Queensland Government Submission to the

Senate Community Affairs Committee - Inquiry into Mental Health Services in Australia

Queensland Government

Foreword

In April 1992, all Australian Health Ministers endorsed the *National Mental Health Policy* and in doing so committed their Governments to a reform process aimed at achieving major improvements in the quality and range of mental health services available to the community. The Policy, together with the three consecutive five-year National Mental Health Plans, their associated funding agreements and the *Statement of Rights and Responsibilities* comprise the *National Mental Health Strategy*. The Strategy underpinns a consistent, bipartisan, strategic approach to mental health reform in Australia.

The Queensland Government has made significant progress in reforming our mental health services in the directions originally agreed when the *National Mental Health Strategy* began in 1993. This progress is well documented in each of the ten National Mental Health Reports.

As Minister Roxon noted last month, “it is also clear that current efforts are far from complete and that Australia does not yet have an adequate system of mental health care”. The Senate Select Committee on Mental Health reports contained overwhelming evidence of the continuing problems that confront people who live with mental illness.

In July 2006, the Queensland Government announced its commitments as part of the Council of Australian Governments’ (COAG) *National Action Plan on Mental Health (NAP)*. At that time, the Queensland Government foreshadowed that more needed to be done and that further investment was required.

In May 2007, the then Premier and Treasurer and I announced the largest single investment by a Queensland Government in mental health. This further investment in mental health came as the culmination of a lengthy consultation and planning process that involved most Queensland Government departments. It brought the total investment by this Government in mental health under the COAG NAP to $895 million between 2006-2011.

This Government has recognised mental health reform involves many areas of government that extend beyond the health portfolio including housing, disability services, family and child safety services, education and training, workforce, justice, corrections and community development. We also recognise that building a better approach to supporting the recovery of people who live with mental illness, to promote greater social inclusion, is a significant challenge that requires a true partnership between both the Australian and Queensland Governments.

Realisation of the social and economic benefits of social inclusion for people who live with mental illness and to the communities in which they live, hinges on governments cooperating with a common vision. This vision should have the long term needs of people who are amongst the most marginalized and disadvantaged in our community at the forefront.

This submission to your committee outlines the progress that has been made to improve the mental health of Queenslanders since the historic announcements in July 2006. We recognise we have started what will be a lengthy reform process in mental health and are pleased to present our progress thus far to the committee. We look forward to a renewed commitment by all governments to build a genuine national approach to mental health in Australia.

Hon Stephen Robertson MP
Minister for Health

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Introduction

In July 2006, the Council of Australian Governments (COAG) agreed to the *National Action Plan on Mental Health 2006-2011* ('the NAP'), recognising the need for a change in the way governments respond to mental illness. The NAP provides a strategic framework that emphasises coordination and collaboration between government, private and non-government providers, aimed at building a more connected system of health care and community supports for people affected by mental illness.

The NAP outlines a series of initiatives that will be implemented between 2006 and 2011, described in individual implementation plans prepared by each government. While most initiatives represent additional commitments to expand ongoing programs, many are new and take the delivery of services for people with mental illness into areas beyond the boundaries of traditional health care.

Key human service programs operating outside the health system that have major responsibilities under the NAP include housing, employment, education and correctional services. Additionally, the initiatives funded under the NAP emphasise the role of the non-government sector in the delivery of a wide range of community support services. These provide the services needed by many people affected by mental illness, complementing the role of health services.

On 8 March 2005, a select committee, known as the Senate Select Committee on Mental Health, was appointed to inquire into and report on the provision of mental health services in Australia (the full Terms of Reference for the committee can be found on www.aph.gov.au). While many state-based inquiries have been conducted, this inquiry was the first of its kind in the history of the Federal Parliament, signifying the widespread level of concern about mental health.

The second and final report of the Senate Select Committee on Mental Health was completed in April 2006. A copy of the report *A national approach to mental health – from crisis to community* as well as other relevant documentation, can be obtained from the Parliament of Australia website (http://www.aph.gov.au/Senate/committee/mentalhealth_ctte).

The report highlighted that access to services remains uneven across Australia, that consumers and their families experience ongoing difficulties in service quality and access to assistance especially during emergencies and that workforce supply distribution and quality remain problematic for all jurisdictions.

Terms of Reference for the Senate Standing Committee on Community Affairs

On 28 March 2007, the Senate referred the matter of mental health services to the Community Affairs Committee with the following terms of reference:

To inquire into and report on:

1. Ongoing efforts towards improving mental health services in Australia, with reference to the *National Action Plan on Mental Health 2006-2011* agreed upon at the July 2006 meeting of the Council of Australian Governments, particularly examining the commitments and contributions of the different levels of government with regard to their respective roles and responsibilities.

2. That the committee, in considering this matter, give consideration to:
   a) the extent to which the action plan assists in achieving the aims and objectives of the *National Mental Health Strategy*;
   b) the overall contribution of the action plan to the development of a coordinated infrastructure to support community-based care;
   c) progress towards implementing the recommendations of the Select Committee on Mental Health, as outlined in its report *A national approach to mental health – from crisis to community*; and
   d) identifying any possible remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness.

3. That the committee have access to, and have power to make use of, the evidence and records of the Select Committee on Mental Health.

On 26 March 2008, the Senate Standing Committee on Community Affairs conducted a public hearing in Brisbane to take further evidence for its inquiry into mental health services in Australia.

Purpose and structure of this submission

The purpose of this report is to update the Senate Standing Committee on Community Affairs on Queensland's progress towards commitments in the NAP as outlined in Queensland's Individual Implementation Plan.

Chapter 1 describes the context in which mental health services are delivered in Queensland. The chapter outlines the significant challenges to service delivery posed by geography and the diverse demographics in Queensland.

Chapter 2 provides an overview of the components of the Queensland mental health service system and also outlines Commonwealth responsibilities for mental health. The chapter emphasises the focus of state public mental health services on the 2.5% of the population with severe mental illness. The chapter also provides data on Queensland's investment in mental health prior to the funding committed in the NAP.

Chapter 3 reviews Queensland's commitment to the NAP as detailed in its Individual Implementation Plan.

Chapter 4 illustrates the growth in Queensland's investment in mental health from the baseline level established in Chapter 2. The chapter begins by reporting Queensland's progress against each initiative in the NAP. The chapter then provides an update of Queensland's 'second round' of mental health funding provided $528.8 million in the *Outline of the 2007-08 State Budget Outcomes for Mental Health*.

Chapter 5 describes how Queensland has begun to address Governments Working Together (Flagship 1) through the establishment of the Queensland COAG Mental Health Group and the Queensland Government Mental Health Inter-Departmental Committee.

Chapter 6 presents the considerable progress Queensland has made towards implementing the Care Coordination Model (Flagship 2) since 2006-07. The chapter emphasises the establishment of 20 Service Integration Coordination positions that will further progress the Care Coordination Model.

Chapter 7 considers the national context for evaluation of Queensland's progress against the twelve COAG Action Plan progress indicators. The chapter also articulates Queensland's approach to evaluating its progress at the state level. Lastly, the chapter considers other systemic issues Queensland is addressing to support achievement of initiatives in the NAP and the *Outline of the 2007-08 State Budget Outcomes for Mental Health*.

Chapter 8 elaborates on other Queensland mental health initiatives that support NAP (but not directly funded by the NAP). The chapter concludes with recommendations for key issues to be addressed over the next four years.

Chapter 1 Queensland in Context

To understand the circumstances in which Queensland delivers mental health care, it is important to appreciate that Queensland faces a variety of unique challenges, outlined below.

1.1 A growing and ageing population

Between September 2006 and September 2007, Queensland experienced the second highest annual rate of population growth in the country (2.2% equal with Northern Territory), while the national average was 1.5% during the same period (ABS data, published 19/03/08).

Queensland's population growth is concentrated in metropolitan and regional areas along the east cost (see Figure 1). A significant proportion of future population growth is projected for the older age groups, with the number of people aged 65 years or more increasing four fold by 2051. Queensland Health recognises the need to further expand services to ensure the capacity to meet the needs of a growing and ageing population.

Challenges for Queensland

- Rapidly growing population
- Ageing population
- Uneven population distribution
- Servicing Indigenous communities
- Rural and remote access to services
- Diverse cultural population

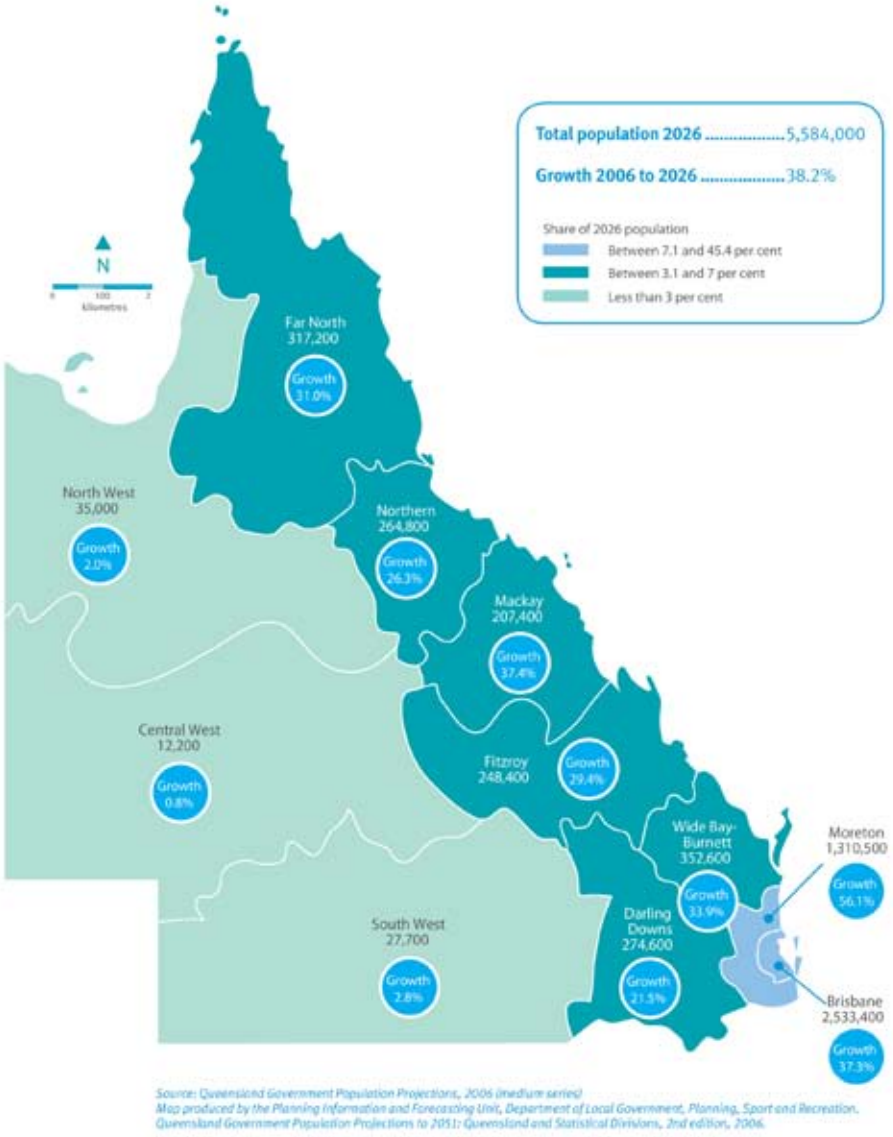
The impact of Queensland's population trends is already being felt in the hospital system, with increasing demand for health services and ever-increasing costs. Over the next 15 years, the number of hospitalisations in Queensland is projected to double as a result of changes in the population and the increasing burden of (potentially avoidable) chronic disease.

1.2 A decentralised population

Currently, almost two-thirds of the Queensland population is concentrated in the south east corner of the State and larger regional coastal centres. Vast areas of the state are only sparsely populated. Queensland faces the challenge of managing the mental health service demands of a rapidly growing population in south east Queensland and some regional coastal centres while at the same time ensuring dependable mental health service provision for the whole state.

Within 25 years south east Queensland is expected to have a population the same size as Queensland's current total of four million people, accounting for three-quarters of the State's total population increase.

Figure 1. Population by the year 2026 and population growth (%), 30 June 2006 to 30 June 2026, statistical divisions – source appropriate version



Source: Queensland Government Population Projections, 2006 (medium series)
Map produced by the Planning Information and Forecasting Unit, Department of Local Government, Planning, Sport and Recreation.
Queensland Government Population Projections to 2051: Queensland and Statistical Divisions, 2nd edition, 2006.

1.3 A diverse population

There are substantial differences in health status and life expectancy within the Queensland population. Significant mortality and morbidity rates are evident in the most disadvantaged populations, particularly Aboriginal and Torres Strait Islander peoples and people experiencing socio-economic disadvantage. Queensland is also responsible for providing mental health services to people of diverse cultural and linguistic backgrounds. Experiences that contribute to mental illness include pre-migration experiences such as trauma and disrupted families and post-migration experiences such as unemployment, lack of skill recognition, social isolation, language barriers and lowered social status.

1.4 Access to services in rural and remote areas

When providing mental health clinical care in many rural and remote areas of Queensland, mental health staff are required to make long journeys by road which is time and resource intensive. Outside of the metropolitan areas there is no access to public transport. For those living beyond the regional coastal areas, access to inpatient services requires either air evacuation or lengthy road trips.

Programs developed in collaboration with the Queensland Centre for Rural and Remote Mental Health and the Queensland Centre for Promotion Prevention and Early Intervention, to promote mental health and prevent the development of mental health problems in rural and remote communities, contribute to the unique challenges in delivering mental health care in Queensland.

1.5 Indigenous communities

Queensland is committed to improving the social and emotional well-being of indigenous people and their communities.

Three-quarters of Aboriginal and Torres Strait Islander peoples in Queensland live outside major cities. Approximately a half live in regional areas and almost a quarter in remote or very remote areas (including an estimated six % who live in the Torres Strait region). Cultural barriers reduce access to mainstream services for Aboriginal and Torres Strait Islander peoples.

The need for a coordinated approach to improving the mental health issues of Aboriginal and Torres Strait Islander people has been acknowledged through the *National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Well Being 2004-2009*, the *National Mental Health Plan 2003-2008* and the *National Standards for Mental Health Services*.

Culturally diverse groups

- Less likely to receive treatment
- Diagnosis received later in onset
- Less likely to receive treatment in both the hospital and community
- Longer stays in hospital
- Over-represented in involuntary admissions
- Less face-to-face contacts in community settings

Chapter 2 Snapshot – Queensland Mental Health Program in 2006

2.1 The Mental Health System in Queensland

This chapter of the submission reports the nature and composition of the Queensland Government's mental health program in the year before the COAG NAP as a baseline. This will allow later chapters to show the progress made during the first two years of the NAP.

At the beginning of the *National Mental Health Strategy* it was agreed that a better delineation of mental health care provision was required. It became clear that the States and Territories should be responsible for providing care to people with mental illnesses at the more severe end of the spectrum, whilst the Commonwealth was responsible for funding the providers of services to people with mild and moderate mental illnesses.

The *National Survey of Mental Health and Well Being* conducted in 1997 showed that approximately 2.5% of Australians experience severe mental illness. Consequently, the Queensland public mental health service system targets those 2.5% (approximately 100,000 people) of the state's population who experience severe mental disorders.

… the Queensland public mental health system targets the 2.5% of the population with severe mental illness …

About half of this group has a psychotic disorder, primarily schizophrenia or bipolar disorder. The remainder primarily comprise individuals with major depression or severe anxiety disorders, particularly generalised anxiety disorder (GAD) and post-traumatic stress disorder (PTSD). Disabling forms of other disorders such as anorexia nervosa are also included.

Of the 2.5% of the population with severe mental disorders, it is estimated that just over half (52% or about 51,000 people) are clients of the Queensland public mental health service system (sourced from Mental Health Branch Technical Paper).

Mental health care in Queensland is delivered by a range of providers operating within and across different sectors. There are significant areas of interface between these sectors, as demonstrated in Figure 2. It should be noted that the Commonwealth Government has a responsibility for funding the private mental health sector as well as the primary care sector.

The mental health sector, supported by the broader health sector, has clear responsibility for a range of services including clinical assessment and treatment services providing crisis response, and acute, non-acute and continuing treatment services in inpatient and community settings.

A wide variety of other interventions, which support mental health and recovery, are provided by the broader government and non-government sectors. These may include services delivered by a housing or employment agency, or personal care from a non-government community support provider.

All sectors, including public mental health services, other government agencies and non-government organisations are involved in identifying and intervening early with people who are at risk of developing mental illness and facilitating timely and effective recovery-oriented pathways to care.

In Queensland, the key groups requiring particular attention in mental health prevention and early intervention include:

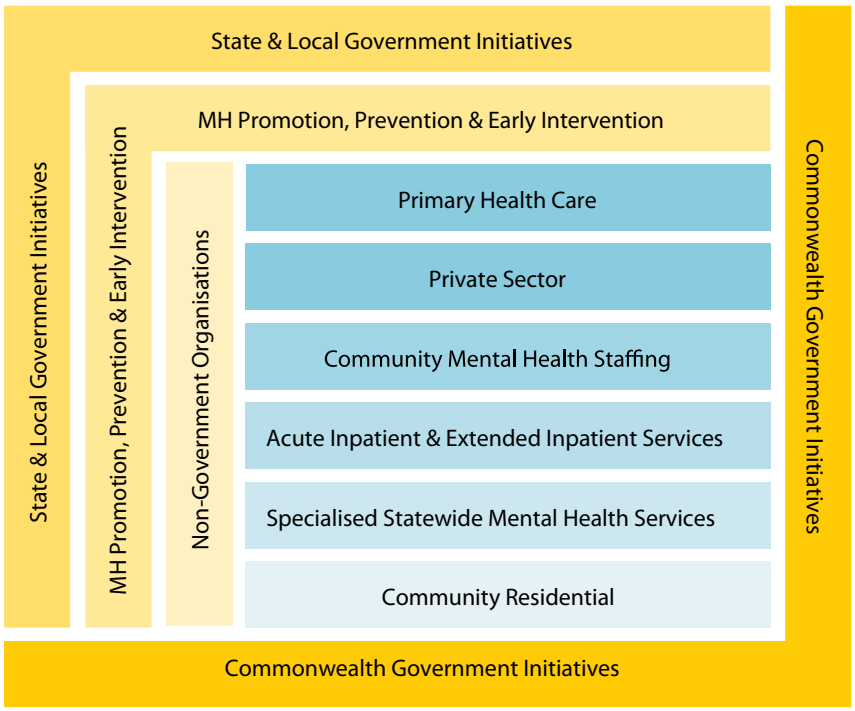
- children of parents with mental illness
- children and youth who have experienced, or are at risk of abuse/neglect
- young people displaying behaviour disturbances and their families.

We recognise the role of a safe environment, adequate income, meaningful social and occupational roles, secure housing, higher levels of education and social support as important aspects of service that are all associated with better mental health and well-being.

Trends in public mental health

- More older persons services needed
- Increasing length of stay has taken up increased bed capacity
- Clinicians are dealing with more complex clinical presentations
- Increasing numbers of people been assessed and treated by community mental health services

Figure 2. Queensland Mental Health Service System



Queensland Government departments are actively working together to deliver programs that aim to strengthen mental health and promote recovery, across the spectrum of interventions. Ensuring mental health services respond as effectively as possible to the needs of consumers, families, their carers, and the broader Queensland community requires effective coordination and collaboration between these sectors and across the spectrum of interventions.

From July 2007, responsibility for funding of mental health services that are contracted from the non-government sector transferred from Queensland Health to Disability Services Queensland (DSQ). This shift aligns responsibility for the development, implementation and management of mental health programs delivered through the non-government sector with other programs administered by DSQ in the community sector.

2.2 Queensland's Baseline in 2005

… the complex and long term nature of the challenges all governments face in responding to mental health in the community …

National Mental Health Report 2007

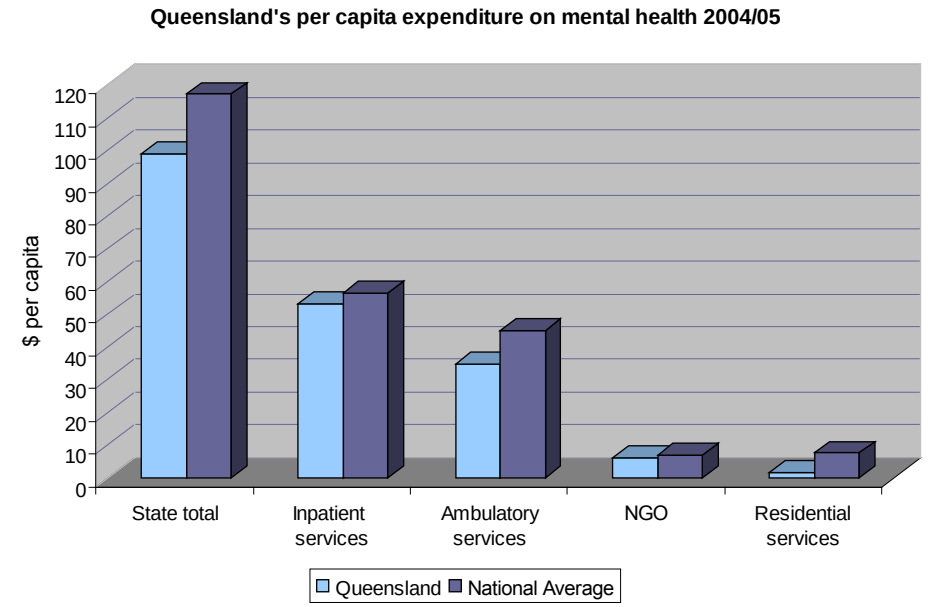
The *National Mental Health Report 2007* emphasises the continuing problems faced by people throughout Australia who have a mental illness.

The *National Mental Health Report 2007* establishes a baseline against which to compare Queensland's progress in key areas under the National Mental Health Strategy.

Key data providing a snapshot of describing Queensland in 2005 has been summarised below (see Figure 3). A comprehensive table of comparative data is provided in Appendix 1.

In 2004-05, Queensland's per capita expenditure in mental health was below the national average at $98.96 while the national average was $117.27. While Queensland's expenditure on inpatient services and rates of beds per 100,000 were generally consistent with the national average, Queensland's spending and levels of resources for community based clinical services lagged the national average in many areas. One notable exception was provision of funding to the non-government sector which was consistent with the national average. In 2004-05, Queensland provided 6.4% of total mental health service expenditure to the non-government sector, which was comparable with the national average of 6.3%.

Figure 3. Queensland's per capita expenditure on mental health 2004-05



Queensland's level of consumer and carer participation was also detailed in the *National Mental Health Report 2007.* In Queensland in 2005, 54% of services had Level 1 participation arrangements, comparable with the national average of 51%. Consumer participation was more pronounced that carer participation, with 2.4 consumer consultants per 1,000 clinical FTE against a national average of 2.9. There were 0.2 carer consultants per 1,000 clinical FTE, less than the national average of 0.7 per 1,000 clinical FTE.

Queensland's commitment to a recovery philosophy and consumer and carer involvement is also embodied in its 2005 publication of *Sharing Responsibility for Recovery* (Appendix 2) and the development of the Carers Matter website (Appendix 3).

