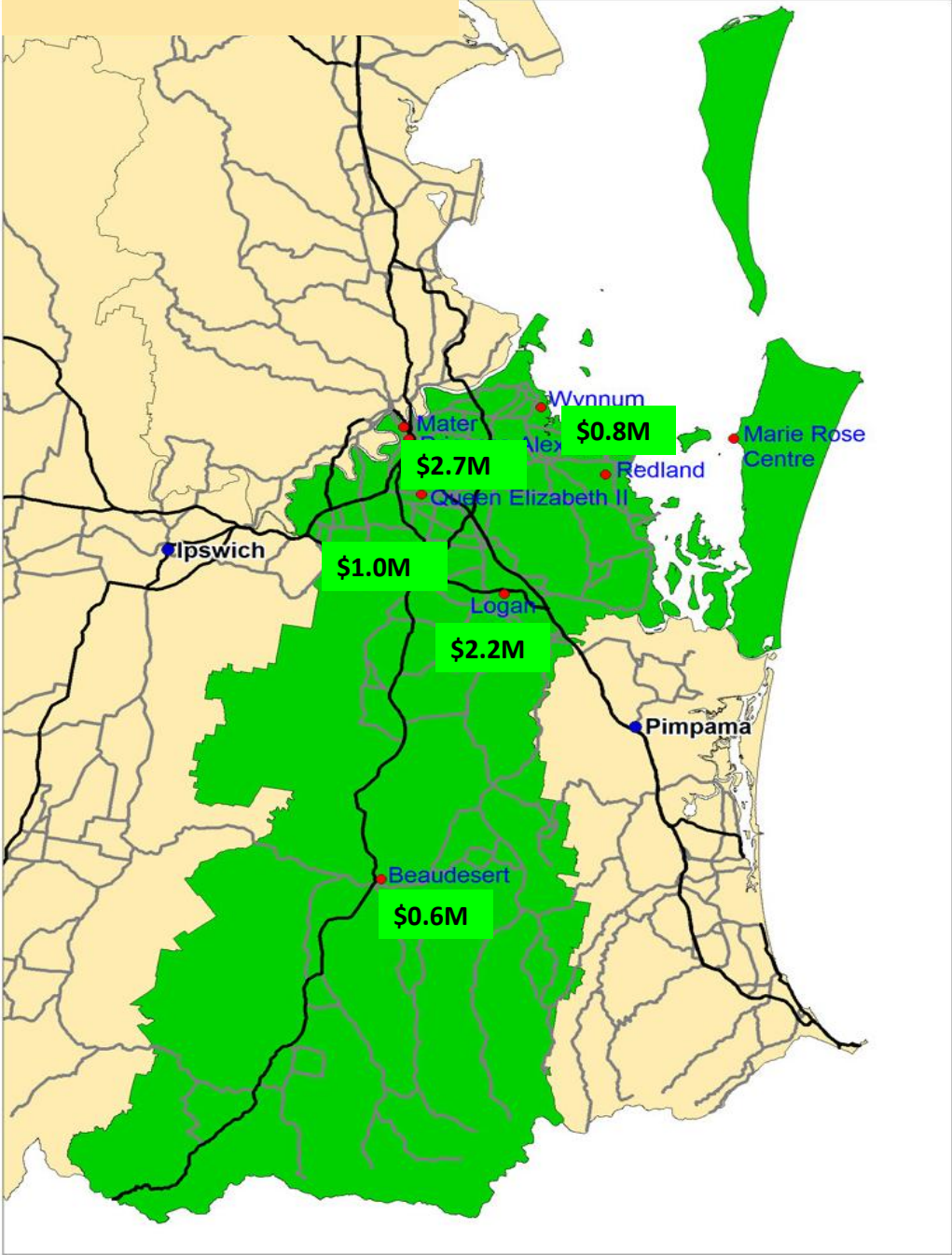


Funding distribution across Metro South Health District



Projects by Health Priority Area

Integrated Health Promotion and Illness Prevention

- [Connecting with Men](#)
- [HYPE – Hip Hop](#)
- [C.H.O.I.C.E.S](#) - Choosing Healthy Options Involves Commitment, Encouragement & Support
- [Somewhere to Call Home](#) - Needs of people resident in caravan parks and hostels in the Beaudesert Region
- [Wise 'n' Well Club](#)
- [Living Well Community Mentors](#)

Aboriginal and Torres Strait Islander populations

- [LIP](#) (Linking Indigenous People) project

Chronic Disease (CD) in Culturally & Linguistically Diverse (CALD) populations

- [CD and Self Management \(CDSM\) Model in CALD populations](#)
- [Health Promoter Project](#)
- [Natural Helper Sustainability Project](#)
- [RaPH – Refugees and Primary Healthcare](#)

