

MENTAL HEALTH, ALCOHOL AND OTHER DRUGS AND SUICIDE PREVENTION

NORTH COAST JOINT REGIONAL PLAN IMPLEMENTATION PLAN

2024 - 2029



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Foreword

We are pleased to bring you the plan for implementation of the Mental Health, Suicide Prevention and Alcohol and Other Drugs Joint Regional Plan 2025-2029 (The Plan).

Utilising the Department of Health and Aged Care's Mental Health Services Planning Framework as the scaffold, Mid North Coast Local Health District, Northern NSW Local Health District and Healthy North Coast have analysed data and delivered co-design and collaborative planning workshops with people with lived experience and their families and carers, representatives from priority populations, and subject matter experts in the primary care and tertiary sector, to identify the key actions for delivery over the next four calendar years to 2029.

This Implementation Plan outlines activities required to address the priorities included in The Plan. Annual action plans will be developed to identify the priority activities for that financial year, with associated outcome measures and performance indicators to support progress monitoring.

We thank people with lived and living experience, consumers, carers, stakeholders and of course our staff who contributed to and worked collaboratively to develop The Plan.

We recognise the outstanding efforts of Aimee McNeill, Diedre Robinson and Sarah Fox, who as Directors of Mental Health across our three organisations, have taken a one health system mindset to planning and working collaboratively for better mental health and wellbeing outcomes across the North Coast region. We also recognise the significant contribution of Jacalyn Grose and Megan James, Associate Directors at Healthy North Coast, who have played lead roles in the development and delivery of The Plan.

Only by working together, with each other, consumers and service delivery partners, will we achieve population-level health improvements for our community. The Plan is an important step forward in achieving this goal.

Monika Wheeler
CEO
Healthy North Coast

Tracey Maisey
Chief Executive
Northern NSW Local Health District

Jill Wong
Chief Executive
Mid North Coast Local Health District



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A note on initiatives

Initiatives relating to Access and Integration and Aboriginal Peoples are crosscutting and relevant to all priority areas and are therefore, only mentioned once and not repeated across associated priority area initiatives.

The implementation plan is a working document and may require adjustment to reflect changes in local needs, and Commonwealth and State Healthcare strategy and policy landscapes.

Definitions

Ambulatory withdrawal service	Outpatient service that provides supervised alcohol and other drug withdrawal management.
Brokerage	Funding provided to support a consumer access required supports or services.
Co-design	Brings citizens and stakeholders together to design new services and products.
Commissioning	To formally appoint a person or organisation to deliver a piece of work.
Coordinating Agency	Organisation who will coordinate the efforts however all parties who are identified as requiring to be involved in the work to take an active role. Coordinating agency is responsible for leading the identification of the who, what, how, when, in project management. This could include non-coordinating agency in the "who".
Digital Literacy	Ability to use information and communication technologies to find information.
EAP	Employee Assistance Program – confidential service that employers offer employees to support wellbeing.
IAR-DST	Initial Assessment and Referral Decision Support Tool – an evidence-based tool for conducting initial assessment and referral of individuals presenting with mental health conditions in primary health settings within Australia.
Joint Coordinating Agency	Co-leads include HNC, MNC LHD and NNSW LHD.
KPI	Key Performance Indicator allows performance to be measured and monitored.
Lived Experience	Individual who has experience engaging with the mental health, suicide prevention or alcohol and other drug service system. Engaging lived experience representatives ensures individual principles and diverse perspectives in co-design, co-production and co-management approaches are respected. This includes direct experiences and choices of individuals.
Market Sounding	Sharing an idea to the market to get feedback before making a formal request. Often before or at the very start of the procurement process.



