collaboration Supports Mental Health Service Provision

Of those who responded (10), 60% (6) indicated the current level of interagency collaboration supports clients with mental health needs from a moderate to a large extent.

Only one respondent suggested the current level of interagency collaboration supports clients with mental health needs to a small extent.

Three additional comments were provided (see table 29).

Table 28: Networks and interagency groups engaged

Networks/Interagency Groups (n=9)	Count	%
Generic Interagency Groups (All providers in the central west, Multi-agency meetings, Member of numerous health consultation groups, Central West Multi-Agency Meeting, Central West Health Partnership, Regional Planning Coordination Committee, Central West Chronic Health Planning Group)	7	77.8%
Mental Health Services and/or Networks (Central West Mental Health Team, Queensland Health allied health including mental health, visiting mental health specialists, Mental Health Professional Network – Longreach,)	4	44.4%
Royal Flying Doctor Service (RFDS) (RFDS mental health, RFDS visiting psychologists, RFDS RAG, RFDS)	4	44.4%
Drought Response Groups (Central West Drought Response Group, Longreach Drought Response Group)	3	33.3%
ATODS and Rehabilitation Services (Lives Lived Well: Drug and Alcohol, Queensland Health allied health including ATODS)	2	22.2%
Child and Youth Services (Youth Network Meetings)	1	11.1%
Community Health	1	11.1%
Allied Health	1	11.1%
Medicare Local	1	11.1%
TOTAL RESPONSES = 9		

Graph 56: Extent interagency collaboration supports clients with mental health needs

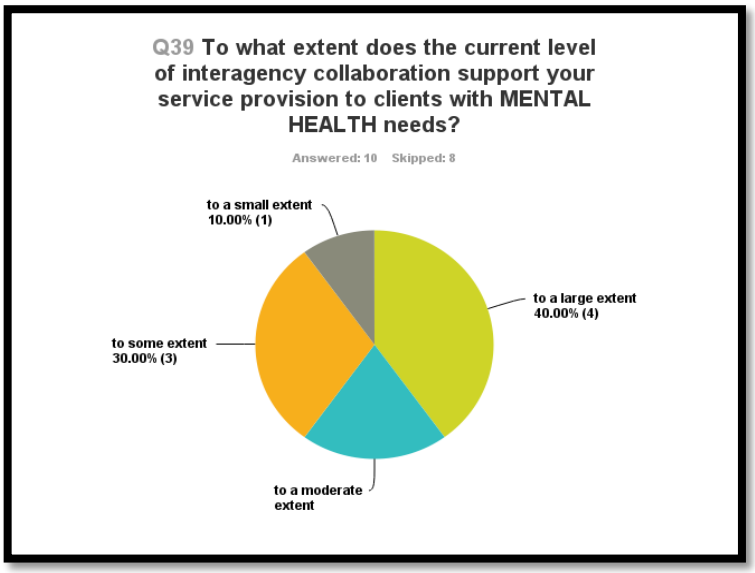


Table 29: Extent interagency collaboration supports clients with mental health needs – additional comments

Comments (n=3)
I have only had one client to date who I needed to refer for mental health support. Any others were already receiving support. Participation in this group helps me know what agencies are around and where to refer.
There are barriers
meetings need to be strategic

Extent Collaboration Supports Clients with Problematic Substance Use

Of those who responded (10), the majority (60%) indicated that the current level of interagency collaboration supports clients with problematic substance use from only some to a small extent.

One respondent even suggested interagency collaboration does not support clients with problematic substance use.

Only one respondent implied the current level of interagency collaboration supports clients with problematic substance use to a large extent.

Three additional comments were provided (see table 30).

Extent Collaboration Supports Service Provision – Weighted Average

Based on the weighted average, overall ratings from respondents indicate that interagency collaboration best supports service provision for people with mental health needs.

Graph 57: Extent interagency collaboration supports clients with problematic substance use

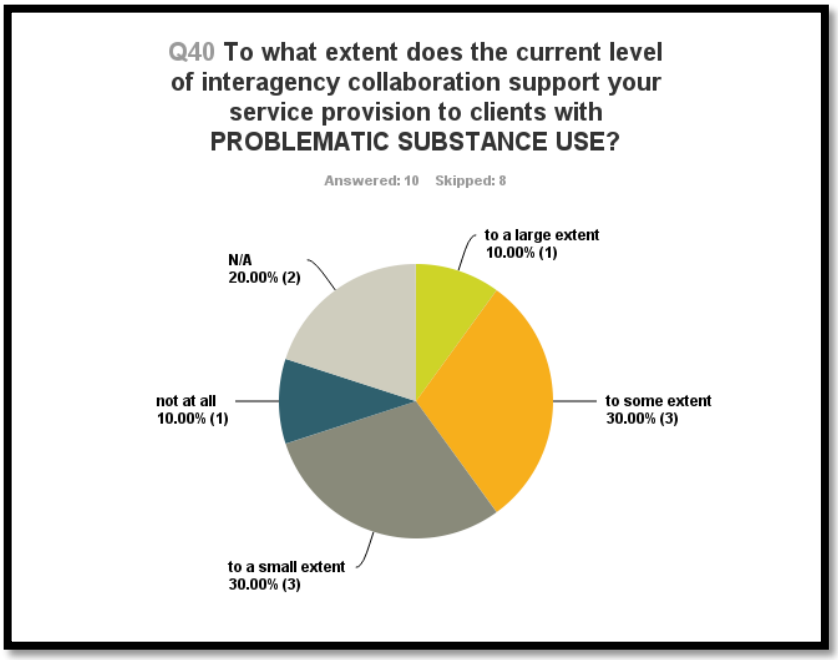


Table 30: Extent interagency collaboration supports clients with problematic substance use – additional comments

Comments (n=3)
To date I have not had any clients with problematic substance abuse
There are barriers
very difficult to refer to in the past

"The more we work together for the individual, the better off we are going to be. Rather than taking ownership of the client, but instead get everyone involved."

Focus Group Participant Comment, Central West HHS Region

Table 31: Extent interagency collaboration supports service provision – weighted average

	to a large extent	to a mod extent	to some extent	to a small extent	not at all	Weighted Average
Extent Collaboration Supports People with Mental Health Needs	40% 4	20% 2	30% 3	10% 1	0.0% 0	3.9
Extent Collaboration Supports People with Problematic Substance Use	10% 1	0% 0	30% 3	30% 3	10% 1	2.1

Enhancing Interagency Collaboration

Six respondents provided suggestions for how to enhance interagency support in the region. Although the suggestions were quite varied, two did identify strategies focusing on referral processes and protocols.

Enhancing Interagency Collaboration

Table 32: Suggestions for how to enhance interagency support in the region

Suggestions for how to enhance interagency collaboration in the region
Break down those barriers, don't take ownership because it's all about what the client wants.
Increased case conferencing and use of technology
Specific and strategic meetings to discuss referral avenues and protocols. Who is new and what services are offered (updates)
Alcohol drug related issues can be better dealt with by identifying the people at risk
More visits following promotions
All agencies understanding the right referral process
Total = 6

"I've found meets and greets for providers really helpful to get to know everyone and what services they provide. Having those good relationships is critical for good integration."

Focus Group Participant Comment, Central West HHS Region

Winton Hospital, Winton, Queensland

Strategies Implemented by Services for Clients

Of those who responded (16), over two-thirds (11; 68.75%) refer clients to another agency for mental health services.

Just over half (9; 56.25%) refer clients to another agency for alcohol and other drug services and/or work with other services for aspects of mental health care / support needs (e.g. clinical, social).

Just under half (7; 43.75%) indicated that they provide all the needed mental health services whereas only three (18.75%) provide all the needed problematic substance use services.

Graph 58: Strategies implemented by services

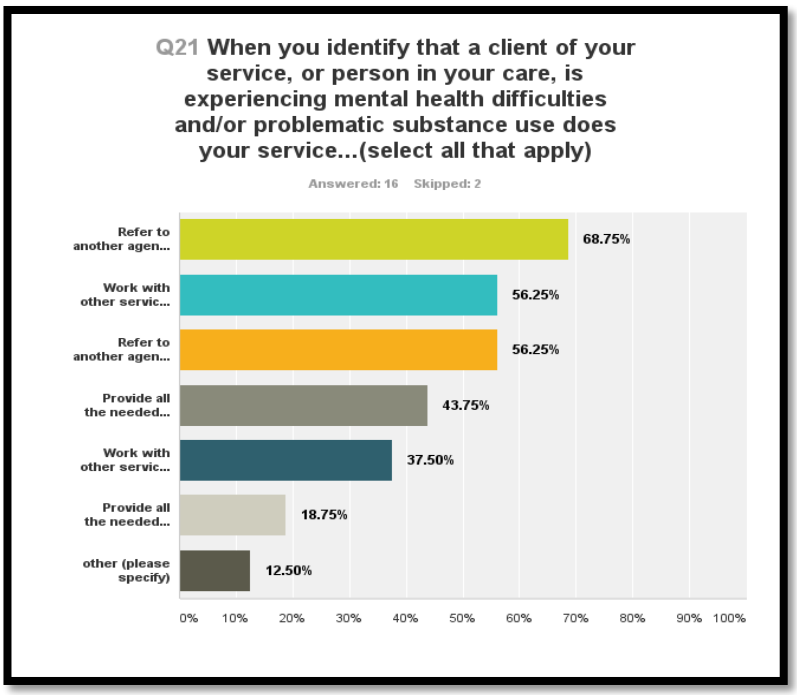


Table 33: Strategies implemented by services

Strategies	Responses
Refer to another agency for mental health services	68.75% 11
Work with other services for aspects of mental health care/support needs (e.g. clinical, social)	56.25% 9
Refer to another agency for alcohol and other drug services	56.25% 9
Provide all the needed mental health services	43.75% 7
Work with other services for aspects of problematic substance use needs (e.g. clinical, social)	37.50% 6
Provide all the needed problematic substance use services	18.75% 3
Other • psychiatrist visits and mental health nurse / psychologist support • refer to MIPU as required	12.50% 2

"Good service integration is a balance of having regular structured meetings to discuss shared clients and the bigger meet and greet meetings for service providers to get to know one another. It's also about being flexible and being able to ring up services and discuss client's needs and identify opportunities to work together."

Focus Group Participant Comment, Central West HHS Region

Ease of Integration with Other Agencies

Of those who responded (16), just under two-thirds (10; 62.50%) indicated the ease of coordinating care / support with other agencies is as expected.

Only small percentage (3; 18.75%) suggested the ease of coordinating care / support with other agencies is easier to much easier than expected.

Three additional comments were provided (see table 34).

Graph 59: Ease of integration with other services

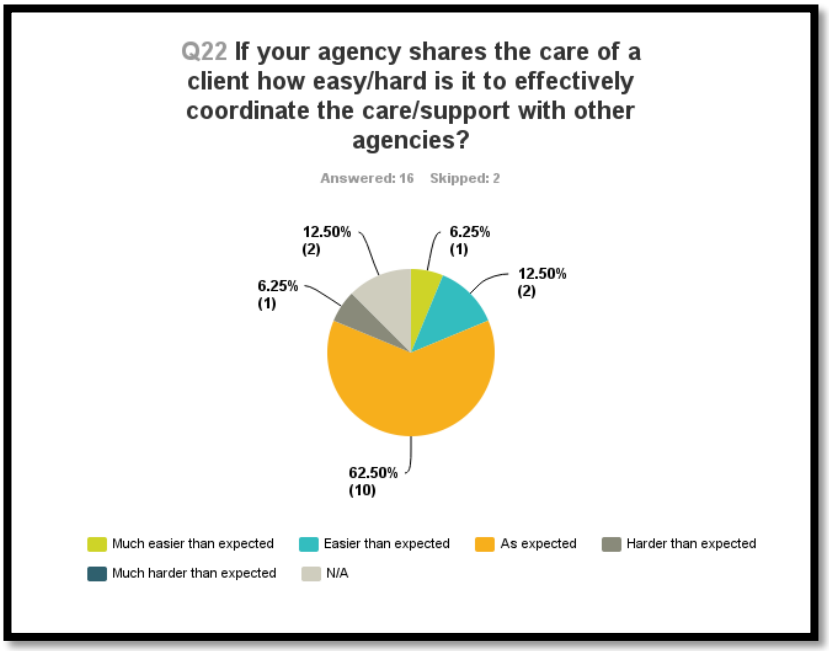


Table 34: Ease of integration with other services – additional comments

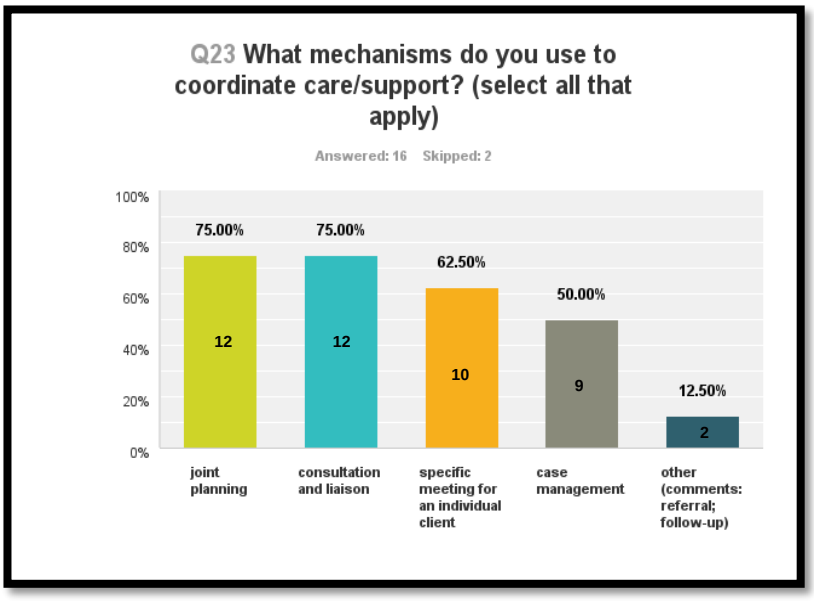
Comments (n=3)
So many organisations work in silos it is hard to engage them.
Ownership, distance, lack of understanding
Depends on the client's issues

Mechanisms Used to Coordinate Care / Support

Of those who responded (16), three-quarters (12; 75%) indicated that they use joint planning and/or consultation and liaison to coordinate care / support for their clients.

Just under two-thirds (10; 62.5%) used specific meetings for an individual client while half (9; 50%) used case management.

Graph 60: Mechanisms used to coordinate care / support



Supports for Integration

Based on a weighted average, strong individual relationships between workers and a dedicated case coordinator or care coordination model were identified as the most effective supports in assisting coordinated care/support. This was closely followed by clear internal policies and practices. Conversely, formal mechanisms between agencies was considered the least effective support in assisting coordinate care / support for clients.

Barriers to Integration

Based on a weighted average, lack of access to services due to distance or cost to clients had the greatest impact on an agency's ability to coordinate care successfully. This was closely followed by lack of access to specialist services.

Waiting times and client reluctance or ability to take up referral were also identified as significant barriers an agency's ability to coordinate care successfully.

Table 35: Effectiveness of supports in assisting coordinated care/support

Not at all effective	Slightly effective	Moderately effective	Very effective	Extremely effective	Weighted Average
strong individual relationships between workers					
0.00% 0	0.00% 0	42.86% 6	21.43% 3	35.71% 5	3.93
dedicated case coordinator or care coordination model					
0.00% 0	0.00% 0	28.57% 4	64.29% 9	7.14% 1	3.91
clear internal policies and practices					
0.00% 0	0.00% 0	28.57% 4	64.29% 9	7.14% 1	3.79
standardised referral forms between agencies					
0.00% 0	7.69% 1	46.15% 6	46.15% 6	0.00% 0	3.38
local structured formal network or governance structure					
7.69% 1	0.00% 0	46.15% 6	38.46% 5	7.69% 1	3.38
formal mechanism between agencies established					
7.69% 1	7.69% 1	46.15% 6	23.08% 3	15.38% 2	3.31
Other*					
50.00% 1	0.00% 0	50.00% 1	0.00% 0	0.00% 0	2.00

*No comment provided

Table 36: Impact of barriers on agency's ability to coordinate care

No impact at all	Very little impact	Some impact	Moderate to high level of impact	Significant impact	Weighted Average
lack of access to services due to distance or cost to clients					
9.09% 1	0.00% 0	27.27% 3	27.27% 3	36.36% 4	3.82
lack of access to specialist services					
9.09% 1	18.18% 2	18.18% 2	36.36% 4	18.18% 2	3.36
waiting times for appointments					
9.09% 1	27.27% 3	27.27% 3	27.27% 3	9.09% 1	3.00
client reluctance or ability to take up referral					
9.09% 1	27.27% 3	27.27% 3	27.27% 3	9.09% 1	3.00
lack of services to refer to					
18.18% 2	27.27% 3	18.18% 2	18.18% 2	18.18% 2	2.91
lack information and understanding about other agencies and their services (currency of service information, staff training/capability)					
9.09% 1	27.27% 3	36.36% 4	18.18% 2	9.09% 1	2.91
information sharing issues (data protection/ privacy/confidentiality/client consent)					
9.09% 1	27.27% 3	54.55% 6	0.00% 0	9.09% 1	2.73
inadequate staff training					
10.00% 1	40.00% 4	30.00% 3	10.00% 1	10.00% 1	2.70

Continued over page

Conversely, lack of clarity about when referrals must be made and the reasons for doing so (no clear internal policies and practices) was identified as the barrier of least impact on an agency's ability to coordinate care.

No impact at all	Very little impact	Some impact	Moderate to high level of impact	Significant impact	Weighted Average
eligibility criteria of other agencies					
9.09% 1	27.27% 3	54.55% 6	9.09% 1	0.00% 0	2.64
varying levels of cultural capability between services (affecting the ability to deliver consistent culturally appropriate services between agencies)					
9.09% 1	36.36% 4	54.55% 6	0.00% 0	0.00% 0	2.45
lack of clarity about when referrals must be made and the reasons for doing so (no clear internal policies and practice)					
27.27% 3	36.36% 4	36.36% 4	0.00% 0	0.00% 0	2.09
Other*					
100.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	1.00

*No comment provided

Strategies to Manage Barriers to Service Integration

Based on a weighted average, built relationships and shared resources were identified as the most effective strategies to manage barriers to successful coordinated care for clients.

This was closely followed by seeking and providing feedback (monitoring quality) and delivering training and/or resources.

Conversely, providing financial support to the client was considered the least effective strategy to manage barriers to successful coordinated care.

Table 37: Effectiveness of strategies to manage barriers to successful coordinated care

Not at all effective	Slightly effective	Moderately effective	Very effective	Extremely effective	Weighted Average
built relationships					
0.00% 0	0.00% 0	36.36% 4	54.55% 6	9.09% 1	3.73
shared resources					
0.00% 0	10.00% 1	40.00% 4	40.00% 4	10.00% 1	3.50
sought and provided feedback (monitoring quality)					
0.00% 0	9.09% 1	36.36% 4	54.55% 6	0.00% 0	3.45
delivered training and/or resources					
0.00% 0	18.18% 2	36.36% 4	36.36% 4	9.09% 1	3.36
promoted your own agency's role and function (e.g. newsletters, website)					
0.00% 0	18.18% 2	36.36% 4	36.36% 4	9.09% 1	3.36
provided practical assistance to clients (e.g. provided or subsidised transport)					
0.00% 0	0.00% 0	66.67% 6	33.33% 3	0.00% 0	3.33
participated in interagency forums or held regular meeting with key agencies					
0.00% 0	20.00% 2	40.00% 4	40.00% 4	0.00% 0	3.20
developed internal policies and referral procedures					
0.00% 0	18.18% 2	45.45% 5	36.36% 4	0.00% 0	3.18
provided financial support to client					
11.11% 1	22.22% 2	44.44% 4	22.22% 2	0.00% 0	2.78
Other*					
100.00% 1	0.00% 0	0.00% 0	0.00% 0	0.00% 0	1.00

*No comment provided

Referrals to Other Services

Of those who responded (13), the majority referred clients of their service to mental health (11; 84.62%), allied health (10; 76.92%) and community health (10; 76.92%).

This was closely followed by child safety, disability support, housing support and financial counselling.

Over half of all respondents referred to all services apart from family support, aged care and education (e.g. school, VET).

Education (e.g. school, VET) was the least referred service.

Three agencies indicated that they refer to 'other' services (see table 38).

Graph 61: Referrals to other services

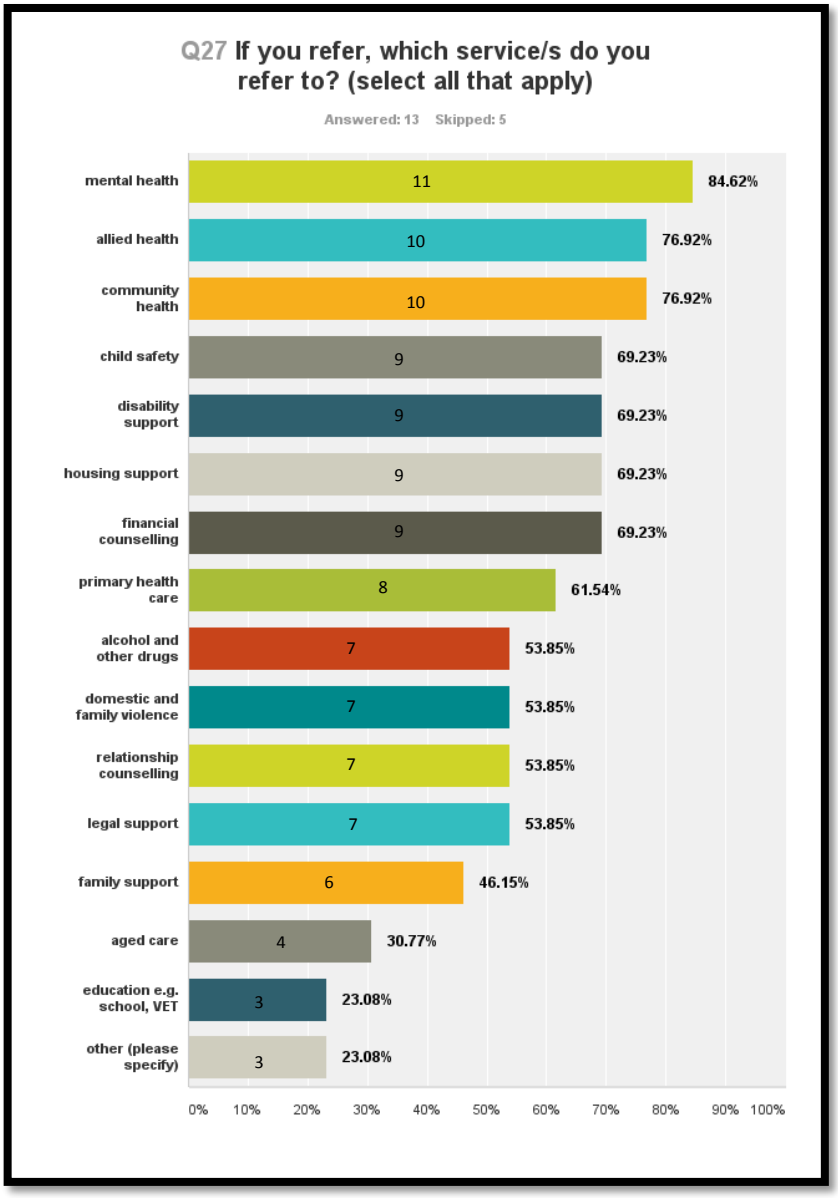


Table 38: Referrals to other services – other comments

Other (n=3)
DAFF, QRAA, Centrelink
other mental health or alcohol and other drug networks for input/residential
RFDS - social & emotional wellbeing service

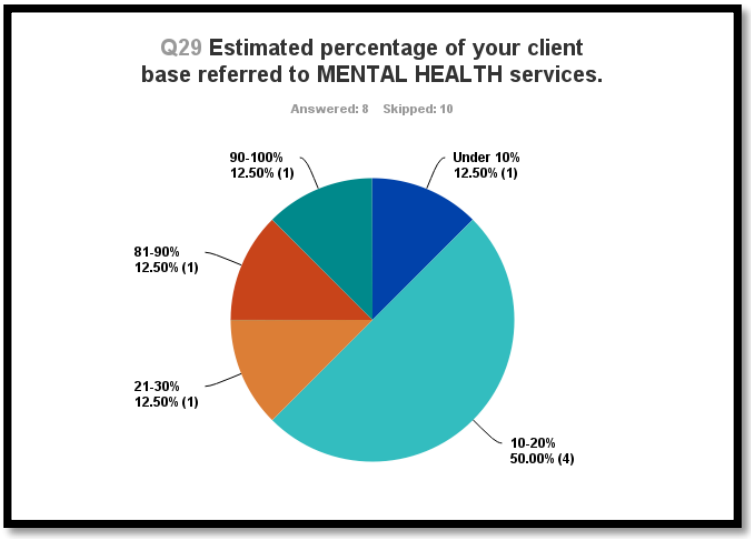
Percentage of Referrals to Mental Health Services

Of those who responded (8), half indicated that they refer 10 to 20 percent of client's mental health services.