Chronic Disease Management and Provision of Complex Care

- [Inala Complex Diabetes Service](#)
- [Model of Primary Care for People with Type 2 Diabetes](#)
- [DISC - Diabetes Insulin Stabilization Clinics](#)
- [Coordination of the Living Well at Home Program \(LWAHP\)](#)
- [eASi – CD - enhanced ACCESS to inter-agencies – chronic disease](#)
- [Partnerships to enhance the management of co-morbidities in patients with chronic liver disease](#)
- [COPD Self Management Support Systems](#)
- [Practice Visits for Renal Team - Logan Hospital](#)
- [Care Collaborations - Paediatric Complex Care](#)
- [Enhancing access to Palliative Care for people living with Advanced Heart Failure](#)
- [Learn to Live](#)

Aboriginal and Torres Strait Islander populations

- [Aboriginal & Torres Strait Islander Cardiac Rehabilitation Program](#)

Early Childhood Health

- [Inala and Surrounds Young Parent Consortium](#)
- [Healthy Babies](#)
- [\(SAIF\) Secure Attached Infant Families](#)

Community Mental Health

- [Resiliency in Bayside Schools \(RIBS\)](#)
- [No Wrong Doors](#)
- [Southside NGO Mental Health Collaborative Development Project](#)
- [Primary Connections in Mental Health](#)
- [Family Support Worker within BeauVisions Mental Health Community Support Service](#)
- [Crossroads](#)
- [Reclink - Logan](#)

Health Priority Areas Addressed

Integrated Health Promotion and Illness Prevention

Connecting with Men (to June 2011)

Purpose: To engage men to take an interest in their own health through a range of educational and practical interventions delivered in a non health environment using the "Pit Stop" healthy lifestyle program. An evaluation consultant will be engaged to implement action research. To offer health assessments at 4 locations including the Sunnybank RSL Community Drop in Centre and Men's Shed, and supported by a team of volunteer medical practitioners and allied health. To encourage participants to follow-up with local GP's / health professionals where it is indicated. To include the A&TSI and the Vietnamese community in the target population. To have the Connecting with Men project managed in the long term by Sunnybank RSL and local community agencies, with the support of stakeholders.

Outputs: Commenced December 2009

Auspice Agency: Brisbane South Division Inc

Project Partner: Sunnybank RSL

Contact: Mark Storrs Ph: 3274 1886

HYPE – Hip Hop (to June 2011)

Purpose: To provide dance workshops and a talent identification program to Logan Youth

Outputs: 6 months delay in finalizing service agreement and receiving funding

Auspice Agency: Griffith University – Logan Campus

Partners: Education Queensland, Queensland Health, Logan-Beaudesert Health Coalition, Logan City Council, Youth and Family Services – Logan, Fresh Elements, Blackstar Media

Contact: Neil Harris n.harris@griffith.edu.au

Choosing Healthy Options Involves Commitment, Encouragement & Support - C.H.O.I.C.E.S (completed)

Purpose: Through the Lighten Up program to assist adults who have a chronic disease to make healthy lifestyle choices through support, education and encouragement. This will include cooking lessons, budgeting skills and exercise programs on an ongoing basis and involve the ongoing development of community partnerships and evolving partnership networks.

Outputs: JCCA linked with Lighten –Up and 1 staff member (Volunteer Coordinator) trained in Lighten –Up and Lighten-Up LMP, 52 referrals to Program, mostly from 1 partner General Practice and a number of patients referred with diabetes , 7 CHOICES Lighten –Up Programs (10 sessions per program) delivered with 36 completing the program, allied health input (Healthy Lifestyle Coordinator and Dietitian), cooking program planned and weekly working group operating

Auspice Agency: Jimboomba Community Care Association Inc (JCCA)

Partners: Jimboomba / Flagstone Early Years Facilitator, Beaudesert Shire Council, The Southern Qld Rural Division of GP's, Jimboomba Medical Centre (GP's), Jimboomba Junction Family Practice (GP's), Flagstone State School, Jimboomba State School, Centacare St Mary's Community Services (HACC Funded Services), RHealth,

Contact: Elina Juusola-Halonen director@caddies.org.au

Somewhere to Call Home - Needs of people resident in caravan parks & hostels in the Beaudesert Region (Completed)

Purpose: To collate relevant local information around the need to support healthy lifestyles through various educational activities including cooking classes, walking groups, and social groups in disadvantaged and marginalized (e.g. caravan parks, hostels etc). To improve linkage to already existing local services and further identify any service gaps in supporting such vulnerable client groups, and suggest any innovative strategies.

Output: Consultant Report: 'Somewhere to call Home'. Key recommendations from this report included: feeding finding into any community consultation process involved in developing a Public Health Plan for the Scenic Rim Council, funding workers to link with this target group, funding formation of and secretariat for an ongoing interagency and partnerships involving the Scenic Rim Council, Industry, Government, Industry, RHealth, NGOs and community organizations, with links to the Beaudesert Region Disability Partnership

Auspice Agency: Centacare St Mary's Community Services

Partners: Jimboomba Community Care Association Inc.(JCCA), Community Health Services (including Indigenous Health; Diabetes Education; COPD experts), Beaudesert Caravan Park management, Jymbilung Respite Centre, Centrelink, Mission Australia, Diabetes Australia, Volunteer Qld

Contact: Sharon Redmond servicemanager@centacarebdst.org.au

Wise 'n' Well Club (Completed)

Purpose: To target socio-economically disadvantaged women aged between 18 and 45 years living in Logan City. To make positive life changes in relation to diet, exercise, and self-esteem and employment skills. To develop a sustainable model of business partnerships and supported pathways to link the target group to relevant health and well being services.