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One Health System	Integrated approach to balance and optimise the health of people whereby multiple service systems work together to create sustainable solutions.
Place-based	Local approaches that address the needs of specific populations. Not necessarily geographically based. Best structured with collaboration across government, non-government and communities of interest.
Referral Spoke Service	A service provided by HNC that manages referrals to local mental health services.
Self-management	Involves taking an active role in your own mental wellbeing. May include proactive engagement with information and tools.
Step up/ step down	Phrase to describe a consumer moving between different levels or intensity of care to best meet current mental health needs.
Value Based Healthcare	Model of care that focuses on improving patient health outcomes while considering the cost of care, ensuring resources are directed to areas that achieve the best health outcomes and improve the experience of delivering care.
Warm transfer of care	When a health professional meets with a new professional to handover the care of a patient to ensure shared understanding of current care needs.

Process for development of the Implementation Plan and Stakeholder Consultation

A collaborative, participatory, evidence and lived experience approach was undertaken to develop The Plan. Stakeholders from across the region, including primary and tertiary care workforce, consumers and community members, people with lived and living experience and Aboriginal people were actively engaged throughout the development process.

Key activities undertaken in the development of The Plan included:

- **Establishment of internal governance structures** to steer the work and lead the development of the Implementation Plan.
- **Desktop review** to understand local data and internal working conditions including current service delivery, presentation and demographics; results of the 2024 Better Health Survey; utilisation of the Mental Health Services Planning Framework and relevant state and national policies and strategies.
- **Ideas generation workshops:** to bring together priority area subject matter experts from tertiary and primary health landscapes as well as people with lived and living experience to identify areas for response. Six workshops were held in June - July 2024, each workshop representing a different priority area outlined in The Plan. The workshop priorities included:
 - Aboriginal Peoples
 - Access and Integration
 - Alcohol and Other Drugs



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- Mental Health for Priority Populations
- Suicide Prevention
- Workforce.

Table 1 provides the breakdown of number of subject matter experts and people with lived/living experience that attended stakeholder consultation workshops, held the week of the 16th of June to the 2nd of July 2024.

Ideas Generation Workshop Priority	Subject Matter Expert Health Representative	Subject Matter Expert Consumer Representative	Total Participants
Aboriginal Peoples	8	1	9
Access and Integration	12	1	13
Alcohol and Other Drugs	12	2	14
Mental Health for Priority Populations	14	3	17
Suicide Prevention	9	3	12
Workforce	10	3	13

- **A Solutions design workshop** brought together priority area subject matter experts from tertiary and primary health spaces as well as people with lived and living experience to design solutions. Total participants for the solutions design workshop were 46, with 32 from LHD’s and HNC, and 14 consumer representatives.
- **Three Service Sector workshops:** Findings from the ideas generation and solutions design workshops were presented to key stakeholders from the service sector, including the Aboriginal Community Controlled Health Organisations and Aboriginal Medical Service workforce partners, Community Managed Organisations and GPs to further identify gaps and improvements.

All workshops were facilitated via interactive online discussions. Workshop data was captured, analysed synthesised and analysed for identification of common themes and trends across the workshops. To remove bias, five independent reviewers from HNC and the LHD’s were engaged to undertake the data analysis.

MHAOD Joint Regional Plan Initiatives

This section describes initiatives for implementation that have been agreed on by key stakeholder across NNSWLHD, MNCLHD and HNC to achieve the desired outcomes across six activity streams within the JRP.

Where appropriate, the lead agency has been identified and agreed upon within the ‘Coordinating Agency’ column. Where achievement of specific initiatives will require each agency to lead and report



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on their implementation progress towards local outcomes, this has been described as ‘Internal to HNC and LHDs’.

Priority: Access and Integration

Goal: People can access quality, affordable services and experience seamless ‘one health system’ care consistent with their needs.

What we want to achieve:

- People can navigate and access mental health (MH) and alcohol and other drugs (AOD) information and services that enable choice and maximise self-management
- Regional collaborations, commissioning and partnerships that are responsive to population health needs, based on reliable data
- Innovative funding models and opportunities for co-commissioning and collaborative service design are designed to meet the needs of North Coast communities
- ‘One health system’ for mental health and AOD services is facilitated by strong partnerships between the parties of The Plan, including Aboriginal Community Controlled Health Services (ACHHSs), general practice, non-government organisations, local and state government, National Disability Insurance Service (NDIS) and community service providers.