Two agency's referred over 81 percent of clients to mental health services.

Only one agency referred under 10 percent of clients to mental health services.

Graph 62: Percentage of referrals to mental health services

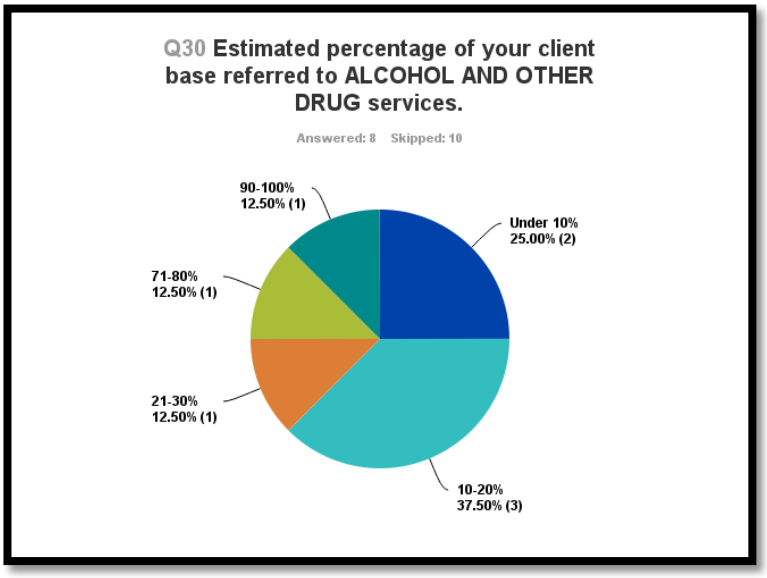


Percentage of Referrals to Alcohol and Other Drug Services

Of those who responded (8), half (4; 50%) indicated that they refer 10 to 30 percent of client's to alcohol and other drug services.

Two agencies referred over 71 percent of clients to alcohol and other drug services.

Graph 63: Percentage of referrals to alcohol and other drug services

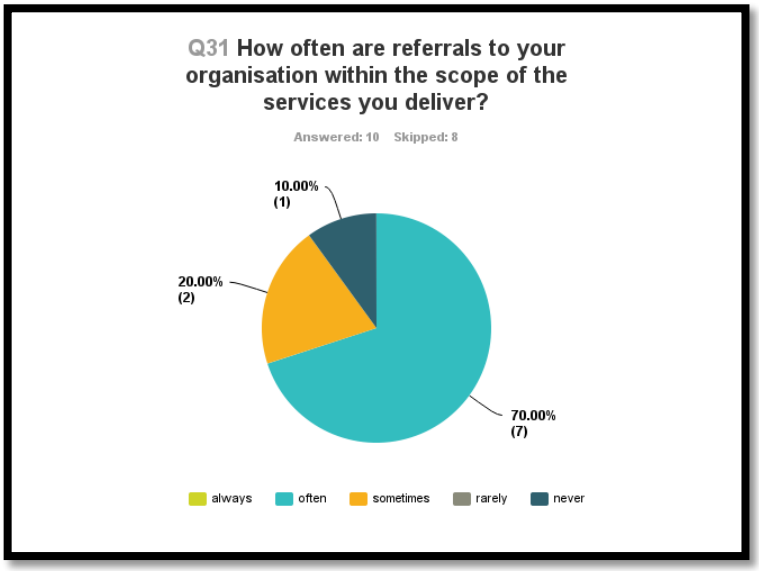


Scope of Referrals

Of those who responded (10), the majority (7; 70%) indicated that referrals received were often within the scope of the services delivered.

Only one agency suggested the referrals received were never within the scope of services they deliver.

Graph 64: Scope of referrals



Mode of Referral Delivery

Of those who responded (10), warm referrals (see table 39 for definition) and supported referrals (see table 39 for definition) were made most frequently.

Ninety percent (9) indicated that they often refer clients through a warm referral process.

Referrals where the client is provided with the referral information (thus the client has responsibility for contacting other organisations) were not made as frequently.

One respondent commented that the mode of referral delivery depends on the nature of the referral and the person involved.

Graph 65: Frequency of mode of referral delivery

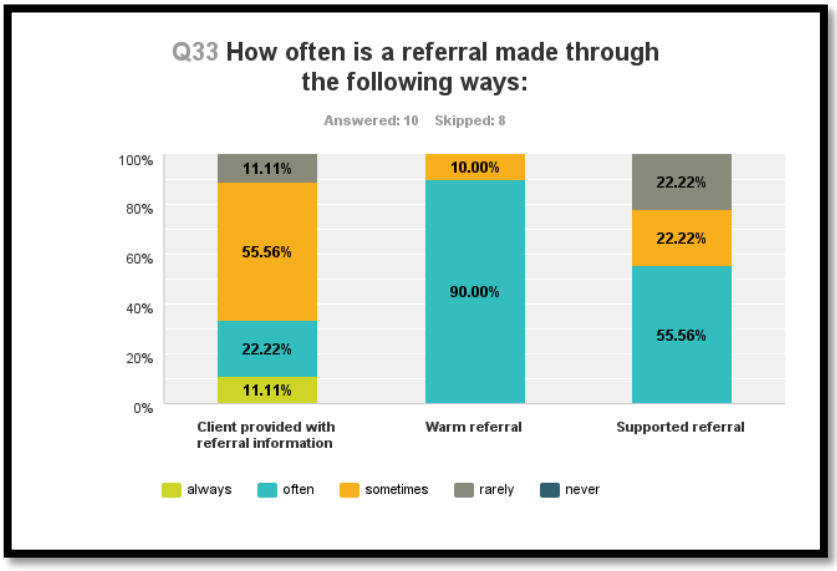


Table 39: Frequency of mode of referral delivery

Type of referral	always	often	sometimes	rarely	never	Total
Client provided with referral information	11.1% 1	22.2% 2	55.6% 5	11.1% 1	0.0% 0	9
Warm referral*	0.0% 0	90.0% 9	10.0% 1	0.0% 0	0.0% 0	10
Supported referral**	0.0% 0	55.6% 5	22.2% 2	22.2% 2	0.0% 0	9

***Warm Referral:** the individual making the referral makes first contact on behalf of the client, and explains to the referral organisation the client's circumstances and the reason they believe the client would benefit from the referral.

****Supported Referral:** accompanying the client to the initial interview, assisting the client to attend the appointment by assisting with support needs such as arranging travel, providing an interpreter

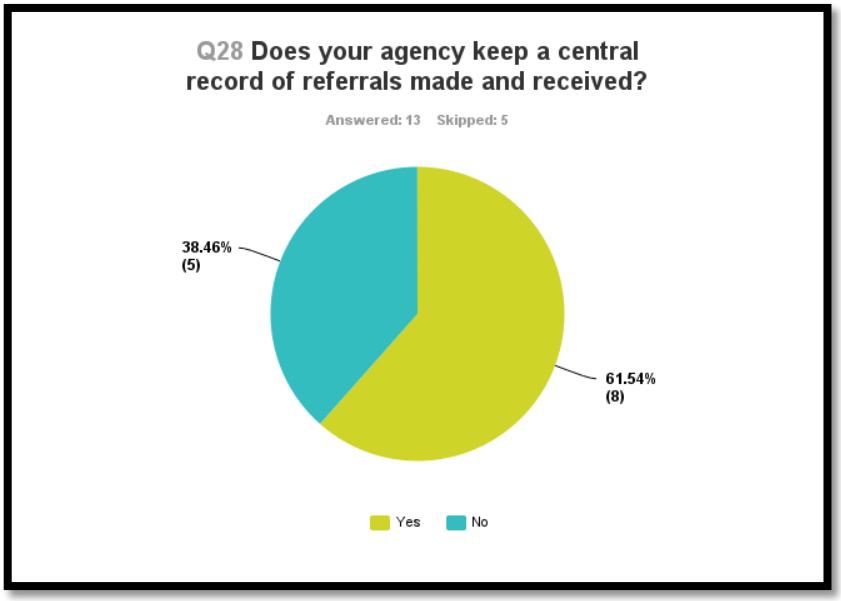
Recording Referrals

Just over 60% (8) of respondents indicated that their agency keeps a central record of referrals made and received.

Two respondents provided additional comments:

- Just noted on client records.
- Referrals documented on CIMHA and/or ATODS-IS.

Graph 66: Central records of referrals

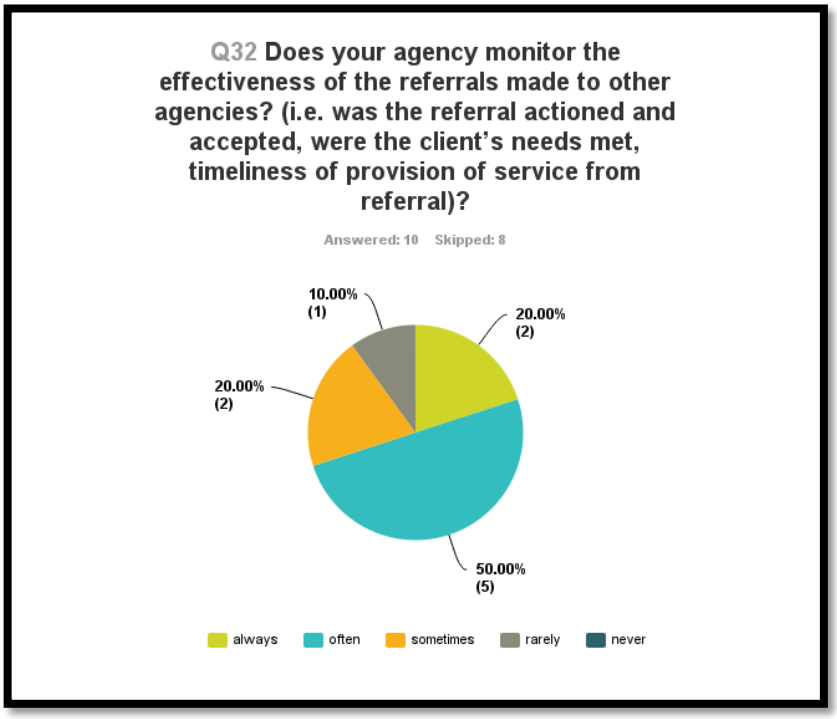


Monitoring Effectiveness of Referrals

Of those who responded (10), 70% (7) indicated that they often or always monitor the effectiveness of referrals made to other agencies.

Only one respondent indicated that they rarely monitor referrals made.

Graph 67: Monitoring effectiveness of referrals made



Ongoing Partnership with Referred / Referring Agency

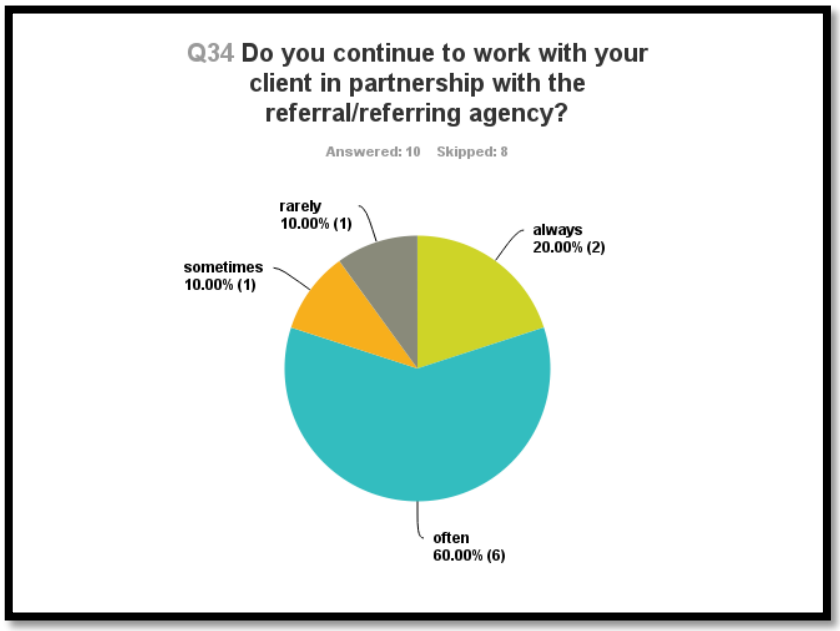
Of those who responded (10), 80% (8) indicated that they often and/or always continue to work in partnership with the referred / referring agency.

Only one agency suggested that they rarely continue to work in partnership.

Two additional comments were received:

- Depends on situation.
- Depends on if it's accepted.

Graph 68: Ongoing partnership with referred / referring agency



Supports for Referrals

Based on a weighted average, a dedicated case coordinator or care coordination model and strong individual relationships between workers were identified as the most effective supports in assisting referral processes to other agencies.

This was followed by clear internal policies and practice. Formal mechanism between agencies established (e.g. service level agreement or memorandum of understanding) was identified as the lease effective support strategy.

Further to this, the most effective supports identified above in assisting referral processes coincide with the most effective supports in assisting coordinated care for clients. This is also the case for the support strategy identified as the least effective in assisting both referral processes and coordinated care for clients (see Table 35).

Table 40: Effectiveness of supports in assisting referral processes

Not at all effective	Slightly effective	Moderately effective	Very effective	Extremely effective	Weighted Average
dedicated case coordinator or care coordination model					
0.00% 0	14.29% 1	14.29% 1	57.14% 4	14.29% 1	**3.71**
strong individual relationships between workers					
0.00% 0	11.11% 1	22.22% 2	55.56% 5	11.11% 1	**3.67**
clear internal policies and practice e.g. referral flowchart available, training provided					
12.50% 1	0.00% 0	25.00% 2	62.50% 5	0.00% 0	**3.38**
local structured formal network or governance structure (may include a focus on how clients can be referred between agencies)					
12.50% 1	0.00% 0	50.00% 4	37.50% 3	0.00% 0	**3.13**
standardised referral forms between agencies making and receiving the referral					
10.00% 1	10.00% 1	40.00% 4	40.00% 4	0.00% 0	**3.10**
formal mechanism between agencies established (e.g. service level agreement or memorandum of understanding)					
11.11% 1	11.11% 1	55.56% 5	22.22% 2	0.00% 0	**2.89**

Winton Medical Practice, Winton

Barriers to Referrals

Based on a weighted average, lack of access to specialist services, lack of access to services due to distance or cost and lack of services to refer to were all identified as the most significant barriers impacting on an agency's ability to refer successfully. This was closely followed by client reluctance or ability to take up referral and waiting times for appointments.

Further to this, the top five barriers identified as having the greatest impact on successful referrals coincide with the top five barriers impacting on an agency's ability to coordinate care/support successfully (see Table 36).

Conversely, lack of clarity about when referrals must be made and the reasons for doing so was identified as the barrier of least impact on an agency's ability to refer successfully. This again correlates with the barrier having the least impact on an agency's ability to coordinate care/support successfully (see Table 36).

Table 41: Impact of barriers on agency's ability to refer successfully

No impact at all	Very little impact	Some impact	Moderate to high level of impact	Significant impact	Weighted Average
lack of services to refer to					
11.11% 1	22.22% 2	0.00% 0	44.44% 4	22.22% 2	**3.44**
lack of access to services due to distance or cost to clients					
11.11% 1	0.00% 0	44.44% 4	22.22% 2	22.22% 2	**3.44**
lack of access to specialist services					
0.00% 0	11.11% 1	44.44% 4	33.33% 3	11.11% 1	**3.44**
waiting times for appointments					
0.00% 0	33.33% 3	22.22% 2	22.22% 2	22.22% 2	**3.33**
client reluctance or ability to take up referral					
11.11% 1	0.00% 0	55.56% 5	22.22% 2	11.11% 1	**3.22**
information sharing issues (data protection/privacy/confidentiality/client consent)					
11.11% 1	22.22% 2	33.33% 3	22.22% 2	11.11% 1	**3.00**
lack information and understanding about other agencies and their services (currency of service information, staff training/capability)					
11.11% 1	33.33% 3	11.11% 1	44.44% 4	0.00% 0	**2.89**
eligibility criteria of other agencies					
0.00% 0	55.56% 5	11.11% 1	33.33% 3	0.00% 0	**2.78**
varying levels of cultural capability between services (affecting the ability to deliver consistent culturally appropriate services between agencies)					
11.11% 1	33.33% 3	33.33% 3	22.22% 2	0.00% 0	**2.67**
Inadequate staff training					
12.50% 1	50.00% 4	0.00% 0	37.50% 3	0.00% 0	**2.63**
lack of clarity about when referrals must be made and the reasons for doing so (no clear internal policies and practice)					
11.11% 1	44.44% 4	22.22% 2	22.22% 2	0.00% 0	**2.56**

"Our referral processes are relatively straight forward. We take self-referrals, GP referrals and pretty much referrals from anyone. I guess it comes down to the local knowledge of what difference services provide. And for a little town we actually do quite well"

Focus Group Participant Comment, Central West HHS Region

Strategies to Address Barriers to Referrals

Based on a weighted average, respondents suggested that promoting own agency role and function was the most effective strategy to address barriers to successful referrals. Built relationships and shared resources were equally identified as the second most effective strategy to address barriers.

Conversely, providing financial support to clients was identified as the least effective strategy address barriers to successful referrals. This correlates with the least effective strategy identified to address barrier for successful coordinated care/support (see Table 37).

Table 42: Strategies to address barriers to refer successfully

Not at all effective	Slightly effective	Moderately effective	Very effective	Extremely effective	Weighted Average out of 5
promoted your own agency's role and function (e.g. newsletters, website)					
0.00% 0	0.00% 0	50.00% 4	50.00% 4	0.00% 0	**3.50**
built relationships					
0.00% 0	11.11% 1	33.33% 3	55.56% 5	0.00% 0	**3.44**
shared resources					
0.00% 0	11.11% 1	44.44% 4	33.33% 3	11.11% 1	**3.44**
developed internal policies and referral procedures					
0.00% 0	11.11% 1	44.44% 4	44.44% 4	0.00% 0	**3.33**
participated in interagency forums or held regular meeting with key agencies					
0.00% 0	11.11% 1	44.44% 4	44.44% 4	0.00% 0	**3.33**
provided practical assistance to clients (e.g. provided or subsidised transport)					
0.00% 0	12.50% 1	50.00% 4	37.50% 3	0.00% 0	**3.25**
delivered training and/or resources					
0.00% 0	11.11% 1	55.56% 5	33.33% 3	0.00% 0	**3.22**
sought and provided feedback (monitoring quality)					
0.00% 0	22.22% 2	44.44% 4	22.22% 2	11.11% 1	**3.22**
provided financial support to client					
0.00% 0	14.29% 1	71.43% 5	14.29% 1	0.00% 0	**3.00**

Additional Open Comments

Only one additional open comment was received.

Additional Open Comments

Table 43: Additional comment

Additional Comment (n=1)
I'm not really sure what input I can provide for tonight. I'm aware of who to refer to but rarely have the need to refer for mental health up to now (been in the role 12 months)

Focus Group Summary

Service providers from within the Central West HHS region were invited to participate (face-to-face and teleconference) in a focus group and actively contribute to a number of key focus group questions to complement the survey results. Seven service providers from across five agencies (Central and North West Queensland Medicare Local, Red Cross, Royal Flying Doctor Service, Queensland Health and Rural Financial Service) participated in the focus group held in Longreach.

The discussion was audio recorded and a summary of key themes was identified and are provided below.

What does effective service integration mean?

Participants commented that effective service integration is about working together, sharing information and collaborating.

Good relationships and communication with other services, staff consistency and being flexible were considered important factors to successful integration.

What does effective service integration mean?

Summary of Comments
Everyone getting involved and working together rather than taking ownership of a client.
Sharing of information and collaborating to prevent patients from having to tell their story over and over again which can be traumatic to people to mental health and alcohol or other drug issues.
Relationships with other services is critical for successful integration.
Good communication is the key to successful integration.
Being flexible and being able to contact services and discuss client's needs and identify opportunities to work together.
Having consistency in staff is very important to ensure clients have a common face and also for providers to have consistency with other services. In smaller towns clients establish personal relationships with providers however often in 3 months they are gone and the clients have to start all over again.

What does good service integration look like in the region?

Participants indicated that providers in the Central West generally work well together. Communication is very good across the region and due to remoteness, providers often know one another.

Two key barriers were identified including ownership of clients and recruiting and retaining good clinical staff.

What does good service integration look like in the region?

Summary of Comments
In general, providers in the Central West work really well together and due to the large region in the Central West, most providers understand that best practice is that no one service is a one-fix-all. Most providers are happy to refer clients onto other services if they are able to support them better.
Meet and greets with other providers to have been very helpful to get to know what services are available. It's important to have a balance of regular structured meetings to discuss shared clients' needs and also bigger meet and greets so service providers can get to know one another.
Due to the rural and remote region, providers often know one another and for those new into the role, they soon find out who everyone is.
Communication between providers in the Central West is very good.
One barrier in the Central West is ownership of clients. For the providers who don't integrate well, these services like to be a one-stop-shop service however this is not effective.
Another barrier is that recruiting and retaining good clinical staff has been challenging for some positions. Trying to recruit skilled people to live in rural and remote areas is difficult.

What do referral pathways look like in the region?

Participants indicated providers predominantly rely on GPs for referrals. Most services have formal referral processes (e.g. formal referral form) and some services also use more informal referral process (e.g. phone call).
Patient consent to refer was identified as a barrier.

Types of supports / services that exist in the region

Participants indicated that there are a number of services in the region who are mostly based in Longreach and provide outreach services to the Central West.

Groups of people whose needs are not being met

Participants suggested that there were a few groups of people in the region whose needs are not being met. These include youth, people who require early psychosis services and residential rehabilitation.
Lack of recruitment to specific positions due to lack of skilled workers was identified as a contributing factor to gaps in services.

What do referral pathways look like in the region?

Summary of Comments
Providers in Central West generally rely on GPs for referrals. GPs generally have referral forms for local services which the complete for clients.
Most services have formal referral forms that can be completed by any provider (including self-referral) for clients.
Some services have informal referral processes such as a phone call, an email or self-referral.
Patient consent to refer has been identified as a barrier to referrals in the Central West.

Types of supports / services that exist in the region for people (and their family and carers) with mental illness, mental health difficulties or problematic substance use.

Summary of Comments
Types of supports / services: • Centacare • Anglicare • Relationships Australia • Disability Queensland • RFDS • Partners In Recovery • Mental Health • ATODS
There are a lot of services in the Central West. Many providers are based in Longreach and provide outreach services to the Central West. Some of the bigger town such as Blackall, Winton and Barcaldine are visited more regularly however some of the smaller towns are not visited as regularly.
Generally services will do outreach visits when there are referrals for patients from these towns.

Specific groups of people whose mental health and alcohol and other drug service needs are not being met for the region.