Outputs: Formalized partnership with all partners except Logan Diggers Club; 272 women (1440 participation contacts over 320 activities) have attended 'Introductory Activities': focus groups, information sessions or activities in community setting mostly at often at LWHWC – little interest in activities round target risk behaviours so activities were offered around creative expression (singing, craft), natural healing and social engagement, 33/39 women signed an agreement to participate and completed Stage 2, 8 week Lifestyle Challenge with activities including physical activity (weekly walking group), creative expression, natural healing, self esteem, goal setting, budgeting and personal presentation, nutrition food and cooking. Graduates of Lifestyle Challenge supported to become program mentors for 'Introductory Activities'; evaluation of partnership using community development strategies

Auspice Agency: Logan Women's Health and Wellbeing Centre Inc

Partners: Logan Diggers RSL Club, Lifestyle Health Clubs, Career Keys, School of Public Health Griffith University, Logan Campus

Contact: Amanda Ahearn wisenwell@loganwomen.com.au

Living Well Community Mentors (to June 2011)

Purpose: Builds on Wise n' Well program pilot. This project will formalize Wise n' Well partnerships in order to develop resource materials and provide the training required to deliver an integrated health program for marginalized women at risk of chronic disease in the Logan area. The program will be extended to 4 Community Center through a team at each location made up of partner staff, trained mentors, postgraduate students and existing underutilized service providers.

Outputs: Commenced July 2010

Auspice Agency: Logan Women's Health and Wellbeing Centre Inc

Partners: Career Keys, Lifestyle Health Club, Logan City Council, Griffith University (School of Public, School of Social work) Logan Campus

Contact: Amanda Ahearn wisenwell@loganwomen.com.au

LIP (Linking Indigenous People) project (to June 2011)

Purpose: To improve chronic disease outcomes of Logan A&TSI population through GP and Allied Health Professional education to increase uptake of Medicare item numbers 704 -710.

Outputs: Practice resource officer for Aboriginal and or Torres Strait Islander organizations needing more information on Health Checks and GP access Regular, regular meetings between resource officer and indigenous stakeholder organizations, culturally appropriate webpage and LIP brochure, 29 Practice visits to promote MBS items and cultural awareness (targeted practices with high A&TSI), 1 cultural awareness training session to 18 GPs, practice Staff and health workers. Cultural Awareness Training Program in consultation with stakeholders, to complement Closing the Gap Cultural Awareness Training around PIP is in development

Auspice Agency: SouthEast Primary Healthcare Network

Partners: AICHS (Aboriginal Islander Community Health Service), MTSIN (Murri Torres Strait Islander Network), Indigenous Health Logan Beaudesert Health Service, Logan Council of Elders, Queensland Health – Living Strong Program

Contact: Tamara Nikolaou tnikolaou@sphn.org.au

Chronic Disease (CD) in Culturally & Linguistically Diverse (CALD) Populations

CD Prevention and Self Management (CDSM) Model in CALD populations (to June 2011)

Purpose: To use up-skilled Multicultural Health Workers (MCHW) to deliver culturally targeted CDSM to CALD patients referred by General Practice. There is evidence that the MCHW model increases participation, access, communication and trust in health care professional in the CALD population. Northside Partnership Council has funded a parallel project.

Outputs: Five draft models identified for linking GPs with MCHW up-skilled in CDSM: GP referrals / MCHW co-located with GP / MCHW co-located with Division or ECCQ / MCHW in community (shared across practices)/ MCHW mobile van. Printed resource materials to promote MCHW services to GP staff and patients developed. 10 Practices with a significant CALD patient population recruited, 32 two GP referrals with 26 patients attending MCHW education

Auspice Agency: Ethnic Communities Council of Queensland

Partners: Brisbane South Division Ltd, Metro South HSD Community and Primary Health Services Lifestyle Management Team, Queensland Transcultural Mental Health Centre

Contact: Nermina Komaric nerminak@eccq.com.au

Health Promoter Project (to June 2010)

Purpose: Addresses the lack of access to services among CALD communities by using a collaborative community-based approach to consultation and recruitment of local bi-lingual community members who will be trained and supported to act as health promoters. Health Promoters will draw on existing community linkages and act as a bridge between the communities and the health system and advocate for improved access, ensure that local communities are consulted appropriately, and support them in their interpretation and use of health services.