Initiative number	Initiatives	Examples of regional planning actions	Coordinating agency/ies
1.1	Support the implementation of the NSW Health Single Front Door initiative to enable consumers easier entry into appropriate services through establishment and maintenance of a service directory to enable seamless referrals, encompassing: <ul style="list-style-type: none"> • primary mental health • suicide prevention • drug and alcohol treatment • psychosocial programs. 	1.1.1 Collaborate with National Early Intervention Service and Medicare Mental Health Program and primary care providers to identify wait times across primary care services to include in directory 1.1.2 Collaboratively design a clear referral pathways map as part of a communication and change management tool kit for primary and tertiary services.	Lead: HNC
1.2	To enable ‘single front door’ entry into services, identify and promote structure to screen for:	1.2.1 Conduct desk top review of available assessment tools for measuring efficacy and safety of	Lead: HNC



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	<ul style="list-style-type: none"> • best practice e-health tools for self-management • clinically safe private mental health providers. 	<p>online platforms and private providers.</p> <p>1.2.2 Develop local strategies informed by lessons learned through the NSW Health Single Front Door project</p> <p>1.2.3 Design North Coast specific tools or identify existing tools for use</p> <p>1.2.4 Use tool to identify and promote resources and services.</p>	
1.3	<p>Collaboratively build mental health and suicide prevention lived experience /peer workforces to:</p> <ul style="list-style-type: none"> • Lead navigation and facilitate warm transfer of care between tertiary and primary care services • Support warm discharge planning and referral • Reduce need for consumer to re-tell their story • Support consumers in suicidal crisis in the emergency departments • Meet the needs of priority populations (including workforces made up of representatives of priority populations). 	<p>1.3.1 Identify co-funding buckets and approach to co-commissioning</p> <p>1.3.2 Design procurement / service models and clinical governance structures for mental health and suicide preventions streams</p> <p>1.3.3 Embed peer workforce models into services.</p>	Lead: HNC in partnership with LHDs
1.4	<p>Create and embed a suite of culturally safe, region-wide documents used across tertiary and primary care mental health, suicide prevention and AOD services that can be shared with the consumer. Areas for development include:</p> <ul style="list-style-type: none"> • Assessments • Referrals • Transfer of care • Triage • Safety planning • Discharge information packs 	<p>a. Audit current documents used by services in tertiary and primary care spaces</p> <p>1.4.1 Design or update single suite of documents for both primary care and tertiary space, that:</p> <ul style="list-style-type: none"> i) Adhere to existing PHN and LHD clinical governance requirements b. Include guidance for services on criteria / 	Lead: HNC in partnership with LHDs



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	<ul style="list-style-type: none"> Complaints and feedback. 	<p>triage / intake tools and service types</p> <p>1.4.2 Operationalise documents through a change management piece with LHD and commissioned service providers through a regional phased approach.</p>	
1.5	In collaboration and with guidance from Aboriginal Community Controlled Health Services (ACCHS), investigate opportunities to co-locate tertiary, primary care and non-clinical services that meet the needs of Aboriginal populations and other priority populations across mental health and AOD service streams.	<p>1.5.1 Establish opportunities for co-location through stepped care meeting, consortium and interagency relationships</p> <p>1.5.2 Identify opportunities for co-location through:</p> <ul style="list-style-type: none"> i) stepped care meeting, consortium and interagency relationships ii) co-commissioned or co-designed services across tertiary and primary care spaces. 	Lead: HNC In partnership with LHDs ACCHOs
1.6	Upskill community champions and clinicians to provide best-practice mental health, suicide prevention and alcohol and other drugs support to consumers by providing evidence-based training.	<p>1.6.1 Develop community and clinician specific calendars and house on LHD and PHN websites for clinicians and public to access</p> <p>1.6.2 PHN IAR-DST training support officer role to provide quarterly training calendar to LHD and primary care services to access IAR-DST training</p> <p>1.6.3 PHN to work with LHD to operationalise IAR-DST into practice.</p>	Lead: HNC in partnership with LHDs
1.7	Increase access to primary mental health, AOD, suicide prevention and psychosocial services in rural / remote locations, targeting priority populations and addressing Aboriginal health through:	<p>1.7.1 Use Health Needs Assessment and National Mental Health Services Planning Framework to identify locations of need for service delivery</p>	Lead: HNC in partnership with ACCHOs, LHDs