Summary of Comments
There are no services targeting youth such as **headspace**.
There is no early psychosis team.
There are some specific positions available but services are unable to recruit to these positions due to the lack of skilled workers and remoteness.
There is a huge gap in drug and alcohol residential rehabilitation facilities. The AOD (Alcohol and Other Drug) Nurse can undertake a general detox however for more severe cases, patients are flown to Brisbane to receive treatment. There is some support for patients once they return including ATOD clinical positions.

Participants' suggested actions and strategies to build better service integration

To address the issue of inconsistencies/changes in staff and lack of awareness of services, participants suggested ongoing interagency meetings and gatherings and the development of a tool or system which providers can access comprehensive information about other services including referral pathways into and out of these services.

Focus group participants' suggested actions and strategies to build better service integration in the region

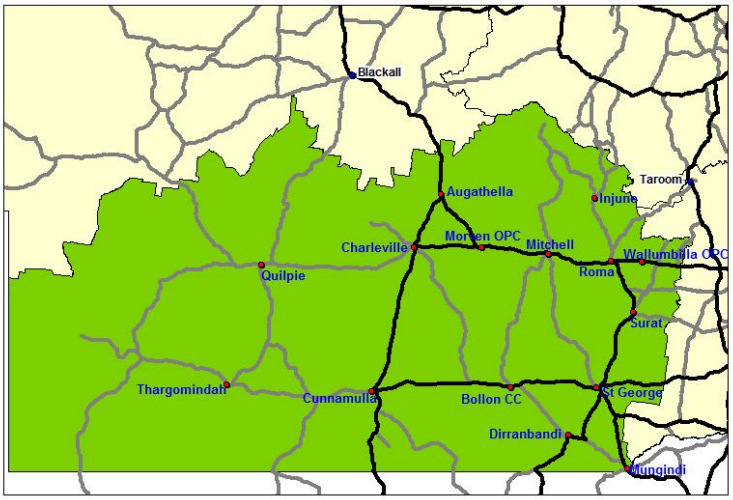
Summary of Comments
More referrals into services.
More opportunities to get to know service providers in the region such as interagency meetings and gatherings with a specific focus. This could include both professional and social gatherings.
A system where local providers are all linked in together and includes a write up of all the services in the area with a mechanism to inform other providers of changes in staff. This could also include information on the referral pathways into and out of each service.

7.0 South West HHS Region

South West HHS Region at a Glance

The South West HHS region covers an area of over 319,000 square kilometres. The region covers the local government area of Balonne, Bulloo, Murweh, Maranoa, Paroo and Quilpie. The area is known for its cattle and sheep industry, cotton farming, opal mining and oil and gas deposits.

Figure 3: South West HHS Region Map



Population Demographics

The estimated population of the South West is 26,464 which accounts for approximately 0.6% of the total population of Queensland. According to the 2011 Census, the Indigenous population accounts for 11.8% of the total population of the South West HHS region with Paroo having the largest proportion of Indigenous residents.

Key Health Conditions

The health status of the population in the South West is poorer than for Queenslanders generally, which in turn is lower than national averages on most measures. There are significant lifestyle risk factors in relation to diabetes, chronic obstructive pulmonary disease, smoking rates, alcohol consumption, nutrition and obesity. In addition, there is higher premature mortality, including deaths from cancers, respiratory system diseases, cerebrovascular diseases, ischaemic heart diseases, suicide and self-inflicted harm.

References:

- *South West Hospital and Health Service Annual Report. Queensland Government. 2013 - 2014.*
- *South West Hospital and Health Service Strategic Plan. Queensland Government. 2014 - 2018 (Updated 2014).*
- *Queensland Health. The health of Queenslanders 2014. Fifth report of the Chief Health Officer Queensland. Queensland Government. Brisbane 2014.*

Survey Respondent Profile

Of the respondents (91) who completed the overall survey, 48 (52.7%) were based in the South West HHS region. Just under half (23; 47.9%) of respondents represented non-government agencies and one-third (16) represented government agencies. The remaining 9 (18.7%) were from a private organisation or a registered charity.

Of the respondents (27) who indicated their level of position within their organisation, 40.7% (11) from middle / regional management positions. An equal proportion (6; 22.2%) were from upper management or service delivery / service provider roles. The remaining four respondents were sole practitioners.

Of those who indicated their age and sex (26), 65.4% (17) were female and the remaining 34.6% (9) were male. Just under half (11; 423%) were aged between 45 and 54 years. This was closely followed by 26.9% (7) aged 55-64 years.

Two focus groups were held across the South West HHS region. Eleven service providers from across five agencies (Queensland Police, Queensland Health, Department of Communities, Lifeline and Partners in Recovery) participated in the focus group held in Charleville, Queensland.

In addition, thirteen service providers across ten agencies (Lifeline, Goondir Health Service, Partners in Recovery, Vital Health, Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health, Primary Health Care Centre, Queensland Health, Centacare, Aftercare and the Community Legal Service) participated in the focus group held in Roma, Queensland.

7.0 South West HHS Region

Key Findings

The Service System

Services Provided

- Just under half (43.8%) of agencies surveyed provide services for mental health and/or alcohol and other drugs.
- One-third indicated their agency's primary focus to be mental health service provision and just over one-third provide alcohol and other drugs as a secondary service delivery focus.
- The majority (60%) also indicated that their service always or most of the time provides direct intervention or support when they identify that a client may be at risk of suicide with half also suggesting that they refer these clients to another agency. In addition, 100% of agencies have policies and procedures in place to assist the identification and management of clients who present at risk of suicide.

Types of Services

- The main types of mental health services provided include suicide risk detection and management, recovery support and care coordination for mental health.
- The main types of alcohol and other drugs services provided include counselling, brief intervention, assessment, support and case management and pharmacotherapy.

Service Demand

- Just under two-thirds (62.9%) indicated the current level of mental health service provision meets demand for the region from not at all to only some extent.
- In addition, just under three-quarters (74.1%) indicated the current level of alcohol and other drug service provision meets demand for the region from not at all to only some extent.
- Over three-quarters (77.8%) indicated the current level of suicide prevention or postvention service provision meets demand for the region from not at all to only some extent.
- Overall these results imply that the current level of service provision for mental health, alcohol and other drugs and suicide prevention may not adequately meet demand for the region.

Networking and Interagency Groups

- Respondents engaged with a large variety of networks or interagency groups with 100% indicating they were involved with one or more adult mental health services and/or networks. This was followed by two-thirds who suggested they engaged with aged care, disability and/or community services.
- Just over half were involved with at least one generic interagency group within the region.
- Over one-third (39.3%) indicated that interagency collaboration supports service provision to clients with mental health needs from a moderate to large extent. Only one-quarter (25%) suggested that interagency collaboration supports service provision to clients with problematic substance use from a moderate to a large extent. Thus implying that interagency collaboration best supports service provision for people with mental health needs.
- Regular networking opportunities and meetings to enhance interagency support were the most common suggestions to enhance interagency collaboration in the region.

Service Integration

Strategies Implemented by Services

- When a client is identified with mental health difficulties and/or problematic substance use, the most common strategies implemented were as follows:
    - refer to another agency for mental health services (70%);
    - refer to another agency for alcohol and other drug services (70%); and/or
    - work with other services for aspects of the mental health care/support needs (70%).

Ease of Integration with Other Services

- Just over half (52.5%) indicated the ease of coordinating care for a client was as expected. In addition just under one-third (35%) suggested the ease of coordinating care was harder to much harder than expected.

Supports for Integration

- Strong individual relationships between workers, clear internal policies and a dedicated case coordinator or care coordination model were identified as the most effective supports in assisting coordinated care for clients.

Barriers to Integration

- Lack of access to services due to distance or cost and lack of access to specialist services were the most significant barriers to service integration.

Strategies to Manage Barriers to Integration

- Built relationships and interagency forums or regular meetings were considered the most effective strategies to address barriers to service integration.

Referrals

Referrals to Other Services

- Mental health services were the most commonly referred service with just over two-thirds (68.6%) indicating that they refer clients to mental health services. This was closely followed by 65.7% who referred clients to domestic and family violence services.
- Over one-third (38.1%) of agencies indicated that they refer 21% to 50% of their clientele to mental health services and just over half (52.4%) suggested they refer 10% to 40% of clients to alcohol and other drug services.
- Warm referrals where the most common types of referrals made with the majority (63.3%) of agencies suggesting referrals were always or often within the scope of services the agency delivers.
- The majority of agencies (60%) keep a central record of referrals however only 36.7% always or often monitors the effectiveness of referrals.

Supports for Referrals

- A strong individual relationships between workers followed by standardised referral forms, a dedicated case coordinator or care coordination model and clear internal policies and practice were identified as the most effective supports in assisting referral processes.

Barriers to Referrals

- Lack of access to services due to distance or cost, lack of access to specialist services and lack of services to refer to were all identified as the most significant barriers impacting on an agency's ability to refer successfully.

Strategies to Manage Barriers to Referrals

- Built relationships, providing practical assistance to clients, interagency forums or regular meetings and shared resources were considered the most effective strategies to address barriers to service integration.

Focus Group Discussion

- Service providers feel that effective service integration is about a key agency taking the lead to work in partnership by strengthening services, sharing information and resources, knowing what each service can offer and undertaking joint problem solving.
- Service providers feel that agencies in the South West HHS region generally work well together however there is a lack of effective integration between private practitioners and other agencies as well as between Aboriginal Medical Services and mainstream services. Personal relationships between service providers was identified as a key enabler for effective service integration.
- Confidentiality, informed consent, lack of awareness of existing services, understanding of cultural protocols and eligibility criteria were all identified as barriers to effective referrals.
- There were a number of groups of people in the region identified whose needs are not being met. These include South East Asian communities, Aboriginal men under the age of 50 with a high ACAT rating, youth aged between 12 and 17 years, parents of children and people with an early diagnosis of dementia.
- Key actions that were identified to build better service integration in the region included networking opportunities such as health expos and gatherings for service providers, development of a range of resources for service providers and the development of a tool or system which providers can access comprehensive information about other services including referral pathways into and out of these services.

Service Delivery

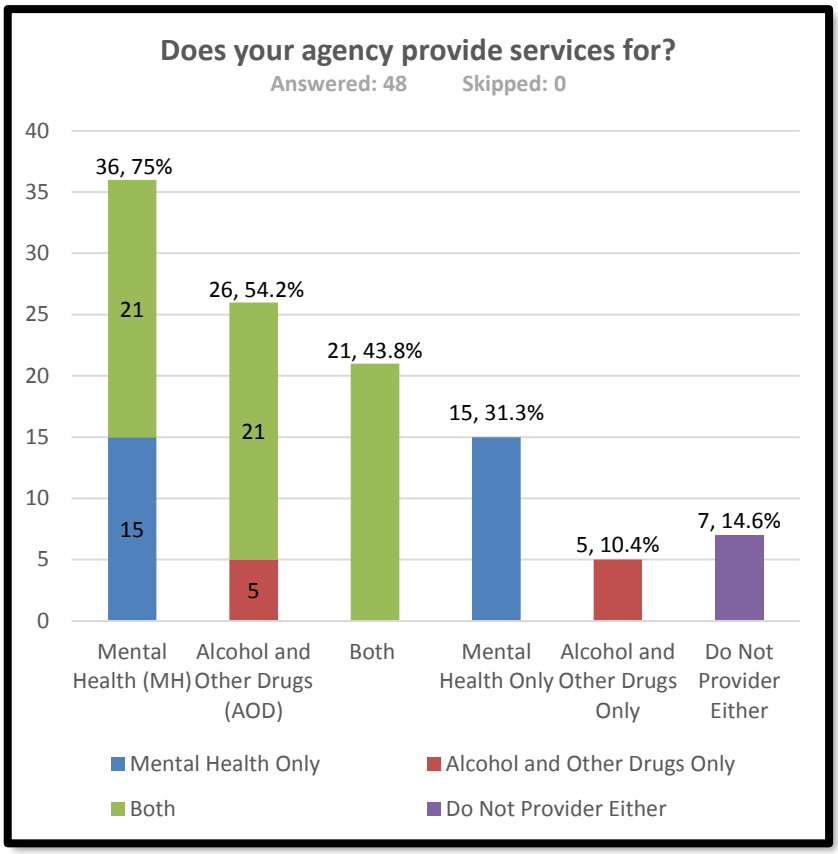
Just under half of respondents (21; 43.8%) provide services for both mental health and alcohol and other drugs. In addition, almost one-third (15; 31.3%) provide services for only mental health. Only a small number (5; 10.4%) of agencies provide services for only alcohol and other drugs.

When looking overall at those who provide services for mental health or alcohol and other drugs, three-quarters (36; 75%) provide services for mental health and just over half (26; 54.2%) provide services for alcohol and other drugs.

Seven (14.6%) agencies indicated that they did not provide services for either.

Overall Service Delivery

Graph 69: Services provided



Charleville Hospital, Charleville, Queensland

Primary Focus of All Services

One-third of respondents (16; 33.3%) indicated their primary service delivery focus to be mental health.

In addition, eight (16.7%) respondents suggested their primary focus to be primary health care.

A number of respondents (9; 18.7%) provided an 'other' primary service delivery focus (see table 44).

Graph 70: Primary focus of all services

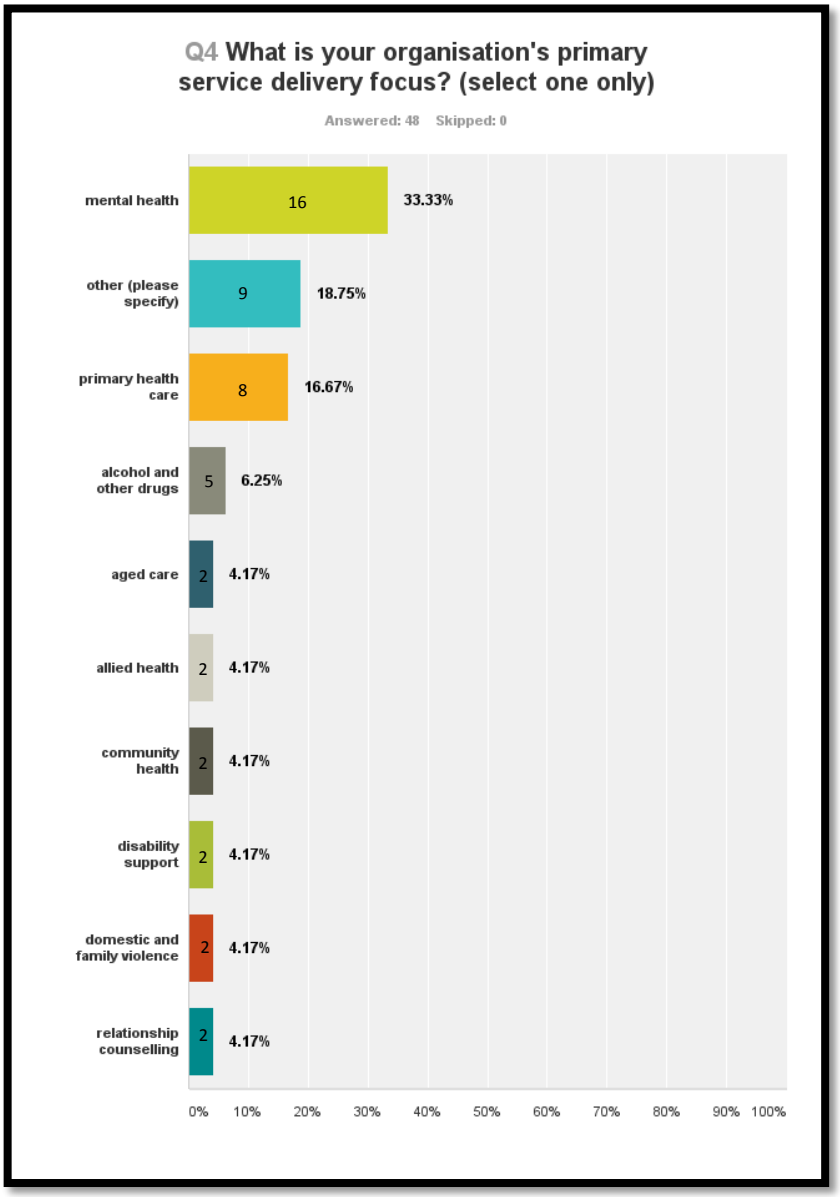


Table 44: Primary service delivery focus – other responses

Other (n = 9)	Count
Community Services and Support (through sports and programs)	3
Women's Health	1
Police	1
General assistance where needed	1
Counselling Services (social and emotional, children and youth)	2
Holistic Primary Care with a focus on Indigenous health outcomes	1

Secondary Focus of All Services

Of all services who responded (48), over one-third (39.6%; 19) indicated that they provide alcohol and other drugs as a secondary service delivery focus. This was closely followed by 37.5% (18) who provide mental health as a secondary service delivery focus.

Approximately one-third provide family support (17; 35.4%) and community health (165 31.2%) as a secondary service.

Six respondents suggested they provide 'other' secondary services (see table 45).

Graph 71: Secondary focus of all services

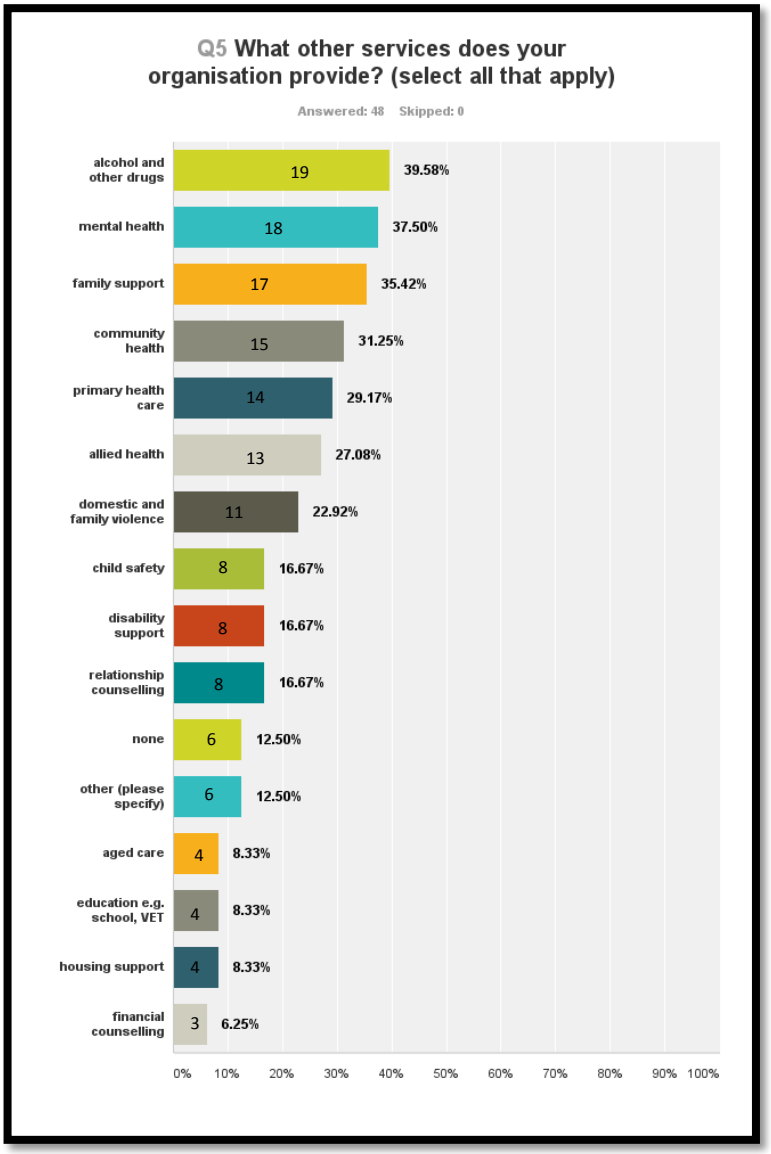


Table 45: Secondary focus of all services – other responses

Other (n=6)
Health Promotion, Prevention and Early Intervention
Queensland Prescribing Service (QPS)
Emergency Relief, Youth Support
Gym and Fitness
Helpline, Prison Work (Young Offenders)
Do you mean the entire Government?

Primary Focus of Mental Health Services

Of those who provide mental health services (36), just under half (16; 44.4%) provide mental health services as their primary service delivery focus.

A further six (16.7%) provide primary health care as their primary service delivery focus.

Five indicated they provided "other" services (see table 46).

Graph 72: Primary focus of mental health services

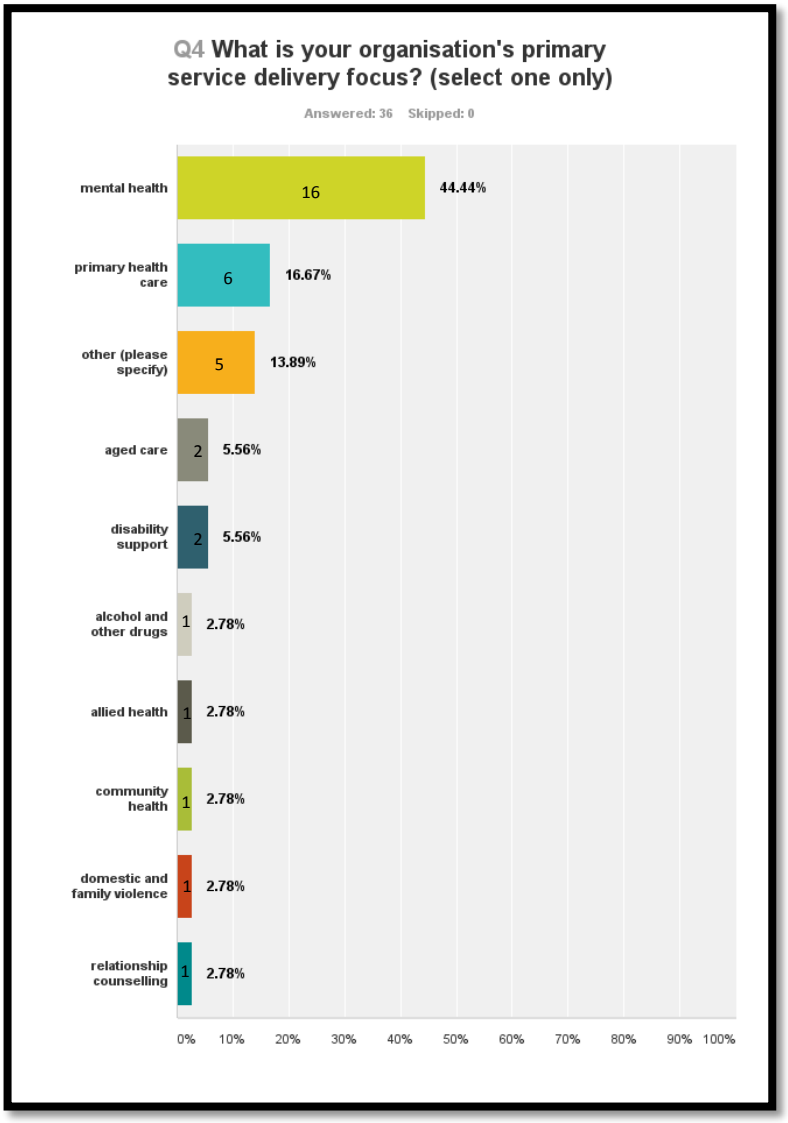


Table 46: Primary focus of mental health services – other responses

Other (n = 5)	Count
Counselling Services (social and emotional, children and youth)	2
Community Services	1
Women's Health	1
Holistic Primary Care with a focus on Indigenous health outcomes	1

Secondary Focus of Mental Health Services

Of those who indicated they provide mental health services (36), half provide (18; 50%) alcohol and other drugs as a secondary service. This was closely followed by 47.2% (17) who provide mental health as a secondary service. An equal proportion (14; 38.9%) provide community health and family support services as a secondary focus. One-third (12; 33.3%) provide allied health and / or primary health care as a secondary service.