Outputs: Culturally appropriate Natural Helper (Community Navigator) Model that uses an asset based community development approach; Implementation Framework and Resource Manual; Multilink & Access Inc. trained in implementation framework; 9 Navigators (Tongan, Samoan, Afghani, Burmese, Sudanese, Maori communities) working alongside target communities and being mentored (rather than trained) in one-to-one training meetings and a weekly group learning circle. Scholarships secured for Navigators to undertake the Griffith University Graduate Certificate in Community and Youth Work developed specifically for CALD communities

Auspice Agency: Griffith University

Partners: Southside Health Service District - CALD Chronic Disease Partnership , Queensland Self-Management Alliance, Multilink, ACCES Services Inc, Griffith University, MSIT TAFE

Contact: Prof Elizabeth Kendall Tel: 61 7 3382 1202 e.kendall@griffith.edu.au

Natural Helper Sustainability and Partnership Innovation Project (to June 2011)

Purpose: To build on the achievements of the Logan Health and Wellbeing health Promoter (Natural Helper) pilot project and the relationships built with the Logan City Samoan, Afghani, Sudanese, Burmese and Maori communities, and key health and social service agencies. This project seeks to transform the Natural Helper (Community Navigator) Model piloted, into a service, embedding it into standard practice within the Logan community and identifying sustainable solutions.

Outputs: Commenced July 2011

Auspice Agency: Griffith University

Partners: Multilink Community Services Inc, ACCES Services Inc, Logan Beaudesert Health Coalition

Contact: Prof Elizabeth Kendall Tel: 61 7 3382 1202 e.kendall@griffith.edu.au

RaPH - Primary care management, including health promotion and prevention, of chronic disease (CD) in refugee communities in Brisbane South with a view to develop a state-wide model (to Dec 2011)

Purpose: To enhance the capacity of local General Practices to provide management to refugee populations with complex care needs or at significant risk of CD on settlement in Australia. To develop and implement a model which coordinates and promotes better integration of existing resources including allied health and community health and contributes to the development of a state-wide refugee primary health network.

Outputs: Revision of Victorian Refugee Service resources - Desk Top Guide for Care of Refugees in General Practice (Qld edition) in electronic and 500 hard copies to be distributed using a strategy developed in collaboration with Refugee Health Queensland and Mater Marketing and Divisions of General Practice, website development (Mater on Line) in collaboration with Mater Refugee Maternity Service, qualitative research data with 5 General Practices and refugee communities using peer interviewing, standardized referral templates and letters to ED departments for Refugee Health Queensland (RHQ), stakeholder forum 'Chronic Care Model for People from a refugee backgrounds' with HealthWest Partnership Victoria'.

Feedback from stakeholder engagement has resulted in a decision to delay progress on sustainable, transferable model of care delayed until a discussion paper is to be written before describing a transferable model. The project has been granted a 6mth timeline extension

Auspice Agency: Mater/UQ Centre for Primary Health Care Innovation

Partners: RHAC, Refugee Health Qld, QPASTT, ECCQ, Griffith University, SEAGP, Brisbane South Division Ltd GPpartners, SouthEast Primary Healthcare Network , Multicultural Development Association MDA, Multilink, Access Services Inc Logan, Queensland African Communities Council (QACC), Queensland Sudanese Community Council, Metro South Community Health Service, Queensland Health – District Multicultural Coordinator, Logan Community and Primary Health Care – Refugee Health Clinic, Queensland Health Multicultural Policy Development.

Contact: Paula Peterson Paula.Peterson@mater.org.au

Chronic Disease Management and Provision of Complex Care

Inala Complex Diabetes Service (June 2010)

Purpose: To develop a sustainable business model for a successful local integrated primary / specialist diabetes pilot for complex diabetes care. To develop a web-based shared e-record to support the model and provide additional training for Brisbane South General Practices and registrars in the management of complex diabetes.

Outputs: Clinical service delivery from the 1st July 2009 [comprising 2 GPs with additional training in management of complex diabetes, part-time endocrinologist, diabetes educator and podiatrist and Special Skills Registrar who commenced in Feb 2010], 5 GPs trained using UQ Advanced On Line Module for Diabetes, on line referral template, 76 new referrals managed by the service with 13 patients discharged back to GP. Sustainable business model not identified.

Additional CD funding allocation to continue service

Auspice Agency: Inala Primary Care (IPC)

Partners: Princess Alexandra Hospital, Inala Indigenous Health Service, Central and Southern Qld Training Consortium (CSQTC), Brisbane South Division Ltd, SEA-GP (Brisbane), Queensland Health Policy, Planning, and Resourcing Division, Dept of Health and Ageing

Contact: Cathy Brown cbrown@inalaprimerycare.com.au

Comprehensive Evidence Based Model of Primary Care for People with Type 2 Diabetes (Completed)

Purpose: To develop and pilot a service delivery model to support service providers across the continuum to work collaboratively, and to use General Practice as the 'hub' for care co-ordination.