In 2004-05, Queensland's provision of funding to the NGO sector was consistent with national benchmarks

Community Mental Health Full-time Equivalent Staff Levels

In 2004-05, prior to any enhancements from the *National Action Plan*, there were approximately 1,550 full-time equivalent staff providing mental health services in the community (Table 1).

Table 1. Full-time equivalent community mental health staff in Queensland.

Total Established Community FTE - Statewide	
Program	**2005-06**
Child & Youth*	312.32
Older Persons*	63.50
Consultation Liaison	48.88
Adult Case Management	580.61
Mobile Intensive Treatment	78.00
Acute Care	261.04
Indigenous Mental Health*	28.90
Primary Care	2.00
Transcultural Mental Health*	0.50
Dual Diagnosis	4.00
Intellectual disability	0.50
Eating Disorder[1]	2.75
Sensory Impaired[2]	0.00
Consumer Consultants	12.10
Leaders & Quality and Safety	140.23
Service Integration	0.00
Forensic Liaison[3]	15.50
Total	**1550.83**

[1] Includes positions for statewide/area-wide Eating Disorder Outreach

[2] Includes new positions for the statewide Deafness & Mental Health Centre in 2008-09

[3] Includes 18 new FTE funded from Implementation of Butler Review of MHA 2000 in 2007-08

[4] Includes new statewide coordination positions in 2008-09 (i.e., E-CYMHS, Psychiatry Training Program, Older Persons, Indigenous Hub, QTCMHC)

Breakdown by Area Health Service	**2005-06**
Northern AHS	310.50
Central AHS	577.44
Southern AHS	660.14
Statewide Eating Disorders	2.75
Total	**1550.83**

2.3 Queensland's Approach to Allocating Resources

Queensland's New Funding Model

- More transparent and accountable
- More responsive, less centralised
- Responds to population changes
- Providing greater budget certainty
- Links to planning and performance monitoring

In 2006, the Queensland Government's *Health Action Plan – building a better health service for Queensland* committed to developing a new funding model based on population health need and casemix funding for (general) hospitals and to devolving decision making closer to the patient.

Until very recently, Queensland was the only Australian State or Territory that funded its health system on a historical basis. In 2007-08, Queensland Health adopted a New Funding Model (NFM) (see Appendix 4).

Applying the New Funding Model to Mental Health Services in Queensland

Queensland employs a systematic approach to allocating resources to mental health services that involves a synthesis of available technical and demographic data and consultation with Area Clinical Networks.

In the first stage, Queensland uses a Resource Allocation Model (RAM) to determine overall staffing numbers to be allocated to each Area Health Service, based on population and other socio-demographic factors. This data is contextualised to local areas with a 'ground up' approach involving senior clinicians. Having analysed available technical data, Queensland engages in extensive consultation with the Area Clinical Networks to determine precise numbers and skill mix of staff required at the local level.

Queensland's approach to resources allocation means that resources are allocated efficiently to where they are most needed at an Area Health Service level, while the consultation with Area Clinical Networks allows flexibility at the local level.

Applying the principles of the RAM component of the New Funding Model (NFM) to mental health services assists service planning, by allocating resources appropriately across the state. Queensland has used the RAM to plan for community mental health staffing allocation within each Area Health Service. Table 2 demonstrates the utilisation of the RAM as a service planning tool for mental health.

Table 2. Estimated and Actual FTE allocations 2007–2011 using Queensland's Resource Allocation Model (RAM).

Area Health Service	Estimated FTE using RAM formula	Actual Allocation
Northern	69	74
Central	130	112
Southern	159	176
TOTAL	**362 FTE**	**362 FTE**

The aim of the additional allocations of community mental health staff is to ensure that service provision keeps pace with population growth. The Mental Health Branch Technical Bulletin which informs planning targets in Queensland suggests community mental health services should employ 70 full-time equivalent clinical staff per 100,000 population.

In 2004-05 the year before the NAP, States and Territories provided the greatest proportion (60.6%) of mental health expenditure in Australia (Figure 4). In addition, it should be noted that the size of the existing mental health program in Australia prior to the NAP, was nearly $20 billion therefore the NAP has added a further 20-25% to spending that was already in place (Figure 5).

Figure 4. Distribution of recurrent spending in mental health 2004-05.

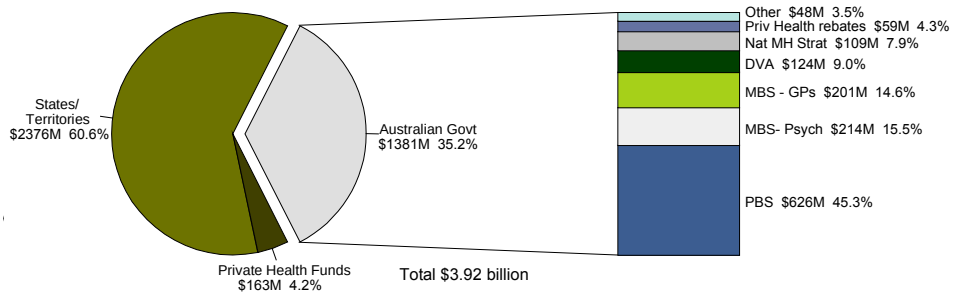
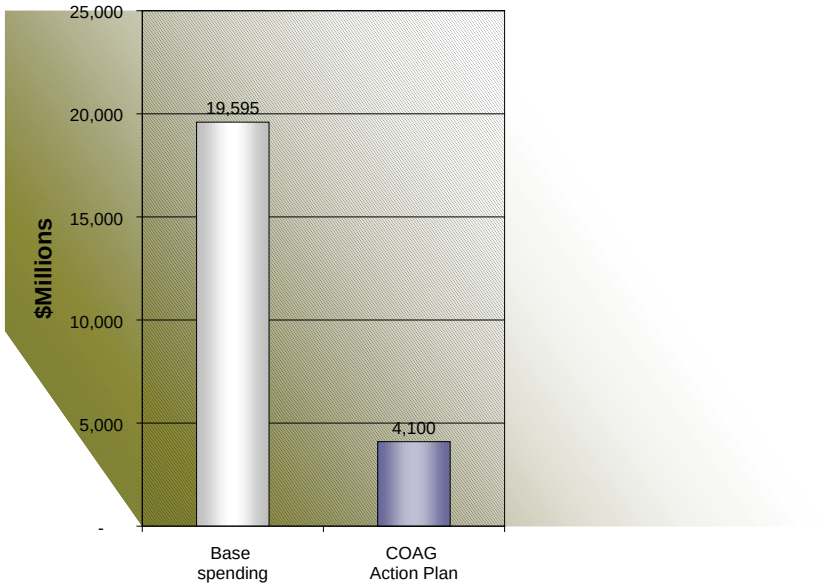


Figure 5. Cumulative "base" spending compared with COAG NAP expenditure on mental health 2006-11.



In summary, Queensland came into 2005-06 (the year prior to the NAP) recognising that it needed a substantial investment in mental health. In the October 2005 *Health Action Plan*, funding of $201 million, was earmarked for mental health of which $189 million from 2006-07 was for five years. This funding would be allocated according to planning that had just commenced on a renewed statewide plan.

The agreement in February 2006 by COAG to develop a mental health plan by July that year allowed Queensland funding to be used in a manner that would be consistent with the overall COAG plan.

The Queensland Government also recognized that the very nature of the COAG plan required across-government commitments. This led to the initial commitment by Queensland Government taking a human services approach involving several departments.

This approach has been continued in the second contribution to the Queensland COAG plan on mental health announced in May 2007. Chapter 3 outlines Queensland's current commitment to the COAG NAP.

Chapter 3 Queensland's Commitment to the National Action Plan

The *National Action Plan on Mental Health 2006-2011* ('the NAP') provides a strategic framework that emphasises coordination and collaboration between government, private and non-government providers, aimed at building a more connected system of health care and community supports for people affected by mental illness.

The NAP identifies five 'Action Areas' for combined government action, with specific policy directions within each area. The Action Areas provide an organising framework for grouping and understanding the relative investments by governments. Governments also committed to four outcomes by which the success of the NAP can be assessed. The Action Areas and outcomes are summarised below.

Table 3: COAG Action Plan agreed Action Areas and outcomes

Action Areas agreed in the COAG Plan (Queensland investment in each Action area)	Agreed outcomes
• Promotion, prevention and early intervention ($16.25M) • Integrating and improving the care system ($634.88M) • Participation in the community and employment, including accommodation ($162.39M) • Increasing workforce capacity ($76.92M) • Coordinating care ('Coordinating care' and 'Governments working together') ($4.77M)	• Reducing the prevalence and severity of mental illness in Australia • Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent long term recovery • Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention • Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation

This chapter outlines Queensland's progress in each of the Action Areas agreed in the COAG Plan.

Data prepared by each Queensland government department has been used to allow for reporting against Queensland's total $895 million investment in mental health. This total amount consists of all mental health funding allocations in areas where the activity is directly relevant to the Action Plan objectives. Additional funding commitments announced subsequent to signing of the Plan have only been included if they are consistent with Queensland's original programs.

Queensland's total commitment to mental health for the period 2006-2011 is captured in Table 4.

Table 4: Action Plan funding commitments 2006-11 (millions)

	Funding commitments 2006-11		
	As reported in the Action Plan July 2006	Subsequent new funding commitments	Total funding commitments 2006-11
Queensland	366.4	528.8	895.2

The full detail of the $895 million commitment to the COAG NAP is outlined in Table 5. This table shows funding broken down by Action Area and by initial and subsequent budget allocations. The table also provides the funding allocated each year and cumulatively for each program. Queensland's Individual Implementation Plan is attached as Appendix 5.

Table 5. COAG National Action Plan Funding Allocations by Action Area and Initiative

	$ Millions				
	Action plan funding commitment 2006-2011	Subsequent additional mental health funding commitments 2006-2011	Funding allocated 2006-07	Funding allocated 2007-08	Cumulative funding allocations from July 2006
Note Ref	**a**	**b**	**c**	**d**	**e**
Action Area 1: Promotion, Prevention & Early Intervention					
Early years service centres	4.90	0.00	0.00		0.00
Prevention strategies in schools (reprioritising budget to allow development)	0.00	0.00	0.00		0.00
Dual diagnosis positions	0.80	0.00	0.29		0.29
Transcultural mental health workforce	1.20		0.24		0.24
QLD centre for promotion, prevention & early intervention	0.00	4.97	0.00	0.55	0.55
Promotion of innovative technologies in mental health promotion, prevention & early intervention	0.00	0.50	0.00	0.00	0.00
Cross-sectoral strategies to reduce suicide risk	0.00	2.91	0.00	0.00	0.00
Perinatal & infant mental health hub	0.00	0.97	0.00	0.00	0.00
Total Action Area 1	**6.90**	**9.35**	**0.53**	**0.55**	**1.08**
Action Area 2: Integrating and Improving the Care System					
Blueprint for the bush service delivery hubs	1.80	0.00	0.08		0.08
Indigenous domestic and family violence counselling	1.20	0.00	0.00		
Child safety therapeutic and behaviour support services	17.60	0.00	9.00		9.00
Health Action Plan - Existing service pressures	58.10	0.00	11.60		11.60
Community mental health service - Enhancement	114.50	0.00	18.00		18.00
Dual diagnosis positions	4.70	2.92	1.62		1.62
Mental health intervention teams	4.10	0.00	1.30		1.30
Forensic mental health services	14.80	10.50	3.60		3.60
Transcultural mental health positions	6.80	1.80	1.36		1.36
Area clinical mental health networks	7.70	0.00	1.50		1.50
Alternatives to admission	17.50	0.00	4.50		4.50
Responding to homelessness	19.7	0.00	11.50		11.50
Mental health services in prisons	8.60	0.00	2.40		2.40
Mental health capital	12.00	121.55	12.00		12.00
Primary care liaison coordinators	0.00	3.24	0.00	0.33	0.33
Implementation of “Partners in Mind”	0.00	1.42	0.00	0.00	0.00

Consumers consultants	0.00	2.97	0.00	0.44	0.44
Child and youth mental health services	0.00	37.78	0.00	3.52	3.52
Adult community mental health services	0.00	9.44	0.00	3.67	3.67
Older person's community mental health services	0.00	18.70	0.00	1.68	1.68
Mobile intensive treatment services	0.00	11.55	0.00	1.49	1.49
Extended hours acute care	0.00	27.47	0.00	4.99	4.99
Consultation liaison	0.00	9.63	0.00	0.50	0.50
Centre for rural and remote	0.00	2.36	0.00	0.12	0.12
ATSI mental health	0.00	5.15	0.00	0.55	0.55
Administrative support staff	0.00	5.70	0.00	0.83	0.83
District leaders, supervisors and quality & safety staff	0.00	15.32	0.00	1.16	1.16
Intellectual disability & mental health	0.00	0.97	0.00	0.00	0.00
Eating disorders	0.00	2.71	0.00	0.00	0.00
Sensory impairment and mental health	0.00	1.12	0.00	0.00	0.00
Implementation of Butler recommendations	0.00	53.48	0.00	13.02	13.02
Total Action Area 2	**289.10**	**345.78**	**78.46**	**32.29**	**110.74**
Action Area 3: Participation in the community and employment, including accommodation					
Housing capital	20.00	40.00	20.00		20.00
Health Action Plan non-government organisation funding	25.00	0.00	5.00		5.00
Disability Services respite and sector capacity building	12.00	0.00	2.40		2.40
Employment and training	5.00	0.00	1.00		1.00
Mental health services in prisons	2.30	0.00	0.50		0.50
DSQ - NGO personal support & accommodation	0.00	35.64	0.00	6.12	6.12
DSQ - Personal support in social housing	0.00	22.45	0.00	2.43	2.43
Total Action Area 3	**64.30**	**98.09**	**28.90**	**8.55**	**37.45**
Action Area 4: Increasing workforce capacity					
Increased workforce remuneration	5.80	0.00	1.16	0.00	1.16
Mental health transition to practice - Nurse education programme	0.30	0.00	0.30	0.00	0.30
Workforce development & research	0.00	8.06	0.00	1.57	1.57
Growth funding	0.00	43.00	0.00	4.00	4.00
Information management	0.00	19.76	0.00	0.55	0.55
Total Action Area 4	**6.10**	**70.82**	**1.46**	**6.12**	**7.58**
Other new mental health funding allocations relevant to COAG Action Plan objectives					
Care Coordination	0.00	4.77	0.00	0.00	0.00
Total Other initiatives relevant to Action Plan	**0.00**	**4.77**	**0.00**	**0.00**	**0.00**
Total funding commitments/allocations	**366.40**	**528.81**	**109.34**	**47.51**	**156.85**

3.1 Breakdown of Queensland's $895M investment in mental health reform

Queensland has allocated $895 million over five years to improving mental health care

From 2006-07 the Queensland Government committed new funding of $366.4 million over five years to improve the quality of, and access to, mental health services. This included:

- $189.0 million announced in the October 2005 Special Fiscal and Economic Statement, with the first full year of funding to commence in 2006-07;
- $109.6 million additional recurrent funding for the expansion of initiatives previously announced;
- $35.7 million in new additional recurrent funding commencing in the 2006-07 State Budget; and
- $32.0 million for capital works, including additional funding for new capital works and works-in-progress.

In addition to the above initiatives, more than $250.0 million has been provided to address wages growth over the next three years to attract and retain skilled mental health staff. Whilst this funding was announced in the Queensland initial Individual Implementation Plan it was not included as part of Queensland's financial contribution to the COAG NAP.

Queensland further enhanced this investment in 2007-08 with the provision of $528.8 million over five years (2007-2011) as described in the *Outline of the 2007-08 State Budget Outcomes for Mental Health* (see Appendix 6). Future funding through to 2011 will be announced in the relevant budget year.

Other funding for mental health programs announced by Queensland Government in 2007-08 that do not correspond with the COAG NAP are not contained in this submission. These programs are not considered by Queensland to be consistent with the original plan. This includes funding for Mental Health Outreach teams as part of the Queensland Government response to the Carter Report.

Chapter 4 Progress on the COAG National Action Plan 2006-2011

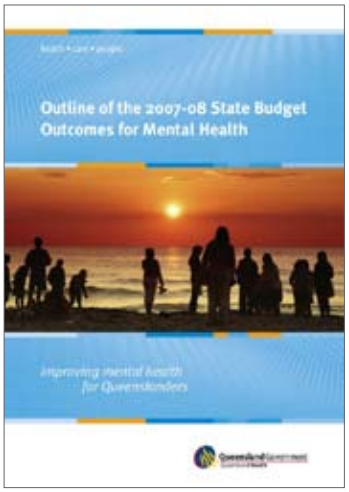
4.1 Queensland's progress towards the NAP

On 14 July 2006, the Queensland Government announced its initial contribution of $366.2 million to the COAG *National Action Plan on Mental Health 2006-2011* (NAP). As noted in Chapters 2 and 3, this initial investment has been increased by an additional $528.8 million over four years as part of the 2007-08 State Budget (Table 6). This has resulted in an unprecedented investment in mental health of $895 million over five years by the Queensland Government.

Highlights of Queensland's implementation of the NAP in 2006-07 included:

- major achievements in the areas of supported social housing, employment, independent living and social support services;
- service hub development in a range of high need areas across Queensland;
- enhancement of community mental health services including those specialist community mental health services targeted at:
    - people with a dual diagnosis;
    - people from a culturally and linguistically diverse background;
    - those in prison; and
    - those who are homeless.
- Queensland has made progress toward the statewide implementation of the Care Coordination Model for people with severe mental illness and complex care needs.

Highlights of Queensland's implementation of the *Outcomes of the 2007-08 State Budget on Mental Health* include:



- $28.5 million to employ and accommodate over 200 new community mental health staff including medical, nursing and allied health professionals to support increased access to mental health services in the community.
- Queensland's coordinated approach to these staffing allocations resulted in 50% of these new positions being filled in the first five months of 2007-08. A further 121 new community mental health positions will be established in 2008-09.
- $13.2 million to commence work on 17 capital works projects, which when completed, will deliver 140 new inpatient mental health beds that meet contemporary standards.

- Significant consultation has been undertaken with clinicians, consumers and carers to develop design considerations for 17 capital works projects.

Queensland is promoting contemporary, recovery-based service models …

… and involving consumers, carers and staff in the design of all new mental health units

- $2.1 million to implement a range of workforce recruitment and retention initiatives. These include a mental health international recruitment drive which recommended 139 candidates for vacant positions, the establishment of candidate care officers in each Area Health Service to support new international recruits into positions, and the development of undergraduate support officers to promote mental health and to assist with students entering the mental health workforce.
- $1.7 million to build on mental health promotion activities and to strengthen mental health prevention and early intervention.

Table 6. Outline of the 2007-08 State Budget Outcomes for Mental Health

Outline of the 2007-08 State Budget Outcomes for Mental Health

Priority Areas	Year 1	Year 2	Year 3	Year 4	TOTAL
Promotion, prevention, & early intervention	$ 1,710,000	$ 2,568,500	$ 2,487,680	$ 2,587,187	**$9,353,367**
Improving & integrating care	$ 41,650,000	$ 66,291,500	$ 90,747,375	$ 98,457,395	**$297,146,270**
Inpatient services	$ 13,685,000	$ 24,999,900	$ 37,084,400	$ 45,954,368	**$121,723,668**
Community services (including Care Coordination)	$ 27,965,000	$ 41,291,600	$ 53,662,975	$ 52,503,027	**$175,422,602**
Workforce, quality & safety	$ 2,120,000	$ 3,239,300	$ 4,284,945	$ 1,715,417	**$11,359,662**
TOTAL	**$ 87,130,000**	**$ 138,390,800**	**$ 188,267,375**	**$ 201,217,394**	**$317,859,299**

Outline of the 2007-08 State Budget Outcomes for Mental Health

Other Funding	Year 1	Year 2	Year 3	Year 4	TOTAL
Department of Housing	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	**$40,000,000**
Disability Services Queensland (NGO funding)	$ 6,120,000	$ 10,300,000	$ 10,680,000	$ 8,540,000	**$35,640,000**
Disability Services Queensland (HASP)	$ 2,430,000	$ 4,670,000	$ 6,730,000	$ 8,610,000	**$22,440,000**
Department of Justice & Attorney-General (Butler)	$ 3,730,000	$ 2,930,000	$ 3,290,000	$ 3,400,000	**$13,350,000**
Queensland Health (Butler)	$ 9,280,000	$ 10,030,000	$ 10,290,000	$ 10,560,000	**$40,160,000**
Funding to replace Commonwealth funded projects	$ 4,000,000	$ 13,000,000	$ 13,000,000	$ 13,000,000	**$43,000,000**
Mental Health Enterprise Information System	$ 9,660,000	$ 4,180,000	$ 1,280,000	$ 1,280,000	**$16,400,000**
TOTAL	**$ 45,220,000**	**$ 55,110,000**	**$ 55,270,000**	**$ 55,390,000**	**$ 210,990,000**

TOTAL	**$528,849,299**

4. 2 Queensland's Achievements in Each COAG Action Area in Detail

Action Area 1: Promotion, Prevention and Early Intervention ($16.25 million)

	$Millions				
	Action Plan funding commitment 2006-2011	**Subsequent additional mental health funding commitments 2006-2011**	**Funding allocated 2006-07**	**Funding allocated 2007-08**	**Cumulative funding allocations from July 2006**
Action Area 1: Promotion, Prevention & Early Intervention					
Early Years Service Centres	4.90	0.00	0.00		0.00
Prevention strategies in schools (reprioritising budget to allow development)	0.00	0.00	0.00		0.00
Dual Diagnosis Positions	0.80	0.00	0.29		0.29
Transcultural Mental Health Workforce	1.20		0.24		0.24
QLD Centre for Promotion, Prevention & Early Intervention	0.00	4.97	0.00	0.55	0.55
Promotion of innovative technologies in mental health promotion, prevention & early intervention	0.00	0.50	0.00	0.00	0.00
Cross-sectoral strategies to reduce suicide risk	0.00	2.91	0.00	0.00	0.00
Perinatal & infant mental health hub	0.00	0.97	0.00	0.00	0.00
Total Action Area 1	**6.90**	**9.35**	**0.53**	**0.55**	**1.08**

Achievements in 2006-07

Early Years Service Centres

Queensland committed to establishing four early years service centres as one stop shops to improve services and support for families with children from 0-8 years of age. The first two centres are funded and began delivering interim services from late 2007. The buildings for the two additional centres will be completed in the second half of 2008 and will be funded during 2009.

Prevention Strategies in Schools

Queensland is committed to developing new strategies to assist schools in supporting students with a mental illness, including: regional contact officers; a statewide senior guidance officer; on-line materials; and staff professional development.

The Department of Education, Training and the Arts (DETA) has made the following progress in relation to initiatives:

- appointed Regional Contact Officers (Mental Health) across 10 regions (16 in total);
- established the 'Learning Place Mental Health Website' enabling teachers, students and parents/carers to access quality on-line resources; and
- developed *SMS-PR-035 Supporting Students' Mental Health and Wellbeing* policy.

The next meeting of the COAG Child, Youth and Education Sector Subgroup will occur after all stakeholder consultations in relation to the Joint Work Plan have been completed. This Work Plan will guide the activities to be undertaken in 2008-09.