Three respondents indicated that they provide 'other' secondary services (see table 47).

Graph 73: Secondary focus of mental health services

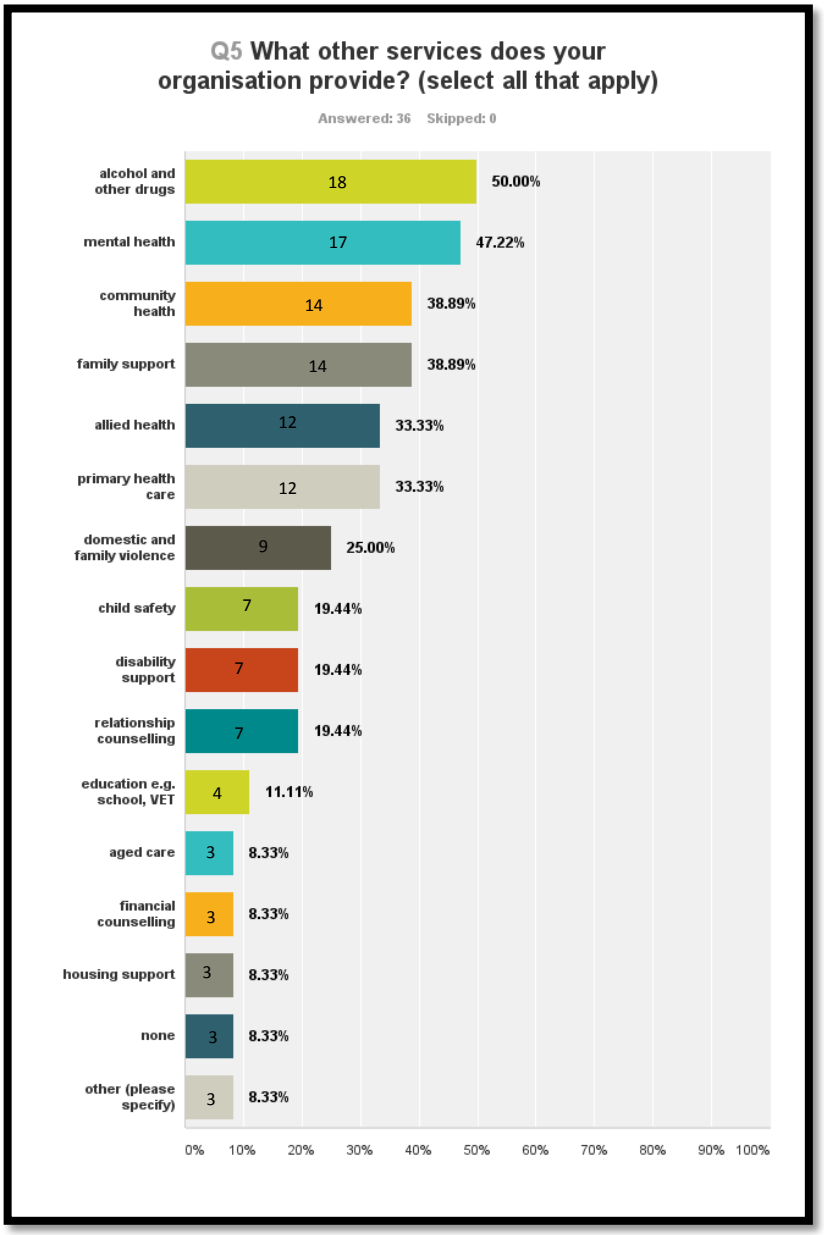


Table 47: Secondary focus of mental health services – other responses

Other (n=3)
Health Promotion, Prevention and Early Intervention
Emergency Relief, Youth Support
Helpline, Prison Work (Young Offenders)

Types of Mental Health Services Provided

The most common type of mental health service provided is suicide risk detection and management (20; 57.1%). This is closely followed by information (19; 54.3%), recovery support (16; 45.7%) and care coordination (16; 45.7%).

Only two agencies indicated they provide respite services.

Six respondents suggested their agency provides 'other' mental health services (see table 48).

Graph 74: Types of mental health services provided

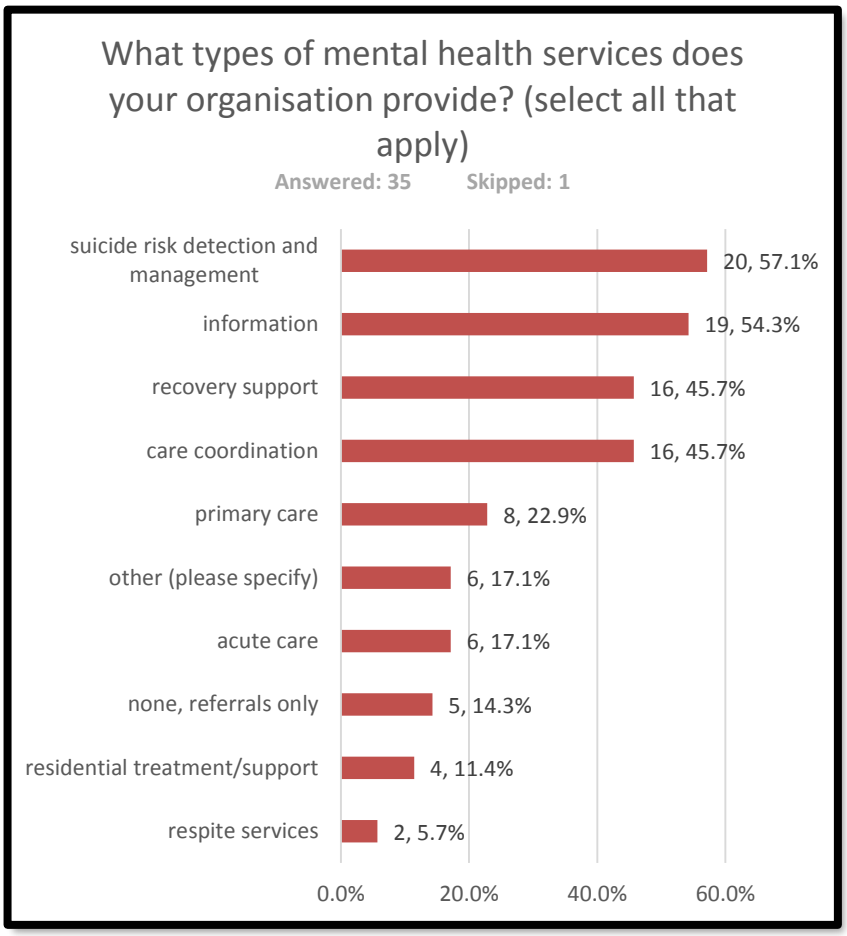


Table 48: Types of mental health services provided – other responses

Other (n=6)
Telephone support to pregnant and new mums from a midwife
Individual/family counselling
All aspects of Partners in Recovery provided
Psychosocial i.e. psychology, counselling, psychological education, therapy etc.
Children/youth and family early intervention, counselling and case management
Sub – acute chronic care (i.e. exercise significantly improves mental health and wellbeing; assisting with chronic pain which is a large contributor to mental health issues, self-esteem and confidence concerns including behavioural issues)

Population Groups Targeted by Mental Health Services

Of those who indicated they provide mental health services (36), just under three-quarters (25; 71.4%) provide services that target Aboriginal and Torres Strait Islander peoples.

This is closely followed by both women (24; 68.6%) and men (24; 68.6%).

Just over half (19; 54.3%) of all agencies indicated that their mental health service targets older persons, farmers, agricultural sector works and people with a disability.

Lesbian, gay, bisexual, transgender and intersex persons were targeted by the least number of agencies (12; 34.3%).

Four respondents suggested their mental health service targets 'other' population groups (see table 50).

Graph 75: Population groups targeted by mental health services

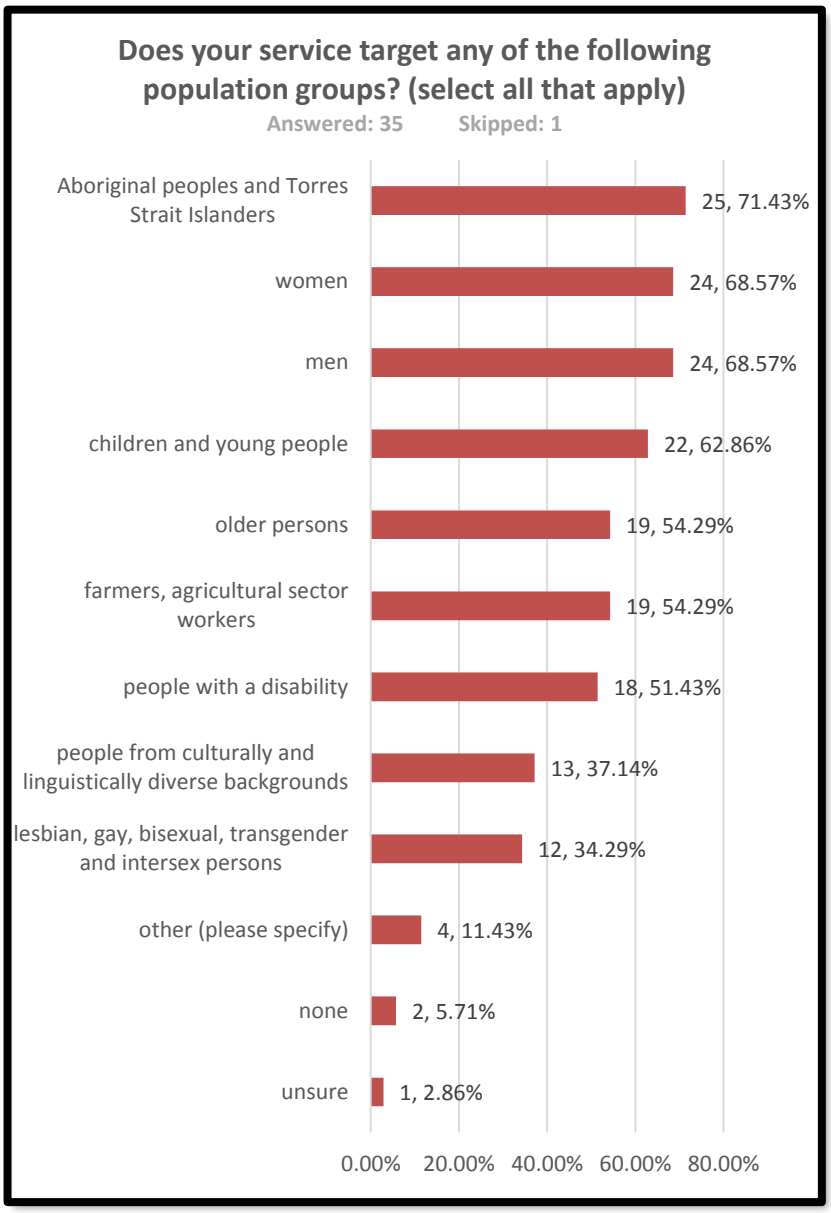


Table 50: Population groups targeted by mental health services – other responses and additional comments

Other (n=4)
Women at risk of domestic and family violence, women at risk of antenatal and postnatal depression and anxiety
We work with participants from all the groups above
Families
Nil specific

Funding Sources for Mental Health Activities

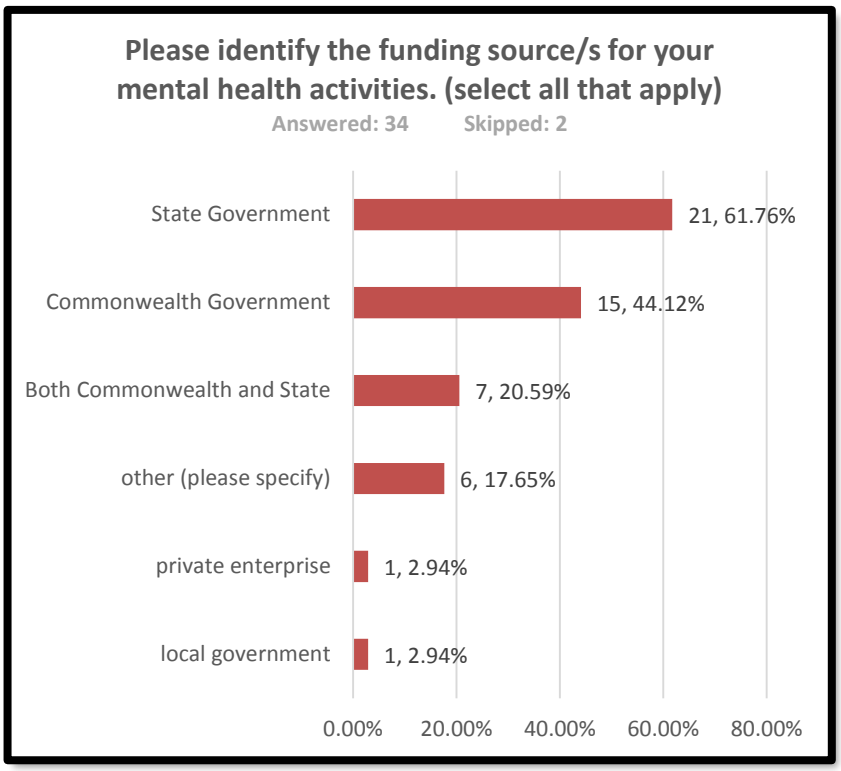
Of the mental health services who responded (34), just under two-thirds (21; 61.8%) received funding for mental health activities from state government sources.

This was closely followed by 44.1% (16) who received funding for mental health activities from commonwealth government sources.

Of these, seven (20.6%) agencies indicated they received funding from both commonwealth and state government source.

Six agencies received funding from 'other' sources.

Graph 76: Funding sources for mental health activities

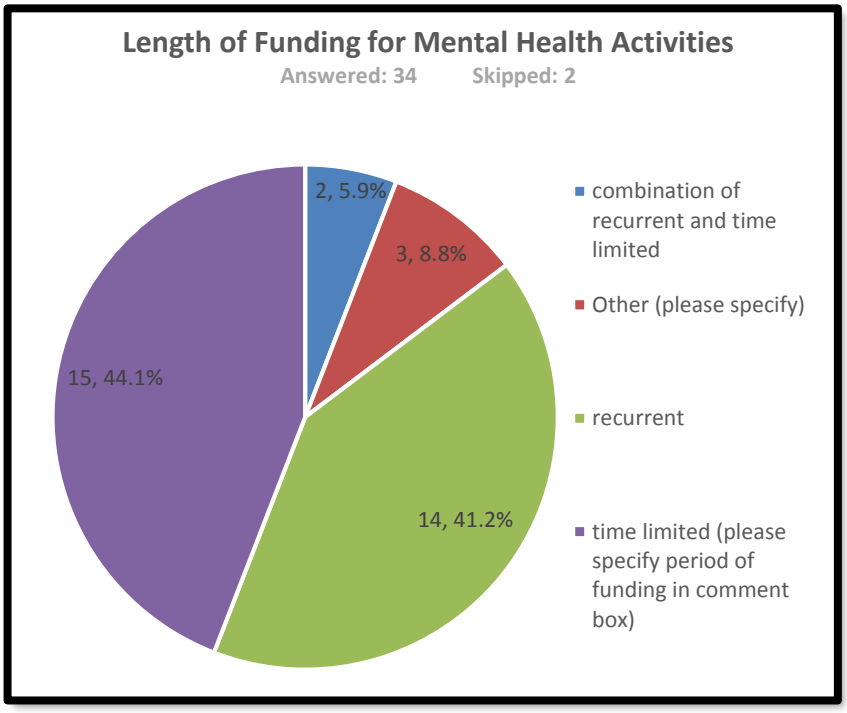


Length of Funding for Mental Health Activities

Of the mental health services that responded (34), just under half received time-limited (15; 44.1%) funding while 41.2% (14) received recurrent funding.

Only two agencies (5.9%) received a combination of time-limited and recurrent funding.

Graph 77: Length of funding for mental health activities



Primary Focus of Alcohol and Other Drug Services

Of those who indicated they provide alcohol and other drug services (26), just under one-third (8; 30.8%) provide mental health services as their primary service delivery focus. A further six (16.7%) provide primary health care as their primary service delivery focus.

Only three (11.5%) agencies indicated they provide alcohol and other drugs services as their primary service delivery focus.

Three suggested they provided "other" services (see table 51).

Graph 78: Primary focus of alcohol and other drug services

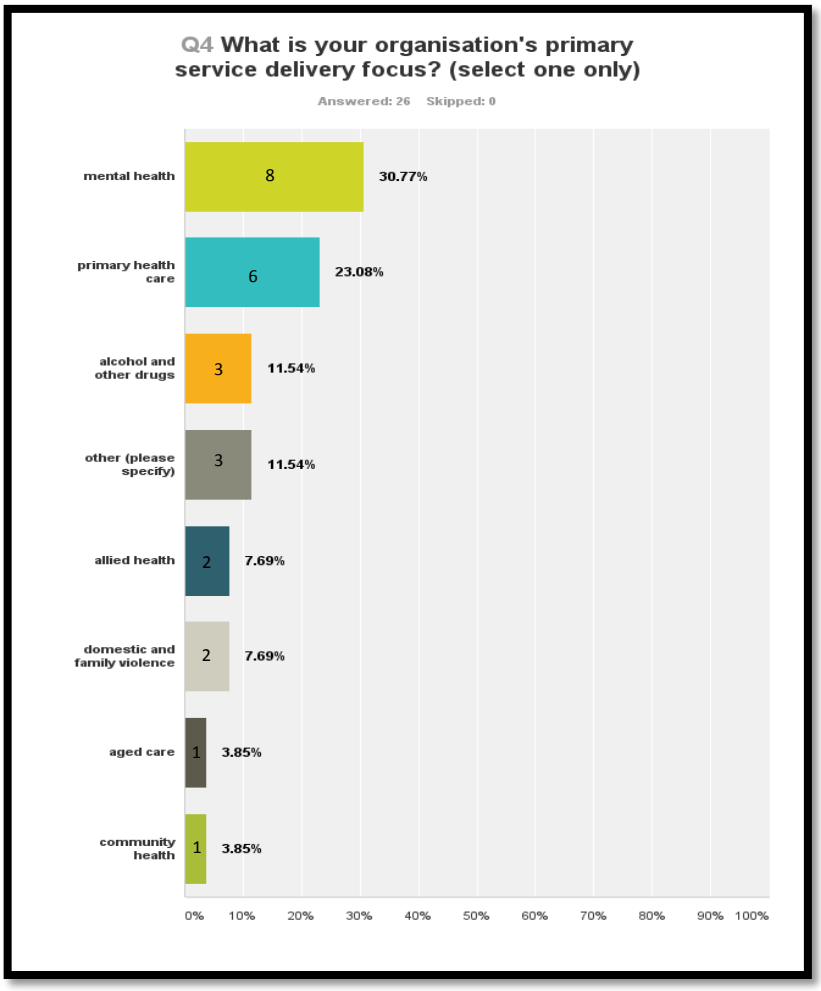


Table 51: Primary focus of alcohol and other drug services – other responses

Other (n = 3)	Count
Counselling Services (social and emotional, children and youth)	2
Holistic Primary Care with a focus on Indigenous health outcomes	1

Secondary Focus of Alcohol and Other Drug Services

Of those who indicated they provide alcohol and other drug services (26), Just under two-thirds (17; 65.4%) provide alcohol and other drugs services as a secondary service.

In addition, half (13; 50%) provide primary health care as a secondary service. This is closely followed by 46.1% (12) who provide mental health as a secondary service.

An equal proportion (11; 42.3%) provides allied health and / or community health as a secondary service.

Two agencies indicated they provide other secondary services (see table 52).

Graph 79: Secondary focus of alcohol and other drug services

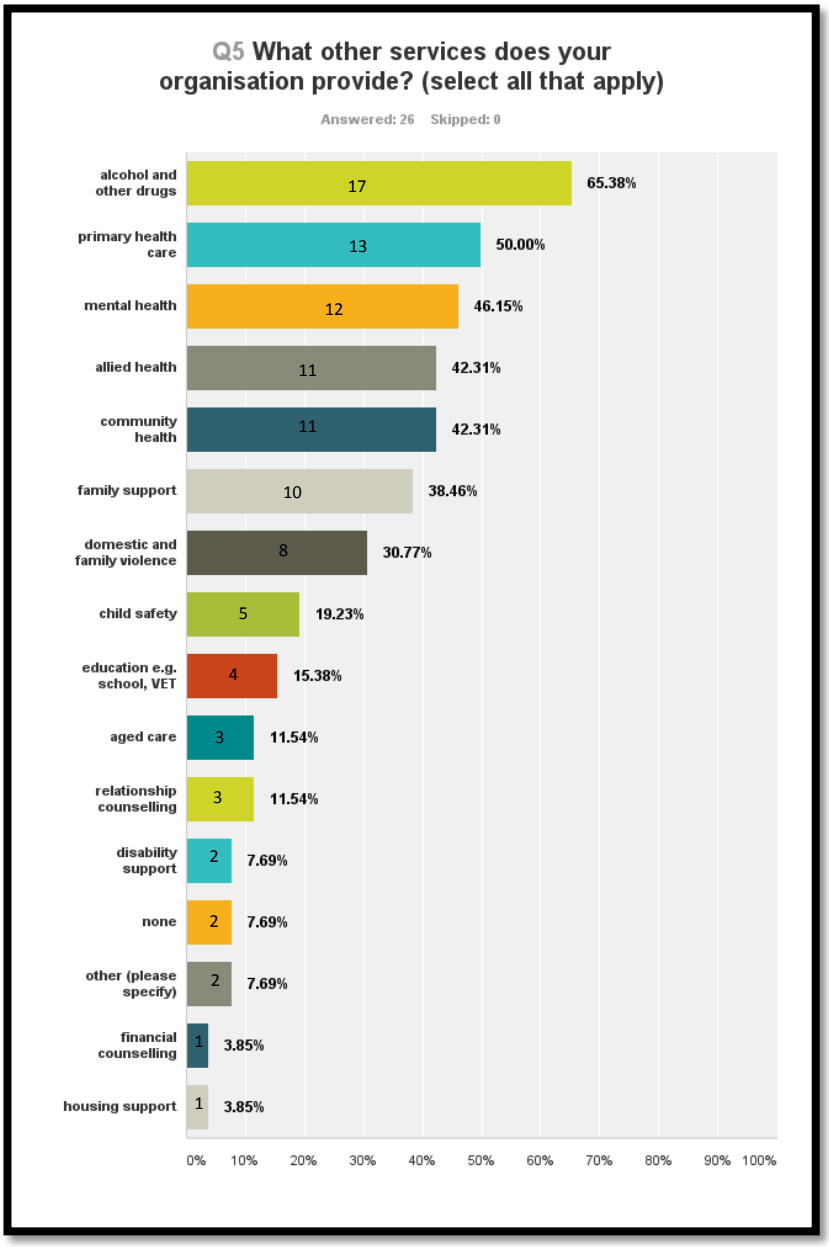


Table 52: Secondary focus of alcohol and other drug services – other responses

Other (n=2)
Do you mean the entire Government?
Helpline, Prison Work (Young Offenders)

Types of Alcohol and Other Drug Services

The most common type of alcohol and other drug service provided is counselling (18; 69.2%). This is closely followed by brief intervention (15; 57.7%), assessment (15; 57.7%), support and case management (14; 53.8%) and pharmacotherapy (13; 50%).

Only a small number of agencies indicated they provide withdrawal management (detoxification) and/or sobering up / intoxication management / diversion centre services.

Four respondents provided additional comments (see table 53).