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	<ul style="list-style-type: none"> initiatives or partnerships increasing access to transport delivery of outreach services expansion of telehealth improving digital literacy. 	<p>1.7.2 Establish a joint meeting to discuss and share data on access across rural and remote communities</p> <p>1.7.3 Provide digital literacy workshops throughout region to support access to telehealth</p> <p>1.7.4 Provide brokerage where possible for consumers with a psychosocial disability to access transport for service provision and NDIS assessment.</p>	
1.8	Embed e-referral pathways for primary care into GP medical software.	1.8.1 Integrate Medicare Mental Health e-referral solution into general practice.	Lead: HNC
1.9	Conduct joint service planning to design, commission and deliver services that minimise duplication of North Coast mental health, alcohol and other drugs and/or suicide prevention services.	<p>1.9.1 Develop planning protocols to support integrated, value-based service design, planning, co-commissioning and service delivery following receipt of new funding</p> <p>1.9.2 Include joint planning in operational plans for LHD and PHN</p> <p>1.9.3 Undertake market sounding to better promote grant / funding opportunities.</p>	Lead: HNC
1.10	<p>Establish data sharing agreement and processes between primary and tertiary services to facilitate streamlined sharing of patient information at transfer of care, considering:</p> <ul style="list-style-type: none"> Data sovereignty Patient / consumer privacy, confidentiality and concerns about how data /information will be used Cultural safety. 	<p>1.10.1 Seek endorsement from CEOs to develop data sharing agreement</p> <p>1.10.2 Form working group to develop data sharing agreement and function across tertiary and primary care spaces</p> <p>1.10.3 Review and update internal policies and procedures to include actions that facilitate information sharing, two-way communications, consent and shared</p>	Lead: HNC



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		<p>decision-making between tertiary and primary care.</p> <p>1.10.4 Leverage and align with existing/planned LHD joint governance groups.</p>	
1.11	<p>Support workforce collaboration and education to improve knowledge of referral pathways, service relationships and needs-based service delivery across primary and tertiary mental health, suicide prevention and Aboriginal health care. Avenues include:</p> <ul style="list-style-type: none"> • Reviewing interagency meetings across the region • Developing two-way workforce education strategies <p>Establishing partnership meetings at the clinical service delivery and project management level across service streams.</p>	<p>1.11.1 Establish working group including representation from priority populations, AOD, suicide prevention and Aboriginal health</p> <p>1.11.2 Conduct review of interagency meeting – considering clinical requirements, information sharing requirements, capacity to include community members and people with lived and living experience. Re-establish new terms of reference, stakeholder lists, standing agendas and monitoring structures</p> <p>1.11.3 Develop education strategies</p> <p>1.11.4 Establish stepped care meetings across the life span across all clinical areas to facilitate clear step-up /step down of services (e.g. – youth stepped care meetings)</p> <p>1.11.5 Establish partnership meetings at managerial level across service streams.</p>	Lead: HNC
1.12	<p>Develop integrated structures for accountability and monitoring of partnerships across primary and tertiary services, including:</p> <ul style="list-style-type: none"> • standardised KPIs across all services that relate to facilitation and monitoring of integration and strong cross-sector partnerships, in alignment with value-based health care requirements. 	<p>1.12.1 Establish working group to identify appropriate KPIs and design integrated framework</p> <p>1.12.2 Embed KPIs and performance indicators into existing and new services' operational plans.</p>	Lead: HNC



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	<ul style="list-style-type: none"> integrated performance framework across tertiary and primary care. 		
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Priority: Mental health for priority populations
Goal: Improved mental health and wellbeing for priority populations

What we want to achieve:

- Reduce stigma associated with mental health issues and willingness to seek help as needed
- Focus on promotion, prevention and early intervention
- A health system that is flexible and responsive to the needs of priority target populations
- Delivery of values-based healthcare
- Improved mental health and physical health outcomes for priority populations
- People experience a 'one health system' approach to mental health and AOD care, as they step up or step down, or move across service systems
- Improved partnerships with organisations and services that can influence the social determinants of health.