Dual Diagnosis Positions

The implementation of a pilot intervention in six sites across Queensland, to increase integration between Mental Health (MH) and Alcohol, Tobacco and Other Drug Services (ATODS), has commenced. A model, developed to guide improved integration between MH and ATODS, is being implemented to direct policy and protocol development in these pilot sites. This intervention including a training package, commenced in all six sites, and will be delivered to both MH and ATODS staff.

A Queensland Health draft policy on the assessment and management of dual diagnosis in both MH and ATODS services has been completed and will be disseminated for feedback from key stakeholders. Development of Queensland Guidelines for the Management of Dual Diagnosis is progressing and will include specific attention to the needs of Aboriginal and Torres Strait Islander people. Negotiations are underway to develop a proposal for a clinical exchange program between MH and ATODS in three sites across Queensland. Sustainable education initiatives are being explored to promote ongoing training opportunities in dual diagnosis service provision.

Planning has commenced for the establishment of additional dual diagnosis positions in 2008-09. A service mapping exercise conducted in 2007 identified service gaps and workforce limitations to enhancing services for people with a dual diagnosis. Results from this exercise are guiding the planning for future dual diagnosis positions. A summary of established dual diagnosis positions is included in Table 7.

Table 7. Established Dual Diagnosis positions

Total Established Community FTE				
Program	**2005-06**	**2006-07**	**2007-08**	**2008-09**
Dual Diagnosis	4.00	15.00	15.00	18.00

In 2007-08, certain program areas (e.g. child and youth and older persons) and other specialist positions were prioritised. The process for determining which positions would be prioritised involved analysis of available data and consultation with Area Clinical Networks. First, the 2006-07 level of resources in each program was analysed in relation to the 70 per 100,000 FTE target to determine the programs most in need of additional resources. Area Clinical Networks were then consulted regarding the positions they considered high priorities. This resulted in a decision to prioritise dual diagnosis and transcultural mental health positions in 2008-09 (along with other specialist positions such as the statewide eating disorder positions).

Transcultural Mental Health Workforce

Overview of Transcultural Mental Health Services in Queensland 2008

Queensland Health funds the Queensland Transcultural Mental Health Centre (QTMHC) with a budget of $2.3 million which includes approximately $900,000 for 11 FTE of Multicultural Mental Health Coordinator positions based in district health services (Table 8).

Mental health non-government organisation funding provides core funding to the Multicultural Centre for Mental Health and Wellbeing for non-clinical support services, and to the Queensland Program of Assistance to Survivors of Torture and Trauma for non-clinical counselling services and to a mental health support program based at the Townsville Migrant Resource Centre.

QTMHC is a statewide service which provides clinical consultation services, education and training programs, mental health promotion, prevention and early intervention programs, a clearinghouse and library of multilingual resources and input into program and policy development.

The QTMHC Clinical Consultation Service has three staff including, 0.1 FTE consultant psychiatrist and has over 150 casual bilingual workers speaking over 80 languages. Bilingual workers include medical, nursing, allied health and cultural consultants and they provide a range of services including: assessments, psychoeducation and short term interventions. The service consults to a wide range of referrers including mental health services, other government and non-government services and receives referrals from multicultural groups as well as self-referrals. The service uses teleconferencing facilities to provide consultations statewide.

The service is currently piloting, under the Access to Psychological Services (ATAPS) program, access to bilingual allied health workers for short term psychological interventions. Referral criteria for this program will include people that GPs are not able to refer under Better Access (most often due to language barriers). This is currently being piloted with one GP Division with the view to making it available across the state.

QTMHC delivers a range of education and training programs including its nine module course '*Managing Cultural Diversity in Mental Health*' which is delivered as a full course or individual modules as stand alone components. This course is also available to be undertaken as a post graduate subject in the Department of Psychiatry, University of Queensland.

In addition QTMHC also delivers training on wide range of cross-cultural practice issues in mental health such as cross-cultural assessment, working with interpreters in mental health, working with survivors of torture and trauma, and working with older migrants. QTMHC also delivers training to interpreters about interpreting in mental health settings.

QTMHC has a number of current initiatives in its Promotion, Prevention and Early Intervention program:

- QTMHC is currently finalising a project of national significance for *Multicultural Mental Health Australia* where it has developed an expert trainers program on reducing stigma in multicultural communities.
- It has commenced a two-year funded program on reducing stigma and increasing mental health literacy in multicultural communities in Queensland which has involved the employment of 16 bilingual mental health promoters from 16 language groups.
- It has developed a group resiliency building program for children and young people from CALD backgrounds called *BRiTA Futures* (Building Resilience in Transcultural Australians). It has trained a number of facilitators to deliver the program and will be training more facilitators in June 08.

- With State chronic diseases funding it has developed a Depression Self Management Program which it is currently piloting with consumers from Indian, Vietnamese, Arabic, Filipino and Spanish speaking backgrounds.

QTMHC coordinates the 11 district multicultural mental health coordinator positions by providing professional supervision, while the positions are being operationally line managed by the local mental health services where they are based. The positions work internally within the mental health service through consultation, advice, training, development and the development of new systems and procedures, and externally through liaison with local multicultural groups focusing on facilitating access and increasing mental health literacy.

Through the CALD consumer and carer participation coordinator, the QTMHC continues to strengthen the Multicultural Consumer and Carer Network through ongoing education and training. The QTMHC has developed a model of CALD consumer participation which involves CALD consumer facilitators to outreach and network with consumers in their cultural community who are isolated by language and culture from mainstream participation processes.

QTMHC continues to participate in a wide range of committees and working parties in the mental health and multicultural sectors ensuring the inclusion of the issues and mental health needs of people from CALD backgrounds.

Table 8. Established Transcultural Mental Health positions

Total Established Community FTE - Statewide				
Program	**2005-06**	**2006-07**	**2007-08**	**2008-09**
Transcultural Mental Health * (District-based)	0.50	7.25	7.75	10.75
Queensland Transcultural Mental Health Centre	6.00	6.00	6.00	7.00
Total	**6.50**	**13.25**	**13.75**	**17.75**

* Includes new statewide coordination positions in 2008-09 (i.e., E-CYMHS, Psychiatry Training Program, Older Persons, Indigenous Hub, QTCMHC).

Achievements in 2007-08

The Mental Health Promotion, Prevention and Early Intervention (PPEI) Subgroup of the Statewide Network has been established to provide and advise the strategic direction and cross-program alignment in relation to MHPPEI planning, implementation and review activities within the Queensland context.

The Queensland Centre for PPEI will be established to promote the development, analysis, and review of mental health promotion, prevention and early intervention policy and practice within Queensland.

Funding provided for PPEI supports a range of initiatives, including:

- cross-sectoral strategies, partnerships and agreements targeted at reducing suicide risk and associated mortality
- a transcultural stigma reduction project (outlined above)
- increasing capacity to provide responsive family sensitive service to COPMI families; increasing interagency cooperation; improving the early detection, assessment and referral for interventions of COPMI; workforce training in COPMI issues; and progressing COPMI research and evaluation
- a state Ed-LinQ coordinator position that will develop and formalise strategic links between Queensland Health, Education Queensland, and other relevant sectors
- Queensland Construction Industry Suicide Prevention Project, piloting the delivery of the *OzHelp Life Skills Tool Box* to apprentices within the Queensland Construction Industry
- establishing Perinatal and Infant Mental Health Coordination positions in Area Health Services.

Key PPEI Initiatives

- Queensland Centre for PPEI
- Ed-LinQ
- Perinatal and Infant Mental Health
- Children of Parents with a Mental Illness (COPMI)
- Mental Health Literacy
- Transcultural Mental Health – stigma reduction project
- Suicide Prevention
- Queensland Construction Industry Suicide Prevention Project
- Alignment of beyondblue activities in Queensland
- Eating Disorders Outreach Service

Action Area 2: Integrating & Improving the Care System ($634.88M)

	$ Millions				
	Action Plan funding commitment 2006-2011	Subsequent additional mental health funding commitments 2006-2011	Funding allocated 2006-07	Funding allocated 2007-08	Cumulative funding allocations from July 2006
Action Area 2: Integrating and Improving the Care System					
Blueprint for the Bush Service Delivery Hubs	1.80	0.00	0.08		0.08
Indigenous Domestic and Family Violence Counselling	1.20	0.00	0.00		
Child Safety Therapeutic and Behaviour Support Services	17.60	0.00	9.00		9.00
Health Action Plan - Existing service pressures	58.10	0.00	11.60		11.60
Community mental health service - enhancement	114.50	0.00	18.00		18.00
Dual diagnosis positions	4.70	2.92	1.62		1.62
Mental health Intervention Teams	4.10	0.00	1.30		1.30
Forensic Mental Health Services	14.80	10.50	3.60		3.60
Transcultural Mental Health Positions	6.80	1.80	1.36		1.36
Area Clinical Mental Health Networks	7.70	0.00	1.50		1.50
Alternatives to admission	17.50	0.00	4.50		4.50
Responding to homelessness	19.7	0.00	11.50		11.50
Mental Health Services in Prisons	8.60	0.00	2.40		2.40
Mental Health Capital	12.00	121.55	12.00		12.00
Primary care liaison coordinators	0.00	3.24	0.00	0.33	0.33
Implementation of “Partners in Mind”	0.00	1.42	0.00	0.00	0.00
Consumers Consultants	0.00	2.97	0.00	0.44	0.44
Child and Youth Mental Health Services	0.00	37.78	0.00	3.52	3.52
Adult Community Mental Health Services	0.00	9.44	0.00	3.67	3.67
Older Person’s Community Mental Health Services	0.00	18.70	0.00	1.68	1.68
Mobile Intensive Treatment Services	0.00	11.55	0.00	1.49	1.49
Extended Hours Acute Care	0.00	27.47	0.00	4.99	4.99
Consultation liaison	0.00	9.63	0.00	0.50	0.50
Centre for Rural and Remote Mental Health	0.00	2.36	0.00	0.12	0.12
ATSI mental health	0.00	5.15	0.00	0.55	0.55
Administrative support staff	0.00	5.70	0.00	0.83	0.83
District leaders, supervisors and quality & safety staff	0.00	15.32	0.00	1.16	1.16
Intellectual disability & mental health	0.00	0.97	0.00	0.00	0.00
Eating disorders	0.00	2.71	0.00	0.00	0.00
Sensory impairment and mental health	0.00	1.12	0.00	0.00	0.00
Implementation of Butler recommendations	0.00	53.48	0.00	13.02	13.02
Total Action Area 2	**289.10**	**345.78**	**78.46**	**32.29**	**110.74**

Achievements in 2006-08

Blueprint for the Bush Service Delivery Hubs

Under the auspices of Blueprint for the Bush, Queensland committed to establishing three Rural Multi-Tenant Service Centres. To date five locations for Service Delivery Hubs have been identified. Three locations including Lockhart River, Charters Towers and Burdekin have been approved with construction of these centres expected to commence in mid to late 2008. Two locations are currently revising their business cases for further assessment by the Department of Communities.

Indigenous Domestic and Family Violence Counselling

The achievements to date in relation to Queensland's commitment to domestic and family violence counselling services in rural communities include:

- Community development activities to develop the service model and procurement process have been completed for the Torres Strait and Cherbourg.
- Establishment of the service in the Torres Strait has commenced.
- The selection of the service provider for Cherbourg is near completion. It is expected that establishment of the service will commence in July 2008.
- Delays have been experienced in progressing community engagement in Cooktown. It is expected that this work will resume in July 2008.

Child Safety Therapeutic and Behaviour Support Services

Disability Services Queensland (DSQ) Evolve behavioural support services teams have been established in seven locations: Townsville, Rockhampton, Wide Bay, Sunshine Coast, Gold Coast, Brisbane and Ipswich. This includes an outreach service to Cairns.

Queensland Health (QH) Evolve therapeutic teams have been established in seven locations which include Gold Coast, Sunshine Coast/Burnett, Townsville, Rockhampton, Logan, North Brisbane and Cairns.

As of 31 January 2008, 212 children and young people were receiving services through Evolve Interagency Services:

- 53% of children who received Evolve Services are aged between 13 and 17 years; 41% are aged 6 to 12 years; 5% are aged 4 to 5 years and 1% of children are aged 0-3.
- 70% of referrals to Evolve Services were for males and 30 % were for females;

- 29% of children and young people using Evolve Services were from Aboriginal and Torres Strait Islander backgrounds; and
- 73% of all Evolve staff positions have been filled. DSQ and QH maintain ongoing recruitment through local press and web-site advertising.

Community Mental Health Services Enhancement

Recruitment has continued to fill the remaining positions funded in 2006-07, and has been incorporated into further recruitment drives to fill new positions funded in 2007-08. A total of 205 new clinical and administrative positions in community mental health services have been established in 2007-08, of which approximately 50% have already been filled.

Mental Health Intervention Project Teams

The Queensland Health Mental Health Intervention Project (MHIP) is a three agency collaborative arrangement between Queensland Police Service, Queensland Ambulance Service and Queensland Health. It is to develop a common approach between all agencies that are likely to be in initial contact with people experiencing a crisis in the community. This project is based on the successful Memphis model.

MHIP training is ongoing across the three partner agencies (Queensland Police Service, Queensland Ambulance Service and Queensland Health) and continues to exceed training targets. Mental Health Intervention Coordinators are in the process of developing local protocols and procedures to support collaborative responses across the three agencies.

At the time of writing this submission, approximate numbers of staff trained were:

- Queensland Health – more than 700 staff trained, with 200-300 additional staff in the Northern Area Health Service to be trained in the next six to eight weeks.
- Queensland Police Service – more than 4,500 staff trained.
- Queensland Ambulance Service – more than 600 staff trained.

Forensic Mental Health Services

The expanded Court Liaison Service in south east Queensland has now been in place for 16 months and is covering 10 Magistrates Courts and Police Watchhouses. A full internal evaluation is underway with a particular emphasis on capturing stakeholder feedback.

Recruitment to new positions in the Northern Area Health Service is proceeding to enhance Court Liaison capacity. Successful recruitment has occurred in Cairns and Mackay and is currently underway for a position to service the Cape York Magistrates Courts in addition to the existing service in Townsville. Regular consultation has been established with the Chief Magistrate regarding the development of this service.

North Queensland Adult and Adolescent Community Forensic positions identified for Townsville have been redistributed across a number of sites to enhance capacity in Mackay and Cairns.

Area Mental Health Clinical Networks

Funding was made available to each of the three Area Mental Health Clinical Networks allowing each network to use this funding for priority projects.

The **Northern Area Mental Health Clinical Network** is progressing with its restructure and has appointed two new consumer and carer consultants. The network is in the process of establishing the Rural and Remote Subgroup and the Mental Health Promotion and Prevention Subgroup. Other Subgroups including Quality and Safety, Seclusion and Restraint and Older Persons are progressing well. The network has endorsed an Area Mental Health Clinical Audit position for two years (from the 2006-07 budget allocation). Other initiatives from the funding allocation include the extension of the Early Intervention Officer Project (Charters Towers and Ayr/Bowen) and top-up funding for travel expenses for the Network Nurse Educators (Cairns, Townsville and Mackay).

The **Central Area Mental Health Clinical Network** has used the 2006-07 budget allocation to fill seven Mental Health Educator positions in the following locations; Royal Brisbane and Women's Hospital (1 FTE), Royal Children's Hospital (1 FTE), The Prince Charles Hospital (1 FTE), Redcliffe/Caboolture (1 FTE), Sunshine Coast (1 FTE), Gympie (0.5 FTE), Wide Bay - Fraser Coast (0.5 FTE), and Rockhampton (1 FTE). In some Districts this has more than doubled the number of Mental Health Educators providing services. These positions have enabled Districts to increase their educational sessions and accordingly the number of staff receiving appropriate training has also increased. Some Districts are also providing services to non mental health staff to reduce stigma and improve understanding of mental health issues. This has facilitated more appropriate and early referral of mental health clients. In the long term, it is anticipated that staff education will assist in the overall recruitment and retention of the Queensland Health mental health workforce.

The **Southern Area Mental Health Clinical Network** funding has been used to purchase accommodation options for consumers on discharge from acute facilities. The funding supports consumers to transition into the community through the purchase of accommodation with the mental health service providing appropriate clinical supports. Non-clinical supports, if required, are provided through existing community based non-government organisations (NGOs). The funding was distributed based on a population basis and included:

- Bayside Health Service District (HSD) - $75,000 for minimum of 3 beds
- Gold Coast HSD - $100,000 for minimum 4 beds
- Logan/Beaudesert HSD - $75,000 for minimum 3 beds
- Princess Alexandra Hospital HSD - $100,000 for minimum 4 beds
- West Moreton HSD - $75,000 for minimum 3 beds
- Toowoomba HSD and rural networks - $75,000 for minimum 3 beds

Toowoomba has expended the funds on the purchase of two 3 bedroom units, and the service model is currently being developed.

Alternatives to Admission

Northern Area

On 10 December 2007, the Townsville Institute of Mental Health Services entered into a service agreement with Kith and Kin to provide non-clinical support to consumers of the Community Assessment and Treatment (CAT) Team. To date, feedback from the consumers utilising the service, Kith and Kin, and clinicians of the CAT Team has been positive. The Townsville Institute of Mental Health Services continues to work with the Community Rent Scheme to identify an appropriate accommodation option to expand the function and effectiveness of the Alternatives to Admission initiative.

Central Area

Progress in the four districts that received funding under the Alternatives to Admission programs is as follows:

- **The Prince Charles Hospital (TPCH)** - The Consumer Support Program (CSP) provides intensive, non-clinical support to enhance recovery of consumers involved in the Mental Health Program. The CSP is diverting a number of clients from other programs including ACT and MIST.
- **Rockhampton** - Provides short term, time limited non-clinical follow up for consumers with multiple admissions. The program provides a long term rehabilitation/recovery and non-clinical response with a focus on reduction in admissions.

- **Royal Brisbane and Women's Hospital (RBWH)** - The Discharge Facilitation Program provides enhanced discharge planning and a more seamless transition from inpatient to community follow up. Program participants have lower than hospital average (28 day) readmission rates as well as improved pre and post discharge outcome measures (i.e. HoNOS scores).
- **Redcliffe Caboolture** - The Mobile Intensive Treatment Team has been operational for two years. The team operates from 8:30 – 17:00, Monday to Friday, and employs four staff members. The team provides intensive assertive case management to an identified cohort of patients who have demonstrated high utilisation of inpatient beds and other services. The team can outline clear examples of a reduction of inpatient bed utilisation over the lifetime of the program.

Southern Area

Progress in the four districts that received funding under the Alternatives to Admission programs is as follows:

- **Logan** - In partnership with a local housing NGO, Logan provides a short stay community-based residential program for clients who require stabilisation. The model provides 'step-down' services from the acute mental health inpatient units, 'step-up' referrals from the Community Acute Care Team and community respite services.
- **Gold Coast** - Created a central intake service within the Acute Care Treatment Team to establish effective after hours intake and prompt community based triage and assessment for mental health consumers presenting at the Gold Coast Emergency Department. Discussions are occurring regarding other innovative opportunities to support alternatives to admission in this district.
- **Bayside** - Development of the Therapy Aide Service which provides community based support to consumers to assist in crisis management and prevent hospital admission. The service operates both a 'step-up' and 'step-down' component to provide services when consumers are most in need. Partnerships have recently been formed with a local housing NGO with a view to including a community based residential component to the service.
- **PAH** - The Early Response Model is a collaborative model with local NGOs which establishes psychosocial support networks and enhances recovery in the community. The service includes both 'step-up' and 'step-down' components and has been broadened to include consumers exiting transitional housing, short term accommodation support in addition to acute inpatient discharge. The model is linked to several other innovative community based support programs running within this district.

Responding to Homelessness

The Queensland Health, Homeless Health Outreach Teams (HHOT) were established in 2006-07 to provide an integrated service to address the complex health needs of people with a mental illness and/or substance abuse problems who are homeless or at risk of homelessness. All areas and initiatives are noting increases in client numbers and referrals.

The Brisbane and Townsville Transitional Housing and Support Programs were established in 2006-07 to provide support for individuals including care planning and assistance, return to work programs and assisting with access to long term accommodation options to facilitate sustainable future tenancies and better health outcomes. Both services work in partnership with the Community Rent Scheme program and local NGOs. In Townsville this partnership extends into the Transitional Housing project with support workers supplied from an external NGO.

The Mt Isa HHOT has commenced operations with a registered nurse employed from the beginning of 2008 and recruitment commenced for the remainder of the health worker team. Good engagement is occurring across the sector in Mt Isa with HHOT becoming an integral part of the homeless service system.

The Mid-Term review of the Whole-of-Government Responding to Homelessness Strategy, conducted through Department of Housing, will be made available through the Department of Housing.

The evaluation of the Queensland Health initiatives has commenced with the engagement of consultants and the initial steering committee meeting.

Mental Health Services in Prisons

All new clinical positions allocated to the Prison Mental Health Service (PMHS) (south east Queensland) in July 2006 have been filled including the position to service Capricornia Correctional Centre (provided by Rockhampton AMHS). One position each to service Townsville Correctional Centre and Lotus Glen Correctional Centre has now been appointed. Additional positions to service Maryborough Correctional Centre (provided by Fraser Coast AMHS) and Lotus Glen Correctional Centre have also been filled. New positions allocated to the Southern and Central PMHS in July 2007 have been filled including two additional care coordinators and a service development coordinator who is currently preparing the service for accreditation and continuing work on joint protocols with Queensland Corrections. An additional psychiatrist (0.6 FTE) for the service has been appointed and a psychiatric registrar commenced in February 2008.

The Transitional Care Coordination program operating in partnership between Richmond Fellowship Queensland and the PMHS (south east QLD) is fully operational with excellent outcomes being reported. A comprehensive evaluation of this new program is planned for 2008.

Mental Health Capital

In 2006-07, an initial $12 million was committed over five years for the construction and redevelopment of designated mental health facilities to support enhanced access to services. Each project and its current status are listed in Table 9.

Table 9. Mental Health Capital Funding

Project	Budget	Status
Cairns Mental Health Community Rehabilitation & Recovery Service	$2.5M	100% complete
Rockhampton Child & Youth Mental Health Community Clinic	$1.6M	100% complete
Community and Primary Health Care Centres		
• Gladstone	$16.2M	100% complete
• Nundah	$14.1M	Due for completion by end May 2008
• Yarrabah	$15.8M	Tender awarded. Construction to begin pending community sign off of ILUA*

* ILUA = Indigenous Land Use Agreement

Achievements in 2007-08

Primary and Private Sector Mental Health Care

Funding has been provided to support the implementation of the Partners in Mind framework, aimed at enhancing the relationship between public mental health services and the primary health care sector (particularly GPs).

Rural and Remote Mental Health Service Models

Considerable work has been completed in reviewing the needs for rural and remote mental health services as detailed in various documents including: *Unfenced Road Ahead 2005*; various Coroner's action plans and service delivery plans; and significant work by the Rural and Remote Subgroup of the Mental Health Services Plan Working Group 2006.