Graph 80: Types of alcohol and other drug services provided

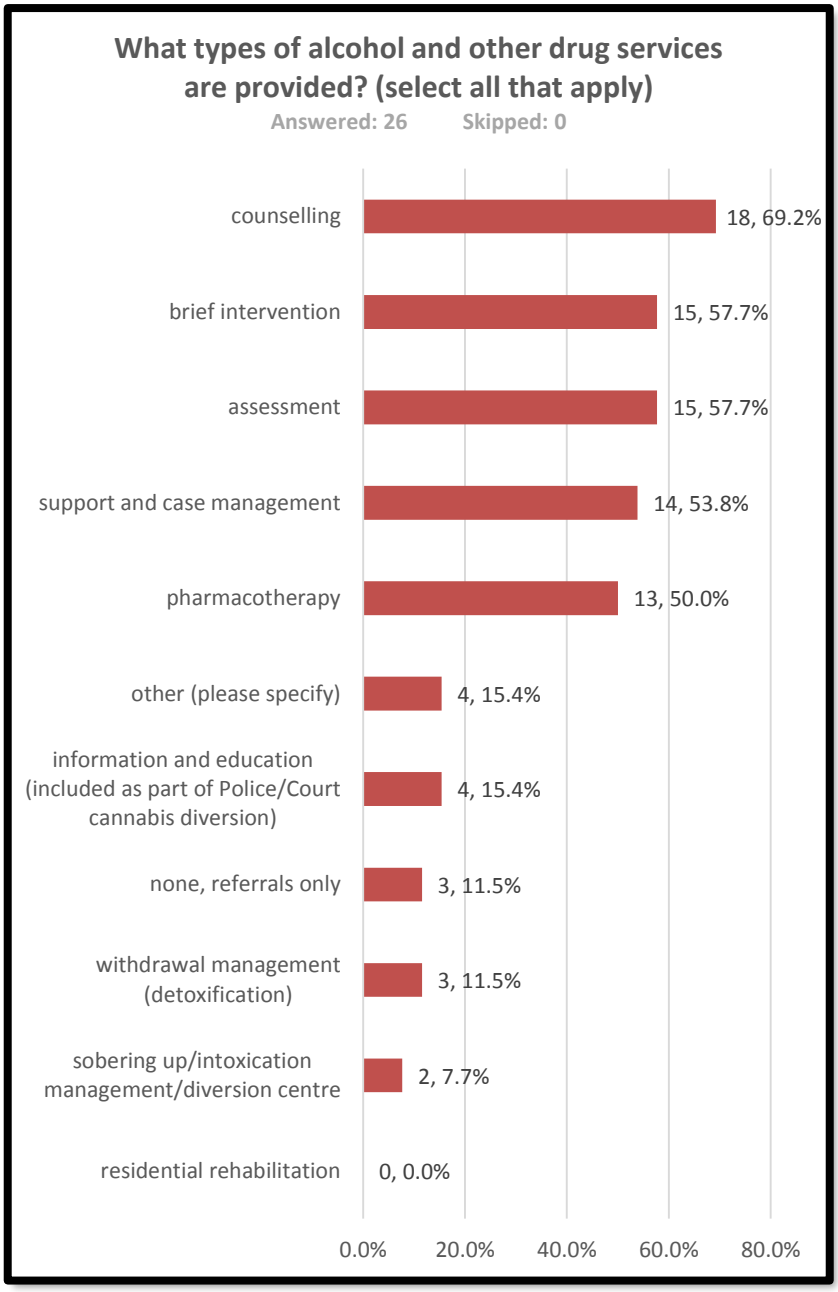


Table 53: Types of alcohol and other drug services provided – additional comments

Comments (n = 4)	Count
Referrals (to rehab and detox facilities; to support services)	3
Facilitation/advocacy	1

Population Groups Targeted by Alcohol and Other Drug Services

Of those who indicated they provide alcohol and other drug services (26), over three-quarters (20; 76.9%) provide services that target Aboriginal and Torres Strait Islander peoples. This is closely followed by both men (19; 73.1%) and women (18; 69.2%).

Just over half of all agencies indicated that their alcohol and other drug service targets older persons and children and young people.

People from culturally and linguistically diverse backgrounds and lesbian, gay, bisexual, transgender and intersex persons were targeted by the least number of agencies (8; 30.8%).

Three respondents suggested their alcohol and other drug service targets 'other' population groups (see table 54).

Graph 81: Population groups targeted by alcohol and other drug services

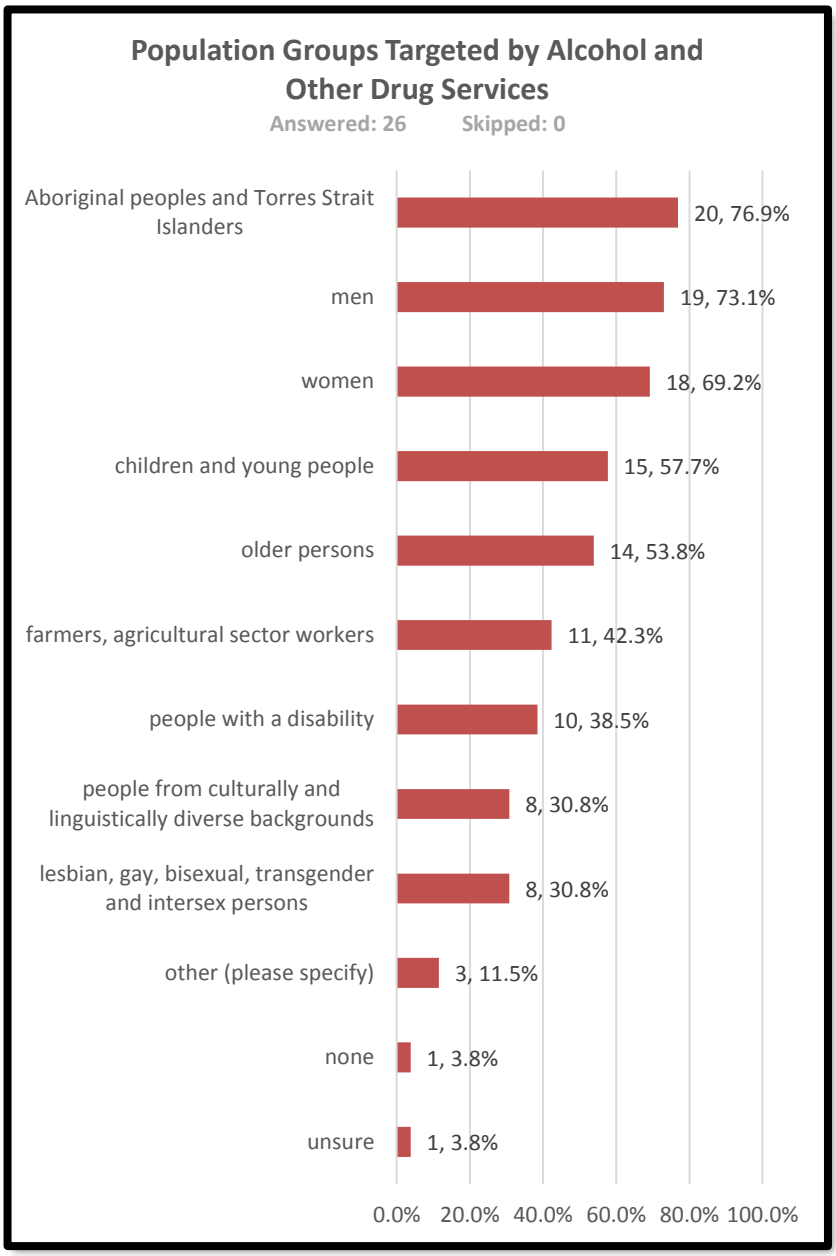


Table 54: Population groups targeted by alcohol and other drug services – other comments

Other (n = 3)
Not targeted but Aboriginal peoples make up 50% of clientele and males 80%
Families
Nil Specific

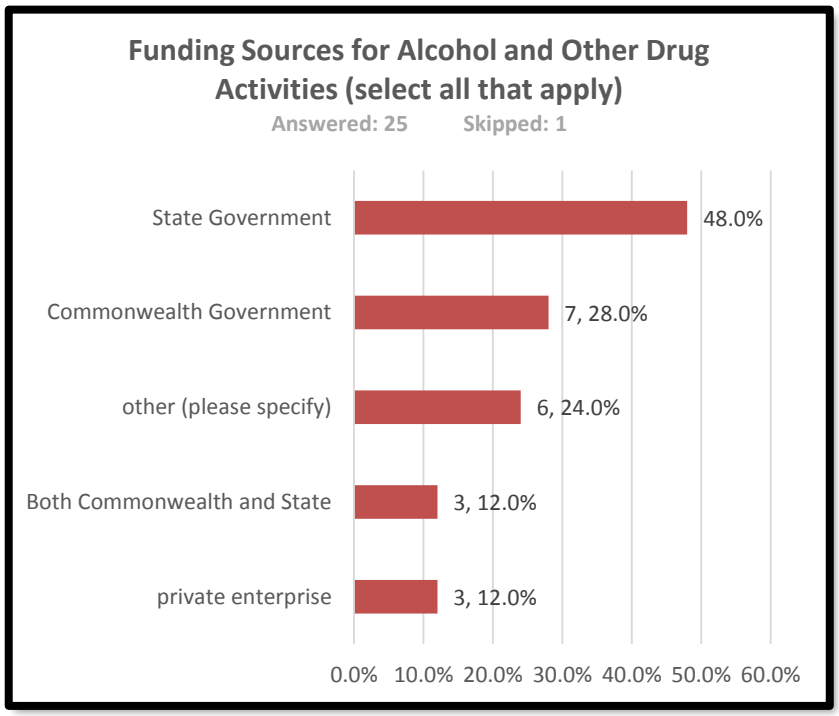
Funding Sources for Alcohol and Other Drug Activities

Of the alcohol and other drug services who responded (25), just under half (12; 48%) funding for alcohol and other drug activities from state government sources.

In additional, 28% (7) received funding for alcohol and other drug activities commonwealth government sources.

Only three agencies received funding for alcohol and other drug activities from private enterprise while none received funding from local government sources.

Graph 82: Funding sources for alcohol and other drug activities



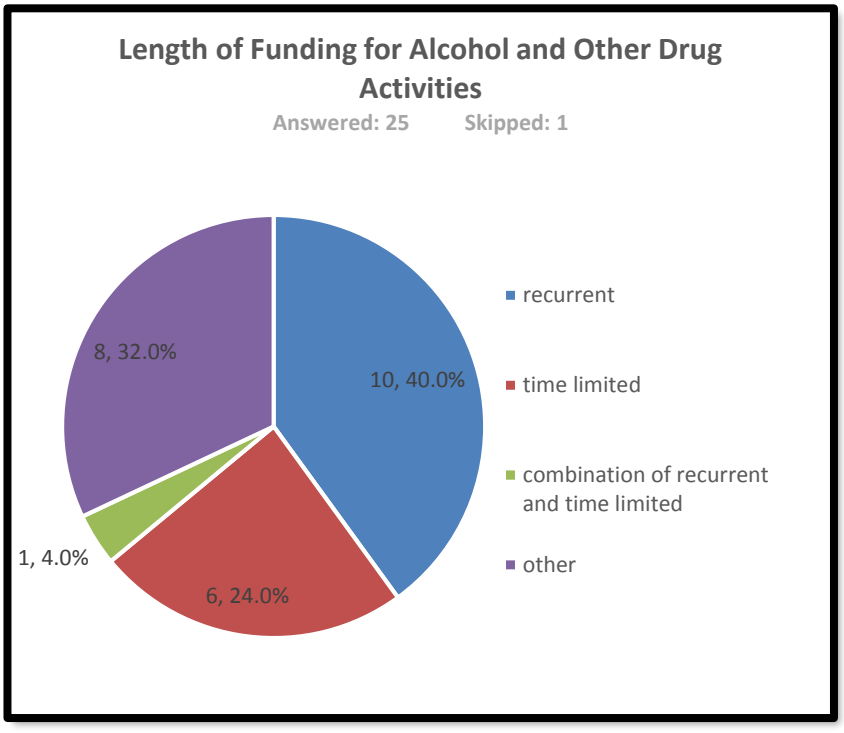
Length of Funding for Alcohol and Other Drug Activities

Of the alcohol and other drug services that responded (25), the majority received recurrent funding for alcohol and other drug activities (10; 40%).

This was closely followed by just under one-third (32%; 8) that received other sources of funding.

In addition, just under one-quarter (24%; 6) received time-limited funding sources or alcohol and other drug activities.

Graph 83: Length of funding for alcohol and other drug activities



Suicide Policies and Procedures

Of those who responded (27), almost all (26; 96.3%) indicated that their agency has policies and procedures in place to assist the identification and management of clients who present at risk of suicide.

Two additional comments were provided (see table 55).

Graph 84: Suicide policies and procedures

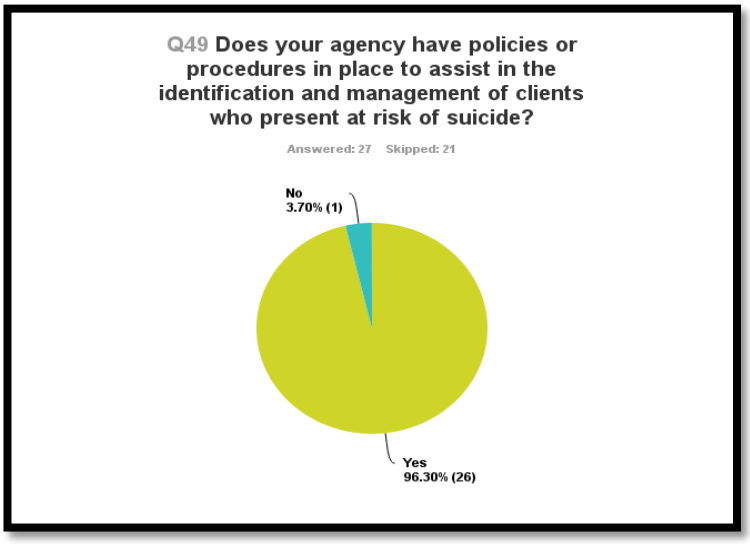


Table 55: Suicide policies and procedures – additional comments

Additional Comments (n = 2)
These policies and procedures are designed to identify risk, however there may be a reluctance to call emergency services because of the dramatic / traumatic consequences (such as transfer to a hospital or placed in watch house for safety).
Formally introduced after the black dog events and mental health awareness campaigns that followed.

Strategies for Clients at Risk of Suicide

Of those who responded (27), just under three-quarters (20; 74%) indicated that when a client of their service is identified at risk of suicide they most of the time or always provide direct intervention or support.

Over one-third (10; 37%) also suggested that they refer to another agency when a client is identified at risk of suicide.

Two additional comments* were provided.

Graph 85: Approach when a client is identified at risk of suicide

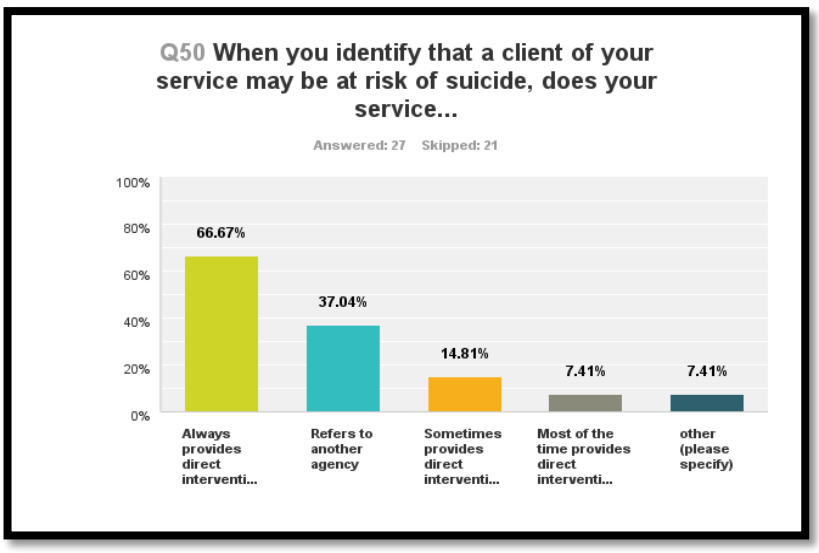


Table 56: Approach when a client is identified at risk of suicide

Answer Choices	Count	%
Always provides direct intervention or support	18	66.7%
Refers to another agency	10	37%
Sometimes provides direct intervention or support	4	14.8%
Most of the time provides direct intervention or support	2	7.4%
other (please specify)*	2	7.4%

***Comments**: (1) Due to lack of professional services on the ground local services have to pick it up at a community level. (2) Health Workers also conduct home visits for a number of weeks to ensure clients are traveling ok.

Use of Videoconferencing or Telehealth

Of those who responded (28), over half indicated that they use videoconferencing or telehealth facilities too access specialist services (16; 57.1%) or other support services (18; 64.3%).

Further to this, a greater percentage indicated they use videoconferencing or telehealth facilities to access other general support services (18; 64.3%) than specialist care (16; 57.1%).

Three additional comments were received (see table 57).

Graph 86: Use of videoconferencing or telehealth facilities

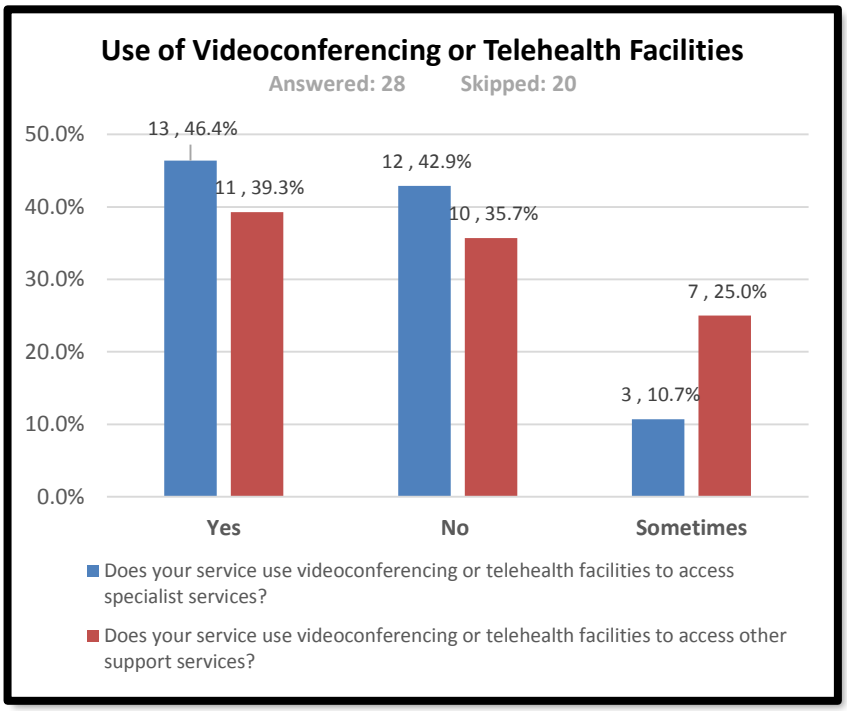


Table 57: Use of videoconferencing or telehealth – comments

Additional Comments (n = 3)
We want to promote use of telehealth much more. It provides affordability and choice to rural clients. However there is a low level of 'literacy' and familiarity with the medium.
We link to services who have these resources.
We have invested in Lync phone system to try to maximise this communication, however internet access has not been consistent enough to make this work as well as it could potentially.

"I think of effective integration in two ways. Integration has to happen to for the person – a person centred approach. So the services that that person needs are available to them in a holistic way. And on the other level it's about organisation's collaborating and working together to make the best use of resources available and not duplicating work. It's about identifying what's working well in the community and if something isn't, problem solving that together. And if there is a gap in services, doing something together that might address that."

Focus Group Participant Comment, South West HHS Region

Mental Health Service Demand

Of those who responded, just under two-thirds (17; 62.9%) indicated the current level of mental health service provision meets demand for the region from not at all to only some extent.

Only 29.6% (8) indicated the current level of mental health service provision meets demand from a moderate to a large extent.

Overall this suggests that the current mental health service provision does not adequately meet demand for the region.

Three respondents provided additional comments (see table 58).

Graph 87: Extent current level of mental health service provision meets demand for the region

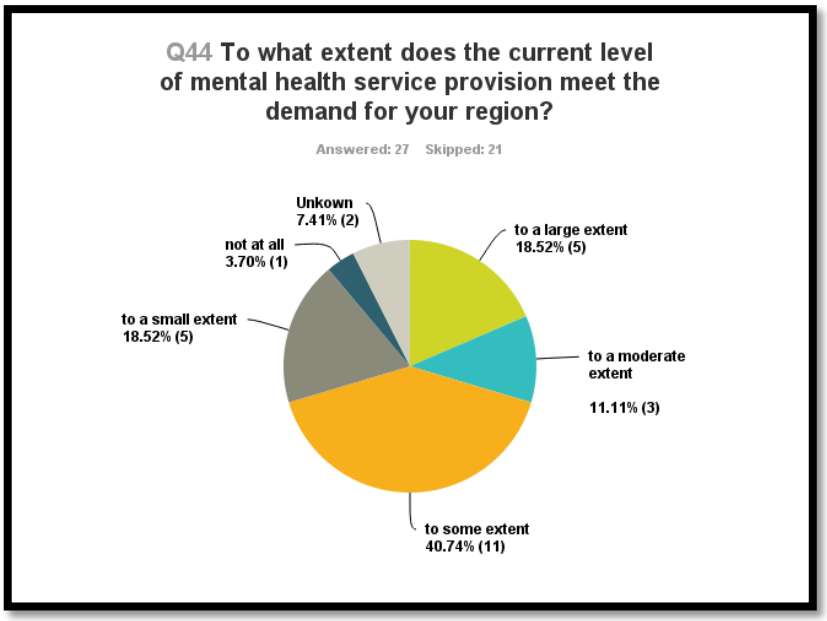


Table 58: Mental health service demand – additional comments

Other (n = 3)
Access to specialist clinicians is very low, however there is an increased access to NGO mental health support.
Too much red tape
Professional services are not available frequently, some are weekly or fortnightly in high pressure situations especially in the area of mental health sometimes clients need urgent assistance.

"Another point of effectiveness is the relationships, it's a key word for mental health. For people who have existing and strong relationships, that's where the value is. When you have a good relationship you could walk up to any number of people and people who know your work are instantly going to have that strong respect so that's great for an existing relationship but also enhances the new ones. I think that's a very strong thing for and effective mental health service."

Focus Group Participant Comment, South West HHS Region

Mental Health Service Demand for Population Groups

Respondents were asked to rate the extent current mental health service provision meets demand in their region for particular population groups. Based on a weighted average (excluding unknown), mental health service provision met demand for older persons and women to the largest extent. This was followed by men and people with a disability.

Conversely, mental health service provision met demand for lesbian, gay, bisexual, transgender and intersex people to the least extent.

Further to this, just under one-quarter indicated mental health service demand for lesbian, gay, bisexual, transgender and intersex people was unknown.

A number of additional comments were also received (see table 60).