Outputs: a web-hosted primary care and referral pathway which identifies each step in the process of evidence based, systematic primary care for type 2 diabetes and links each step to supporting resources such as Medicare items, referral templates, clinical decision tools and patient self management information; clinical models supported by business models to increase patient and GP access to specialist support including business models around employment of a Credentialed Diabetes Educator to support General Practice

Auspice Agency: SEA-GP (Brisbane)

Partners: Metro South HSD - Southside Diabetes Service, Mater Health Services - Queensland Diabetes Centre and DAART, Mater /UQ Centre for Primary Health Care Innovation

Contact: Vicki McGowan vmgowan@seagp.org.au

DISC - Diabetes Insulin Stabilization Clinics (to June 2010)

Purpose: To establish Diabetes and Insulin Stabilisation Clinics within General Practice to enhance patient centred care for people with type 2 diabetes. To schedule Diabetes Educator visits to clinics to provide support and facilitate liaison between GP and Endocrinologist. To hold educational events facilitated by an endocrinologist for General Practices. To schedule case studies conducted by the Endocrinologist and Credentialed Diabetes Educator with the General Practitioners and Practice Nurses.

Outputs: 2 part-time CDE employed to visits General Practices and support GPs and practice nurses as required. 3 General Practice diabetes clinics reported to be in operation but no integrated model for delivery model developed. Project Reference Group has met only once.

Auspice Agency: SouthEast Primary Healthcare Network

Partner: Metro South Health Service District – Logan Beaudesert Diabetes Services, General Practice - General Practitioners and Practice Nurses consulted, Murri and Torres Strait Islander Network

Contact: Laura Jordan ljordan@shpn.org.au

Coordination of the Living Well at Home Program (LWAHP) (Completed)

Purpose: To develop a network of local providers and promote a coordinated approach to the implementation of the LWAHP to other service providers (home care workers and health professionals) in the Southside HSD. The LWAHP early intervention program has been operating through collaboration between DAART (Domiciliary Allied Health Acute care and Rehabilitation Team) and Community Health since 2004 and has been observed to increase health and well being of people over the age of 65 years with chronic and complex care needs and decrease demand on home care services by increasing functional ability.

Outputs: An information package for clients with referral protocols, screening tools, and information brochures, an information and training package for allied health staff, a visual presentation to train and educate referring organizations, an external evaluation of the program's efficacy, up skilling of 734 service providers, a Partnership Committee (Blue Care, DAART, Community Health -HACC, Prescare, Ozcare, Spiritus) that has undertaken to continue to meet after project completion, efficacy evaluation of program.

Uptake by partner agencies was limited due to service capacity issues and recommendations included approaching HACC to allocate separate funding for early intervention / rehabilitation and growth funding to help address capacity issues.

Auspice Agency: Mater Misericordia Health Services Brisbane Limited - DAART Program

Partners: Blue Care Brisbane Region, Southside Centre, PresCare Allied Health Service, HACC AREA Manager, Southside Community and Primary Health Services Home and Community Care QE11 Bayside, SPIRITUS, DAART, OZCARE, South East Alliance of General Practice (Brisbane)

Contact: Trish Kimball Trish_Kimball@health.qld.gov.au

eAsi – CD - enhanced ACCESS to inter-agencies – chronic disease (Completed)

Purpose: to enhance access to existing community services for persons with CD and medium to high risk of hospital admission, in Metro South HSD – Bayside area. To develop a brokerage model.

During the course of the project it was decided that the complex care needs of people with chronic disease could not be addressed by a brokerage model, but could be best supported through improving knowledge and understanding of existing home and centre-based government subsidized services, across acute and community sectors (including General Practice).

Outputs: A web-hosted Domiciliary Services Directory for Redlands, Wynnum, Manly Area. A series of information workshops for General Practice Staff, Queensland Health and Domiciliary Agencies.

Auspice Agency: SEA-GP (Brisbane)

Partners: Spiritus Bayside, Blue Care Redland Community Care Services, Metro South HSD – Bayside (community & acute), Mater Private Hospital – Redland, Oz Care

Contact: Helen Price-Jones hpricejones@seagp.org.au

Partnerships to enhance the management of co-morbidities (metabolic risk factors and depression) in patients with chronic liver disease (Completed)

Purpose: To up skill primary care clinicians to provide “share the care” arrangements for people with metabolic risk factors and depression which contribute to substantial morbidity in patients with chronic liver diseases and to facilitate this through agreed care plans and referral pathways for people with chronic liver disease and metabolic co-morbidities, depression, anxiety and related psychological issues.

Outputs: Audit and statistical analysis of 1223 referrals (including 856 category 3 Aged Referrals) and audit of triage practices completed, Minimum Data Set for referral (and referral template for Qld Health Aged Referral Project) established and endorsed by GP Liaison Committee (also established through project), alignment of Referral Requirements for Metro South hospitals, monthly Metabolic Physician clinic to review patients with metabolic co-morbidities and provide

detailed letters including care plans to GP, collaboration with BSDL GPLO to provide GP education to update referring practices and discuss shared care options using practice visits and detailing, list of on-line resources for GP and patient education about Hepatology and distribution of hard copy books and facts sheets to GPs in BSDL, agreed care plan for the management of depression, anxiety and related psychological issues including substance abuse, excess alcohol intake, in patients with chronic liver diseases.