Building on this work, Queensland Health has developed a joint proposal with the Centre for Rural and Remote Mental Health – Queensland to develop a sustainable model for rural and remote mental health service delivery and professional development of mental health staff. Implementation of this plan has commenced.

Acute and Extended Treatment Facilities

Between 2007–11, $121.55 million has been allocated for more than 270 new, upgraded or redeveloped acute and extended treatment beds that meet contemporary standards. Table 10 provides a summary of the commissioning dates for the 17 capital works projects funded.

A Mental Health Capital Works Steering Committee has been convened to provide oversight of these projects and to provide regular progress reports to the Mental Health Plan Implementation Steering Committee.

Staffing profiles have been developed for each of the units described below. It is envisaged that recruitment to these staffing profiles would commence approximately three to six months prior to the commissioning dates listed.

Table 10. Implementation Schedule for Mental Health Capital Works projects

Milestones	Timing	Deliverable
West Moreton Community Care Unit	October 2009	New 18 bed community care unit commissioned.
West Moreton Extended Treatment Forensic Unit	December 2009	Additional 20 bed extended treatment forensic beds commissioned.
West Moreton High Secure Unit	November 2009	Additional 9 high secure beds including 5 high dependency beds commissioned.
Adolescent Extended Treatment	January 2011	New 15 bed extended treatment unit child and youth beds commissioned.
Bayside Community Care Unit	July 2010	Additional 20 bed community care unit commissioned.
PAH/Mater	June 2010	New 20 bed community care unit commissioned.
Logan Acute Unit Redevelopment	June 2011	Additional 25 bed acute unit commissioned.
Logan Community Care Unit	July 2010	New 16 bed community care unit commissioned.
Toowoomba Child and Youth Unit	April 2010	Additional 2 acute child and youth beds commissioned.
Rockhampton Psychogeriatric Unit	February 2010	Additional 4 psychogeriatric beds commissioned.
Sunshine Coast	June 2009	Additional 5 extended care beds commissioned.
Caboolture Acute Unit	March 2011	Additional 20 bed acute unit commissioned.
Caboolture Medium Secure Unit	March 2011	Additional 23 medium secure beds commissioned.
Townsville Child and Youth Unit	January 2011	Additional 6 acute child and youth beds commissioned.
Mackay Acute Unit	November 2009	Additional 6 acute beds commissioned.
Townsville Upgrade Extended Treatment	May 2008	Upgraded 8 bed extended treatment beds commissioned (no additional operational funding required).
Townsville Medium Secure Unit	September 2010	Upgraded 25 bed medium secure unit (no additional operational funding required).

Consumers, carers and staff have been consulted at every stage of the design process

Queensland has consulted consumers, carers and staff at every stage of the design process for the new facilities. Consumer, carers and staff have also been asked for their input into the development of staffing profiles, including numbers of staff and skill mix.

The final Design Considerations due to be completed at the end of May 2008, will challenge those building new mental health facilities to consider:

- Overarching principles for design
- Culturally sensitive design
- Homelike, rather than institutional environments
- Privacy versus interaction with others
- Viewing and experiencing nature
- Safety and security
- Mainstreaming and location
- Functional relationships
- Use of specific rooms.

Queensland hosted a staff satisfaction workshop to ensure staff could provide input into designing facilities that would attract and retain staff. In addition to inviting a broad range of staff, the Mental Health Branch has consulted unions through the Queensland Health Reform Consultative Group (the highest level, strategic HR/IR group within Queensland Health) and formally invited all union representatives to attend the workshop.

Queensland has also developed strategies to decrease demand on inpatient mental health beds through coordinated action across a number of mental health services including:

- increased access to community based personal support and accommodation;
- improved mental health promotion, prevention and early intervention; and
- increased access to community mental health services.

Community Mental Health Staffing

A framework and process to measure progress towards the 2017 community mental health staffing targets has been established and agreed with the Area Mental Health Clinical Networks and associated District Mental Health Services. Progress to date on the establishment of new community mental health positions is detailed in the tables below.

Queensland has significantly increased community mental staff numbers since 2005-06 to support the provision of high quality mental health care to consumers, carers and their families.

Table 11 demonstrates that funding provided in 2006-07 increased Queensland's community mental FTE by 12.93% from the baseline level in 2005-06. Queensland further enhanced this initial investment in 2007-08, resulting in a 25.38% increase in community mental health staffing from 2005-06 levels. With additional staff that Queensland will fund in 2008-09, it is estimated that community mental health FTE will be around 2047.96, representing a 32.06% increase in community mental health staff since 2005-06.

As shown in Tables 12 and 13, Queensland's coordinated approach to the allocation and establishment of these additional positions resulted in 49% of the 193.10 FTE being appointed by November 2007 – only five months after the funding became available. Queensland's progress in appointing to these new positions will be reviewed again in June 2008.

Queensland Highlights

- An additional 179 positions to provide a variety of mental health services
- An additional 479 new positions over three years funded by the 2007-08 State Budget

Table 11. Established community FTE 2005-06 to 2008-09

Total Established Community FTE - Statewide				
Program	**2005-06**	**2006-07**	**2007-08**	**2008-09**
Child & Youth*	312.32	341.02	375.12	393.12
Older Persons*	63.50	78.00	93.30	110.80
Consultation Liaison	48.88	50.38	55.88	59.38
Adult Case Management	580.61	650.61	687.01	688.51
Mobile Intensive Treatment	78.00	84.50	98.00	103.50
Acute Care	261.04	291.94	342.84	350.84
Indigenous Mental Health*	28.90	39.10	40.10	43.43
Primary Care	2.00	3.00	6.00	10.00
Transcultural Mental health*	0.50	7.25	7.75	10.75
Dual Diagnosis	4.00	15.00	15.00	18.00
Intellectual disability	0.50	0.50	0.50	3.50
Eating Disorder[1]	2.75	3.25	3.25	9.25
Sensory Impaired[2]	0.00	0.00	0.00	3.00
Consumer Consultants	12.10	12.60	16.60	19.60
Leaders & Quality and Safety	140.23	157.63	168.53	176.28
Service Integration	0.00	0.00	0.00	20.00
Forensic Liaison[3]	15.50	16.50	34.50	34.50
Total	**1550.83**	**1751.28**	**1944.38**	**2054.46**

[1] Includes positions for statewide/area-wide Eating Disorder Outreach

[2] Includes new positions for the statewide Deafness & Mental Health Centre in 2008-09

[3] Includes 18 new FTE funded from Implementation of Butler Review of MHA 2000 in 2007-08

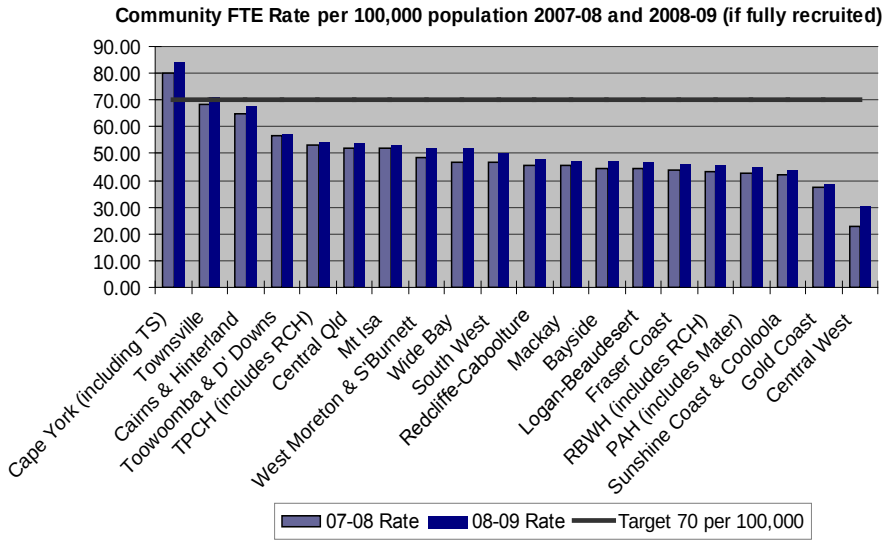
* Includes new statewide coordination positions in 2008-09 (i.e., E-CYMHS, Psychiatry Training Program, Older Persons, Indigenous Hub, QTCMHC)

Figure 6 demonstrates Queensland's projected progress for 2007-08 and 2008-9 toward the target of 70 community mental health FTE per 100,000 population around 47.84 FTE per 100,000 population.

Queensland's investment over the initial two years of the NAP is projected to result in Cape York (including Torres Strait) and Townsville districts reaching the 70 FTE per 100,000 target. Cairns and Hinterland District will also be approaching the target by the end of 2008-09 with 67.65 FTE per 100,000 population. By 2008-09 several other districts will be approaching or will have surpassed the 50 FTE per 100,000 mark – between 65%-70% of the way to meeting the 70 per 100,000 target.

It should noted that there are approximately 84 additional positions to be funded across the state in 2009-10, which will further improve Queensland's progress towards it target of 70 community mental health FTE per 100,000 population.

Figure 6. Community FTE rate per 100,000 population 2007-08 and 2008-09



Tables 12 to 13 highlight Queensland's actual progress toward the target of 70 clinical FTE per 100,000 population by district and by program. Some districts with a smaller number of staff to recruit have completed recruiting 100% of their 2007-08 staffing allocations. Many other districts are making good progress on recruitment. There are some districts that had not made significant progress in recruitment as at November 2007.

Queensland is actively working with all districts to ensure that funded positions are recruited in a timely manner. Queensland's strategies in this regard will be discussed later in the 'Workforce, quality, information and safety' section of this submission.

Table 12. Established and appointed community FTE by Area & District

Area	District	2007/08 New Positions Established*	2007/08 New Positions Appointed	% Appointed	2007/08 New Positions Vacant	% Vacant
Northern	Cairns & Hinterland	11.00	4.50	41%	6.50	59%
	Townsville	10.00	4.00	40%	6.00	60%
	Mackay & Moranbah	9.50	0.00	0%	9.50	100%
	Mt Isa	3.00	3.00	100%	0.00	0%
	Cape York & Torres Strait	3.00	1.00	33%	2.00	67%
	Total	**36.50**	**12.50**	**34%**	**24.00**	**66%**
Central	RCH	2.00	2.00	100%	0.00	0%
	RBWH	8.00	4.00	50%	4.00	50%
	Redcliffe-Caboolture*	10.00	3.00	30%	7.00	70%
	TPCH	6.00	0.00	0%	6.00	100%
	Wide Bay	2.00	2.00	100%	0.00	0%
	Sunshine Coast & Cooloola	9.00	6.00	67%	3.00	33%
	Fraser Coast	3.00	3.00	100%	0.00	0%
	Central Qld*	9.00	8.50	94%	0.50	6%
	Central West	0.00	0.00	0%	0.00	0%
	Total	**49.00**	**28.50**	**58%**	**20.50**	**42%**
Southern	Gold Coast	32.60	11.60	36%	21.00	64%
	Logan-Beaudesert	17.00	12.50	74%	4.50	26%
	Bayside*	15.10	5.60	37%	9.50	63%
	South West*	1.60	0.00	0%	1.60	100%
	West Moreton & S' Burnett	9.50	3.00	32%	6.50	68%
	Toowoomba & D'Downs*	7.80	2.00	26%	5.80	74%
	PAH	17.00	14.00	82%	3.00	18%
	Mater*	7.00	5.00	71%	2.00	29%
	Total	**107.60**	**53.70**	**50%**	**53.90**	**50%**
State	**Grand Total**	**193.10**	**94.70**	**49%**	**98**	**51%**

Explanatory Notes:
Includes all positions in the 70FTE/100,000 total population community mental health target
Vacancy figures recent as at November 2007. Excludes temporary appointments.
Excludes new positions established in Tertiary/Statewide services.
Central Qld includes 1 FTE established from savings
Bayside includes 3.1FTE established from savings
South West inclues 0.6 FTE established from savings
Toowoomba includes 1.8 FTE established from savings/alternative funds
Mater includes 2 FTE established from other funding sources.

Table 13. Established and appointed community FTE by Program

Area	Classification	2007/08 New Positions Established*	2007/08 New Positions Appointed	% Appointed	2007/08 New Positions Vacant	% Vacant
Northern	Nurses (NO)	3.00	1.00	33%	2.00	67%
	Professional Officers (PO)	1.50	1.00	67%	0.50	33%
	Psychiatrists (Psych)	4.00	1.00	25%	3.00	75%
	Registrars (Reg)	1.00	1.00	100%	0.00	0%
	Nurses/Professional (NO/PO)	18.00	6.00	33%	12.00	67%
	Other (eg., Admin AO4 & above)	6.00	1.50	25%	4.50	75%
	Technical/Operational (TO/OO)	3.00	1.00	33%	2.00	67%
	Total	**36.50**	**12.50**	**34%**	**24.00**	**66%**
Central	Nurses (NO)	6.00	4.00	67%	2.00	33%
	Professional Officers (PO)	9.50	7.50	79%	2.00	21%
	Psychiatrists (Psych)	3.00	2.00	67%	1.00	33%
	Registrars (Reg)	7.50	6.00	80%	1.50	20%
	Nurses/Professional (NO/PO)	21.00	8.00	38%	13.00	62%
	Other (eg., Admin AO4 & above)	2.00	1.00	50%	1.00	50%
	Technical/Operational (TO/OO)	0.00	0.00	0%	0.00	0%
	Total	**49.00**	**28.50**	**58%**	**20.50**	**42%**
Southern	Nurses (NO)	20.50	12.00	59%	8.50	41%
	Professional Officers (PO)	46.00	19.00	41%	27.00	59%
	Psychiatrists (Psych)	8.70	6.70	77%	2.00	23%
	Registrars (Reg)	12.00	12.00	100%	0.00	0%
	Nurses/Professional (NO/PO)	17.80	3.00	17%	14.80	83%
	Other (eg., Admin AO4 & above)	1.60	1.00	63%	0.60	38%
	Technical/Operational (TO/OO)	1.00	0.00	0%	1.00	100%
	Total	**107.60**	**53.70**	**50%**	**53.90**	**50%**
State	**Grand Total**	**193.10**	**94.70**	**49%**	**98.40**	**51%**

Explanatory Notes:
Includes all positions in the 70/100000 community mental health target
Vacancy figures recent as at November 2007. Excludes temporary appointments.

Implementation of the recommendations from Brendan Butler's review of the *Mental Health Act 2000*

Review of Queensland's Mental Health Legislation

The Mental Health Act 2000

Queensland's *Mental Health Act 2000* ('the Act') provides for the involuntary assessment and treatment, and the protection of persons with a mental illness.

The Act also establishes special processes for admission of mentally ill offenders from court or custody, decision making about criminal responsibility where the person has a mental illness, and the detention, involuntary treatment and review of mentally ill offenders.

Review of the Mental Health Act 2000

A review of the *Mental Health Act 2000* was announced on 23 May 2006 by the Honourable Stephen Robertson MP, Queensland's Minister for Health. The announcement followed media coverage regarding the alleged sighting of a high profile mental health patient on the Gold Coast. This publicity raised public interest in issues relating to whether certain mental health patients should be allowed to return to the community on limited community treatment (a form of leave) and the rights of victims of crime and information provided to them in matters where an offender has a mental illness.

The Queensland Government appointed Brendan Butler AM SC to conduct the Review, which commenced in July 2006. The full Terms of Reference for the Review are available from http://www.reviewmha.com.au.

On 8 December 2006, after extensive consultation with a broad range of stakeholders, Mr Butler provided the Queensland Government with *Promoting balance in the forensic mental health system – Final Report – Review of the Queensland Mental Health Act 2000* ('the Review Report'). The Report is at Appendix 7.

The Report contains 106 recommendations directed at legislative and administrative reforms to address the needs of victims of crime and to enhance public confidence in the system dealing with forensic patients. The recommendations focus on strategies to:

- promote more balance in the legislation;
- provide better support and information for victims;
- enhance the forensic mental health system;

- build mental health services' risk management capability; and
- increase community awareness of the forensic mental health system.

After consideration of the Review and its findings, the Queensland Government allocated $53.484 million over four years to implement all 106 recommendations. The formal government response to the Report articulates Queensland Government's commitment to improving the forensic mental health system and provides an interim report on progress and future plans to fully implement the recommendations (Appendix 8).

Key achievements

Legislative amendments

The legislative amendments are a significant component of the implementation of the Review Report recommendations since they reinforce the complementary reforms to administrative and clinical practice.

The full suite of amendments to the Mental Health Act 2000 resulting from the *Health and Other Legislation Amendment Act 2007* and the *Mental Health and Other Legislation Amendment Act 2007* commenced on 28 February 2008. The latest reprint of the *Mental Health Act 2000* is available at: http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/M/MentalHealA00.pdf

Several, highly significant legislative amendments have commenced including:

- amendment of the Act's purpose to require consideration of community protection and the needs of victims when making decisions about forensic patients
- replacement of the term 'non party submission' with 'victim or concerned person submission' to take a more sensitive and relevant approach to victims
- provision of detail of the purpose and nature of such submissions to the Mental Health Review Tribunal and the Mental Health Court
- addition of the requirement that the Mental Health Court give reasons for taking or refusing to take into account submissions by victims
- inclusion of a statement stating that the role of the Attorney-General in the Mental Health Review Tribunal is to represent the public interest
- establishment of information orders for classified and forensic patients

- establishment of a legislative sub-category of forensic order entitled ‘special notification forensic orders’ for patients charged with more serious offences
- changes to the administrative decision-making system for patients charged with less serious offences
- addition of requirements relating to the Director of Mental Health’s provision of policy and practice guidelines for forensic patients and special notification forensic patients, and to monitor statutory compliance.

Further amendments to the *Mental Health Act 2000* may be made to implement recommendation 5.1 of the Review Report. These amendments would focus on forensic provisions in the Act as they relate to people with an intellectual disability.

Providing better information and support to victims

The Report identifies the importance of victim access to information as well as support to understand and negotiate the forensic mental health system. Several improvements in this area have been achieved.

The Queensland Health Victim Support Service (QHVSS) has been established. It provides a statewide service for victims of an offence committed by people who have a mental illness and are diverted to the forensic mental health system from the criminal justice system. The QHVSS provides information, support, and counselling services that are appropriate to the individual circumstances of the victim. It is intended that improved access to information and support will assist victims to contribute to decision making processes in the Mental Health Court and Mental Health Review Tribunal systems.

The QHVSS became operational on 28 February 2008 and operates from Brisbane with 8 full-time staff. Work is underway to establish an office in Townsville with two additional staff to meet the needs of victims in north Queensland. Outreach services will also be provided throughout Queensland by five victim support coordinators through face-to-face, telephone and video-conference links. In addition, the QHVSS undertakes activities to improve coordination of services for victims with other key stakeholders.

Victim information registers have been established, which enable victims to register to receive information about the detention of a classified patient or forensic patient. The register system allows victims to be better informed about changes in the patient’s status, for example, the patient’s transfer to another mental health service or authorisation to undertake limited community treatment (a form of leave).

Victims can apply to the Mental Health Review Tribunal for a Forensic Patient Information Order (FPIO) or to the Director of Mental Health for a Classified Patient Information Order (CPIO).

Enhancing the forensic mental health system

The Review Report notes that delays in matters being heard by the Mental Health Court can have a detrimental affect on victims, mental health patients and the mental health sector generally. Resources have been enhanced to enable an increase in Mental Health Court sittings (including increased resources for agencies who participate in Court sittings) to address the backlog of cases and the resulting hearing delays. Achievements so far include:

- increased Mental Health Court sittings commenced in February 2008 with a 50 percent increase in hearings scheduled on the Court calendar;
- establishment of additional staff for Legal Aid Queensland, the Office of the Director of Public Prosecutions, the Office of the Director of Mental Health and the Mental Health Court Registry; and
- increased remuneration for assisting psychiatrists in the Mental Health Court has increased to help make these positions more attractive to suitably qualified candidates.

Other strategies have been employed to improve the timeliness of decisions in the forensic mental health system. The Director of Mental Health has established a reporting process to monitor statutory timeframes for clinical reports relating to involuntary patients charged with an offence. These reports assist the Director of Mental Health to determine whether to refer the matter to the Director of Public Prosecutions or the Mental Health Court, and to inform decisions about whether the person has a mental health defence. In addition, significant progress has been made towards development of a training package for psychiatrists who write the s238 Forensic reports.

Building mental health services' risk management capability

Ensuring a clinician's understanding of assessment and management practices across a continuum of risk associated with mental health clients must be a high priority. The Review Report acknowledges that Queensland Health has already made significant achievements in this area but that a more comprehensive and coordinated approach to risk assessment and management is needed. Queensland Health has adopted a mutli-strategic approach to address these issues.

Funding has established an additional 35 forensic mental health clinicians across the State including:

- three forensic psychiatrists;
- twenty-eight specialist forensic clinicians; and
- four Indigenous mental health workers.

Three risk management training positions, one of which has been filled, will develop and deliver risk management training to mental health clinicians across Queensland. The training will be competency-based with tertiary institutions involved in its development.

New policies and procedures to improve practices in the management of forensic patients (including those patients under the Special Notification Forensic Patient category) have been developed and released to Queensland Health mental health clinicians. Amendments to the *Mental Health Act 2000* stipulate that these policies and procedures (and others issued by Director of Mental Health) must be followed.

The Report also highlights the need for more systematic monitoring and auditing of compliance with the *Mental Health Act 2000*. A team has been established in the Office of the Director of Mental Health to undertake this work.

Enhancing community awareness of the forensic mental health system

The Report notes that stigma and discrimination borne from lack of community understanding of the forensic and broader mental health system continues to have negative effect on the wellbeing of mental health patients, their families, carers and the community. At the same time, maintenance of public confidence in the forensic mental health system, as well as promoting peace of mind of victims and patients, are acknowledged as important objectives.

To address this objective, $800,000 over four years will be spent on developing and maintaining strategies to enhance community awareness and understanding of the forensic mental health system. Three resource packages are being developed in 2007-08. One package focuses on improving general community understanding, another is tailored to the needs of Indigenous people, while the third targets media professionals' practice.

These packages are being developed by the Queensland Centre for Mental Health Learning, which is undertaking extensive research and consultation to ensure the resources provide a user-friendly reference for the intended audiences.

Action Area 3: Participation in the Community and Employment, including Accommodation ($162.39 million)

	$Millions				
	Action Plan funding commitment 2006-2011	Subsequent additional mental health funding commitments 2006-2011	Funding allocated 2006-07	Funding allocated 2007-08	Cumulative funding allocations from July 2006
Action Area 3: Participation in the community and employment, including accommodation					
Housing Capital	20.00	40.00	20.00		20.00
Health Action Plan Non-Government Organisation Funding	25.00	0.00	5.00		5.00
Disability Services Respite and Sector Capacity Building	12.00	0.00	2.40		2.40
Employment and training	5.00	0.00	1.00		1.00
Mental health services in prisons	2.30	0.00	0.50		0.50
DSQ - NGO personal support and accommodation	0.00	35.64	0.00	6.12	6.12
DSQ - Personal support in social housing	0.00	22.45	0.00	2.43	2.43
Total Action Area 3	**64.30**	**98.09**	**28.90**	**8.55**	**37.45**

Achievements in 2006-08

Housing Capital

Housing & Support Program

Disability Services Queensland (DSQ) in collaboration with the Department of Housing (DoH) and Queensland Health (QH) housed and supported 80 consumers in 2006-07 to enter the Housing and Support Program (HASP) in accordance with the commitment in the COAG *National Action Plan on Mental Health 2006-2016*.