Table 59: Mental health service demand for population groups

Population Group	to a large extent	to a mod extent	to some extent	to a small extent	not at all	Unkn-own	Weighted Average (excludes unknown)
Older persons	14.8% 4	33.3% 9	18.5% 5	25.9% 7	3.7% 1	3.7% 1	**3.42**
Women	14.8% 4	18.5% 5	40.7% 11	18.5% 5	3.7% 1	3.7% 1	**3.23**
Men	14.8% 4	18.5% 5	29.6% 8	29.6% 8	7.4% 2	0% 0	**3.04**
People with a disability	11.5% 3	15.4% 4	38.5% 10	26.9% 7	3.8% 1	3.8% 1	**3.04**
Children and young people	14.8% 4	18.5% 5	22.2% 6	33.3% 9	7.4% 2	3.7% 1	**3.00**
Aboriginal and Torres Strait Islander Peoples	3.7% 1	25.9% 7	33.3% 9	25.9% 7	7.4% 2	3.7% 1	**2.92**
People from a culturally and linguistically diverse background	7.4% 2	18.5% 5	22.2% 6	18.5% 5	18.5% 5	14.8% 4	**2.74**
Lesbian, Gay, Bisexual, Transgender and Intersex people	3.7% 1	14.8% 4	18.5% 5	25.9% 7	14.8% 4	22.2% 6	**2.08**

Table 60: Mental Health Service Demand for Population Groups – additional comments

Additional Comments (n = 10)
Older persons • Community options such as Men's Sheds doing the best interventions for older people. Also HACC funded services e.g. Anglicare, Blue Care.
Women • Services - both clinical and non-clinical – are biased towards women both in numbers of clients and gender of clinicians and other staff.
Men • Increased awareness around men's mental health, especially in relation to farmers and property owners. However, still a barrier in help-seeking behaviour from men in rural communities.
People with a disability • LAC's do a great job. Disability Services are probably better in the bush than in the city, because of these positions.
Children and young people • CYMS only. Need for **headspace** style services - multidisciplinary, age-appropriate and non-stigmatizing early intervention approaches.
Aboriginal peoples and Torres Strait Islanders • AMS's doing a good job - especially social and emotional wellbeing workers, e.g. in St George, Cunnamulla and Charleville. • Distance is an issue • From clinical perspective weekly & fortnightly services are not adequate for demand. This impacts on the local support services.
People from a culturally and linguistically diverse background • CALD communities have recently emerged in south west, and services may not have experience and training suited to responding appropriately.
Lesbian, Gay, Bisexual, Transgender and Intersex people • Stigma and lack of understanding or acknowledgement of different sexualities in small communities.

Alcohol and Other Drug Service Demand

Of those who responded, just under three-quarters (20; 74.1%) indicated the current level of alcohol and other drug service provision meets demand for the region from not at all to only some extent.

Only 22.2% (6) indicated the current level of alcohol and other service provision meets demand from a moderate to a large extent.

Overall these results suggest that the current alcohol and other drug service provision may not adequately meet demand for the region.

Four respondents provided additional comments (see table 61).

Graph 88: Extent current level of alcohol and other drug service provision meets demand for the region

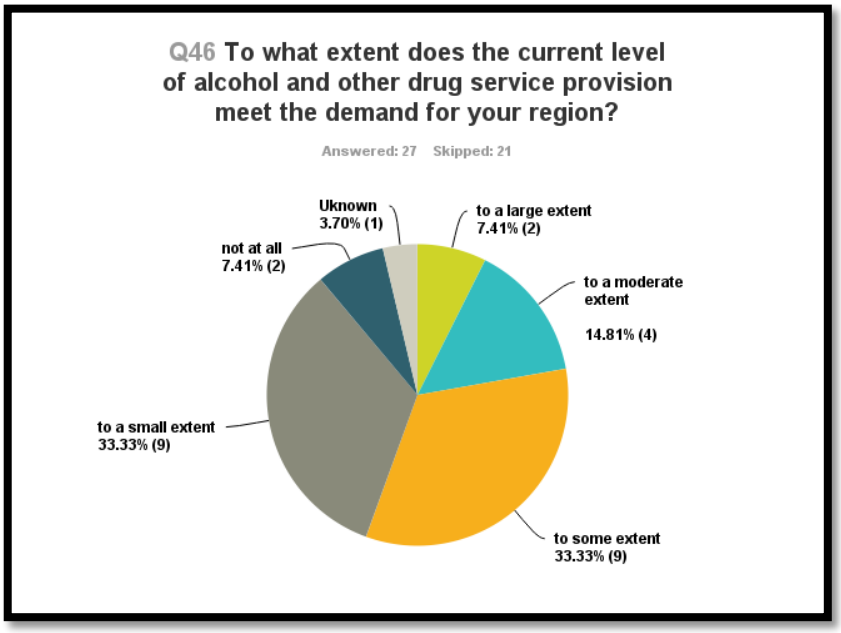


Table 61: Alcohol and other drug service demand – additional comments

Other (n = 4)
Desperate need for full range of AOD services, especially those which are culturally appropriate.
The service is there but the users are not willing to use it.
High need for ATODS professionals to be based in the communities rather than outreach.
One staff member allocated for the entire region is not acceptable given the extent of AODS issues within the region.

"We could do with a local rehab facility. Even if they go to the closest one in Toowoomba it is still seven hours drive at least and that is seven hours where there is self-doubt, questioning motive and maybe withdrawing."

Focus Group Participant Comment, South West HHS Region

Alcohol and Other Drug Service Demand for Population Groups

Respondents were asked to rate the extent current alcohol and other drug service provision meets demand in their region for particular population groups. Based on a weighted average (excluding unknown), alcohol and other drug service provision meets demand for older persons to the greatest extent. This was closely followed by women, men and people with a disability.

Conversely, alcohol and other drug service provision met demand for people from a culturally and linguistically diverse background as well as lesbian, gay, bisexual, transgender and intersex people to the least extent.

Further to this, six respondents indicated alcohol and other drug service demand for people from a culturally and linguistically diverse background as well as lesbian, gay, bisexual, transgender and intersex people was unknown. This might suggest service demand for these populations groups are unclear to some service providers in the region.

Table 62: Alcohol and other drug service demand for population groups

Population Group	to a large extent	to a mod extent	to some extent	to a small extent	not at all	Unkn-own	Weighted Average (excludes unknown)
Older persons*	11.1% 3	14.8% 4	18.5% 5	40.7% 11	3.7% 1	11.1% 3	**2.88**
Women*	11.1% 3	14.8% 4	18.5% 5	44.4% 12	3.7% 1	7.4% 2	**2.84**
Men*	11.1% 3	14.8% 4	18.5% 5	37.0% 10	7.4% 2	11.1% 3	**2.83**
People with a disability*	11.1% 3	14.8% 4	18.5% 5	37.0% 10	7.4% 2	11.1% 3	**2.83**
Aboriginal and Torres Strait Islander Peoples*	7.4% 2	14.8% 4	22.2% 6	37.0% 10	7.4% 2	11.1% 3	**2.75**
Children and young people*	3.7% 1	22.2% 6	22.2% 6	22.2% 6	14.8% 4	14.8% 4	**2.74**
People from a culturally and linguistically diverse background *	7.7% 2	7.7% 2	15.4% 4	34.6% 9	11.5% 3	23.1% 6	**2.55**
Lesbian, Gay, Bisexual, Transgender and Intersex people*	7.4% 2	11.1% 3	14.8% 4	25.9% 7	18.5% 4	22.2% 6	**2.52**

*Comment: Across the board AOD services are very scarce, poorly resources, not integrated with other kinds of services, and not culturally appropriate. Having to leave home to access specialist AOD services multiplies psychological and social problems associated with misuse.

Suicide Prevention or Postvention Service Demand

Respondents were asked to rate the extent the current level of suicide prevention or postvention service provision meets demand in their region.

Of those who responded (27), over three-quarters (21; 77.8%) indicated the current level of suicide prevention or postvention service provision meets demand for the region from not at all to only some extent.

Only a small proportion (3; 11.1%) feel the current level of suicide prevention or postvention service provision meets demand for the region to a moderate extent.

Overall these results suggest that the current level of suicide prevention or postvention service provision may not adequately meet demand for the region.

Three respondents provided additional comments (see table 63).

Graph 89: Extent current level of suicide prevention or postvention service provision meets demand for the region

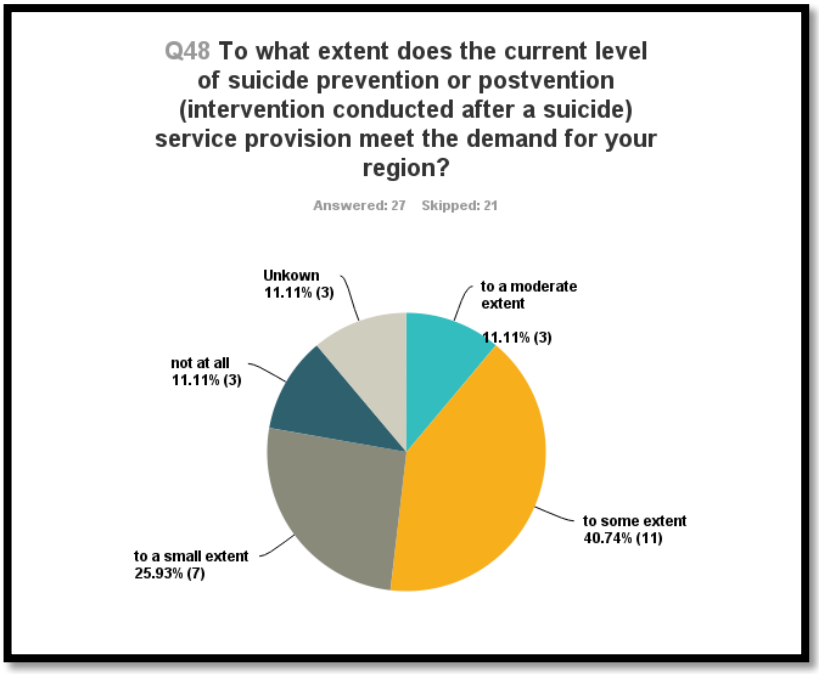


Table 63: Suicide prevention or postvention service demand – additional comments

Comments (n = 3)
Feedback is that some very good community level work has taken place to develop protocols in response to suicide, however these protocols may not be well known and understood and are not consistently used. May depend on which Police Officer is on duty, or how new a staff member may be in the service where the person has presented.
Community dynamics and lack of on the ground services impacts on any follow ups that are required.
No effective follow up - what is followed up depends on clients relationship with service providers

Networks and Interagency Groups Engaged

Respondents were asked to list the networks or interagency groups they were involved with.

Of those who responded (24), 100% indicated they were involved with one or more adult mental health services and/or networks.

This was followed by two-thirds (16; 66.7%) who suggested they engaged with aged care, disability and/or community services.

Just over half (13; 54.2%) were involved with at least one generic interagency group within the region.

Table 64: Networks and interagency groups engaged

Networks/Interagency Groups Total Responses: 24	Count	%
Adult Mental Health Services and/or Networks (Mental Illness Fellowship, Queensland Health - Mental Health Clinical, Queensland Health - Mental Health Counselling, PHaMS - Mental Health Mentors and Support, Primary Health - Social & Emotional Wellbeing, Mental Health Services - EEO delivery, Partners in Recovery, South West HHS Mental Health, Lifeline, ASQ Mental Health, Private Psychologists, Aftercare, Mental Health Primary Networks, Centacare Mental Health, Anglicare Mental Health, Mental Health Interagency Network, Rural Financial Counsellors)	24	100%
Aged Care, Disability and Community Services (Centacare, Blue Care, Anglicare, Community Health, Housing, ASQ Community Care and Disability Services, Endeavour Foundation, Multicap, South West HHS Community Care, Aged Care Network, Carers Queensland)	16	66.7%
Interagency Groups (Interagency Networks across Darling Downs, Clinical Collaborative, Regional Interagency Network, Community Interagency Network, Disability Services Interagency Network, Roma Interagency Network, South West Partnership Council)	13	54.2%
Public Health Services (Queensland Health, Chronic Disease Clinic, South West Hospital and Health Service, Maranoa Health, Health Centre)	8	33.3%
Police and Emergency Services (Police, Support Link, Ambulance)	5	20.8%
Allied Health Services (Physiotherapist, Speech Pathologist, Exercise Physiologist, Occupational Therapist)	5	20.8%
Local Councils (Maranoa Regional Council - Community Care, Family Support and Drought Funding, Paroo Shire Council)	5	20.8%
Sporting and Education (State Schools, Catholic Schools, Education Queensland, Sporting Groups)	5	20.8%
Legal and Criminal Justice Services (Queensland Youth Justice, Probation and Parole, Community Justice Group, Aboriginal Family Legal Services)	4	16.7%
Child and Youth Services (Child Safety, **headspace**, Youth Services)	3	12.5%
Employment Services (Max Employment)	2	8.3%
Medicare Local (Darling Downs and South West Queensland Medicare Local Forums)	2	8.3%
Royal Flying Doctor Service	1	4.2%
ATODS and Rehabilitation Services	1	4.2%
Aboriginal and/or Torres Strait Islander Services (Aboriginal Medical Services)	1	4.2%
Total Responses = 24		

Extent Collaboration Support Mental Health Service Provision

Of those who responded (28), just under two-thirds (17; 60.7%) indicated the current level of interagency collaboration supports clients with mental health needs from only a small to some extent.

Only 39.3% (11) suggested the current level of interagency collaboration supports clients with mental health needs from a moderate to a large extent.

Three additional comments were provided (see table 65).

Graph 90: Extent interagency collaboration supports clients with mental health needs

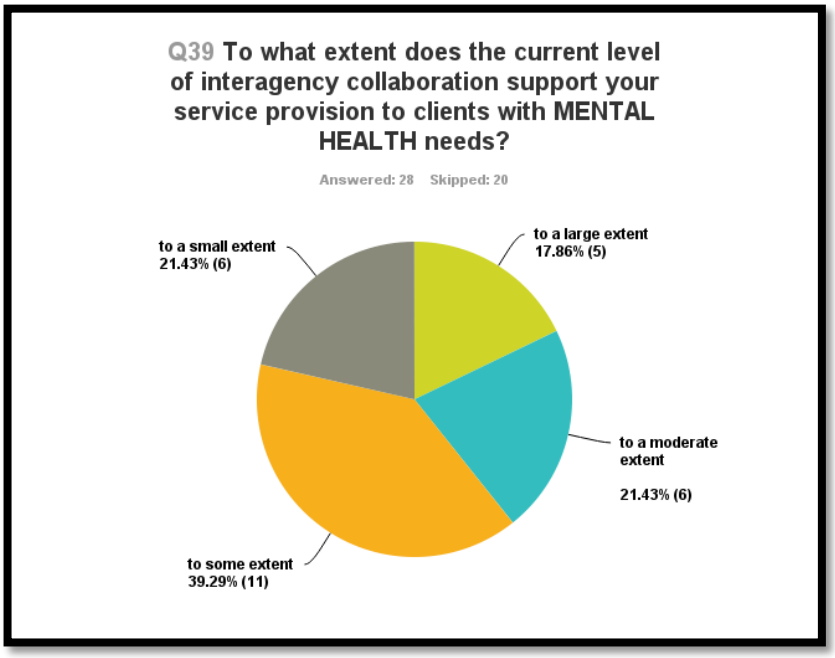


Table 65: Extent interagency collaboration supports mental health – additional comments

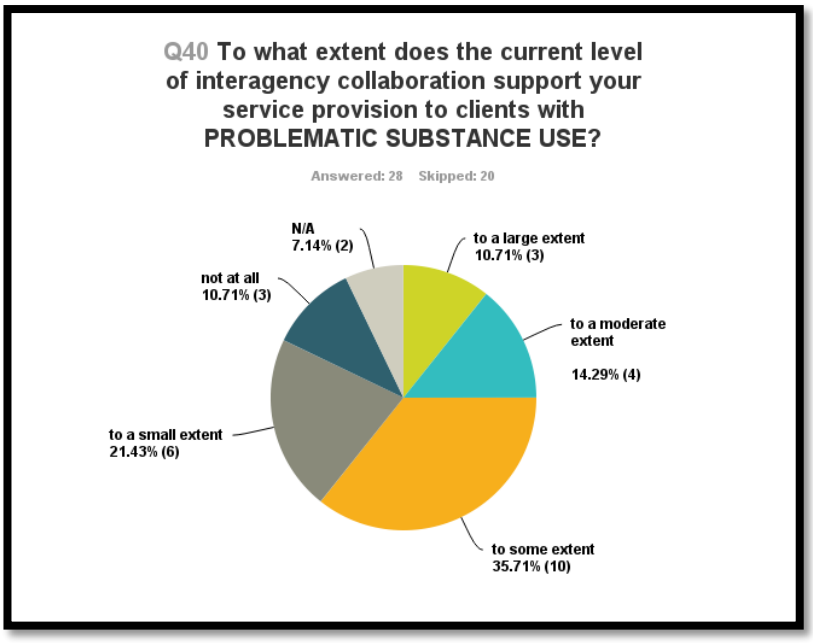
Comments (n = 3)
Interagency collaboration is a focus for improved service delivery in the South West, so there is momentum for strengthening partnerships that offer good options for people around mental health (both clinical and non-clinical needs).
All services that need to be involved with a mental health client would be called upon to assist.
Depends on client needs

Extent Collaboration Support Problematic Substance Use

Of those who responded (28), over two-thirds (19; 67.8%) indicated the current level of interagency collaboration supports clients with mental health needs from not at all to only some extent.

Only one-quarter (7; 25%) suggested the current level of interagency collaboration supports clients with mental health needs from a moderate to a large extent.

Graph 91: Extent interagency collaboration supports clients with problematic substance use



Two additional comments were provided (see table 66).

Extent Collaboration Supports Service Provision – Weighted Average

Based on the weighted average, overall ratings from respondents indicate that interagency collaboration best supports service provision for people with mental health needs.

Enhancing Interagency Collaboration in the Region

Twenty respondents provided suggestions for how to enhance interagency support in the region. Just over one-third suggested regular networking opportunities and meetings to enhance interagency support in the region. For example regular facilitated discussions, meet and greet opportunities and interagency meetings.

Three respondents also suggested strategies to increase awareness of services such as a collaborative document, Facebook page, community email or website providing a description of local services.

Table 66: Extent interagency collaboration supports problematic substance use – additional comments

Comments (n = 2)
Major issues around substance abuse (especially Ice) are overwhelming the very few services available in AOD. The absence of detox and rehab services is a major barrier to referrals and effective service provision in problematic substance abuse issues.
All services that need to be involved with a mental health client would be called upon to assist.

Table 67: Extent interagency collaboration supports problematic substance use – additional comments

	to a large extent	to a mod extent	to some extent	to a small extent	not at all	Weighted Average (not including N/A)
Extent Collaboration Supports People with Mental Health Needs	17.9% 5	21.4% 6	39.3% 11	21.4% 6	0.0% 0	3.36
Extent Collaboration Supports People with Problematic Substance Use	10.7% 3	14.3% 4	35.7% 10	21.4% 6	10.7% 3	2.92

Enhancing Interagency Collaboration

Table 68: Suggestions for how to enhance interagency support

Suggestions for how to enhance interagency collaboration in the region	Count
Regular Networking Opportunities and Meetings (facilitated discussions and monthly meetings to discuss local issues; a meet and greet focused on mental health and alcohol and drug concerns; interagency meetings work extremely well; mental health interagency collaboration; inaugural mental health services recovery pathway day held in March; More informed agency interaction and a desire on behalf of the agencies to connect and interact; Increased connections between child and maternal groups and youth and adult services).	6
Strategies to Increase Awareness of Services (A collaborative document, community email, Facebook page or website with a description of local services; Direct communication of services in each community; New service providers should be given a list of services).	3
More Local Services	2
Clear Referral Pathways (Legislated referral pathways; Sharing of referral pathways).	2
Commitment to common goals (commitment to outcomes; having a common goal).	2
Less Red Tape.	1
Workers on the ground to be valued for their services at a community level.	1
A uniform approach to providing and organising training so that resources can be pooled to minimise costs and travel requirements.	1
Case management from all agencies needs to take place to ensure client's care is coordinated and effective for improved health outcomes.	1
Promote stronger partnerships.	1
Total = 20	

Strategies Implemented by Services for Clients

Of those who responded (40), just under three-quarters (28; 70%) either work with other services for aspects of mental health care / support and /or refer clients to another service for mental health and/or alcohol and other drug issues.

Just over half (22; 55%) work with other services for aspects of problematic substance use.

Only a small percentage indicated they provide all the needed mental health services (10; 25%) and/or all the needed problematic substance use services (8; 20%).

Graph 92: Strategies implemented by services

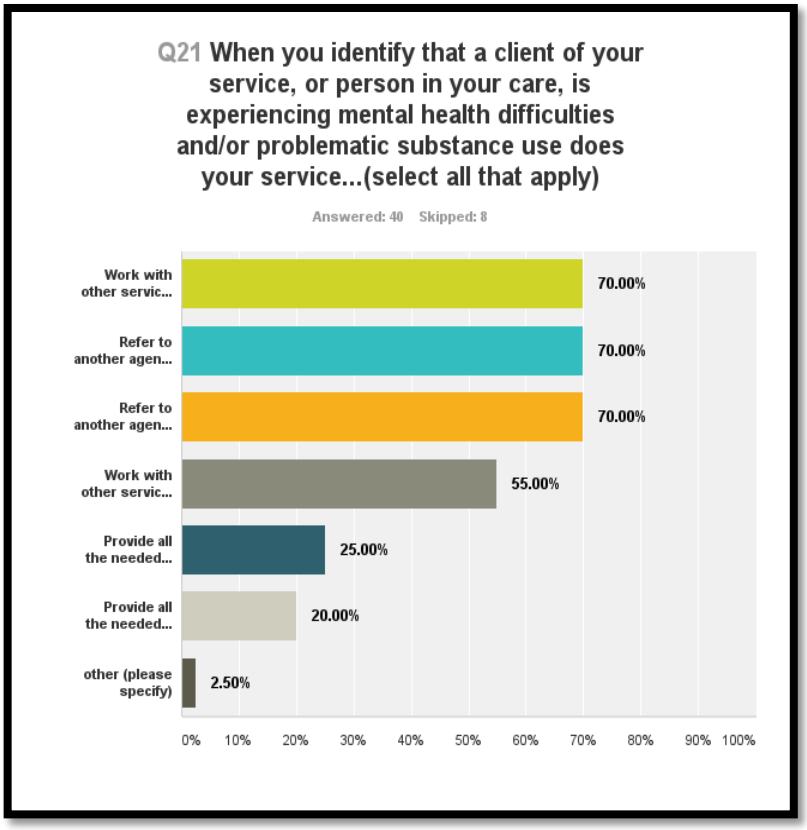


Table 69: Strategies implemented by services

Strategies	Responses
Work with other services for aspects of mental health care/support needs (e.g. clinical, social)	70% 28
Refer to another agency for mental health services	70% 28
Refer to another agency for alcohol and other drug services	70% 28
Work with other services for aspects of problematic substance use needs (e.g. clinical, social)	55% 22
Provide all the needed mental health services	25% 10
Provide all the needed problematic substance use services	20% 8
Other • As a psychologist I see clients individually for up to 10 sessions but I work with other providers	2.5% 1

Ease of Integration with Other Services

Of those who responded (40), just over half (21; 52.50%) indicated the ease of coordinating care / support with other agencies is as expected.

In addition, over one-third (14; 35%) suggested the ease of coordinating care / support with other agencies is harder to much harder than expected.

Only small percentage (4; 10%) felt the ease of coordinating care / support with other agencies is easier to much easier than expected.

Seven additional comments were provided (see table 70).

Mechanisms Used to Coordinate Care/ Support

Of those who responded (40), consultation and liaison (32; 80%) was the most common mechanism used to coordinate care / support for clients.

Just over two-thirds (27; 67.5%) used specific meetings for an individual client while under half used case management (18; 45%) and/or joint planning (16; 40%).