Auspice Agency: Princess Alexandra Hospital

Partners: SEA-GP (Brisbane); Brisbane South Division Ltd (Aged Referrals Project)

Contact: Leigh Horsfall Leigh_Horsfall@health.qld.gov.au

COPD Self Management Support Systems (to June 2011)

Purpose: To deliver improved health care to people with chronic obstructive pulmonary disease (COPD) by delivering clinical communication skills training (using an existing program comprising 4x3hr workshops) to clinicians (GPs and Practice Nurses) to facilitate better engagement with patients to manage their health. The outcomes from the project will be trained clinicians who have completed the Advanced Development Program. To use 'champion' clinicians to train other clinicians. It has been decided not to do the patient self management education as originally intended, but to refer patients to the existing self management services (Brisbane South Respiratory service, ECCQ MCHW CDSM Service, Inala IHS).

Outputs: 28 clinicians trained, data extraction software provided to participating practices to support development of COPD patient registers and data collection; baseline data using a survey collected from patient samples for 22 of these clinicians; 6 trained clinicians trained as trainers

Auspice Agency: Brisbane South Division of General Practice (BSDGP)

Partners: The Australian Lung Foundation, Brisbane South Respiratory Service, Inala Indigenous Health Service, Ethnic Community Council Queensland

Contact: Debbie Croydon DCroyden@brisbanesouth.com.au

Practice Visits for Renal Team - Logan Hospital (Completed)

Purpose: To develop a partnership between SPHN and Nephrology (Logan Hospital) to provide better integrated care for people with chronic renal disease and improve communication and referral systems. To establishment of a Renal team member visiting program to provide one on one education and support to GPs and Practice Nurses.

Outputs: Toolkit for General Practitioners to use to navigate the Logan Hospital renal services, and a flow chart to guide referrals.

Auspice Agency SouthEast Primary Healthcare Network (SPHN)

Partners: Southside (Metro South) Health Services District – Nephrology Department, General Practice - General Practitioners and Practice Nurses consulted

Contact: Amanda Adams AAdams@sphn.or.au

Care Collaborations - Paediatric Complex Care (to June 2011)

Develop, implement and evaluate an enhanced model of care for children and young people with chronic, complex care needs which integrates their care between hospital and home and provides a more sustainable delivery of service within the community.

Outputs: 6mths delay in commencing project

Auspice Agency: Domiciliary Allied Health Acute Rehabilitation Team (DAART) Mater

Partners: SEAGP, South East Division of General Practice, Queensland Child & Adolescent Renal Service, Department of Respiratory & Sleep Medicine, Mater Children's Hospital, Department of Education, Training & the Arts – Mater Children's Hospital Special School, UQ Centre for Primary Health Care

Contact: Elizabeth Shepherd elizabeth.sherherd@mater.org.au

Enhancing access to Palliative Care for people living with Advanced Heart Failure (to June 2011)

Purpose: To facilitate the introduction of evidence based palliative care guidelines for people with End Stage Heart Failure (ESHF) into the practice of local service providers operating within Metro South (Southside) HSD.

Outputs: Map of current care with respect to ESHF, identification of barriers to access to palliative care, development of a MSHSD preferred model and supporting documentation required for model implementation and comprising an ESHF Pathway and an ESHF Non-Acute Management form.

Education strategies & resources slightly behind schedule.

12 month extension with additional funding to integrate trial the model with the trial of the Qld Health Acute Resuscitation Plan platform (CHOICES Project)

Auspice Agency: Brisbane South Palliative Care Collaborative (BSPCC)

Partners: Brisbane South Palliative Care Service, SEA-GP (Brisbane), Heart Foundation Queensland, Diabetes and Respiratory Service – QEII, Integrated Respiratory Service – Logan-Beaudesert, Prince Charles Hospital

Contact: Maree Lyons-Micic maree_lyons-micic@health.qld.gov.au

Learn to Live (to June 2011)

Purpose: To deliver a holistic, multi-disciplinary, home based program for people suffering two or more chronic diseases to clients with two or more Chronic Diseases who reside in the Inner South and Bayside areas of the Metro South Health District, and who have difficulty accessing current centre based programs at the time of referral. To address the underlying elements commonly found to be associated with Chronic Disease that often become a significant factor for hospitalisation.

Outputs: Delay in recruitment of project officer and project has been granted 6 months extension to timeline

Auspice Agency: DAART Mater

Partners: Inala IHS , ECCQ, Aboriginal and Torres Strait Islander Health Service (Woolloongabba), Eight Miles Plains Community Health, SEA-GP (Brisbane), Mater Hospital Chronic Disease Project

Contact: Carmel Brennan carmel.brennan@mater.org.au

Aboriginal & Torres Strait Islander Cardiac Rehab Program (to June 2011)

Purpose: To modify existing Cardiac Rehabilitation Programs (CRP) to include cultural and ethical considerations and to increase participation and retention of Aboriginal and Torres Strait Islander clients these programs. To Enhance partnerships; improve referral processes.