The Queensland Government has allocated an additional $22.4 million to DSQ and $40.0 million to the DoH over four years to house and support approximately an additional 160 people as part of the HASP. In 2007-08, 42 individuals have been referred to HASP and are in the process of being transitioned from Queensland Health facilities into social housing with support. The process of identifying, verifying and assessing consumers to enter HASP in 2008-09 has also commenced.

Health Action Plan Non-Government Organisation Funding

Responsibility for oversight of the Mental Health Non-Government Sector Funding Program has been transferred to Disability Service Queensland (DSQ) as part of Queensland Government Machinery of Government changes.

Queensland Highlights

- 80 social housing places in 2007/08
- 240 supported social housing places over the next 5 years
- 100 Community Jobs Program places each year
- $450,000 to engage employment specialists
- An additional 20 NGOs funded to provide independent living and social support services
- An additional $35.64 million over four years for the NGO sector

The Queensland Government provided $150,000 to the Queensland Alliance & the Queensland Aboriginal and Islander Health Council to support their member organisations to tender for available funds

Sector Development

In recognition of the issues faced by the non-government mental health sector in Queensland as a result of this major investment in the sector by both the State and Commonwealth governments, DSQ is also progressing work to determine strategies to assist the sector to manage its growth.

Disability Services Respite and Sector Capacity Building

Funding rounds were completed in 2006-07 for the Adult Lifestyle Support Program (ALSP), Respite and Respite for Ageing Carers Programs, Family Support Program, Hostel Response Program and for the Emergency and Crisis Program for support to individuals. The Resident Support Program and the Strengthening Non-Government Organisations Accommodation Services and Day Services Programs tendering were also completed.

DSQ met its target of referring 61 individuals (from Project 300, ALSP and Hostels Response) to the Housing and Support Program (HASP). All 61 individuals were assessed as meeting eligibility criteria by Queensland Health, Department of Housing (DOH) and DSQ. Since being accepted for the program, one person has passed away, and another has been admitted to a Queensland Health extended treatment facility. Additional individuals were identified in 2007-08 to replace the referrals for any individuals who did not move into their housing allocation with supporting 2006-07. At this point, this means an additional two people in 2007-08.

Individuals referred to this initiative in 2006-07 are currently working with DSQ to plan the type of supports they require to transition and sustain their accommodation options.

The Queensland Government has also allocated an additional $22.4 million to DSQ and $40.0 million to the DoH over four years to house and support approximately an additional 160 people as part of the Housing and Support Program. This funding will enable further clients to transition from Queensland Health facilities to community living with disability support from DSQ, additional social housing stock from the DOH and the continued clinical services provide by Queensland mental health services.

Employment and Training

In 2006-07, the Department of Employment and Industrial Relations (DEIR) met its commitment to assist 100 persons with a mental illness each year through the *Work in Place Project* (previously Community Jobs Program) funded under *Skilling Queenslanders for Work* initiative and delivered by the Mental Health Association (Qld).

… 63% of participants gained long-term employment …

Through ongoing liaison between Metropolitan and Regional Coordinators with Local Area Coordinators, host placement agencies and regional and central employment officers, 53 persons have been assisted as at 31 January 2008. The assistance provided has been as follows and has been through paid work placements, job preparation and training with many of the participants undertaking more than one component of the assistance offered under the initiative (Table 14).

Table 14. Summary statistics for the Work in Place Project

Region	Work Placements	Job Preparation	Accredited Training
Bundaberg	7	7	0
Cairns	5	5	0
Gold Coast/ Beenleigh	13	16	3
Redlands Corridor	8	14	6
Toowoomba	6	10	6
TOTAL	**39**	**52**	**15**

Achievements in 2007-08

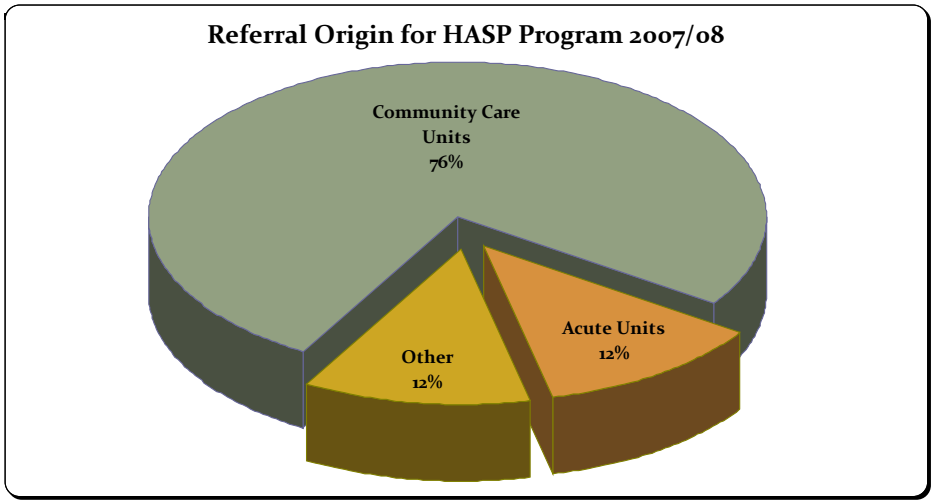
New Mental Health Initiatives

In the 2007-08 State Budget the Queensland Government committed an additional $35.6 million over four years to implement four new initiatives through the non-government sector including:

- Transitional Recovery Programs (TRP) to help people ‘step down’ from acute inpatient care in a timely manner and receive the require psychosocial rehabilitation to resume their social roles and contacts.
- Residential Recovery Programs (RRP) to support vulnerable and inappropriately housed people with mental illness in boarding houses and hostels.

- Prison Transition Support Program (PTSP) to support people with mental illness during and post release from correctional facilities.
- Peer Operated Crisis/Respite Programs to avoid inappropriate hospitalisation particularly for people experiencing a relapse.
- Models and project plans for the TRP, RRP and PTSP have all been developed in consultation with a range of key non-government, government and consumer and carer stakeholders; endorsed by Minister and currently in the process of going to procurement.
- A Think Tank was conducted in mid December 2007 to develop up the Peer Operated Crisis/Resite Program. This program will commence in 2008-09.

As illustrated in the accompanying graph, referrals to HASP have primarily been from Community Care Units and Acute Mental Health Units. In addition to the $121.55 million Queensland has allocated to fund new acute and extended treatment mental health facilities, referrals to HASP should also help to relieve pressure on inpatient beds.



Action Area 4: Increasing Workforce Capacity ($76.92 million)

	$Millions				
	Action Plan funding commitment 2006-2011	Subsequent additional mental health funding commitments 2006-2011	Funding allocated 2006-07	Funding allocated 2007-08	Cumulative funding allocations from July 2006
Action Area 4: Increasing Workforce Capacity					
Increased Workforce Remuneration	5.80	0.00	1.16	0.00	1.16
Mental Health Transition to Practice Nurse Education Programme	0.30	0.00	0.30	0.00	0.30
Workforce development & research	0.00	8.06	0.00	1.57	1.57
Growth funding	0.00	43.00	0.00	4.00	4.00
Information management	0.00	19.76	0.00	0.55	0.55
Total Action Area 4	**6.10**	**70.82**	**1.46**	**6.12**	**7.58**

Achievements in 2006-08

Increased Workforce Remuneration

Funding has been allocated to Districts to facilitate increased workforce supply. Across the broader health workforce, more competitive remuneration packages have been introduced for doctors and nurses through the recent enterprise bargaining process to improve opportunity to successfully recruit and retain a high quality medical and nursing workforce. A significant wage increase for nurses has been supported in order to align Queensland Health nurses with those from other states.

Mental Health Transition to Practice Nurse Education Program

Following meetings with key stakeholders, responsibility for overall accountability and the majority of the operational management activities for the Transition to Practice Nurse Education Program – Mental Health (TPNEP-MH) program has been transferred from the Queensland Centre for Mental Health Learning (QCMHL) to the School of Mental Health, The Park, West Moreton South Burnett Health Service District.

The Nursing Director (Education), School of Mental Health, The Park will supervise the TPNEP-MH with the Statewide Coordinator (TPNEP-MH) to ensure that the nursing education linkages are managed and monitored to achieve the identified outcomes and that they remain consistent with the principles identified within the establishment of the program under the auspices of the Queensland Health Nursing and Midwifery Staff Development Framework (2007).

The QCMHL will continue to contribute to the TPNEP-MH as a strategic management stakeholder via its membership on the TPNEP-MH Education Management Group to ensure the program objectives are consistent with current and future statewide mental health educational projects and programs. QCMHL will also continue to provide independent evaluation of the program. Data from a three-month evaluation is currently being analysed, with 64% of surveys completed.

Statewide plans for the 2008 intake are under way, with approximately 70 participants statewide commencing in January and February 2008. QCMHL will commence the 2008 evaluation of the program when the intakes commence with 11 of the 15 Health Service Districts participating in research activities. Toowoomba and Darling Downs Health Service District and the Sunshine Coast and Cooloola Health Service District (Nambour IMHS) will not undertake the TPNEP-MH program in 2008.

End of year arrangements for course accreditation of individual participants from the 2007 statewide cohort of approximately 65 participants are now being finalised.

Achievements in 2007-08

There has been significant growth in community based services for people with a mental illness over the past decade and a commensurate level of community mental health staffing targets have been set; however high levels of unmet need persist. Given the global workforce shortage, the workforce gap in this state will simply not be met without an innovative and well managed approach to increasing workforce capacity.

Moreover, there is an increasing complexity to mental health service delivery and a rapidly changing paradigm of care, resulting in urgent demands to update the knowledge and skills of the existing workforce; and to do so at pace and quality, not seen before in this State. When one acknowledges that workforce development in Queensland is facing the same unique contextual factors as service delivery outlined in Chapter 1 of this submission (i.e. an ageing, geographically dispersed workforce that operates within a very traditional learning culture), the complexity and pressure for workforce development becomes magnified.

Nevertheless, Queensland is rising to the challenge by investing in and coordinating a well considered program of workforce initiatives.

Establishing the Queensland Centre for Mental Health Learning

The Queensland Centre for Mental Health Learning (QCMHL) has developed a key set of training initiatives that are strategically aligned with the NAP. The Centre has been operational for 12 months and under the direction of a Strategic Advisory Board appointed by the Chief Health Officer in 2006.

The initial funding for the Centre has been invested into establishing high quality systems for curriculum design, evaluation of training outcomes and educational technology that will address the current pace and demand for training, in a sustainable way.

QCMHL is a Registered Training Organisation which strategically places it to provide learning bridges through accredited vocational training programs to support the broadening mental health workforce and the inter-departmental and NGO collaborations under way at present.

The Centre has expanded quickly and is currently operating at three locations in the state through innovative learning partnerships with the Skills Development Centre at the Royal Brisbane and Women's Hospital and the Centre for Rural and Remote Mental Health in Cairns. The Centre is currently teaching 14 formal courses in fundamental mental health knowledge and skills. There are also a current series of stand-alone workshops that are on offer, including topics such as: Mental State Examination; Suicide Risk Assessment and Management; Practice Supervision and Educator Development.

The QCMHL Training Catalogue and Training Resource Centre can be viewed online at www.health.qld.gov.au/qcmhl. It is important to note that QCMHL has established a consumer and carer consultancy pool to enable active participation of consumers and carers in the design, delivery and evaluation of QCMHL learning materials.

In terms of quality and innovations being developed at QCMHL, the preliminary learning products produced over the past year have been positively reviewed by the NSW Institute of Psychiatry leading to a formal partnership to co-produce a range of interactive learning DVDs for mental health practitioners which will be valuable in enhancing mental health knowledge throughout Queensland and more broadly in Australia in the years to come.

International Mental Health Recruitment Campaign

- Manchester
- Birmingham
- Bristol
- Newcastle
- London
- Glasgow
- Edinburgh
- Southhampton
- York

International Mental Health Recruitment Campaign

In order to address the difficulty recruiting to new positions in 2007-08 agreement was reached to conduct an international recruiting campaign. The Queensland Health UK mental health recruitment drive, which consisted of six clinicians and three administrative staff, was conducted from 25 February to 15 March 2008. The campaign included promotional information evenings held in various locations from 25-29 February and face-to-face interviews from 3-14 March.

Promotional 'Living and working in Queensland' evenings for mental health professionals were held in Manchester, York, Newcastle, Edinburgh, Glasgow, Birmingham, Bristol, Southampton and London. Over 230 potential candidates attended these sessions.

139 suitable candidates

- 5 psychiatrists
- 54 mental health nurses
- 80 allied health staff

A total of 170 mental health candidates were interviewed of whom 139 were recommended for appointment with Queensland Health. Five medical practitioners with specialty qualifications in psychiatry were interviewed, all of whom were recommended for employment. In total, 54 mental health nurses were recommended for employment.

An additional 80 allied health staff were recommended for appointment. This group includes 35 psychologists, 23 social workers and 22 occupational therapists.

Queensland is Supporting New Staff to Make the Transition to Queensland Health

Queensland has developed a coordinated plan to plan to support new staff from overseas and new graduates from university. Queensland's plan seeks to harmonise the efforts of:

- Corporate Office workforce units;
- Queensland Health Recruitment Unit;
- Area Health Service workforce units;
- District mental health services; and
- Queensland Centre for Mental Health Learning.

Queensland provided funding to each Area Health Service to establish Candidate Care positions. In 2007-08, four candidate care positions were established within Districts with high recruitment needs. These positions will support all new staff to seamlessly transition into the service. This will include the provision of intensive support from the time of selection by the District into commencement and for the first six to twelve months after commencement.

Queensland has also funded two additional Undergraduate Support Officer positions in the Southern and Central Area Health Services. These positions will develop and implement strategies to enhance recruitment of mental health staff, primarily from major universities, and systematically transition them into the QCMHL induction program and other Queensland Health learning opportunities.

Maintaining a Skilled Workforce in Queensland Mental Health Services

The Queensland Centre for Mental Health Learning (QCMHL) has developed an induction program to ensure new graduates and other clinicians new to Queensland Health are appropriately skilled to provide safe, high quality mental health services.

QCMHL has redeveloped and is currently offering the Certificate IV in Mental Health (non-clinical) at three teaching sites throughout the State. This new approach to inter-disciplinary learning within Queensland Health, aims to ensure the acquisition of fundamental knowledge and skills for contemporary and safe mental health practice. It is complemented by traditional approaches to transitional training that occur across the mental health professions including profession specific practice requirements and formal training programs including the Psychiatry Registrar Training Program and the Transition to Practice Nursing Education Program.

The Centre is also in process of developing an intranet accessible Training Resource Centre for staff and managers. Additionally, the QCMHL and the Mental Health Association have offered over 100 scholarships in 2008 for NGO staff to undertake modules within the Certificate IV- Mental Health (non-clinical).

Leadership in mental health practice

The Director of Mental Health has sponsored a mental health leadership development program that will support clinical leaders to assertively respond to the many reform challenges in each of the COAG Action Areas.

The purpose of the mental health-specific clinical leadership program is to develop a leadership cohort that will take responsibility for assertively using evidenced-based information to lead mental health reform across the state. The proposed program is a natural extension of the existing Queensland Health Leadership Development Program model, specifically design to supporting new and existing team leaders and managers in mental health. The leadership program is scheduled to commence in the second half of 2008.

Information Management

The Queensland State Budget 2007-08 made substantial investments in Information and Communication Technology highlighting the pivotal importance of information to support reforms outlined in the *Statewide Health Services Plan 2007-2012*. Two substantial investments were identified for mental health over the period 2007-2011:

1. $16.4m for the establishment of an integrated information system for mental health, known as the Consumer Integrated Mental Health Application (CIMHA).

2. $3.36m to support the implementation of a range of information management initiatives.

Consumer Integrated Mental Health Application (CIMHA)

The Client Events Services Application (CESA) implemented in 1999 currently supports the clinical and business processes of Queensland's integrated mental health services that extend across inpatient, community/ambulatory and extended treatment service settings. CESA also collects the National Minimum Data Set – Community Mental Health Care (NMDS-CMHC) required under the current Australian Health Care Agreement (AHCA).

CESA is now hosted on an unsupported platform making it vulnerable to possible failure. CESA is unsupported by a vendor and no functional changes have been possible to the system for over 5 years. As a result, functionality required to meet the requirements under the *Mental Health Act 2000*, and the National Outcomes and Casemix Collection has been met through the development, implementation and maintenance of two additional standalone systems, the *Mental Health Act 2000* Information System (MHAIS) in 2001 and the Outcomes Information System (OIS) in 2002.

Queensland public mental health services have made significant advances in the areas of organisational change, standardised business processes and the establishment of human resource infrastructure to support the information agenda. However these strategies, on their own, are insufficient to meet mental health's current and on-going information management requirements.

A new information system is required to ensure that mental health information is of a high quality and consistently collected across the State. The implementation of CIMHA is intended to provide the following benefits:

- Address recommendations from the *Achieving Balance: Report of Queensland's Review of Fatal Mental Health Sentinel Events* and recent coronial inquiries that call for the integration of mental health information systems to ensure timely access to accurate mental health clinical information.
- Support continuity of care as consumers move between inpatient and community settings or between Health Service Districts.
- Improve the quality and accountability of mental health service delivery by ensuring that key clinical activities are supported by a structured standardised framework.
- Ensure patient and community safety by improving the speed, efficiency, and accuracy of the recording of clinical and *Mental Health Act 2000* data.
- Provide staffing efficiencies and minimising data consistencies by removing the need to replicate data entry in multiple systems.

CIMHA progress to date

CIMHA … consumer-centric electronic clinical tool supporting consumer continuity of care …

In April 2007 Queensland Health approved the commencement of the project for the development and implementation of the single clinical information system that will replace, enhance and integrate the functionality of CESA, MHAIS and OIS. CIMHA is being developed by Dialog, a Queensland-based company, whose development team is co-located with Queensland Health CIMHA Project Management and Business Team staff.

System development continues to move forward with a number of key system modules successfully completing end-user acceptance testing. Expected additional requirements to incorporate legislative changes and the Butler Recommendations, as well as recent changes to policy for the protection of the needs of children, have extended the development schedule. The specifications for the development of CIMHA to be implemented in Stage 1 have been finalised. Statewide simultaneous implementation is currently scheduled for late November 2008.

What CIMHA will deliver

- A consumer-centric clinical information system designed to support mental health clinicians in the provision of safer quality mental health services.

- A shift from current thinking where systems exist only for 'data collection' to a future where electronic clinical tools support the consumer's continuity of care.

- Support for consumer and community health and safety by providing timely access to up-to-date clinical information across service settings and between Districts. That is, one system for a consumer wherever they access services.

- The efficient entry of clinical information by integrating and streamlining the functionality previously provided by three separate systems.

- The ability to review consumer demographic, activity, *Mental Health Act 2000* and outcomes information in one location to inform recovery and treatment plans, evaluate service delivery and assist with service planning.

- New functionality for the recording of on-line clinical notes and care plans. PDFs with secure e-Signatures attached ensure clinicians can trust these entries to inform clinical decision making.

Using Information in Clinical Practice

Queensland has provided funding to support the effective use of information in clinical practice, service planning and policy development.

In 2007-08, the total allocation of funding was dispersed as a one off payment to districts to support the training of new clinical staff in the use of clinical outcome measures and in the use of mental health applications including CESA, OIS and MHAIS. This allocation will support the capacity of District mental health services to meet some immediate and additional information management requirements that will challenge the existing capacity of Mental Health Information Managers. Districts will be supported through the Area Clinical Information Teams to ensure that the funds are used to develop sustainable strategies that support training of new clinical staff in information systems and collections into the future.

In 2008-09, funding will be directed towards activities associated with the development of an Integrated Data Reporting Repository for mental health. Work with the Information Division to establish a project to develop an integrated data reporting repository for mental health has commenced. Details regarding the progress of this work will be reported through the Information Management Subgroup of the Statewide Mental Health Network. In addition, recurrent funds will be allocated to positions recruited to drive initiatives specifically targeted to enhancing services capability to utilise information in clinical practice, service planning and policy development.

Ongoing costs associated with the 2008-09 investments, as well as additional funds for a database administrator, will be allocated in 2009-10.

The QCMHL has been provided seeding funds to develop an electronic Training Resource Centre, to support the translation of evidence and innovation into improved services. The Training Resource Centre will improve quality control and broader access to training resources, which is particularly critical for mental health clinicians working in rural and remote locations.

Queensland Health Mental Health Patient Safety Plan

Queensland has made progress on the development of a safety plan for mental health. A preliminary discussion paper was developed in late 2007 and circulated to key stakeholders. Subsequent to this a forum was held to further progress the proposed safety plan. A revised draft is currently being circulated for further discussion, prior to formal approval by the Statewide Mental Health Network in 2008.

Chapter 5 Flagship 1 – Governments working together

5.1 Queensland COAG Mental Health Group and Mental Health Interdepartmental Committee (MH-IDC)

Premier or Chief Minister Departments in each State and Territory and the Australian Government Department of Health and Ageing have convened COAG Mental Health Groups to provide forums for oversight and collaboration in planning and implementing initiatives under the Action Plan.

One of two ‘flagship’ initiatives outlined in the NAP, ‘Governments working together’, is directed at providing more seamless and coordinated health and community services for people with a mental illness. It was anticipated that work in this area would be undertaken within existing resources with no funding earmarked in the NAP. In Queensland, there are two groups that give effect to ‘Governments working together’ as indicated in the NAP:

- the Queensland COAG Mental Health Group; and
- the Mental Health Interdepartmental Committee.

Queensland has been successful in achieving a high level of collaboration between State and Commonwealth government agencies responsible for the implementation of the NAP. This new collaborative approach reflects an intense relationship with high levels of contribution, commitment and joint effort, shared goals, higher levels of trust and a commitment to working towards system change.

It is crucial that within this whole-of-government approach Queensland government agencies coordinate their intervention at the population and service delivery levels to ensure that consumers, carers and their families have access to the full range of interventions and services no matter the context in which they may find themselves.

5.2 Queensland COAG Mental Health Group

The first meeting of the Queensland COAG Mental Health Group took place on 4 August 2006. The group has met ten times since then; the next meeting scheduled for 23 May 2008.

Consistent with the National Policy, Queensland involves consumers and carers at all levels of decision making

Queensland remains the only jurisdiction to comply with the National Policy of including consumers and carers at all levels of decision making by including them as key members of the Queensland COAG Mental Health Group.

Queensland has included, in addition to State and Commonwealth Government agencies, other stakeholders on the Queensland COAG Mental Health Group. The decision to include a broader range of stakeholders has proved to be positive.
As a result other jurisdictions are reconsidering their membership and considering the Queensland approach.

The Queensland COAG Mental Health Group, which is chaired by the Department of the Premier and Cabinet, was convened to strengthen coordination and opportunities for collaboration between Queensland and the Commonwealth Governments.