Initiative number	Initiatives	Regional planning actions	Coordinating agency/ies
2.1	Design health promotion and help-seeking campaigns that: <ul style="list-style-type: none"> engage voices of leaders and celebrities who have lived experience are targeted to different priority populations encourage early help seeking use non-stigmatising language align with existing National and international days – (for 	2.1.1 Conduct needs analysis to prioritise populations to receive help seeking messaging, recognising the differences between primary producers and coastal communities within the region 2.1.2 Co-design messaging and communication plan including platforms, approach, evaluation and timelines 2.1.3 Deliver campaign.	Lead: HNC



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	example, mental health week).		
2.2	Embed non-clinical therapeutic spaces into facilities and service delivery models, with consideration given to priority populations and services for Aboriginal people.	2.2.1 Primary and tertiary services to review policies and procedures that support care delivery in non-clinical spaces 2.2.2 New physical service spaces to consider adoption of non-clinical spaces in their service design and where possible, co-design these 2.2.3 Partner with Councils and local services such as neighbourhood centres to deliver outreach services in areas where priority populations feel safe. For example, engagement at skate parks when working with young people (where appropriate).	Lead: HNC/LHDs HNC and LHDs in partnership with ACCHOs
2.3	Operationalise an integrated approach to discharge planning from all service areas, so that prior to discharge, all consumers and their families/carers/support networks have: <ul style="list-style-type: none"> • Understood and accepted an established, clear pathway of care • met with or spoken to the care team. 	2.3.1 Design approach 2.3.2 Embed approach into: <ol style="list-style-type: none"> i) stepped care meetings ii) co-commissioned peer workforce service models iii) policies and procedures across tertiary and primary care where appropriate iv) Aftercare models. 	Lead: LHDs
2.4	Build on existing tertiary and primary care pathways for perinatal infant and child mental health.	2.4.1 Conduct unmet needs assessment of perinatal infant and child mental health 2.4.2 Identify opportunities for building on existing pathways, increasing service capacity and partnerships across primary and tertiary care.	Lead: LHD
2.5	Implement/replicate effective models in schools to build	2.5.1 Work with Department of Education and Catholic	Lead: HNC



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	capacity in in-reach mental health wellbeing teams.	<p>Schools Division to conduct unmet needs assessment of mental health supports available in schools and identify opportunities for leveraging and enhancing existing education programs, and in-reach mental health wellbeing models as needed</p> <p>2.5.2 Build awareness of wellbeing team and mental health referral pathways for young people</p> <p>2.5.3 Where possible, address unmet needs through in-reach, place based and capacity building approaches to increase access to youth mental health supports in schools and alternative education facilities.</p>	
2.6	<p>Consult and engage with existing priority population groups to:</p> <ul style="list-style-type: none"> • identify priority populations and emerging populations • meet the emerging needs of priority populations as they arise • lead systems improvements across tertiary and primary care. 	<p>2.6.1 Develop working group terms of reference and governance arrangements. Appoint members from priority populations, including a co-chair</p> <p>2.6.2 Annually identify priority populations to focus on</p> <p>2.6.3 Working group to establish annual systems improvement workplan.</p>	Lead: HNC
2.7	<p>Increase physical health screening and metabolic monitoring by services who deliver care to people living with severe and enduring mental health conditions.</p> <p>Test programs that address physical health conditions of people living with severe and enduring mental health conditions.</p>	<p>2.7.1 Tertiary and primary care services to adopt or increase best practice physical health screening and metabolic monitoring</p> <p>2.7.2 Primary care services for people requiring >level 4 supports to include physical health screening</p> <p>2.7.3 Identify opportunities to test physical health programs.</p>	Lead: Locally led by each agency