Outputs: Commencement 6 months behind schedule and 6 month extension of timeline approved

Auspice Agency: Inala Indigenous Health Service

Partners: Inala Elder Corporation , Aboriginal and Torres Strait Islander Community Health Service Brisbane (ATSIHS), School of Human Movement Studies University of Queensland (HMUQ), Lifestyle Management Team (LMT), Diabetes and Respiratory Services (DRS)

Contact: Linnette Skinner linnette_skinner@health.gov.au

Early Childhood Health

Inala and Surrounds Young Parent Consortium (Completed)

Purpose: To build on and enhance the services currently being provided to young parents at the Spiritus Early Parent Centre in Inala (EPC) by coordinating currently fragmented services, including forming a consortium. To better meet the needs of young parents and offer a more diverse range of outreach services from conception to early childhood.

Outputs: ongoing negotiations with the Mater Mothers around an outreach service based at the EPC, links with the Inala Interagency Network to progress a 'Strengthening Referral Pathways Plan' developed jointly with Relationships Australia, delivery of parent education sessions at EPC supported by Inala Child Health; EPC attendance at other existing Interagency meetings (QH Early Years Initiative, Infant Mental Health Network, and Early Childhood Partnership).

Auspice Agency: Spiritus Early Parent Centre

Partners: Mater Health Service, Mater Children's Hospital, Child Youth and Family Health Service, Spiritus – The Early Parent Centre, Mission Australia

Contact: Bernadette Pitman bpitman@spiritus.org.au

Healthy Babies (Completed)

Purpose: Development phase of the Healthy Babies Project to formalize existing partnerships around refugee nutrition into a functioning Healthy Babies Coalition and, with active involvement of this Coalition, develop a series of culturally appropriate early infant nutrition resources for African refugee families (for both the community and service providers).

Outputs: 2 readers, 2 A-sized posters and 2 DL-sized brochures: "Breastfeeding your baby in Australia" (infant feeding 0-6 months) and "Introducing Solids" (infant feeding 6-12 months); 2 A4 breastfeeding fact sheets addressing milk supply issues and how to continue breastfeeding when away from your baby; and introduction to solids fact sheets addressing iron rich foods and the table in the poster; Audio DVD available in Swahili, Kirundi and Arabic. The Healthy Babies Coalition will be a key strategy to support the implementation phase for these resources.

Auspice Agency: Queensland University of Technology

Partners: State-wide Multicultural Health Program, Brisbane Southside Population Health Unit, QIRCHC, Qld TAFE, Milperra State High School, MDA, VoRTCS, TESOL, NAYSS, South East Queensland Breastfeeding Coalition, ABA, QPASTT

Contacts: Fiona McKenzie Lewis Fiona.Lewis@health.qld.gov.au; Jan Payne j.payne@qut.edu.au

(SAIF) Secure Attached Infant Families (to June 2011)

Purpose: To employ a SAIF Coordinator to work across the 4 key non-government Child Health Outreach sites in the Inala Carole park area in order to develop and strengthen linkages between these sites, Child Health and other relevant services. To also deliver skills building and education programs for families with children 0-4 yrs, and use the SAIF Coordinator as a complementary worker to Child Health clinicians

Outputs: Commenced July 2010

Auspice Agency: Mission Australia Communities for Children

Partners: Inala Community House, Inala Child Health, Carole Park Community Centre (Community Action in Carole park Inc.), Spiritus Early Parent Centre, Child Youth and Family Health Services Metro South HSD

Contact: Jenny Chaves chavesj@missionaustralia.com.au



Community Mental Health

Mental Health Promotion Initiatives Within the Bayside Area Resiliency in Bayside Schools (RIBS) (Completed)

Purpose: To improve the positive mental health and well being of young people in Bayside with the use of mental health promotion initiatives; and to improve networks between schools and local mental health service and primary care providers.

Outputs: 6 State High Schools (SHS) recruited to deliver Mind Matters with education of staff provided by Qld Mind Matters Coordinator. Memorandum of Understanding between SEA-GP and each SHS to provide teacher (staff) release payments to backfill staff attending training (Mind Matters and for welfare staff from 1 SHS Mental Health First Aid). Management Group established with executive representation from 5 SHS to encourage schools to focus on implementation of Mind Matters approach, and develop internal policy documents around promoting mental health as primary goal in yearly plan. 4 SHS completing level 1 PD in Mind Matters Implementation Framework.

Youth Services Directory not yet achieved

Auspice Agency: SEA-GP (Brisbane)

Partners: Education Queensland, Bayside Mental Health Service, Southside Population Health Unit, School Based Youth Health Nurses, South East Alliance of General Practice GPs, Bayside Adolescent Boarding Inc. (BABI), IN-SYNC

Contact: Olivia Fisher ofisher@seagp.org.au

No Wrong Doors (to June 2011)

Purpose: To provide adults with mental health and drug and alcohol problems with appropriate services (or links them to) regardless of where they enter the system of care. To do this by improving service collaboration and knowledge of Dual Diagnosis for agencies to be able to deliver more appropriate services for people with co morbid substance use issues and mental health problems.

Outputs: 6 month delay in commencement due to delays in finalization of Service Agreement

Auspice Agency: Queensland Injectors Health Network

Partners: Metro South ATODS (C&PHS), Metro South Mental Health, SEA-GP, Qld Alliance

Contact: Geoff Davey general.manager@quihn.org.au.