The group is an advisory rather than a decision making body thus its purpose is twofold:

1. to provide expert advice to relevant Queensland and Commonwealth government agencies responsible for implementing the initiatives announced in the NAP; and

2. to ensure that implementation is progressed in a way that optimises outcomes for people with mental illness in Queensland, minimises duplication and service gaps, and improves access for mental health consumers to the broad range of community services and social supports.

Throughout 2006-07, the Queensland COAG Mental Health Group met every six to eight weeks to provide updates relating to the implementation of all initiatives. Since mid 2007, the Queensland COAG group has met quarterly and continues to provide oversight and inform the implementation of the NAP in Queensland.

5.3 Subgroups of the Queensland COAG Mental Health Group

The Queensland COAG Mental Health Group has established time limited purpose specific subgroups to inform opportunities for better linkages, coordination and collaboration between the different systems and initiatives announced in the NAP.

Queensland COAG Mental Health Subgroups

- Rural and remote
- Care coordination
- PHaMs
- Child, Youth and education
- Employment specialists
- Suicide prevention
- Dual diagnosis

The subgroups provide operational advice to the Queensland COAG Mental Health Group and the departments with portfolio responsibility for the initiative. The final decision in relation to the implementation of the announced initiatives rests with the relevant Commonwealth or State government agency.

Participating members may be required to chair a relevant subgroup for a time-limited period and provide the required support to that group. Each member is also required to identify an appropriate operational officer who is available to work with the Queensland COAG Mental Health Team. Secretariat support for all subgroups is provided by the Queensland COAG Mental Health Team.

Queensland has involved consumers and carers in all levels of decision making. The Statewide Mental Health Network (SWMHN) includes two consumer representatives (plus an additional proxy position) and two carers (plus and additional proxy position). Consumer and representation on the SWMHN is listed in Table 15.

Table 15. SWMHN Consumer and Carer Representatives

Statewide Mental Health Network Consumer and Carer Representatives				
Subgroup	**Con-sumer**	**Carer**	**Proxy**	**Total**
Acute Inpatient	2	2	1	**5**
Mental Health PPEI	2	2	-	**4**
Indigenous	1	-	-	**1**
Eating Disorders	1	1	1	**3**
Mental Health Information	1	1	-	**2**
Forensic	1	1	-	**2**
Older Persons	2	2	-	**4**
Child and Youth	1	1	-	**2**
Seclusion and Restraint	1	-	-	**1**
Total	**12**	**10**	**2**	**24**

Personal Helpers and Mentors Program (PHaMs)

Queensland was successful in securing five PHaMs sites in Round 1 and a further seven sites in Round 2. This has provided Queensland with approximately 60 PHaMs workers. Following consultation with the Queensland PHaMs subgroup, Queensland submitted 23 site proposals for Round 3 which is awaiting further announcement by FaHCSIA.

Queensland has provided information to FaHCSIA about existing respite services in Queensland and disseminated information about the Community measure to relevant stakeholders to ensure an adequate uptake by Queensland agencies. Seven respite centres across Queensland are providing brokerage services for carers of people with a mental illness under the Mental Health Respite Program. In Phase 1 of the Community Based Program, Queensland secured one Family Mental Health Support Services project to deliver local community based projects to assist people affected by mental illness, and in Phase 2, a further six non-government organisations were successful in securing program funding to deliver projects to support families, carers, children and young people affected by mental illness.

Similarly, support has been provided to DoHA in the identification and selection of successful locations and organisations for the Rural and Remote Allied Health measure where four non-government organisations were identified to provide additional treatment services; the Support for Day-to-Day Living in the Community measure where a total of 15 locations were identified in the first round; information disseminated about aligning future Commonwealth suicide prevention programs with existing Queensland Government programs; and information disseminated about the Drug and Alcohol and Mental Illness measure to relevant non-government agencies (seven successful locations in total) to ensure an adequate uptake by Queensland agencies.

5.4 Achievements of the Queensland COAG Mental Health Group

Increased accountability, greater transparency, and the ability to collaborate on issues of concern with various stakeholders have been the outcomes of Queensland's inclusive approach to membership of the Queensland COAG Mental Health Group.

Queensland has made considerable progress with the Care Coordination Model. The Queensland model has supported the Care Coordination model development in other jurisdictions.

Benefits of Queensland's inclusive approach

- Increased accountability
- Greater transparency
- Stronger collaboration among stakeholders

The Queensland COAG Mental Health Team has successfully supported the Department of the Premier and Cabinet in its role as chair of the Queensland COAG Mental Health Group; provided advice to and negotiated with various stakeholders about the implementation of their initiatives; identified risks and policy barriers that hinder an integrated approach to implementation; and shared good practice examples across sectors. Queensland has established effective processes for cross-sector collaboration and integration.

This cross-sectoral approach has been complemented with a comprehensive communication and marketing strategy which includes regional visits, organisation of consultation forums, and the establishment of one-off and ongoing subgroups. The production of a Queensland COAG Mental Health Group *Communiqué* (Appendix 9), which is distributed quarterly to approximately 1000 key stakeholders throughout the state, has assisted local engagement and keeps all stakeholders updated on progress.

Distribution of the newsletter coincides with each Queensland COAG Mental Health Group meeting. Further complementing this communication matrix is the website of the Queensland COAG Mental Health Group. Queensland Health hosts the website which is updated quarterly to coincide with each edition of *Communiqué*. Mental Health Branch also produces *Mental Health Biz* is designed to keep staff up to date on mental health issues, services, policies and programs. This publication also highlights initiatives undertaken by our government and community partners (Appendix 10).

Queensland is driving implementation of state and Commonwealth initiatives in an integrated way

An evaluation of the Queensland COAG Mental Health Group, conducted in 2007, found that:

- the majority of members were satisfied with the structure of the group;
- there was broad agreement that the membership was effective, appropriate and adequate;
- members felt the group provided an opportunity to influence important issues in mental health; and
- participants were satisfied with the process for reporting.

5.5 Queensland Government Mental Health Inter-Departmental Committee

The second group that focuses on the implementation of the NAP is the Queensland Government Mental Health Inter-Departmental Committee (MH-IDC). The establishment of the MH-IDC, by the then Premier, has initiated a strategic and formal cross-government approach to improving the mental health and well-being of the Queensland community.

The MH-IDC comprises senior representatives from Queensland Government departments with responsibility for mental health policy and service delivery. The formal interagency approach proposed by the MH-IDC has placed the State Government in a strong position to support the implementation of the NAP in Queensland and meet the mental health needs of Queenslanders across the spectrum of interventions.

The MH-IDC is anchored upon the understanding that Queensland Health (Mental Health Services) cannot be responsible for all aspects of a person's mental health. The MH-IDC identifies opportunities for better linkages, coordination and collaboration between Queensland government departments. The MH-IDC provides a forum for building strategic alliances across Queensland government departments and the spectrum of mental health interventions, including promoting wellness, preventing the development of mental illness, early identification and intervention, access to timely and appropriate treatment, and access to

continuing care and support. The full Terms of Reference for the Committee are provided in Appendix 11.

Having met formally for the first time in April 2007, the Committee will continue to meet every second month for the life of the NAP. This formal interagency approach is supporting the implementation of various COAG initiatives in Queensland, including the Care Coordination Model. A draft Memorandum of Understanding, committing relevant Queensland Government agencies to participation in Care Coordination, is being endorsed through the MH-IDC.

The Committee is also in the process of coordinating the development of an Interagency Action Plan on Better Mental Health which will identify key priority areas, individual agency responsibilities and expected outcomes. The Plan will be a testament to the government's commitment to better mental health and will provide clear evidence of Queensland's strong support for the key principles outlined in the NAP.

Chapter 6 Flagship 2 - Care Coordination

Through the Action Plan COAG committed to ensuring that care is coordinated for people with severe mental illness and complex needs who are most at risk of falling through the gaps in the system. This group of people have persistent symptoms and significant disability, have lost social or family support networks, and often need the support of multiple health and community services to maintain their lives within the community.

In particular, access to clinical care needs to be complemented by access to accommodation support to ensure stable housing, and a range of community support services focused on employment, income support, education and social and family support. When one or more of these needs is not met, the person's recovery and their capacity to live in the community are jeopardised.

The aim was a new system, building upon existing coordination arrangements, whereby care coordinators, with the support of clinical providers, will ensure the person is connected to these services.

A set of high-level principles and implementation guidelines have been developed to guide the work. The implementation by each jurisdiction is, however, flexible reflecting local systems.

Work is progressing on the development of state-based care coordination models in all states and territories through care coordination sub-groups of the state-based COAG Mental Health Groups. It was anticipated that work in this area would be undertaken within existing resources with no funding earmarked in the NAP.

Queensland's commitment to implementing this 'flagship' initiative of the NAP has been reinforced by the allocation of $4.77m in the 2007-08 State Budget. This funding has been provided to appoint 20 Service Integration Coordinators whose role will include the implementation of a consistent model of care coordination across Queensland.

Queensland allocated $4.77 million towards the Care Coordination model in the 2007-08 State Budget

Queensland has approximately 100,000 people with severe mental illness and approximately 5,000 – 10,000 of this group meet the target group identified in the NAP as needing care coordination. The establishment of cross-sector collaboration will ensure that people in the target group do not fall through the service gaps and will assist those with persistent symptoms and significant disability to access the required clinical and non-clinical support services in the community.

Queensland's implementation of Care Coordination for people with severe mental illness and complex care needs has been considerably progressed since 2006/07.

On 15 September 2006, a model which identified the target group and the eligibility criteria was developed and outlined in the Queensland Care Coordination Information Paper. The model was endorsed by the Queensland COAG Mental Health Group. A copy of the Care Coordination Information Paper and the draft Memorandum of understanding between various Queensland Government agencies are provided in Appendices 12 and 13 respectively.

In October 2006, the Queensland COAG Mental Health Team conducted a workshop with approximately 50 participants representing key stakeholders from government, non-government, consumers and carers, and private sectors. A range of specific issues were highlighted at the workshop, including the need to establish infrastructure at the local level across the state to drive implementation of the new model of services collaborating to provide services for people with mental illness.

To support this vital initiative, Queensland Health established a position within the Queensland COAG Mental Health Team to drive the implementation of the Care Coordination Model at a statewide level.

In January 2007, further consultation occurred with a range of government, non-government and private sector representatives specifically in relation to the district infrastructure required to operationalise the Care Coordination Model.

In April 2007, Queensland Health committed to the establishment of 20 Service Integration Coordinator positions, located in each Queensland Health district mental health service, to operationalise the agreed model of Care Coordination for the target group.

The purpose of these positions is to implement the Queensland model for Care Coordination that will support people with severe mental illness and complex care needs to access a range of clinical and community support services which are tailored to meet individual needs and assist people to live meaningful lives in the community. Care Coordination will assist people to engage in their local community and develop support networks to enhance their quality of life.

Queensland has established 20 Service Integration Coordinator positions to assertively progress the Care Coordination model

The person with a mental illness will be supported to develop skills associated with activities of daily living and regain control of their illness by linking with appropriate clinical and community networks. This will increase the individual's independence as they will be better equipped to function within their community. As more people with a mental illness are supported to regain independence and/or control of their illness, society will continue to develop an understanding and awareness of mental illness, which in turn will reduce current levels of stigma and discrimination.

Service Integration Coordinators will focus on improving systems coordination and collaboration between government, non-government and private providers for people with severe mental illness and complex needs and improve service provision for individuals identified in the target group who are not accessing appropriate clinical and community services.

These positions are non-clinical (they are not case managers) and incumbents are not expected to have contact with individuals in the program. Instead, Service Integration Coordinators will engage local existing service providers in the government, non-government and private sectors to actively participate in the Care Coordination model. These positions will enable Queensland to maximise its benefit from the COAG investment in mental health, in particular the alignment of Australian Government initiatives with the existing and new investments in mental health announced by the Queensland Government.

The strategy for implementing the Care Coordination model in Queensland includes:

- the establishment of the 20 Services Integration positions (Table 16);
- the development of Memoranda of Understanding and Local Partnership Agreements between all key stakeholders across government, non-government and private sectors;
- the development of local referral pathways, protocols and guidelines for the operationalisation of Care Coordination;
- the establishment of a local governance structure to oversee and support implementation; and
- the implementation of a cross-sector training and professional development strategy.

Table 16. Established Service Integration Coordination positions

Total Established Service Integration Coordinator Positions	
Location	**Positions**
Northern Area Health Service	
Cairns	1.50
Townsville	1.50
Mackay	1.00
	4.00
Central Area Health Service	
Central Queensland	1.00
Wide Bay	1.50
Sunshine Coast	1.00
Northside	2.00
RBWH	1.00
RCH	0.50
	7.00
Southern Area Health Service	
PAH	2.00
Southside	2.00
Gold Coast	1.00
Toowoomba	1.50
West Moreton South Burnett	1.50
South West	1.00
	9.00
Total	**20.00**

Of critical importance to the implementation of Care Coordination is the development of systems that address the differing access criteria, employed by various agencies, so that people in the target group do not fall through gaps in service provision.

Role of Service Integration Coordinators

- provide leadership in the development and implementation of the Queensland Care Coordination Model
- promote the development of a coordinated cross-sector response to people with severe mental illness and complex care needs by developing and maintaining cross sector communication and consultation with and between local service providers
- establish supportive and collaborative relationships with and between all clinical and community coordinators
- implement strategies ensure clinical and community coordinators develop a collaborative recovery plan for individuals in the target group
- deliver regular training and education regarding the Care Coordination Model, to local agencies and organisations involved in Care Coordination
- develop Local Partnership Agreements (LPA) and Operational Protocols and Guidelines (OP&G) to secure commitment to the operationalisation of Care Coordination
- develop a local interagency governance structure to support the local implementation of Care Coordination
- promote and implement system changes
- in consultation with key stakeholders assess referrals to the program
- maintain accurate and timely documentation, and in consultation with the clinical and community coordinators collate evaluation and clinical outcome measures
- participate in the monitoring and review process of the Care Coordination Model

It has been identified that Service Integration Coordinators will align with Queensland Health's Connecting Healthcare in Communities (CHIC) initiative, particularly those locations where mental health is identified as a priority by the Partnership Councils. The positions will also work closely with the Partnership Council Coordinator positions in locations where mental health has not been identified as a priority, to enhance service coordination and integration for this target group. Service Integration Coordinators will focus on people with severe mental illness and in addition to the Partnership Council coordinator positions, will ensure integration with primary health care providers and engage housing, employment, disability support, income support and other agencies to ensure the delivery of a more seamless and connected system of care for people with severe mental illness and complex care needs.

Finally, it is vital that the Care Coordination Model aligns with the implementation of the Queensland "Partners in Mind" framework (Appendix 14). This framework was developed by the Queensland Mental Health Branch and General Practice Queensland. It has been supported in 2007-08, by funding from Queensland Health to seven Divisions of General Practice to progress the implementation of the model.

Chapter 7 COAG Indicators for Evaluation

Queensland's Alignment with the COAG Indicators for Evaluation

The NAP identifies four outcome areas targeted for long term change. Collectively, the actions committed by governments aim to improve the status of the population's mental health, stimulate better outcomes from health services, as well as achieve improvements at the broader social and economic level. A total of 12 National progress indicators are identified to track improvements across the agreed outcome areas. The indicators are representative rather than comprehensive, and are designed to provide a snapshot of progress in key areas.

Figure 8. COAG Action Plan outcome areas and progress indicators

Four Outcome Areas	Twelve Progress Indicators	What the Progress Indicators tell us about Improved Mental Health
Reducing the prevalence and severity of mental illness in Australia	1. The prevalence of mental illness in the community 2. The rate of suicide in the community	**Population Health Outcomes** Are we more mentally healthy as a nation, with less risk factors for mental illness?
Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery	3. Rates of use of illicit drugs that contribute to mental illness in young people 4. Rates of substance abuse	
Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention	5. Percentage of people with a mental illness who receive mental health care 6. Mental health outcomes of people who receive treatment from State and Territory services and the private hospital system 7. The rates of community follow up for people within the first seven days of discharge from hospital 8. Readmissions to hospital within 28 days of discharge	**Health Service Delivery Outcomes** Are health services more effective in the care they provide to people with mental illness?
Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation	9. Participation rates by people with mental illness or working age in employment 10. Participation rates by young people aged 16-30 with mental illness in education and employment 11. Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile 12. Correctional facilities 13. Prevalence of mental illness among homeless populations	**Social and Economic Outcomes** Have we increased opportunities for participation in community life for people with mental illness? And reduced the social impact of mental illness

This section of the report presents Queensland information for the 12 progress indicators, drawn from currently available data. Not all indicators are suitable for reporting annually and not all indicators are separated by jurisdiction. Primary data sources for only five of the indicators are collected on an annual basis (Indicators 2, 6, 7, 8, 12), while the remainder are collected periodically (3 to 5 yearly) through special, sampled collections.

Indicator 5: Percentage of people with a mental illness who receive mental health care

Widespread concern about access to mental health care and the need for better coordinated services were key main factors that placed mental health as priority issue on the COAG agenda. An updated picture on the extent of unmet need for mental health care is not yet available, and will not be so until the results of the next national population mental health survey are published in late 2008. As an interim measure, health administrations within each jurisdiction agreed to pool related data on the number of people receiving services through all the government-funded clinical mental health care streams.

Queensland's results for 2006-07, the first year of the Action Plan, are presented in Table 17. The figures need to be interpreted carefully, given that most of the Action plan initiatives were not in place for the whole year and do not give a full year picture. For example, the Australian Government *Better Access to Mental Health Care* initiative that expanded Medicare-funded mental health services were only operational for seven months (from November 2006).

Table 17: Percentage of population receiving clinical mental health care, 2006-07

	State Community Mental Health Services	Private hospitals	Medicare-funded services				
			Private Psychiatrists	General Practitioners	Clinical Psychologists	Allied Health	All MBS funded services
Queensland	1.80%	0.10%	1.20%	1.70%	0.10%	0.60%	2.80%
Australia	**1.50%**	**0.10%**	**1.30%**	**1.90%**	**0.20%**	**0.60%**	**3.10%**

Indicator 7: Rates of community follow up for people within the first seven days of discharge from hospital

Discharge from hospital is a critical transition point in the delivery of mental health care. People leaving hospital after an admission for an episode of mental health care have heightened vulnerability and, without adequate follow-up, may relapse or be readmitted. It is also a period of great stress and uncertainty for families and carers.

Evidence gathered in recent years from a number of consultations around Australia suggests that the transition from hospital to home is often not well managed. The inclusion of this indicator as a measure of progress under the Action Plan targets the performance of the overall health system in providing continuity of care, recognising the need for substantial improvement in this area. The standard underlying the measure is that continuity of care involves prompt community follow-up in the vulnerable period following discharge from hospital.

In 2005-06, Queensland's result on this indicator was 46% (against a national benchmark of 54%). In 2006-07, Queensland had narrowed this gap, improving to 51% (while the national average was 55%).

Indicator 8: Readmissions to hospital within 28 days of discharge

Readmission rates can be regarded as a non-specific indicator of the overall functioning of health systems. High rates may point to deficiencies in hospital treatment or community follow-up care, or a combination of the two.

Readmission rates are also affected by other factors, such as the cyclic and episodic nature of some illnesses or other issues that are beyond the control of the health system. Not withstanding the complexity of the indicator, it is used by many countries to monitor health system performance. It has special relevance to areas of health care that involve provision of services to people with longer term illnesses who need a combination of hospital and community-based treatment. The underlying standard is that, while multiple hospital admissions may be necessary over the course of a lifetime for some cases, unplanned readmissions occurring shortly after discharge largely reflect failures in the care system.

The greatest risk period for re-admission is in the month following discharge. Unplanned readmissions following a recent discharge may indicate that treatment provided during the inpatient stay was incomplete or ineffective, or that follow-up community care was inadequate to maintain the person out of hospital.

In 2005-06, Queensland's result on this indicator was 20% (against a national benchmark of 16%). In 2006-07, Queensland 28-day readmission rate had decreased to 17%, while the national average was 14%.

Reasonable targets for readmission rates have not yet been identified, and are likely to differ within subspecialties (adult, aged, child and adolescent and forensic mental health services). Ongoing work at the national level to promote benchmarking within the mental health industry is expected to contribute to better understanding of good practice targets over the next few years.

Queensland's Framework for Evaluation at a State Level

In addition to reporting on the 12 COAG Indicators, Queensland's evaluation strategy includes indicators in the traditional evaluative domains of inputs, outputs and outcomes. The requirements for the inputs and output indicators have been broadly established and further work is required to develop a set of indicators for the outcomes of the *Queensland Plan for Mental Health 2007–2017* ('the Plan') (Figures 9 and 10).

Queensland will take a considered approach to the development of its evaluation Framework. Queensland's process will involve:

- mapping of actions and outcomes from the *Queensland Plan for Mental Health 2007-2017*;
- scoping possible indicators and identifying data sources;
- consulting with Statewide Mental Health Network representatives; and
- refining possible indicators, identification of final indicator set and specify date sources.

Table 18 summarises Queensland's progress to date.

Table 18. Progress towards the development of Queensland's evaluation framework.

Key Area		Task						
		Map actions/ outcomes	Scope possible indicators	Explore possible data source	Consultation with statewide representative	Decide final indicators	Specify final indicators	Confirmed data source
1.0	Promotion, prevention & early intervention	✔	✔	✔	✔	X	X	X
2.0	Consumer and carer participation	✔	✔	X	X	X	X	X
3.1	Public acute and community MHS	✔	✔	✔	X	X	X	X
3.2	Public extended inpatient MHS	✔	✔	X	X	X	X	X
3.3	Public specialised statewide MHS	✔	X	X	X	X	X	X
4.0	Private sector specialists	✔	✔	X	X	X	X	X
5.0	Primary health care	✔	X	✔	X	X	X	X
6.0	Other government & NGO - Disability	✔	✔	✔	✔	X	X	X
7.0	Workforce information quality and safety	✔	X	X	X	X	X	X
8.0	Special needs	✔	X	X	X	X	X	X
9.0	Unmet need	✔	X	X	X	X	X	X

Proposed Qualitative Project: Perceptions of Service Provision

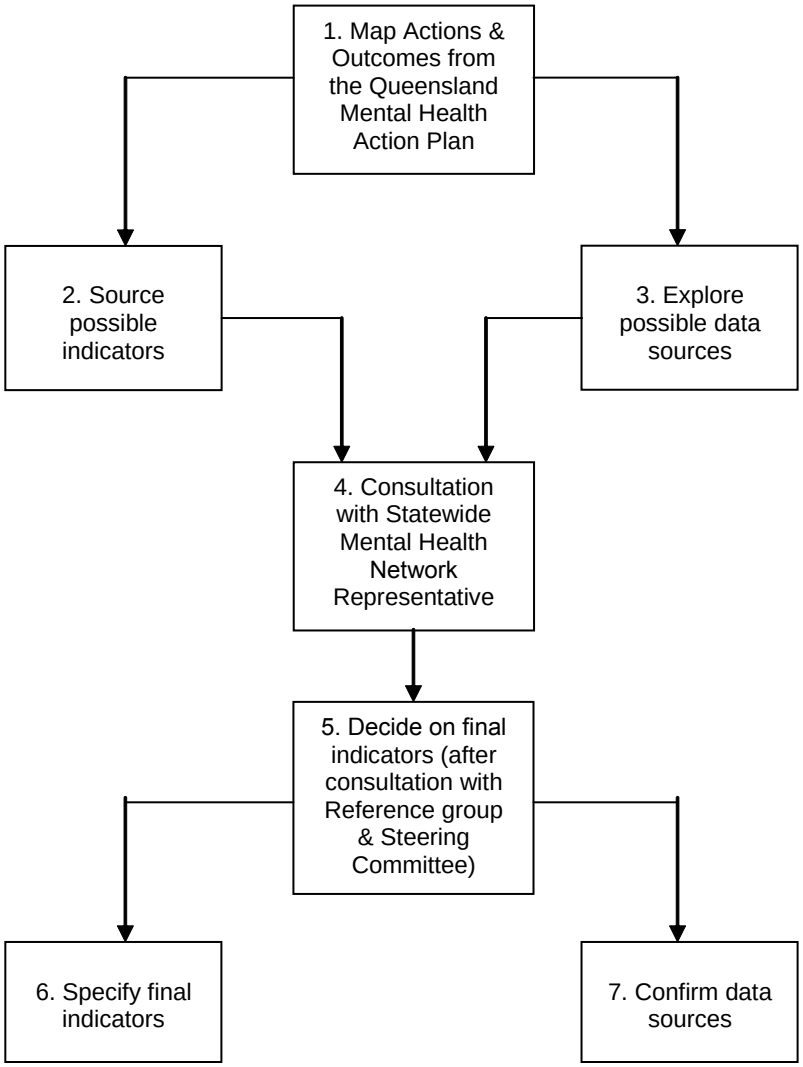
Work undertaken so far has identified a need for a more detailed evaluation of perceptions of service provision. This component of the evaluation will supplement the quantitative data being collected. It aims to assess changes in consumer and carer perceptions of the mental health services provided as the *Queensland Plan for Mental Health 2007-17* is implemented.