Graph 93: Ease of integration with other services

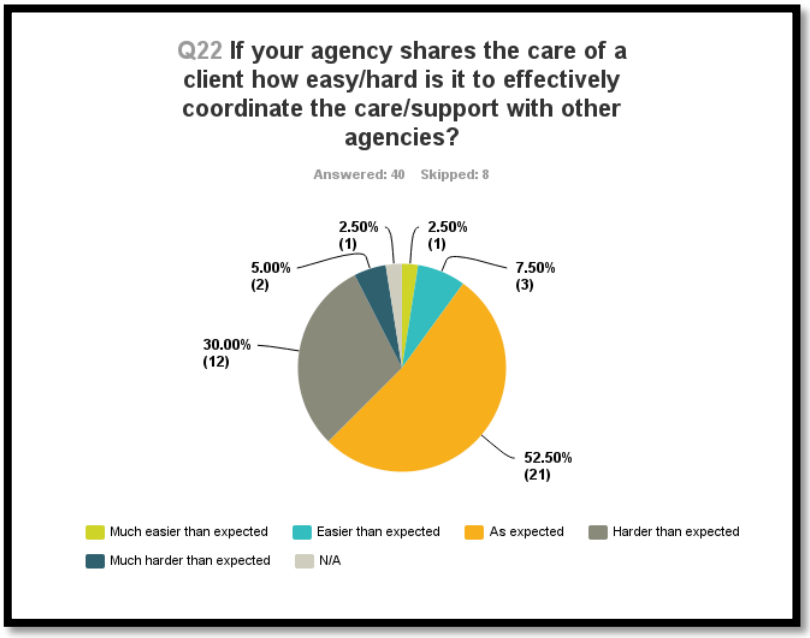
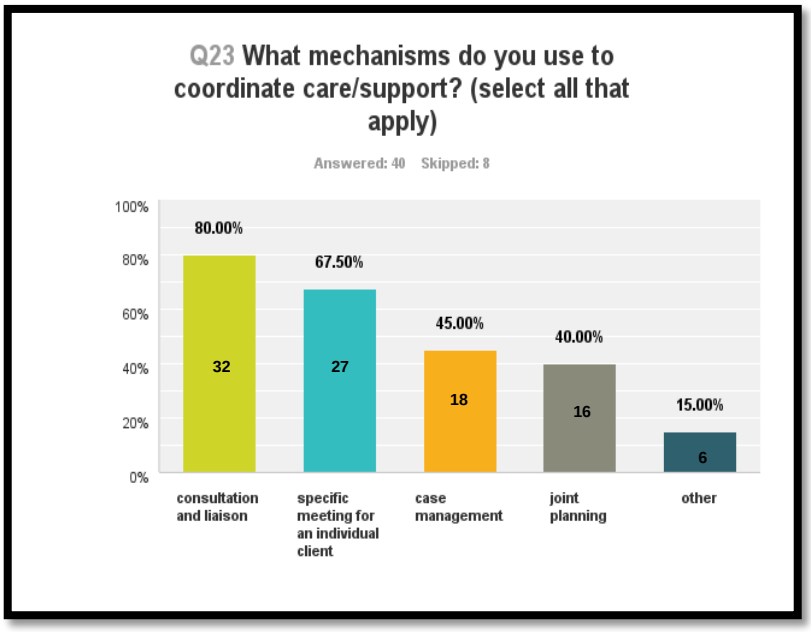


Table 70: Ease of integration with other services – additional comments

Comments (n = 7)
High demand
This varies considerably across the South West HHS communities. It is certainly improving, but collaborative practice is not the established norm.
Liaison is extraneous to a clinical role yet would be invaluable.
Collaboration between agencies/service providers is very good.
Insufficient mental health training of locum medical staff.
Knowing the practitioner is helpful and assists the recovery process.
'Silo' behaviour can come into play.

Graph 94: Mechanisms used to coordinate care / support



Seven respondents suggested they use "other" mechanisms to coordinate care / support. Of these, five provided comments (see table 71).

Supports for Integration

Based on a weighted average, strong individual relationships between workers was identified as the most effective support in assisting coordinated care/support. This was closely followed by clear internal policies and practices and a dedicated case coordinate or care coordination model.

Conversely, formal mechanisms between agencies was considered the least effective support in assisting coordinate care / support for clients.

Five respondents provided additional comments (see table 73). The importance of effective relationships between service providers was identified as a strong theme from the comments provided.

Table 71: Mechanisms used to coordinate care / support – other comments

Other (n = 7)
High demand
This varies considerably across the South West HHS communities. It is certainly improving, but collaborative practice is not the established norm.
Liaison is extraneous to a clinical role yet would be invaluable.
Collaboration between agencies/service providers is very good.
Insufficient mental health training of locum medical staff.
Knowing the practitioner is helpful and assists the recovery process.
'Silo' behaviour can come into play.

Table 72: Effectiveness of supports in assisting coordinated care / supports

Not at all effective	Slightly effective	Moderately effective	Very effective	Extremely effective	Weighted Average
strong individual relationships between workers					
2.63% 1	7.89% 3	26.32% 10	39.47% 15	23.68% 9	3.74
clear internal policies and practices					
5.41% 2	16.22% 6	32.43% 12	35.14% 13	10.81% 4	3.30
dedicated case coordinator or care coordination model					
5.88% 2	14.71% 5	32.35% 11	38.24% 13	8.82% 3	3.29
standardised referral forms between agencies					
5.56% 2	11.11% 4	47.22% 17	25.00% 9	11.11% 4	3.25
local structured formal network or governance structure					
14.29% 5	14.29% 5	48.57% 17	17.14% 6	5.71% 2	2.86
formal mechanism between agencies established					
12.90% 4	19.35% 6	45.16% 14	19.35% 6	3.23% 1	2.81
Other					
25.00% 3	8.33% 1	41.67% 5	16.67% 2	8.33% 1	2.75

Table 73: Effectiveness of supports in assisting coordinated care / supports – other comments

Other (n = 5)
Informal relationships between organisations seems to be significantly more effective in rural and remote communities than more formalised 'top down' arrangements. Workers always emphasise the importance of relationships and this is both at the organisational and individual level.
All service providers in our community have the clients best interest at heart because of our community being small we all work together to achieve the same goal.
This is a sole clinical role with no governance or benchmarking of any kind.
Local agencies and service providers knowing of each other and understanding what services are provided in the region. Good linkages between individual case workers. Knowledge of what is available.
Individual support for clients is at times based on the relationship to service providers

Barriers to Integration

Based on a weighted average, lack of access to services due to distance or cost to clients has the greatest impact on an agency's ability to coordinate care successfully. This was closely followed by lack of access to specialist services and lack of services to refer to.

Client reluctance or ability to take up referral, varying levels of cultural capability between services and inadequate staff training were also considered significant barriers an agency's ability to coordinate care successfully.

Conversely, lack of clarity about when referrals must be made and the reasons for doing so (no clear internal policies and practices) as well as waiting times for appointments were considered as the barriers of least impact on an agency's ability to coordinate care.

Four respondents suggested "other" barriers to integration. Of these, three provided additional comments (see table 75).

Table 74: Impact of barriers on agency's ability to coordinate care

No impact at all	Very little impact	Some impact	Moderate to high level of impact	Significant impact	Weighted Average
lack of access to services due to distance or cost to clients					
0.00% 0	6.06% 2	15.15% 5	33.33% 11	45.45% 15	4.18
lack of access to specialist services					
0.00% 0	11.43% 4	22.86% 8	22.86% 8	42.86% 15	3.97
lack of services to refer to					
0.00% 0	3.03% 1	33.33% 11	30.30% 10	33.33% 11	3.94
client reluctance or ability to take up referral					
2.86% 1	0.00% 0	40.00% 14	40.00% 14	17.14% 6	3.69
varying levels of cultural capability between services (affecting the ability to deliver consistent culturally appropriate services between agencies)					
3.03% 1	9.09% 3	36.36% 12	30.30% 10	21.21% 7	3.58
inadequate staff training					
0.00% 0	17.65% 6	32.35% 11	29.41% 10	20.59% 7	3.53
lack information and understanding about other agencies and their services (currency of service information, staff training/capability)					
0.00% 0	15.15% 5	42.42% 14	33.33% 11	9.09% 3	3.36
information sharing issues (data protection/ privacy/confidentiality/client consent)					
2.94% 1	23.53% 8	35.29% 12	20.59% 7	17.65% 6	3.26
eligibility criteria of other agencies					
3.23% 1	16.13% 5	45.16% 14	22.58% 7	12.90% 4	3.26
lack of clarity about when referrals must be made and the reasons for doing so (no clear internal policies and practice)					
0.00% 0	24.24% 8	39.39% 13	27.27% 9	9.09% 3	3.21
waiting times for appointments					
0.00% 0	29.03% 9	38.71% 12	25.81% 8	6.45% 2	3.20
Other					
40.00% 4	0.00% 0	10.00% 1	30.00% 3	20.00% 2	2.90

Table 75: Impact of barriers on agency's ability to coordinate care – other comments

Other (n = 3)
The constant changes in programs and short term funding cycles, especially drought related funding for positions or projects is a barrier to effective integration. Programs and staff become a moving feast, and may complicate referral pathways. However even short term funding is received with appreciation in locations where mental health resources are very scarce.
Sometimes it is hard to engage mental health staff when things happen in our community after hours.
Mostly lack of appropriate services in the region

Strategies to Address Barriers to Service Integration

Based on a weighted average, built relationships and interagency forums or regular meetings with key agencies were identified as the most effective strategies to manage barriers to successful coordinated care for clients.

This was closely followed by promoting own agency's role and function, providing practical assistance to clients and developing internal policies and referral pathways.

Conversely, providing financial support to the client and seeking and providing feedback (monitoring quality) were considered the least effective strategies to manage barriers to successful coordinated care.

Three respondents suggested "other" strategies to manage barriers to integration. Of these, two provided additional comments (see table 77).

Table 76: Effectiveness of strategies to manage barriers to successful coordinated care

Not at all effective	Slightly effective	Moderately effective	Very effective	Extremely effective	Weighted Average
built relationships					
0.00% 0	5.88% 2	23.53% 8	52.94% 18	17.65% 6	3.82
participated in interagency forums or held regular meeting with key agencies					
3.23% 1	22.58% 7	12.90% 4	38.71% 12	22.58% 7	3.55
promoted your own agency's role and function (e.g. newsletters, website)					
9.68% 3	16.13% 5	22.58% 7	32.26% 10	19.35% 6	3.35
provided practical assistance to clients (e.g. provided or subsidised transport)					
8.00% 2	16.00% 4	24.00% 6	40.00% 10	12.00% 3	3.32
developed internal policies and referral procedures					
9.68% 3	12.90% 4	25.81% 8	38.71% 12	12.90% 4	3.32
shared resources					
8.00% 2	32.00% 8	12.00% 3	28.00% 7	20.00% 5	3.20
delivered training and/or resources					
10.00% 3	23.33% 7	26.67% 8	26.67% 8	13.33% 4	3.10
provided financial support to client					
17.65% 3	17.65% 3	23.53% 4	35.29% 6	5.88% 1	2.94
sought and provided feedback (monitoring quality)					
14.29% 4	17.86% 5	35.71% 10	25.00% 7	7.14% 2	2.93
Other*					
42.86% 3	0.00% 0	28.57% 2	28.57% 2	0.00% 0	2.43

Table 77: Effectiveness of strategies to manage barriers to successful coordinated care – other comments

Other (n = 2)
Demonstrating good practice by doing it. That is the 'seeing is believing' approach. Rural and remote area staff are much more interested in action than in talk-fests about action.
This would be a good thing if all services assisted with the above.

"To me service integration relies on someone actually being recognised or someone taking a lead. I think lead agencies are a really important point and that is probably something that has been a bit lacking especially since we lost our public health building and all the staff in that and therefore we have lost all of the liaison type work that was occurring."

Focus Group Participant Comment, South West HHS Region

Referrals to Services

Mental health services were the most commonly referred service with just over two-thirds (68.6%; 24) indicating that they refer clients to these services. This was closely followed by 65.7% (23) who referred clients to domestic and family violence services.

A significant proportion (60% or more) also referred clients to primary health care, allied health, housing support, alcohol and other drugs and community health services.

Education (e.g. school, VET) was the least referred service.

Two agencies indicated that they refer to 'other' services (see table 78).

Graph 95: Referrals to services

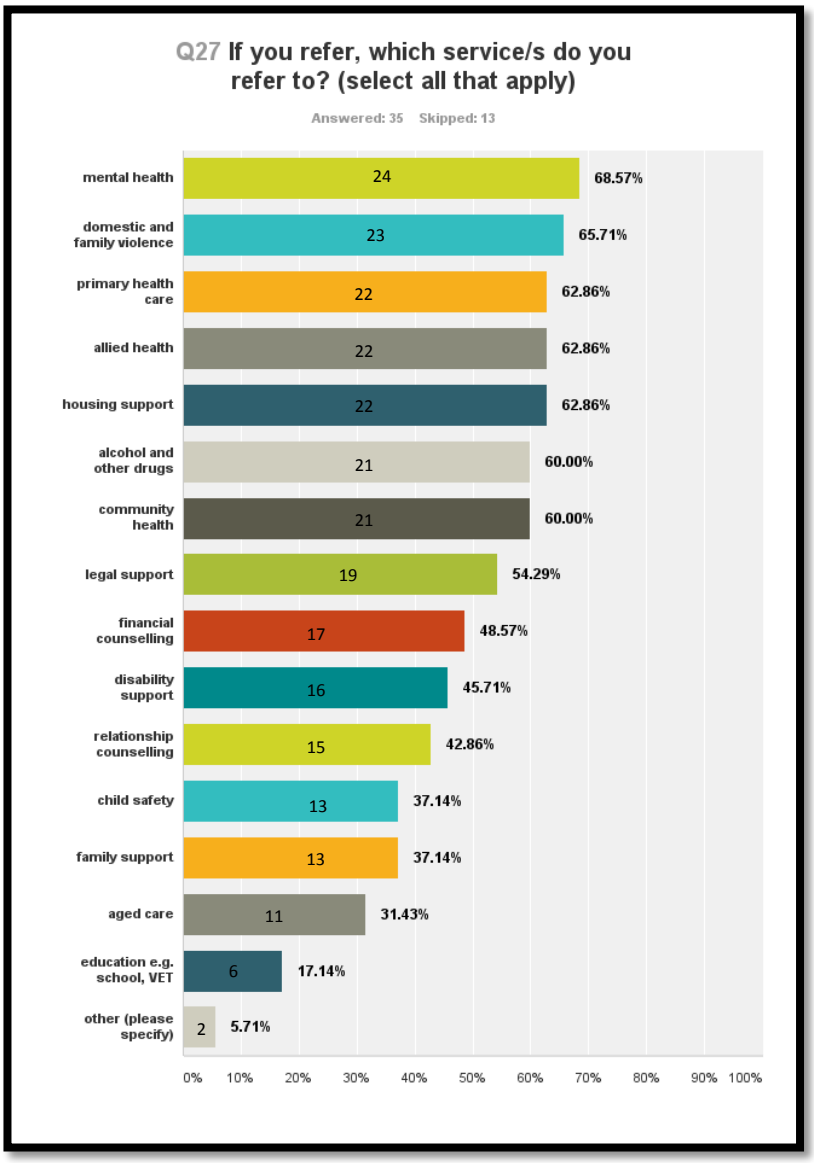


Table 78: Referrals to other services

Other (n = 2)
Informal supports - community clubs and groups (community choirs, drumming groups, service clubs etc.) have been as important as referrals to formal service providers in Partners in Recovery.
Additional Mental Health services where available

"The question that comes out of that for me is – do all services know what the other services do? - so that they know who they can refer to or how they can work together where clients are concerned."

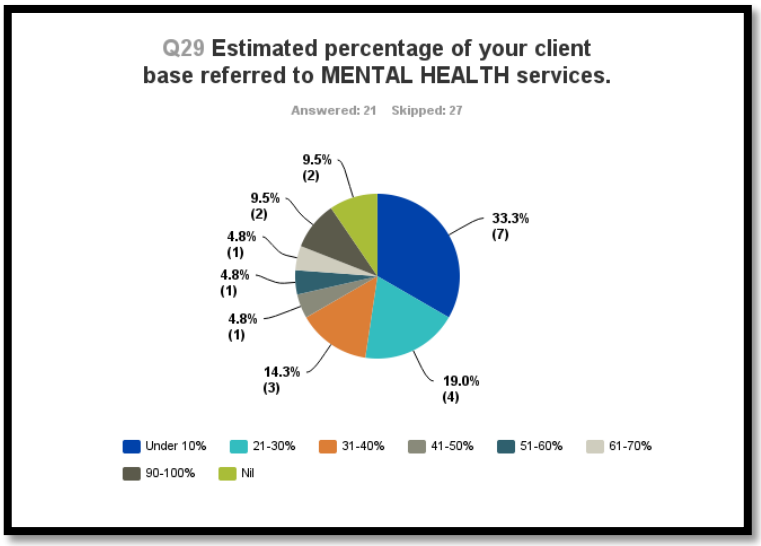
Focus Group Participant Comment, South West Region

Percentage of Referrals to Mental Health Services

Of those who responded (21), over one-third (8; 38.1%) indicated that they refer 21 to 50 percent of their clientele to mental health services.

A further 19% (4) suggested they refer 51 to 100 percent of clients to mental health services.

Graph 96: Percentage referrals to mental health services

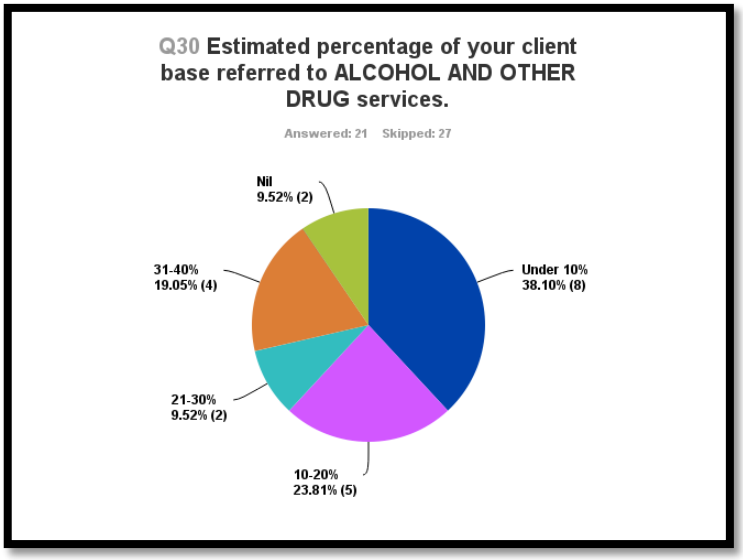


Percentage of Referrals to Alcohol and Other Drug Services

Of those who responded (21), just over half (11; 52.4%) suggested they refer 10 to 40 percent of clients to alcohol and other drug services.

In addition, just under half (10; 47.6%) indicated that they refer nil to under 10 percent of their clientele to alcohol and other drug services.

Graph 97: Percentage referrals to alcohol and other drug services

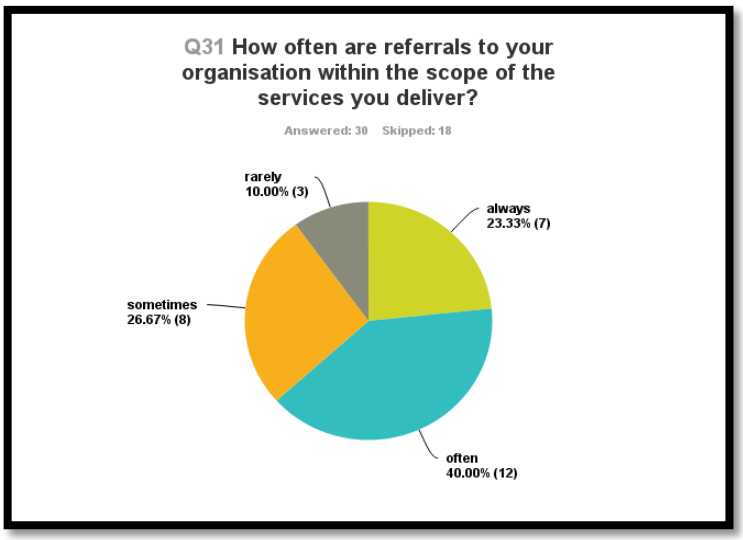


Scope of Referrals

Of those who responded (30), just under two-thirds (19; 63.3%) indicated that referrals received were always or often within the scope of the services delivered.

Only three agencies suggested referrals received were rarely within the scope of services they deliver.

Graph 98: Scope of referrals



Five additional comments were received (see table 79).

Mode of Referral Delivery

Of those who responded (30), warm referrals (see table 80 for definition) were made most frequently with just under three-quarters (22; 73.3%) indicating that they often or always refer clients through a warm referral process.

This was followed by over one-third (11; 37.9%) suggesting they often or always provide clients with referral information.

Supported referrals (see table 80 for definition) were not made as frequently.

Three additional comments were received (see table 81).

Table 79: Scope of referrals – comments

Comments (n = 5)
Referrals to Partners in Recovery are generally well targeted, and usually meet the criteria. If not, then other Lifeline services can often be accessed.
Community & Service Providers are familiar with what our organisation has to offer.
New program in the region. As agencies and service providers understand what the scope of service delivery is, referrals are appropriate.
Referrals are always made to us within our allied health scope, however when we come across mental health / drug / alcohol concerns these may not always be within our scope, so we refer if we can / need to or treat accordingly if applicable.
Referrals based on individual client requirements.

Graph 99: Frequency of mode of referral delivery

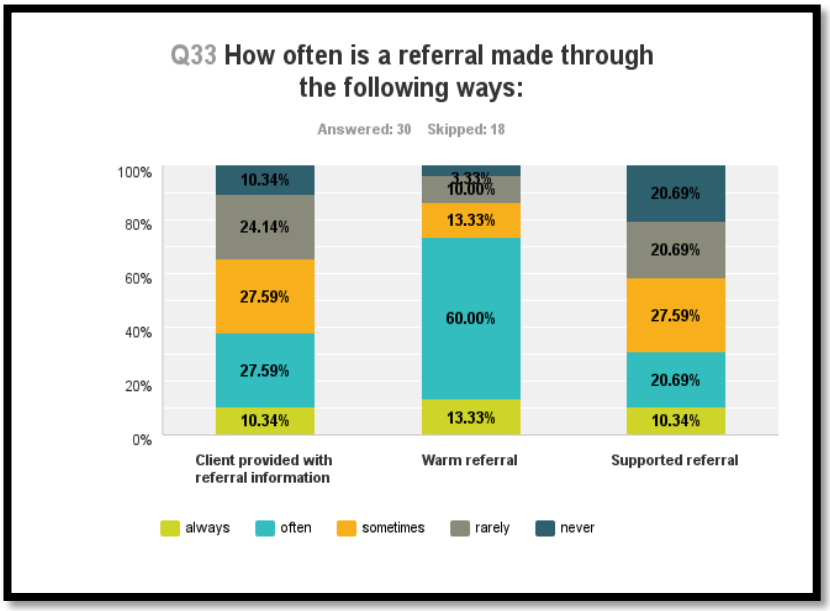


Table 80: Frequency of mode of referral delivery

Type of referral	always	often	sometimes	rarely	never	Total
Client provided with referral information	10.3% 3	27.6% 8	27.6% 8	24.1% 7	10.3% 3	29
Warm referral*	13.3% 4	60.0% 18	13.3% 4	10.0% 3	3.3% 1	30
Supported referral**	10.3% 3	20.7% 6	27.6% 8	20.7% 6	20.7% 6	29

***Warm Referral:** the individual making the referral makes first contact on behalf of the client, and explains to the referral organisation the client's circumstances and the reason they believe the client would benefit from the referral.
****Supported Referral:** accompanying the client to the initial interview, assisting the client to attend the appointment by assisting with support needs such as arranging travel, providing an interpreter.

Table 81: Frequency of mode of referral delivery - comments

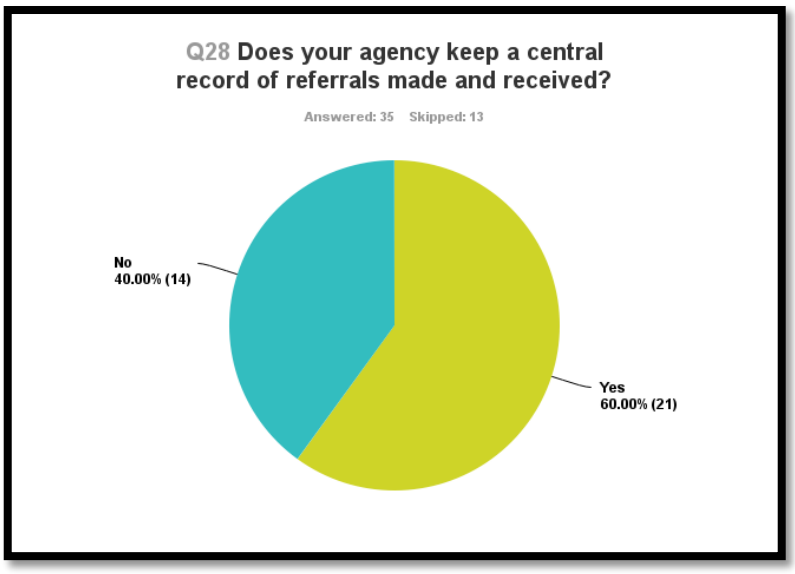
Comments (n = 3)
This will be different according to the individual's confidence and need for support. A warm referral is most typical in Partners in Recovery, especially at the beginning stage of engagement.
Often working on a different 'symptom'.
Depends on client's individual needs.