Southside NGO Mental Health Collaborative Development Project (to June 2011)

Purpose: To improve the mental health and well-being of our local community by strengthening relationships and improving collaboration among health care providers, consumers, families and communities.

Outputs: Project Management Group and Terms of Reference

Auspice Agency: The Brook RED Centre Inc

Partners: Queensland Alliance, Kyabra, The Benevolent Society, Steppingstone Clubhouse, Metro South Mental Health (PA), Open Minds, Commonwealth Carer Respite, Brisbane South Division of General Practice, Neami Ltd

Contact: Jude Bugeja jbugreja@brookred.org.au

Primary Connections in Mental Health (Completed)

Purpose: To develop and pilot a model of service delivery providing integrated care to people needing mental health services. To employ a primary health care worker with mental health expertise to work between 2 general practices in the Logan area to assist in building capacity in general practice, strengthen links with the acute mental health sector and act as an interface between patients, hospital, public mental health services and primary health care.

Outputs: CNC Mental Health Liaison service between Browns Plains Adult Mental Health Service (BPAMHS) and SPHN GPs, including weekly CNC clinics within General Practice to undertake intensive mental health assessments and work with GPs, patients and local NGOs to improve mental health literacy. Processes for distribution of 3 monthly BPMHS team reviews to GPs, GP access to phone consults with psychiatrist, linkage of BPMHS clients to GPs, and sharing of patient file notes. Reduction in referrals to Queensland Health Mental Health intake teams. Assessment and referral toolkit for GPs not achieved. No ongoing funding for this position at completion of project through Queensland Health.

Auspice Agency: SouthEast Primary Healthcare Network

Partners: Queensland Health

Contact: Anna Johnston anna_johnston@health.qld.gov.au

Family Support Worker within BeauVisions Mental Health Community Support Service (to June 2011)

Purpose: To employ a Family Support Worker (FSW) within the BeauVisions Mental Health Community Support Service to work with parent clients and their children to improve relationships by educating and re-educating parents on how better to manage their symptoms and the impacts of these on their children, whilst also renewing and developing their parental skills. To use knowledge gained from this service to develop a specific parenting skills training program with a focus on the effects of mental illness. To use this program up-skill relevant organisational (and partner agency) staff.

Outputs: Individual Counselling of 16 parent clients attended individual counselling with referrals from Mental Health Program Coordinator and Department of Child Safety); Parent Effectiveness Training (PET) training for FSW as PET identified as having wider application than Triple P, with more focus on effective communication (e.g. addresses low literacy), PET used in individual sessions and 11 parents accessing PET training, increased communication with Dept of Child Safety, Mununjali community engaged, 'Beaudesert Region Family Assistance Network' (BRFAN) auspiced and convened by Centacare with the minute taking responsibilities by Spiritus' TRACK Logan program.

Auspice Agency: Centacare St Mary's Community Services

Partners: Aboriginal & Torres Strait Islander Health, Southside Health – Logan/Beaudesert, JCCA, TMCCA, Jymbilung House, Mununjali/Jymbi Centre, Commonwealth Carer Respite Centre, Queensland Health, Beaudesert Shire Council, Beaudesert Chapter of the Division of GP's.

Contact: Matt Gordon fsw@centacarebdst.org.au

Crossroads (Completed)

Purpose: To train a group of volunteers linked with the New Horizon Depression Support Group to undertake home visits to individual clients and to work as para-professionals to encourage clients to manage their illness and to link with local services.

Outputs: Depression Support Group facilitators Training Manual reviewed and updated, Introduction to Mental Health Training Package, Policy and Procedures for Crossroads Home Visiting, Referral form for external providers, NGO Reference group established (Beau-Care, Jimboomba Junction Family Practice, JCCA), 3/ 5 volunteers trained in facilitation and mental health education doing home visits, 5 clients visited, 'granny group to support young mothers who suffer from post natal depression'

Auspice Agency: Jimboomba Community Care Association Inc (JCCA)

Partners: New Horizon Depression Support Group, Caddies Volunteers, Interact Counselling Service – Mental Health Social Workers, BeauVisions Mental Health Program, Logan/Beaudesert Mental Health Services – Psychiatrists, Carer Liaison and Community Liaison Services, Local Medical Centres, Dianna East, Self Support Group Worker, CHOICES program facilitator

Contact: Elina Juusola-Halonen director@caddies.org.au

Reclink Logan (to June 2011)

Purpose: To establish a sustainable Reclink Network in the Logan Area consisting of 50 Human Services organizations and to provide a range of free / low cost sports, art and recreation activities specifically designed to meet the needs of their client groups. To introduce a new community development and service delivery model

Outputs: Commenced July 2010

Auspice Agency: Reclink

Partners: Youth and Family Services (Logan City) Inc., Logan Women's Health and Wellbeing Centre Inc., Karakan Hostels, Logan Beaudesert Mental Health Community Collaborative

Contact: Ben Pennings ben.pennings@reclink.org