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2.8	Establish mental health clinician roles in GP practices, for example, mental health nurses or other allied health, to provide brief intervention, clinical services and assessment.	2.8.1 Design service models 2.8.2 Explore funding opportunities to work in an integrated way with GPs across mental health space for example, open Dialogue trials, social workers in general practice 2.8.3 Engage GPs to test mental health allied health positions in General Practice.	Lead: HNC
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Priority: Alcohol and Other Drugs
Goal: People live in safe, healthy and resilient communities where alcohol and drug harm is minimised

What we want to achieve:

- Reduced impact of AOD related harms through prevention and health promotion, early and brief intervention, treatment, relapse prevention and recovery
- People access and navigate place-based drug and alcohol treatment services.
- People experience consistent care pathways between mental health and AOD services.
- AOD use for people with a mental illness is effectively managed.
- Organisations and individuals have adequate capacity to prevent and respond to problematic AOD use and promote evidence-informed practice.

Initiative number	Initiatives	Regional planning actions	Coordinating agency/ies
3.1	Collaboratively conduct research in mental health, alcohol and other drugs and suicide prevention.	3.1.1 Establish partnerships across primary and tertiary space to: <ul style="list-style-type: none"> i) identify research opportunities ii) establish a joint framework and research team ensuring representation of primary and tertiary sectors 	Lead: LHDs



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		3.1.2 Continue integrated approach to AOD research node.	
3.2	Primary care AOD providers to deliver annual health promotion / prevention campaigns.	3.2.1 Work with commissioned service providers to develop/adopt messaging for AOD help seeking 3.2.2 Lean on existing state funded messaging to ensure no duplication.	Lead: HNC
3.3	Establish a co-commissioned alcohol and other drugs primary care coordinator role to work in partnership with primary and tertiary services to address priorities (for example, OTP support in MNC).	3.3.1 Conduct unmet needs analysis 3.3.2 Develop work plan.	Lead: HNC
3.4	Identify and promote pathways for carer support.	3.4.1 Establish or identify psychoeducation opportunities for carers 3.4.2 Establish capacity building opportunities for carers to increase confidence in supporting people with substance use 3.4.3 Establish partnerships with carer support services.	Lead: Locally led by each agency.
3.5	Establish co-commissioned, place-based withdrawal services supported by GPs and local care providers.	3.5.1 Identify funding 3.5.2 Co-commission co-designed service models 3.5.3 Promote existing ambulatory withdrawal services.	Lead: LHDs in partnership with HNC
3.6	Increase AOD screening in general practice, mental health assessment and other services.	3.6.1 Build clinician capacity to increase AOD assessment and treatment planning in tertiary and primary mental health services.	Lead: HNC

Priority: Aboriginal Peoples

Goal: Aboriginal peoples experience positive social and emotional wellbeing and can access culturally safe services



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What we want to achieve:

- Service design and delivery is driven by Aboriginal knowledge and wisdom in partnership with the Aboriginal Community Controlled Health Sector (ACCHS)
- Services are culturally safe, flexible and responsive to the needs of Aboriginal peoples and facilitate self-determination
- The social inequalities and wider determinants of Aboriginal peoples health are addressed
- Positively contribute to Closing the Gap between Aboriginal and non-Aboriginal peoples inequities and health status.

Initiative number	Initiatives	Regional planning actions	Lead agency/ies
4.1	Grow and retain Aboriginal workforce in primary and tertiary care.	4.1.1 Workforce planning working group established or enhanced to include representation from tertiary and primary care services 4.1.2 Work with Aboriginal health leaders and consider lived experience from both a health and cultural perspective, to develop an integrated workforce plan and enhance existing plans.	Lead: LHDs
4.2	Support primary care non-Aboriginal specific services to engage in best practice cultural safety training.	4.2.1 Scoping activity to identify best practice cultural safety training 4.2.2 Guidelines/procedure developed for primary care service providers.	Lead: Locally led by each Agency
4.3	Develop formal mechanisms for Aboriginal Health representatives to advise priority populations initiatives.	4.3.1 Establish consultation mechanisms with the HNC Aboriginal Partnership Forum.	Lead: Each Agency lead locally in partnership with ACCHOs.