Interview and survey data will be collected from a sample of consumers and carers at two points over the initial first five years of the Plan. Time 1 (pre) evaluations are planned to commence in the near future to provide some baseline data. It is proposed that Time 2 (post) evaluations will be carried out in year five of the Plan.

In addition, a discourse analysis of key documents related to mental health service provision will be carried out to identify themes and changes in themes relevant to mental health provision in Queensland. It is proposed that this analysis will be completed at the same time as the data described above (i.e. pre and post implementation of the Plan).

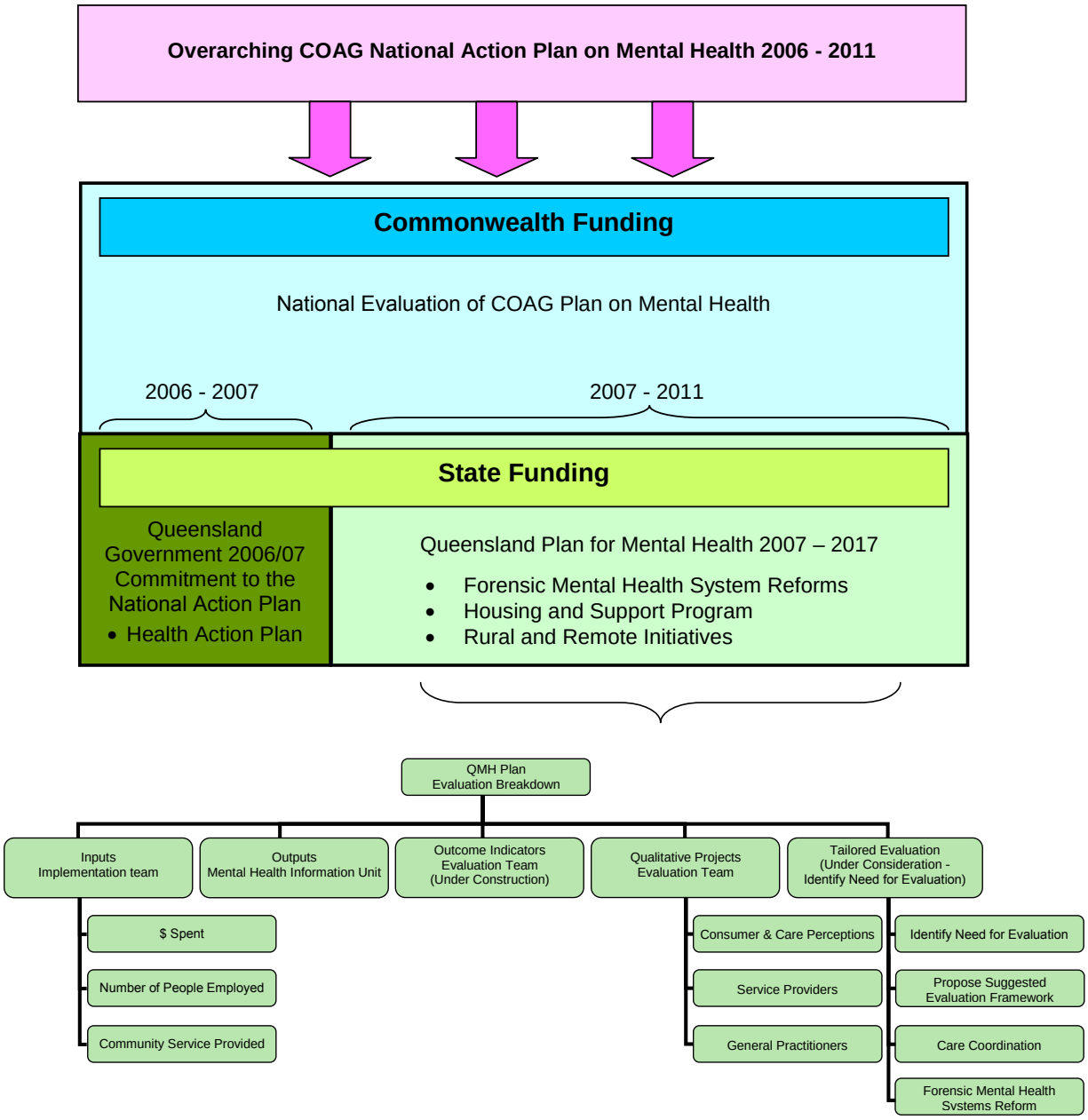
The intent of the overall evaluation strategy for the *Queensland Plan for Mental Health 2007-2017* is to capture qualitative data from consumers, carers and service providers. While qualitative research can capture some of the impressions of change retrospectively, a repeated-measures approach is more powerful. For this reason Queensland intends to conduct a follow up evaluation at the post-implementation time point with the same people who participate at the pre-implementation time point. This proposal recognises that the collection of qualitative data will need to begin immediately to enhance the evaluation.

Figure 9. Evaluation framework process map



Queensland Plan for Mental Health 2007–2017
Framework of Overall Evaluation Approach

Figure 10. Evaluation framework



Chapter 8 Conclusions and Recommendations

The agreement by the Council of Australian Governments to the *National Action Plan on Mental Health 2006-2011* (COAG NAP) was a watershed for mental health services in Australia. For the first time since 1992, when Health Ministers agreed to a *National Mental Health Strategy* the commitment by all governments to mental health reform changed with the adoption of a cross-government approach to funding a range of services.

Full realisation of the benefits of this policy shift requires an accompanying shift in the relationship between the Commonwealth, States and Territory Governments. It is clearly dependent on level of cooperation, not just between the two levels of government but also between departments within each level of government, which have not had a track record of working together in the area of mental health.

Implementation has been predicated on a level of collaboration between senior officials of mental health programs and a degree of open two-way exchange of information that has not been a feature of relationships in health for some time.

Even the title of the recently released first report of the *National Health and Hospitals Reform Commission*, “Beyond the blame game” is testament to what has been long considered a style of interaction between the different levels of government. The COAG NAP called upon governments to work together in a way that had no clear precedents in mental health.

An additional complexity was introduced because many departments in both levels of government either had little experience with mental health program development, or little understanding of modern approaches to the recovery concept and social inclusion. Social policy is not readily translated into a logical program structure if there is no understanding of the complex health environment. Much of the experience that people who have mental illness have to negotiate each day requires that they navigate both systems.

This submission has focused on progress made in Queensland in this space. It has primarily focuses on implementation of Queensland initiatives and the two flagships; Care Coordination and Governments Working Together. It does not report progress of Australian Government measures in Queensland, apart from where they are a result of a process of ‘governments working together’.

The Queensland Government has made its largest ever financial commitment to mental health during the life of this plan. This commitment has been supplemented by other initiatives, that are not expressly reported under COAG, as they are considered as out of the scope of the NAP, but are still necessarily remaining important to improving the mental health of Queenslanders. These initiatives include, among other things: establishing Mental Health Assessment and Outreach Teams (in response to the Carter Report); expansion of Mental Health Nursing Scholarships; activities of the Mental Health Network and Clinical Collaboratives; historic wages growth to medical staff, nurses and health practitioners; numerous child safety and mental health initiatives; the development of an evaluation framework and secretariat support to all public mental health implementation activity in Queensland.

Queensland has made significant progress in a number of keys areas of its implementation and whilst we recognise we start from a low base, compared with other jurisdictions, believe that results are beginning to become apparent. We now have a plan to guide the reform of mental health in Queensland in the next decade. However, the currently available information suggests that Queenslanders have not fully realized the potential of many of the Australian Government commitments under the NAP.

In particular, the *Better Access* to Mental Health program remains un-integrated with the services provided by Queensland Health or any system that gives people who have mental illness a choice of provider. Anecdotal information is that people with mental illness who have used public mental health services have difficulty either accessing or affording "*Better Access*".

In many instances, the Personal Helpers and Mentors program does not appear to have a connectedness to mental health systems whether they are state-provided or commonwealth-funded. This hiatus has presented difficulties because it is important to strike the right balance between what people who enter this program expect to receive to assist their recovery, and issues which are fundamental to services connecting with each other.

Where any program has parameters that exclude people from access, the nature of this barrier needs to be clearer. Historically, pathways into and out of care have not always been well understood by all service providers. Appendix 15 describes the interactions between the different components of the mental health system as outlined in the *Queensland Plan for Mental Health 2007-2017*.

It has been difficult in Queensland to understand how some organisations that do not have a track record in providing mental health care, become providers when well established and successful providers are overlooked by one government but not the other. Ultimately, one organisation can end up with funding from multiple different sources and have reporting requirements and accountabilities to several departments. We do not believe it is the intention of either level of government to consume un-necessary resources on administration at the expense of providing services.

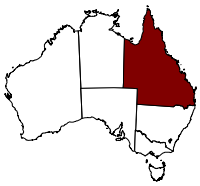
Recently, the Australian Government announced the establishment of the National Health and Hospitals Reform Commission and it is reported that the Federal Minister for Health will also establish a National Advisory Council on Mental Health. Queensland is eager to see how these two processes will help give direction to a reform process that is now consistent with the calls from the sector over the past two decades.

We believe that a new direction for mental health in Australia has been articulated through the COAG NAP. It will be important for future government activity to help translate the new policy directions into programs that promote recovery and enable people with mental illness to participate more meaningfully in society. To achieve this requires national leadership and collective commitments.

Appendices

Appendix No.	Indicative description (need to double check correct titles)	
1	Queensland National Mental Health Report – Queensland statistics	
2	Sharing Responsibility for Recovery	tabled separately
3	Carers Matter Website pdf	tabled separately
4	Queensland Health New Funding Model	tabled separately
5	Qld Individual Implementation Plan	
6	Outline of the 2007-08 State Budget Outcomes for Mental Health	tabled separately
7	Final Report for Butler	tabled separately
8	Final Government Response to Butler	tabled separately
9	Copies all COAG Communiques	tabled separately
10	Copies of all Mental Health Biz	tabled separately
11	Terms of Reference for Mental Health IDC	
12	Care Coordination Information Paper	
13	Care coordination MOU	
14	Partners in Mind Framework	tabled separately
15	Queensland mental health service system and specialist service descriptions	

Appendix 1 Queensland National Mental Health Report - Queensland Statistics



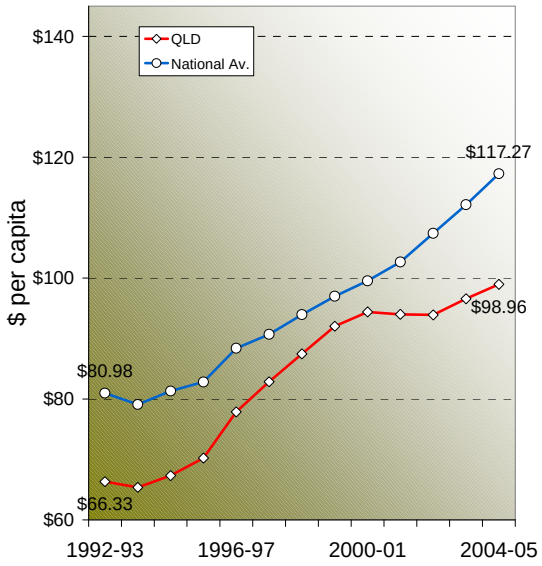
Queensland

Table 13: Indicators of mental health service provision in Queensland

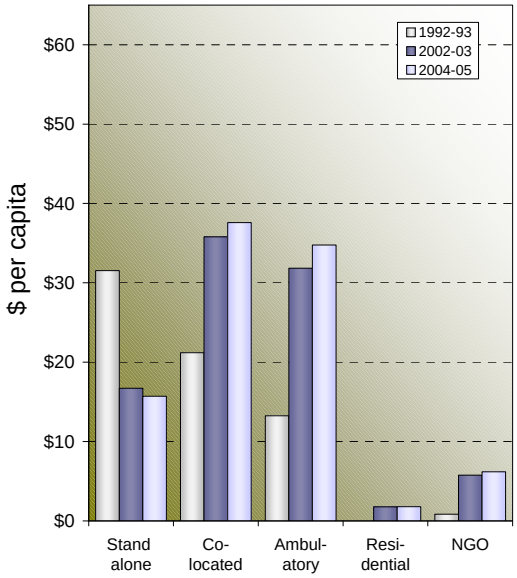
INDICATOR			QUEENSLAND			AUSTRALIA
			1992-93	2002-03	2004-05	2004-05
STATE GOVERNMENT EXPENDITURE						
• State spending on mental health services ($Millions)			203.4	353.6	390.6	2,376
• State spending per capita ($)			66.33	93.92	98.96	117.27
• Per capita spending rank			8	7	8	
• Average annual per capita spending growth during current National Mental Health Plan				2.6	2.7	4.5
SERVICE MIX						
• % total service expenditure	– Community services		21.1	42.9	44.5	51.1
	– Stand alone psychiatric hospitals		47.2	18.2	16.4	17.8
	– Colocated hospitals		31.7	39.0	39.1	31.1
INPATIENT SERVICES						
• Total hospital beds			1,607	1,323	1,334	6,202
• Per capita expenditure on inpatient care ($)			52.73	52.51	53.30	56.50
• Inpatient beds per 100,000			52.4	35.1	34.0	30.6
• Acute inpatient beds per 100,000			21.3	18.1	17.5	20.0
• Non acute inpatient beds per 100,000			31.1	17.1	16.5	10.6
• % acute inpatient beds located in general hospitals			84.0	100	100	84.4
• Stand alone hospitals as % of total beds			65.9	29.9	29.4	37.7
• Average cost per patient day ($)			333	528	507	575
COMMUNITY SERVICES						
• Ambulatory care	– % total service expenditure		19.8	34.6	36.2	39.0
	– Per capita expenditure ($)		13.25	31.83	34.76	45.08
• NGOs	– % total service expenditure		1.3	6.3	6.4	6.3
	– Per capita expenditure ($)		0.84	5.77	6.18	7.31
• Residential services	– % total service expenditure		-	1.9	1.9	6.6
	– Per capita expenditure ($)		-	1.78	1.78	7.68
	– Adult beds per 100,000:	24-hour staffed	-	3.3	3.2	5.1
		Non-24 hour staffed	n.a	-	-	4.3
	– Older persons beds per 100,000:	24-hour staffed	-	-	-	28.9
		Non-24 hour staffed	n.a	-	-	0.4
• Supported public housing places per 100,000			n.a	-	-	17.9
CLINICAL WORKFORCE						
• Number Full Time Equivalent (FTE) staff			2,200	3,225	3,436	18,826
• FTE per 100,000			71.7	85.7	87.0	92.9
• % FTE in community based services			19.3	38.2	40.2	49.6
• FTE per 100,000 – ambulatory services			13.8	30.8	33.1	38.0
IMPLEMENTATION OF NATIONAL SERVICE STANDARDS						
• % services Level 1 implementation of Standards			n.a	29	78	76
• % service expenditure covered by Level 1 services			n.a	35	85	76
CONSUMER AND CARER PARTICIPATION						
• % services with Level 1 consumer participation arrangements			27	49	54	51
• Consumer consultants employed per 1000 clinical FTE			n.a	2.0	2.4	2.9
• Carer consultants employed per 1000 clinical FTE			n.a	0.4	0.2	0.7
MBS-FUNDED CONSULTANT PSYCHIATRIST SERVICES						
• Attendances per 100 population			10.6	9.0	8.8	9.8
• % population seen			1.5	1.2	1.2	1.3
• Benefits paid per capita			10.88	8.72	8.65	10.49
PBS-FUNDED PHARMACEUTICALS						
• Benefits paid per capita			5.32	31.42	32.64	32.38

Legend: n.a. Signifies that the indicator is not available because relevant national data not collected.
– Indicates zero.

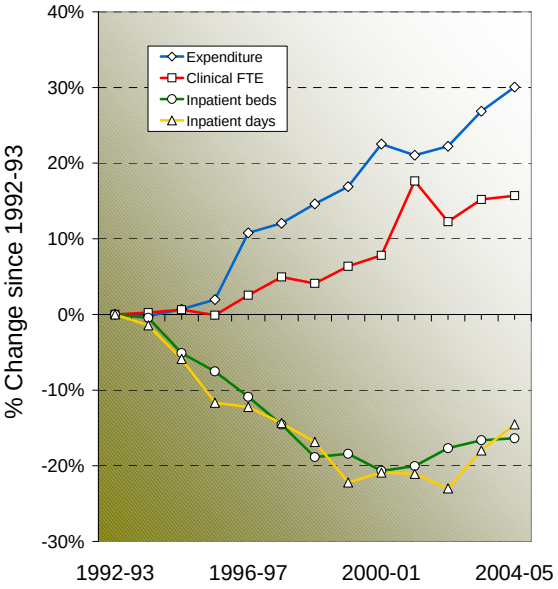
Overall spending on mental health



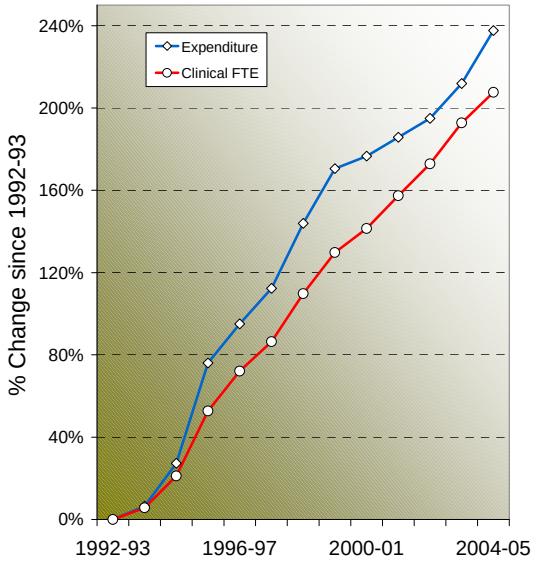
Changes in spending mix



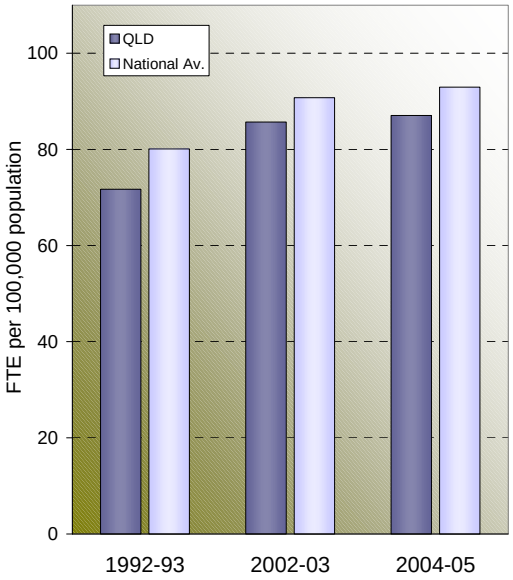
Changes in inpatient services



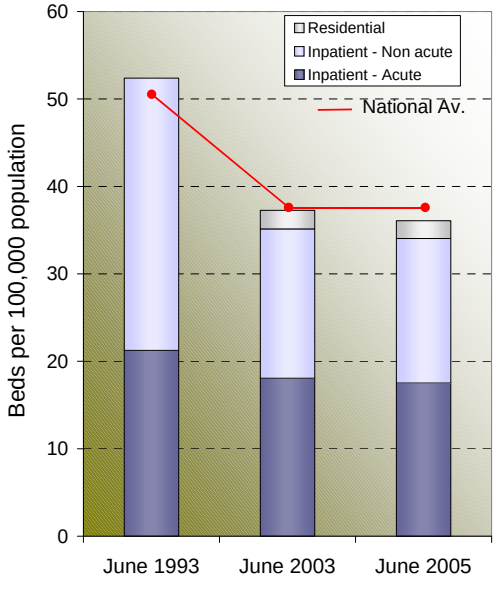
Changes in ambulatory care services



Clinical workforce



Inpatient and 24 hour residential beds



Appendix 2 **Sharing Responsibility for Recovery** (tabled separately)

Appendix 3 **Carers Matter Website pdf** (tabled separately)

Appendix 4 **Queensland Health New Funding Model** (tabled separately)

Appendix 5 Queensland Individual Implementation Plan

Transcultural Mental Health Workforce ($1.2 million)

Eleven transcultural mental health workers will be employed across thirteen District Health Services to support mental health services working with people from culturally and linguistically diverse backgrounds. Staff will dedicate a proportion of their time to work with local multicultural groups to initiate mental health promotion, illness prevention and early intervention strategies. The Queensland Transcultural Mental Health Centre will engage a range of bilingual mental health promoters, who will implement community activities that promote mental wellness. Part of the funding package is to improve the care system and is represented in that section. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2006

Integrating and Improving the Care System ($289.0 million)

Queensland will enhance mental health service delivery across a range of sectors. It will target both the general population and specific population sub-groups, including children and young people in care; Indigenous people; people from culturally and linguistically diverse backgrounds; the homeless; people who come into contact with police and the criminal justice system; and those in correctional facilities. Queensland will supplement its existing investment through the following initiatives.