Recording Referrals

Of those who responded (35), although 60% (21) indicated that their agency keeps a central record of referrals made and received, a significant percentage (14; 40%) suggested their agency does not. Two respondents provided additional comments:

- This is done by the individual services.
- Documented in individual client files.

Graph 100: Central record of referrals



Monitoring Effectiveness of Referrals

Of those who responded (30), over one-third (11; 36.7%) indicated that they often or always monitor the effectiveness of referrals made to other agencies.

This was followed by one-third who rarely or never monitor the effectiveness of referrals made.

The remaining 30% (9) suggested they only sometimes monitor the effectiveness of referrals.

Four respondents provided additional comments (see table 82).

Graph 101: Monitoring effectiveness of referrals made

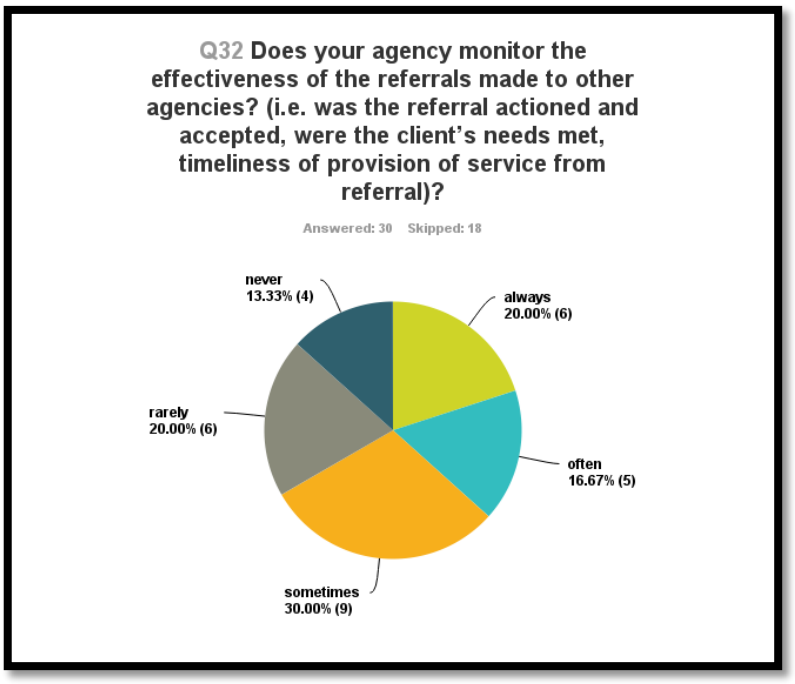


Table 82: Monitoring effectiveness of referrals – comments

Comments (n = 4)
Although regarded as standard practice, it is not always followed through. The client will generally be the informant about the outcome of referrals to other agencies.
Thorough follow up/case conferencing to ensure appropriateness of the referral.
Through client feedback as opposed to a formal procedure.
Where client consent is in place, some agencies do not allow this to take place effectively.

Ongoing Partnership with Referred / Referring Agency

Of those who responded (30), just under half (14; 46.7%) indicated that they often or always continue to work in partnership with the referred / referring agency.

Half (14; 46.7%) also suggested they sometimes continue to work in partnership with the referred / referring agency.

Only two respondents said they rarely or never continue to work in partnership with the referred / referring agency.

Six respondents provided additional comments (see table 83).

Graph 102: Partnership with referred / referring agency

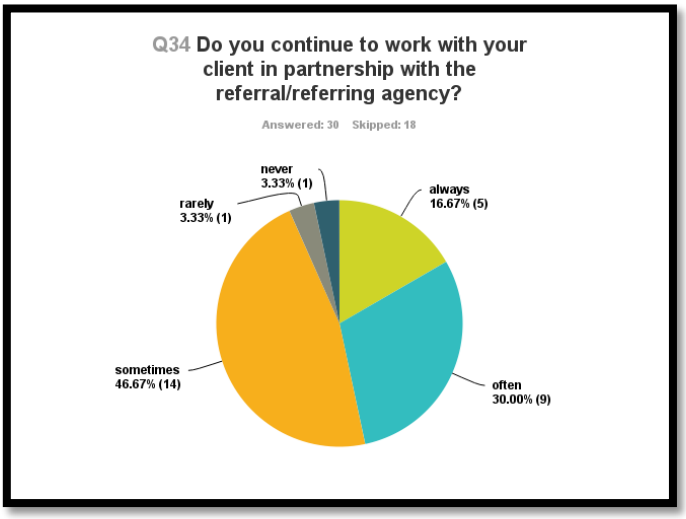


Table 83: partnership with referred/referring agency - comments

Comments (n = 6)
The exception would be if the person is not eligible for Partners in Recovery, and another referral pathway has been suggested as an alternative.
Always meet with the services we refer to for client follow-up.
Usually leave that work to them and carry on with our specific role.
Mostly working in partnership with the referring agency, then with additional services as needed.
Where we can and when it is appropriate we do, given we are an allied health team confidentiality is utmost and is respected between clinician, client and referral to other professions.
Where client requires follow-up and referral pathways allow.

RFDS Health Clinic, Charleville, Queensland

Supports for Referrals

Based on a weighted average, a strong individual relationships between workers was identified as the most effective support in assisting referral processes.

This was followed by standardised referrals forms, dedicated case coordinator or care coordination model and clear internal policies and practice.

Local structured formal network or governance structure was identified as the lease effective support strategy.

Further to this, the top four most effective supports identified to assist referral processes are the same as the top four most effective supports to assist coordinated care for clients. In addition, the support strategy identified as the least effective in assisting both referral processes and coordinated care for clients (see Table 72).

Two respondents provided additional comments (see table 85).

Table 84: Effectiveness of supports in assisting referral processes

Not at all effective	Slightly effective	Moderately effective	Very effective	Extremely effective	Weighted Average
strong individual relationships between workers					
3.57% 1	10.71% 3	10.71% 3	50.00% 14	25.00% 7	**3.82**
standardised referral forms between agencies making / receiving the referral					
7.14% 2	17.86% 5	28.57% 8	32.14% 9	14.29% 4	**3.29**
dedicated case coordinator or care coordination model					
16.00% 4	12.00% 3	**24.00% 6**	28.00% 7	20.00% 5	**3.24**
clear internal policies and practice e.g. referral flowchart available, training provided					
14.29% 4	14.29% 4	17.86% 5	42.86% 12	10.71% 3	**3.21**
formal mechanism between agencies established (e.g. service level agreement or memorandum of understanding)					
16.67% 4	16.67% 4	37.50% 9	29.17% 7	0.00% 0	**2.79**
local structured formal network or governance structure (may include a focus on how clients can be referred between agencies)					
14.29% 4	25.00% 7	46.43% 13	14.29% 4	0.00% 0	**2.61**
Other					
20.00% 1	0.00% 0	20.00% 1	60.00% 3	0.00% 0	**3.20**

Table 85: Effectiveness of supports in assisting referral processes – comments

Comments (n = 2)
Informal mechanisms between agencies established are very effective, and may or may not be formalised into MOU's depending on the circumstances.
Local networks are very strong and will continue to be strong as we know all the people in our community.

"An effective referral pathway needs to be established outlining each agencies/services role to ensure effective outcome based client journey from the commencement of service delivery."

Survey Participant Comment, South West Region

Barriers to Referrals

Based on a weighted average, lack of access to services due to distance or cost, lack of access to specialist services and lack of services to refer to were all identified as the most significant barriers impacting on an agency's ability to refer successfully. This was closely followed by client reluctance or ability to take up referral, lack of information and understanding about other agencies and waiting times for appointments.

Lack of clarity about when referrals must be made and the reasons for doing so was identified as the barrier of least impact on an agency's ability to refer successfully.

Further to this, the top four barriers identified as having the greatest impact on successful referrals are the same as the top four barriers impacting on an agency's ability to coordinate care / support successfully (see Table 74).

Two respondents provided additional comments (see table 87).

Table 86: Impact of barriers on agency's ability to successful referrals

No impact at all	Very little impact	Some impact	Moderate to high level of impact	Significant impact	Weighted Average
lack of access to services due to distance or cost to clients					
3.70% 1	0.00% 0	29.63% 8	14.81% 4	51.85% 14	**4.11**
lack of access to specialist services					
0.00% 0	7.14% 2	21.43% 6	32.14% 9	39.29% 11	**4.04**
lack of services to refer to					
3.70% 1	0.00% 0	25.93% 7	40.74% 11	29.63% 8	**3.93**
client reluctance or ability to take up referral					
7.41% 2	3.70% 1	29.63% 8	25.93% 7	33.33% 9	**3.74**
lack information and understanding about other agencies and their services (currency of service information, staff training/capability)					
0.00% 0	3.70% 1	48.15% 13	33.33% 9	14.81% 4	**3.59**
waiting times for appointments					
3.85% 1	0.00% 0	42.31% 11	42.31% 11	11.54% 3	**3.58**
Inadequate staff training					
3.70% 1	7.41% 2	40.74% 11	25.93% 7	22.22% 6	**3.56**
varying levels of cultural capability between services (affecting the ability to deliver consistent culturally appropriate services between agencies)					
7.41% 2	7.41% 2	33.33% 9	33.33% 9	18.52% 5	**3.48**
information sharing issues (data protection/privacy/confidentiality/client consent)					
7.14% 2	10.71% 3	32.14% 9	28.57% 8	21.43% 6	**3.46**
eligibility criteria of other agencies					
0.00% 0	7.14% 2	50.00% 14	35.71% 10	7.14% 2	**3.43**
lack of clarity about when referrals must be made and the reasons for doing so (no clear internal policies and practice)					
7.14% 2	14.29% 4	53.57% 15	17.86% 5	7.14% 2	**3.04**
Other					
20.00% 1	0.00% 0	20.00% 1	40.00% 2	20.00% 1	**3.40**

Table 87: Impact of barriers on agency's ability to successful referrals - comments

Comments (n = 2)
Maximizing the use of AMS resources and developing good referral protocols will improve integration and make the most of what is available in rural and remote communities.
All agencies work well together. This only changes when we a dealing with personalities.

Strategies to Address Barriers to Referrals

Based on a weighted average, respondents suggested that built relationships was the most effective strategy to address barriers to successful referrals. This was closely followed by providing practical assistance to clients, participating in interagency forums or regular meetings with key agencies and sharing resources.

Conversely, providing financial support to clients and developing internal policies and referral procedures were identified as the least effective strategy address barriers to successful referrals.

Built relationships and sharing resources were also identified as effective strategies to address barriers to coordinate care / support successfully (see table 76).

Two respondents provided additional comments (see table 89).

Table 88: Strategies to Address Barriers to Successful Referrals

Not at all effective	Slightly effective	Moderately effective	Very effective	Extremely effective	Weighted Average out of 5
built relationships					
3.45% 1	3.45% 1	17.24% 5	41.38% 12	34.48% 10	**4.00**
provided practical assistance to clients (e.g. provided or subsidised transport)					
9.52% 2	9.52% 2	19.05% 4	38.10% 8	23.81% 5	**3.57**
participated in interagency forums or held regular meeting with key agencies					
8.00% 2	12.00% 3	20.00% 5	40.00% 10	20.00% 5	**3.52**
shared resources					
8.70% 2	13.04% 3	17.39% 4	39.13% 9	21.74% 5	**3.52**
promoted your own agency's role and function (e.g. newsletters, website)					
7.41% 2	11.11% 3	18.52% 5	51.85% 14	11.11% 3	**3.48**
sought and provided feedback (monitoring quality)					
8.33% 2	4.17% 1	37.50% 9	45.83% 11	4.17% 1	**3.33**
delivered training and/or resources					
4.00% 1	24.00% 6	32.00% 8	24.00% 6	16.00% 4	**3.24**
provided financial support to client					
17.65% 3	5.88% 1	35.29% 6	23.53% 4	17.65% 3	**3.18**
developed internal policies and referral procedures					
11.54% 3	15.38% 4	34.62% 9	30.77% 8	7.69% 2	**3.08**
Other					
20.00% 1	0.00% 0	20.00% 1	60.00% 3	0.00% 0	**3.20**

Table 89: Strategies to address barriers to successful referrals - comments

Comments (n = 2)
Being present, good continuity and being seen to be responsive and flexible assist greatly in breaking down barriers in effective referral processes.
We do a lot of consultation between networks.

Additional Open Comments

Seven respondents provided additional open comments (see table 90).

Additional Open Comments

Table 90: Additional open comments

Additional Comment (n=7)
There is a sense among South West service providers that collaborative practice has improved, but we could do better. I commend the leadership taken by the South West Health Partnerships Council and by the Mental Health managers in the Hospital and Health Service. Alcohol and other drugs is the area where much more work is needed, and where significant additional resources are required to prevent further community breakdown and harm caused to individuals, families, and children.
I would like to think that we as services providers working in our small community would have the confidence of the professional mental health team to be able to talk with us about clients in our community so we would continue to monitor them and report back to the professional teams.
Better services for rural communities.
The mental health first aid and awareness courses were a really great step in the right direction about reducing the stigma that is attached to mental health. The more we can get it 'normalised' the better!
South West Hospital and Health Service mental health services and other agencies in the region have recognised the need for us to all work more cooperatively and cohesively. To this end we are now developing and moving forward with an interagency planning day for mental health in the region to be held on 11 March.
Generally there is little support for male perpetrators of domestic and violence. Dealing with the crime and not the triggers for offending takes priority.
An effective referral pathway needs to be established outlining each agencies/services role to ensure effective outcome based client journey from the commencement of service delivery. This needs to also outline each agencies role/services/scope to ensure understanding.

Focus Group Summary

Service providers from within the South West HHS region were invited to participate (face-to-face and teleconference) in focus groups and actively contribute to a number of key focus group questions to complement the survey results. Two focus groups were held across the South West HHS region. Eleven service providers from across five agencies (Queensland Police, Queensland Health, Department of Communities, Lifeline and Partners in Recovery) participated in the focus group held in Charleville, Queensland.

In addition, thirteen service providers across ten agencies (Lifeline, Goondir Health Service, Partners in Recovery, Vital Health, Charleville and Western Areas Aboriginal and Torres Strait Islanders Community Health, Primary Health Care Centre, Queensland Health, Centacare, Aftercare and the Community Legal Service) participated in the focus group held in Roma, Queensland.

The discussion was audio recorded and a summary of key themes were identified and are provided below.

What Does Effective Service Integration Mean?

Participants commented that effective service integration is about a key agency taking the lead to work in partnership by strengthening services, sharing information and resources, knowing what each service can offer and undertaking joint problem solving to achieve patient centred outcomes.

What does effective service integration mean?

Summary of Comments
Relies on someone or a key agency actually taking the lead.
Is about strengthening of services by being able to offer more to clients and the community when services work in collaboration.
Is about creating efficiency through working in partnership to make best use of available resources and minimising duplication by drawing on the strengths of each agency.
Is about sharing of resources (including staff, time, budgets, exchange of knowledge and information and other resources).
Is knowing what each other do, what each service can and can't provide, what the referral pathways are and how to best integrate services based on this information.
Is person centred to ensure that the services that person needs is available to them in a holistic way.
Is about identifying if something is not working well or there is a gap in the community and problem solving or addressing that together.

"What I can provide solely and also what I can provide in collaboration with other services is much greater. It's a strength perspective for the client. It`s about working in partnerships."

Focus Group Participant Comment, South West Region

What Does Good Service Integration Look Like?

Participants indicated that agencies in the South West HHS region generally work well together. Personal relationships between service providers was identified as a key enabler for effective service integration in the region.

Participants commented that there is a lack of effective integration between private practitioners and other agencies as well as between Aboriginal Medical Services and mainstream services across the region.

Staff rollover, limited skill level of staff, lack of awareness of existing services, funding requirements and compartmentalisation of services were all identified as barriers to effective service integration.

What does good service integration look like?

Summary of Comments
In Roma, agencies generally work very well together due to existing personal and professional relationships between staff members across different organisations.
Good service integration depends on the area, the agencies involved and the staff involved. With small communities if there are issues between agencies or staff members (personally or professionally), good service integration does not occur.
The use of Skype, videoconferencing and telehealth work well in the region once people are accustomed to using the technology.
There is still a lack of effective service integration between Aboriginal Medical Services and mainstream services across the region.
There is limited evidence of GPs in the region providing good mental health intervention across the continuum of care through effective mental health treatment plans and review cycles.
Integration between Private Practitioners and other agencies is lacking. Private practitioners often do not attend events or meetings due to time away from private practice, overworked staff and/or lack of funding to compensate their attendance at meetings/events.
Agencies are so caught up in achieving KPIs to meet funding requirements and receive ongoing funding.
Staff rollover and inconsistencies is a major barrier to effective service integration. This staff rollover is often a result people not wanting to live in remote communities and also as funding for programs discontinue.
Some mainstream services are afraid to engage with Indigenous specific services and thus maintain a distance from these services due to lack of knowledge and confidence in the cultural protocols.
The skill level of workers employed in the region (especially remote areas) is often limited due to general staffing issues in remote communities.
Lack of awareness of the existing services on the ground and what the individual services actually offer was identified as a major barrier to effective service integration.
Mental health and alcohol and other drugs are compartmentalised within the health system (due to community stigma, lack of understanding, limited staff skills and compartmentalised funding) resulting in lack of integration across all health services.

"In Roma we work particularly well together perhaps because we know one another well already from past experiences. With us it's only a phone call asking who's going to help my client. You know people personally so you make that call. It's about communication and relationship building."

Focus Group Participant Comment, South West Region

What Do Referral Pathways Look Like?

Participants indicated that Queensland Health and GPs are the primary referrers in the region. However referrals from GPs into community support agencies and referrals from mainstream services into Indigenous specific services does not occur well.

Participants identified that patients who have a dual diagnosis of mental health issues and problematic substance use are often neglected as no one organisation is willing to take responsibility for them.

Confidentiality, informed consent, lack of awareness of existing services, understanding of cultural protocols and eligibility criteria were all identified as barriers to effective referrals.

Types of Supports / Services

Participants indicated that although services in the region exist, a number of service providers often work outside of their role description to meet the needs of their clients due to overall lack of services.

What do referral pathways look like?

Summary of Comments
In Roma, there are not too many issues with referrals from GPs as the GPs are quite familiar with the referral pathways.
GPs and clinicians are overworked and do not have time to be patient centred. As a result people with mental health and alcohol and other drug issues are simply prescribed with medication.
Primary referrers into services are Queensland Health (mental health and ATODS) and GPs.
The pathway from GPs and clinicians into community support agencies (who provide practical and community level support) and programs does not occur well in the region. This is due the attitude of clinicians that mental health and alcohol and other drugs should sit with clinical services and also it is not an accepted pathway for mental health patients to be referred to community based services.
Due to the lack of referrals into community base services, there are limited patients recorded on their books however there is strong desire for more clients. Consequently, funding bodies do not see the value of these services due to the limited number of patients recorded.
Confidentiality and patient informed consent is one of the biggest barriers to referrals for mental health and alcohol and other drugs across all services. Lack of patient consent is often due to clients not recognising they have a problem (not being at the appropriate stage of change), lack of service provider skills in motivating a client towards consent (motivational interviewing techniques) and lack of service provider time to achieve consent.
Service providers also experience false consent issues where clients are forced to consent (i.e. made to sign a form) which results in client refusal to activate referrals.
For some services (e.g. Police Service), referral processes are very clear as there are legislations and laws in place which means that these services must work within these constraints. Anything beyond this must be referred to another service.
When there is dual diagnosis, patients are often neglected as no one organisation wants to take responsibility for them.
Lack of awareness of the existing services on the ground and what the individual services actually offer was identified as a major barrier to effective referrals.
Some mainstream services are afraid to make referrals to Indigenous specific services and due to lack of knowledge and confidence in the cultural protocols.
An issue with RNs is that they do not have the ability to make a decision about the care of a patient. They are required to wait for a specialist doctor to make the decision.
Eligibility criteria due to funding restrictions was identified as a key barrier for referrals into some services.

Types of supports / services that exist in the region for people (and their family and carers) with mental illness, mental health difficulties or problematic substance use.

Summary of Comments
Types of supports / services: • Lifeline • Centacare • Blue Care • ATODS • Mental Health • Neighbourhood Centres • Aboriginal Health Services
Often service providers are working outside of their role description and brief to meet the needs of their clients due to either lack of services or the inability to seek the support required for their clients. This poses a number of risks to themselves, their organisations and their clients.

Groups of People Who's Needs Aren't Being Met

Participants suggested that there were a number of groups of people in the region whose needs are not being met. These include South East Asian communities, Aboriginal men under the age of 50 with a high ACAT rating, youth aged between 12 and 17 years, parents of children and people with an early diagnosis of dementia.

Suggested actions and strategies to build better service integration

To address the issue of inconsistencies/changes in staff and lack of awareness of services, networking opportunities such as health expos and gatherings for service providers, development of a range of resources for service providers and the development of a tool or system which providers can access comprehensive information about other services including referral pathways into and out of these services.

Professional development and training was recommended for service providers to address the lack of skill and confidence in supporting clients with mental health issues and problematic substance use.

Participants felt the lack of dual-diagnosis services, lack of rehabilitation facilities and the need for funding at a community level needs to be considered by Government at a policy level.

Specific groups of people whose mental health and alcohol and other drug service needs are not being met for the region.

Summary of Comments
There is a large South East Asian community in Charleville that are employed at the meat works on a short-term basis. There are significant language barriers as most are Visa workers or family of Visa workers and do not feel the need to learn English. Some agencies attempt to use phone interpreter services however this has been identified as quite ineffective.
There is a challenge with identifying where to place Aboriginal men under the age of 50 with high ACAT ratings. Aged care (both public and private) facilities will not accept these men.
There is a gap of services in the region for children between 12 and 17 years of age as often parent consent is required or the patient does not meet the eligibility criteria set out by the funder.
There are a number of community based parenting programs such as the Triple P and 123 Magic in Roma that are no longer being funded. This means that there is now an important group in the community, parents, where their needs are not being met.
There are limited services available to support people with early diagnosed dementia and often people are unable to access services until their dementia is classified as severe, in which case they are often hospitalised.

Focus group participants' suggested actions and strategies to build better service integration in the region

Summary of Comments
Provide opportunities such as health expos and gatherings for local service providers (including clinicians) to get to know one another and the services they offer. These need to be coordinated by a lead agency.
Develop resources to increase awareness of services including brochures, posters, clear case notes or patient records, frameworks, policies and an interactive service provider database. The interactive service provider database was discussed as a potential strategy to support service providers (particularly new providers) to identify services in the local area and gain a clear understanding of what these services can offer including the referral pathways into and out of these services.
Professional development and training for GPs and other health professionals may assist to address the issue of lack of skill and confidence addressing mental health and alcohol and other drug issues with clients.
There needs to be a focus on addressing the issues and challenges of dual-diagnosis at a policy level.
There is a clear need for rehabilitation facilities in the region. Patients are currently required to travel to Brisbane or Townsville to access adequate rehabilitation services.
The issue in relation to mental health and alcohol and other drugs in the region is much bigger than just the health system as education and employment a major factors. There is a need for government to invest into smaller communities to enable a more sustainable community with future employment for the younger generation.