Priority: Suicide Prevention

Goal: Reduce the incidence of suicide on the North Coast through a systems-based approach to suicide prevention, aftercare and postvention

What we want to achieve:



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- Build a system of care that considers factors that relate to suicidal distress
- Enable recovery through aftercare and postvention
- Cross sector collaboration between health and non-health care organisations effectively support suicide prevention and knowledge transfer
- Lived experience is integrated into planning, intervention and workforce
- Investment is prioritised in prevention and early intervention
- Prevalence of protective factors is increased.

Initiative number	Initiatives	Regional planning actions	Coordinating agency
5.1	Upskill frontline workforce to recognise and respond to suicidality.	5.1.1 Identify workforce cohorts to be trained 5.1.2 Identify who is to deliver training 5.1.3 Include ASIST and other relevant suicide prevention training into training calendar/s for promotion.	Lead: Locally led by each Agency
5.2	Expand aftercare supports across the North Coast.	5.2.1 Conduct unmet needs analysis and review of current available aftercare supports available 5.2.2 Identify opportunities to address unmet need 5.2.3 Promote aftercare supports to community.	Lead: Locally led by each Agency
5.3	Hold a regional forum on suicide prevention.	5.3.1 Tertiary and primary care to work with planning and education teams to establish target audience, session content and timelines.	Lead: HNC in partnership with LHDs
5.4	Support evolving postvention suicide collaborative/s across the region.	5.4.1 Identify future state of postvention collaboratives	Lead: HNC



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		<p>5.4.2 Work with LHD and partners to implement changes</p> <p>5.4.3 Identify opportunities to expand where possible.</p>	
5.5	Target interventions for suicide prevention to priority cohorts.	<p>5.5.1 Carry out the Targeted Regional Suicide Prevention (TRISP) Planning work</p> <p>5.5.2 Annual action plan following analysis of unmet need to be designed for anything that falls outside of TRISP.</p>	Lead: HNC



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Priority: Workforce

Goal: A sustainable, capable and well-resourced compassionate workforce that is supported to deliver services that meet the current and future population needs

What we want to achieve:

- A supported, safe and healthy workforce now and into the future
- Responsive and flexible workforce and workplaces working at top of scope
- A ‘one workforce’ mindset to facilitate integrated patient centred care
- A well supported and growing Aboriginal health workforce
- Psychosocial support services operating as partners with clinical service providers
- Available low intensity mental health workforce to take pressure off tertiary care and provide place-based services.

Initiative number	Initiatives	Regional planning actions	Coordinating agency/ies
6.1	Build capacity of and support the peer workforce.	6.1.1 Identify national best practice for peer workforce support, retention and training and embed into service design 6.1.2 Embed into co-designed service models for peer workforce enhancement and establishment.	Lead: LHD
6.2	Promote workforce wellbeing.	6.2.1 Embed wellbeing officers into commissioned services 6.2.2 Promote EAP access across LHDs and PHN	Lead: Internal to HNC and LHDs



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6.3	Develop a region wide workforce plan for tertiary and primary care.	<p>6.3.1 Leverage existing governance groups to share strategies across between primary and tertiary care</p> <p>6.3.2 Embed strategies using telehealth to engage specialists nationally.</p>	Lead: Led by each Agency
6.4	Increase the reach of clinical societies.	6.4.1 Co-design training calendar.	Lead: HNC



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Governance

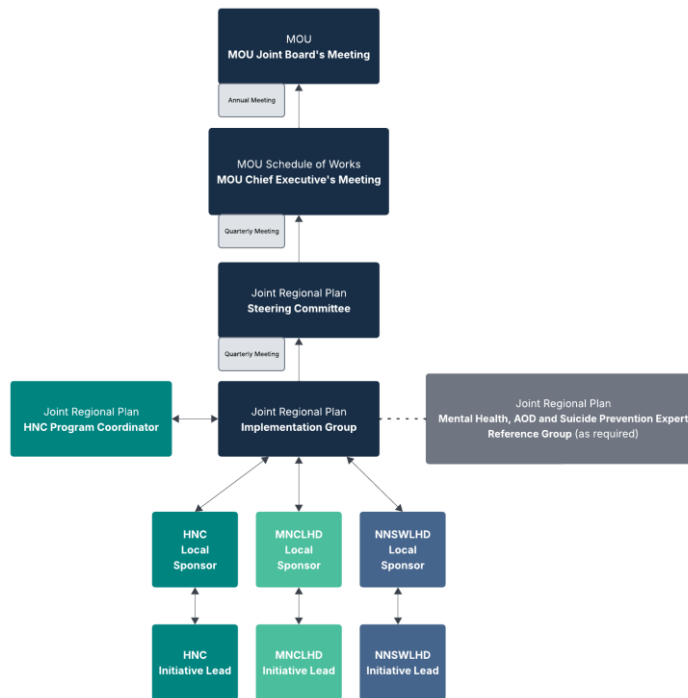
A governance structure was established to steer development of the comprehensive, targeted initiatives **which are included** this Implementation Plan. The JRP governance structure was established to ensure the effective collaboration between the three organisations and successful implementation of the initiatives under each of the six domains.

The overarching Joint Regional Plan's governance structure for the implementation phase is shown in Figure 1 to provide oversight of implementation of the initiatives and ensure the achievement of outcomes.

Key responsibilities of the governance structure:

- Development of a comprehensive monitoring, formative, outcome and impact evaluation framework.
- Continuous monitoring, reflection and improvement on processes.
- Shared data approaches to support a 'one health system' data resource.
- Providing clear reporting lines and points for escalation for risk management when required.
- Remove barriers and blocks to initiative implementation to ensure intended outcomes are achieved.

Figure 1: Governance Structure of the Joint Regional Plan Implementation Phase





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Program level Coordination of Implementation

Program-level coordination of The Plan’s implementation will be led by the HNC in partnership with Implementation Leads from each LHD. A four-year Action Plan, developed collaboratively by partner agencies, sequences key initiatives implementation and will be collaboratively reviewed annually by all agencies.

Collaborative annual review and planning sessions will confirm initiative sequence through reprioritisation, ensuring alignment with evolving State and Commonwealth priorities, policy changes, and the current needs of our communities.

The agreed yearly Action Plan initiatives will include defined implementation monitoring measures and performance indicators for quarterly reporting to the Mental Health, AOD and Suicide Prevention Steering Group. Progress will be evaluated annually to assess achievement of intended outcomes. Findings will be reported to the Steering Group and presented at the annual MOU Joint Boards Meeting.

Each partner agency will report quarterly on progress measures and outcomes of initiatives, to ensure accountability and enable a regular feedback loop with joint leadership and with the community and stakeholders across the region via the HNC website.

Advocacy

The following items are priorities for integrated advocacy efforts:

Advocacy
Identify opportunities to establish more ‘no wrong door’ services such as Medicare Mental Health Hubs, safe havens or similar models in the community
Identify opportunities to establish detox and rehab services
Advocate for a perinatal AOD service
Review evidence base for efficacy of establishment of recovery colleges
Trial a mental health short stay unit at Tweed Valley hospital (advocacy)
Advocate for increased funding to respond to outpatient needs for people experiencing problematic AOD use.
Increase supervision access for all clinical and psychosocial workforce.




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Version Control


Version	Date	Description of changes made	Author
V2	November 24	Embedding LHD clinical teams feedback	Jac Grose (HNC)
V3	18 December 24	Embedding Steering Committee Feedback	Jac Grose (HNC) Riley Bice (NNSW LHD) Judy O'Mara (MNC LHD)
V3	28 March 25	Embedding CEO HNC feedback and updating of coordinating agency roles.	Megan James (HNC), Aimee McNeill (HNC), Deidre Robinson (NNSWLHD), Tamahra Manson (NNSWLHD) Sarah Fox (MNCLHD), Judy O'Mara (MNCLHD)
V4	15 June 25	Embedding feedback from LHDs.	Megan James (HNC)

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