Blueprint for the Bush Service Delivery Hubs ($1.8 million)

Under the auspices of Blueprint for the Bush, Queensland will establish three multi-tenant service hubs in rural and remote areas. The hubs will co-locate a range of services including family support workers; support services to vulnerable families with children from 10 to 14 years of age; and suicide prevention initiatives for older men at risk of suicide and self-harming behaviour and to promote social inclusion for isolated older people. *Implementation arrangements:* through the non-government sector. *Implementation commencement date:* from July 2007

Indigenous Domestic and Family Violence Counselling ($1.2 million)

Domestic and family violence counselling services will be piloted in three rural communities (the Torres Strait, Cooktown and Cherbourg) to provide support to Indigenous victims and child witnesses of domestic and family violence. The services will also provide outreach support to surrounding Indigenous communities. These counselling services can assist clients to overcome anxiety and depression, often associated with being a victim of violence, and reduce the likelihood of more serious mental illness developing. *Implementation arrangements:* through the non-government sector. *Implementation commencement date:* from March 2007

Child Safety Therapeutic and Behaviour Support Services ($17.6 million)

Queensland will provide capital and operational funding to establish two new therapeutic residential facilities in South East Queensland. The facilities will each provide placement options for four to six children and young people with complex to extreme needs at any point in time. It is part of a statewide roll-out of therapeutic services established to provide professional treatment for complex emotional, mental and behavioural problems in children. *Implementation arrangements:* to be operated under service agreements by the non-government sector. *Implementation commencement date:* July 2007

Health Action Plan - Existing Service Pressures ($58.1 million)

The pressure on acute mental health inpatient services and emergency departments has increased over the years as a result of approximately twice the national average population growth and increases in the level of acuity in people presenting with mental health problems. Additional funding will be targeted specifically at these services components to deal with high levels of bed occupancy and the high volume of mental health presentations in Emergency Departments. *Implementation arrangements:* through District Health Services. *Implementation commencement date:* from January 2006

Community Mental Health Services – Enhancement ($114.5 million)

Queensland will improve specialist community mental health services to provide acute care, crisis assessment, mobile intensive treatment, continuing care and intake and assessment services in

community settings. More people with mental illness will be able to access services and receive treatment in the community and in settings closer to their natural support networks. *Implementation arrangements:* through District Community Mental Health Services. *Implementation commencement date:* from 1 July 2006

Dual Diagnosis Positions ($4.7 million)

Thirteen new dual diagnosis positions will be created across Queensland to respond to people showing early symptoms of mental health and/or drug and alcohol problems. The positions will enhance service capacity in both the mental health and drug and alcohol sectors by: integrating assessment, intervention and care processes; implementing workforce development and training initiatives; and formalising collaboration and leadership development. Part of the funding package is for promotion and prevention activities and is represented in that section. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2006

Mental Health Intervention Teams ($4.1 million)

Funding will be provided to improve responses to mental health incidents that require police or ambulance officers. This initiative aims to prevent and resolve mental health crisis situations by establishing collaborative responses between Queensland Health, the Queensland Police Service and the Queensland Ambulance Service. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* 1 January 2006

Forensic Mental Health Services ($14.8 million)

Additional funding will be provided to enhance service responses to high-risk forensic patients in Queensland. This will include the provision of support services to people with mental illness transitioning through the criminal justice system and the provision of support, advice and education to district mental health staff to manage high-risk patients. *Implementation arrangements:* through Community Forensic Mental Health Services. *Implementation commencement date:* from 1 July 2006

Transcultural Mental Health Positions ($6.8 million)

Eleven transcultural mental health workers will be employed across 13 District Health Services to support mental health services working with people from culturally and linguistically diverse backgrounds. Staff will dedicate a proportion of their time to work with local multicultural groups to initiate mental health promotion, illness prevention and early intervention strategies. At the statewide level, the Queensland Transcultural Mental Health Centre will engage a range of bilingual mental health promoters who will implement community activities that promote mental wellness. Part of the funding package is for promotion and prevention activities and is represented in that section. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2006

Area Clinical Mental Health Networks ($7.7 million)

In recognition of ongoing pressures on mental health services, Queensland will allocate funding to Area Mental Health Clinical Networks to address priority service capacity issues and to initiate innovative responses to area-wide service delivery issues. *Implementation arrangements:* through Area Mental Health Clinical Networks. *Implementation commencement date:* from 1 July 2006

Alternatives to Admission ($17.5 million)

Nine District Health Services have been funded to develop and implement a range of alternatives to acute admission, in collaboration with the non-government sector, consumers and carers. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2007

Responding to Homelessness ($19.7 million)

As part of the Responding to Homelessness Strategy 2005-2009, Queensland will establish homeless outreach teams in Brisbane, the Gold Coast, Townsville, Cairns, and Mount Isa as part of a commitment to address homelessness and public intoxication. In addition, 36 transitional housing places will be established in Brisbane and Townsville. This will assertively tackle the high prevalence of mental illness amongst homeless people in high-need areas and reduce the number of people with mental illness being discharged into homelessness. *Implementation arrangements:* through District Mental Health Services; Department of Housing and the non-government sector. *Implementation commencement date:* this project has been underway since 1 July 2005

Mental Health Services in Prisons ($8.6 million)

Queensland will enhance clinical mental health services to people in correctional facilities across the state, including in-reach assessment and treatment services. *Implementation arrangements:* through Community Forensic Mental Health Services and District Mental Health Services. *Implementation commencement date:* from 1 July 2006

Mental Health Capital ($12.0 million)

Queensland has committed capital funding of $5.8 million over five years for the construction and redevelopment of designated mental health facilities to support enhanced access to services. In 2006-07, the Cairns Mental Health Community Rehabilitation and Recovery Service and the Rockhampton Child and Youth Mental Health community clinic will be completed. An investment of $41.0 million over five years in a number of community health and primary health care centres including Gladstone, Nundah, and Yarrabah will also result in enhanced access to community-based health and mental health services. This $41.0 million investment includes $6.1 million which will be specifically for access to community mental health services. *Implementation arrangements:* through District Health Services. *Implementation commencement date:* from 1 July 2006

Participation in the Community and Employment, including Accommodation ($64.3 million)

Queensland will supplement its existing investment through the following initiatives.

Housing Capital ($20.0 million)

A mix of accommodation to best meet the needs of individual clients will be procured for adults with a mental illness and moderate to high support needs (clinical and non-clinical) who are currently housed inappropriately, and who are assessed as being able to live independently in the community, with appropriate support. Housing for about 80 people will be provided in 2006-07 in accordance with social housing eligibility guidelines. Planning is currently under way with Queensland Health and Disability Services Queensland to link identified clients with support arrangements who are ready to live independently with suitable accommodation arrangements. *Implementation arrangements:* through the Department of Housing. *Implementation commencement date:* from 1 July 2006

Health Action Plan Non-Government Organisation Funding ($25.0 million)

Funding will be provided to Queensland non-government organisations to support people with a mental illness living in the community, including people living in housing provided by the $20.0 million capital investment identified above. This will ensure that people living in the community have access to adequate clinical and non-clinical support to assist them in their recovery process. *Implementation arrangements:* through the non-government sector. *Implementation commencement date:* 1 July 2006

To further complement the $20.0 million housing capital, the Queensland Government will support clients through the Special Fiscal and Economic Statement funding announced in October 2005, specifically the Mental Health Community Organisation Funding Programme; and growth funding to Disability Services Queensland for accommodation support services. The housing capital investment will also enable some acceleration of Project 300 clients to access appropriate accommodation.

Disability Services Respite and Sector Capacity Building ($12.0 million)

Additional funding will be provided for the establishment of new, and enhancement of existing, respite and day services. Additional services under the Resident Support Programme will be funded to assist people living in private residential facilities, while people inappropriately housed in hostels and boarding houses will be supported to relocate to alternative accommodation through Hostels Response funding. Funding through both the Family Support and Adult Lifestyle Support Programmes will enable people with a psychiatric disability to maintain their community living either independently or with their families. *Implementation arrangements:* mostly through the non-government sector. *Implementation commencement date:* from August 2006

Employment and Training ($5.0 million)

Financial assistance will be provided to the non-government sector as part of the 'Breaking the Unemployment Cycle' initiative, to provide job and training opportunities to people with a mental illness who experience disadvantage in the labour market. Funding will initially be provided under the Community Jobs Programme to community and public sector organisations to provide job search assistance and training to people with a mental illness and/or employment for three to six months on projects that will enhance skills development and future employment prospects. It is proposed that approximately $1.0 million will be directed towards projects during 2006-07 to assist 130 people with a mental illness. From 2007-08 onwards, it is proposed that about 100 people with a mental illness will be assisted each year for the following four years. *Implementation arrangements:* predominantly through the non-government sector. *Implementation commencement date:* from August 2006

Mental Health Services in Prisons ($2.3 million)

Funding will be provided to the non-government sector to support the enhanced prison mental health services, particularly to provide post-release support to people with mental illness returning to the community. *Implementation arrangements:* through the non-government sector. *Implementation commencement date:* 1 July 2006

***Increasing Workforce Capacity* ($6.1 million)**

Queensland is the most decentralised state in Australia, and as such, needs a workforce for the large, urban specialist inpatient and community mental health services, and a workforce for its small rural and remote communities. This requires a range of different skill sets to meet differing needs and appropriate remuneration and conditions of employment to ensure that Queenslanders have access to high-quality health care. Queensland will supplement its existing investment through the initiatives outlined below.

Increased Workforce Remuneration ($5.8 million)

As a result of this overall increased investment in mental health, remuneration and conditions of employment have improved for all mental health staff which will assist in attracting and retaining the required workforce. This will particularly assist in the areas of community mental health services ($3.6 million), community forensic mental health services ($1.0 million), services to correctional facilities ($1.0 million) and services designed to assist situations where the first response is by police or ambulance officers ($0.2 million). *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2006

Mental Health Transition to Practice Nurse Education Programme ($0.3 million)

Queensland Health will establish a Mental Health Transition to Practice Nurse Educator Programme to provide adequate practical clinical experience for inexperienced nurses before they enter the mental health sector. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* 1 July 2006

Appendix 6 **Outline of the 2007-08 State Budget Outcomes for Mental Health** (tabled separately)

Appendix 7 **Final Report for Butler** (tabled separately

Appendix 8 **Final Government Response to Butler** (tabled separately)

Appendix 9 **COAG Communique** (tabled separately)

Appendix 10 **Mental Health Biz** (tabled separately)

Appendix 11 Terms of Reference for Mental Health Inter-Departmental Committee

QUEENSLAND GOVERNMENT
MENTAL HEALTH INTERDEPARTMENTAL COMMITTEE

Terms of Reference

Background

In Queensland 16.6% of the population (647,000 people) are affected by mental disorders in any one year. This estimate excludes dementia and alcohol and drug-related disorders, except where co-existing with another mental disorder. The figure rises to about 22% (854,000) people when alcohol and drug-related conditions are included. Anxiety-related and depressive disorders are the most prevalent, affecting approximately 7% and 6% respectively of the population within any year.

Almost 100,000 Queensland people (2.5%) experience severe mental illness. About half of this group have psychosis, primarily schizophrenia or bipolar disorder and the remainder have major depression or severe anxiety disorders, particularly generalised anxiety disorder and post-traumatic stress disorder. Other disorders such as anorexia nervosa are included.

More than 175,000 people (4.5%) have a mental disorder of moderate severity. This group mainly includes individuals with depression, generalized anxiety disorder, post-traumatic stress disorder and panic disorder/agoraphobia. A further 9.6% (373,000 people) have a disorder of mild severity and are at risk of recurring mental illness. Primarily this group experiences depression, generalized anxiety disorder, post-traumatic stress disorder, dysthymia and panic disorder/agoraphobia.

Context

Building stronger and more effective collaboration across sectors is an important priority for meeting the needs of people with mental illness as identified by the prevalence rates above, particularly collaboration between Queensland government agencies. The MH-IDC is anchored upon the understanding that Queensland Health (Mental Health Services) cannot be responsible for the full spectrum of mental health intervention needed across the life span and variety of contexts. Contemporary evidence clearly suggests that mental health within the community is dependent on the full spectrum of interventions; however, most of the social determinants of good mental health lie outside the domain of health and mental health clinical service delivery. Policy, financial and service silos have created obstacles to the delivery of integrated responses across the spectrum of mental health interventions needed to maintain good mental health, prevent the development of mental illness, intervene early wherever possible and provide access to timely treatment and continuing care. Identified areas for improved collaboration as outlined in the *Sharing Responsibility for Recovery 2005* include:

- Peer Support and Self Help
- Family Education and Support
- Mental Health Services
- Primary Health Care
- Disability Support

- Community Infrastructure
- Education, Vocational Rehabilitation and Employment
- Housing and Supported Accommodation
- Drug and Alcohol Services
- Trauma and Abuse Services
- Police, Ambulance and Emergency Services.
- Legal and Correctional Services.

The National Mental Health Strategy and the COAG National Action Plan on Mental Health have introduced a whole-of-government approach to mental health and new relationships between mental health services, the wider health care system, non-government sector, and other support services provided outside the health sector (housing, disability support, domiciliary care, income support, employment and training programs). It is crucial that within this approach Queensland government agencies co-ordinate their intervention at the population and service delivery levels to ensure that consumers, carers and their families have access to the full range of interventions and services no-matter the context where they may find themselves, e.g. in the broader community or within a correctional facility.

The mental health sector needs to advance current partnerships and establish formal intersectoral collaboration between mental health and other sectors within Queensland Health and other Queensland Government agencies. Collaborative partnerships at the population or service delivery levels need to develop intense relationships with high levels of contribution, commitment and joint effort, shared goals and a higher level of trust. A formal interagency approach as proposed by the MH-IDC will place the Queensland Government in a strong position to support the implementation of the COAG National Action Plan in Queensland and meet the mental health needs of Queenslanders across the spectrum of interventions.

With the establishment of the MH-IDC, the Queensland Government has initiated a strategic and formal cross-government approach to improving the mental health and well-being of the Queensland community. This approach builds on and is linked to the cross-government and cross sector approach employed to oversee the implementation of the COAG National Action Plan on Mental Health. The aim of this approach is to enhance the mental health of people at risk of, or affected by, mental illness by improving the responsiveness and coordination of service and population level interventions.

Objectives

The MH-IDC will:

1. identify opportunities for better linkages, coordination and collaboration between Queensland government agencies
2. formalise collaboration between Queensland Government agencies responsible for the mental health of the Queensland community
3. provide a forum for building strategic alliances across Queensland government agencies and the spectrum of mental health interventions, including promoting wellness, preventing the development of mental illness, early identification and intervention, access to timely and appropriate treatment, and access to continuing care and support.

Key Tasks

- Develop an interagency work plan which will identify key priority areas of work and incorporate existing bilateral and multilateral work stemming from, for example, the Queensland Government Suicide Prevention Strategy, the Strategic Plan for Psychiatric Disability Services and Support, Sharing Responsibility for Recovery, and MOUs between QH/MH and QPS, QAS, DCS, DSQ, and DoH.
- achieve cross-agency endorsement of the plan at the Director-General or Ministerial levels.
- gain cross-agency contributions to the implementation of the work plan, including joint responsibility for achieving the agreed outcomes and sustainability.
- provide a forum for cross-government engagement, information exchange, and problem solving.
- provide regular feedback to the MH-IDC on progress with implementation of the initiatives identified in the work plan.
- report on progress to Cabinet through the Premier on an annual basis.
- make recommendations to the Queensland COAG Mental Health Group on issues that have cross-sector (NGO and private) and cross-government (Commonwealth/state) implications.

Anticipated Outcomes

- Bilateral and multilateral MOUs
- Bilateral and multilateral LCAs
- Operational protocols and guidelines
- Joint professional development and training initiatives
- Shared models of service delivery
- Agreed and articulated pathways to care
- Agreed communication protocols
- Joint administrative governance structures
- Shared investment, accountability and responsibility for sustainability.

Working arrangements

4. The Executive Director, Social Policy, Department of the Premier and Cabinet (or his/her delegate) will chair the MH-IDC, which will meet every second month from April 2007**.** Should the Executive Director (or his/her delegate) not be available, the Director of Mental Health will substitute.

5. The MH-IDC will comprise senior representatives from all key Queensland government agencies with responsibility for mental health policy and service delivery within their organizational context. All members should make every effort to attend meetings or nominate an appropriate senior representative to attend.

6. Membership will comprise of the following Queensland government agencies:

- Department of the Premier and Cabinet
- Queensland Health
- Department of Housing
- Disability Services Queensland
- Department of Communities
- Department of Child Safety
- Department of Education, Training and the Arts

- Department of Employment and Industrial Relations
- Queensland Police Service
- Queensland Corrective Services
- Department of Justice and Attorney-General
- Department of Emergency Services.

7. Bi-lateral and multilateral meetings can be convened on an *ad hoc* basis to progress specific work, make decisions or examine issues in more detail.

8. The MH-IDC may consider commissioning research or inviting external experts to submit evidence to help support the implementation of the work plan.

9. A secretariat position will be established to support the MH-IDC and be collocated with the COAG Mental Health Team. The position will be funded by the Mental Health Branch, Queensland Health.

10. The secretariat position will be responsible for:
    - forward planning of meetings, in consultation with the chair
    - preparing the agenda, minutes, and papers for MH-IDC meetings
    - liaising with the various sub-groups and other nominated individuals
    - preparing Cabinet submissions as required, and
    - preparing reports, briefs and correspondence as required.

11. The MH-IDC may establish sub-groups to progress specific work at a bilateral or multilateral level between relevant agencies. The final decision in relation to the implementation of the various initiatives will rest with the relevant agency or agencies.

12. Participating members may be required from time to time to chair a relevant sub-group and provide the required support to that group. Each member will also be required to identify an appropriate operational officer within their agency who will be available to work with the secretariat.

Confidentiality

13. The proceedings and records of MH-IDC meetings will generally not be considered confidential. Proceedings will be minuted by the secretariat and will be broadly available. However, information may from time to time be given by members or participants in confidence. Where the MH-IDC chair identifies information is of a confidential nature, that information will not be minuted and members and participants will respect that decision.

Reporting

14. The MH-IDC with the support of the secretariat will compile annual progress reports in December, which will be submitted to Cabinet through the Premier.

Modifications to Terms of Reference

15. Modifications to these terms of reference may be proposed and adopted at any MH-IDC meeting.

Sunset Clause

16. The committee will operate for the life of the COAG National Action Plan on Mental Health 2006-1011. The operational arrangements beyond this period will be informed by Cabinet decisions.

Appendix 12 Care Coordination Information Paper

Council of Australian Governments (COAG) Mental Health Group - Queensland

[13 September 2006]

Information Paper: Care Coordination

[The below headings are provided as prompts - please alter as relevant. Papers should be kept as concise as possible – no more than 2-5 pages. Attachments may be used if necessary.]

Purpose:

The purpose of the Care Coordination Model is to support people with serious mental illness and complex care needs to access a range of clinical and community support services which are tailored to meet individual needs and assist people to live meaningful lives in the community.

Guiding Principles:

The Care Coordination Model will be:

- person centered and consumer driven,
- carer and family inclusive,
- recovery orientated,
- socially inclusive, and
- suit individual consumer needs.

Perceived Benefits:

- improved care planning and continuity of care across service boundaries,
- improved systems coordination and communication between service providers,
- improved service provision for the target group who are not accessing mainstream Public and Private Mental Health Services,
- less duplication in service provision and more efficient use of available resources.

Major features of the Care Coordination Model:

The Care Coordination Model will bring together clinical and community support service providers to:

- identify the target group and determine eligibility for Care Coordination,
- provide a single point of contact and a single care plan for the target group,
- promote access to a range of clinical and non-clinical services,
- coordinate the respective roles and responsibilities of each agency involved,
- review overall progress and specific consumer outcomes.

Target Group:

Adults with a serious mental illness and complex needs, including those with persistent symptoms and significant disability who fall through the gaps in the current service system, have lost social and family support networks and rely extensively on multiple health and community services for assistance to maintain their lives in the community.

Suggested definition:

> "Serious and persistent mental illness means a mental illness which is severe in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and an inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long term treatment and support and which may be of lifelong

duration. Serious and persistent mental illness includes schizophrenia as well as a wide spectrum of psychotic and other severely disabling psychiatric categories, but does not include infirmities of aging or primary diagnosis of mental retardation or of alcohol or drug dependence" (Wisconsin statutes, Chapter 51).

Accessibility and Eligibility Criteria:

Access to Care Coordination will be prioritised for people over the age of 16 years with serious mental illness and complex needs as identified above and have ***one or more*** of the following characteristics:

(a) have a long period of contact with the mental health system, particularly those with frequent admissions and discharge from acute inpatient care.
(b) require intensive/assertive case management.
(c) are at greater risk of harming themselves or others.
(d) have multiple social care problems and needs, particularly drug and alcohol and accommodation problems.
(e) are more likely to disengage with services.
(f) have no contact with the public mental health services or other mainstream health/mental health services.

Potential Numbers in the Target Group:

In order to estimate this portion of the population Whiteford and Buckingham (2006) have suggested that not all people with a serious mental illness have the same need for coordinated care. For example, some members may live with their families, others may live in long term residential care and others may already have support networks that provide necessary services to allow the individual to access appropriate services. However a small group experience frequent co morbid substance abuse, high risk of relapse and multiple hospital admissions and an absence of functional family and social support networks. In Queensland, almost 100,000 people experience serious mental illness, approximately 51,000 are seen by state public mental health services, and it is estimated that between 5,000 and 10,000 of the 100,000 people in Queensland with a serious mental illness will require Care Coordination to maintain their lives in the community (Whiteford & Buckingham: 2006).

Composition of Care Coordination Team:

(a) Clinical Care Coordinator

Clinical Care Coordinators will primarily focus on mental state assessments, interventions and treatment and the physical health needs of people with serious mental illness and complex needs. This will include a focus on compliance with medication, the management of symptoms, mood fluctuations and side effects of medication. The clinical service providers in the Care Coordination Team may include one or a number of the following:

- Public Mental Health Services
- Private Psychiatrist
- General Practitioner
- Private Psychologist
- Aboriginal and Torres Strait Islander Community Controlled Health Service
- Mental Health Nurse in General Practice and Private Psychiatry
- Allied Health Workers and Mental Health Nurses in Divisions of General Practice

(b) Community Support Coordinator

Community Support Coordinators will focus on addressing the social disruptions and the diminished level of functioning caused by the severity and persistence of the mental illness. The primary focus for Community Support Coordinators will be on addressing aspects of the consumer's daily living skills, ability to cope with the ordinary demands of life which may impact on family and social roles, ability to maintain or enter employment, or the ability to access or maintain appropriate accommodation. The Community Support Coordinators in the Care Coordination Team may include one or a number of the following:

- NGOs funded by Queensland Health, Disability Services Queensland and the Australian Government that provide a range of support services, particularly those that provide services which enhance independent living skills, facilitate social connections and provide respite and disability support.
- Personal Helpers and Mentors (PHAMs).
- Indigenous Agencies.
- Community and Social Housing Agencies.
- Employment Agencies, particularly those funded through either the Community Jobs Program or the Personal Support Program.

(c) Other Specialist Service Providers

Other specialist service providers will also be invited to be members of the Care Coordination Team and provide both clinical and non-clinical input. Other Specialist Service Providers in the Care Coordination Team may include one or a number of the following:

- Drug and Alcohol Services
- Intellectual Disability Services
- Services for people with eating disorders
- Multicultural Health/Mental Services
- Community Forensic Mental Health Services

(d) Clinical and Community Support Coordinators

There will be two care coordinators identified in the Care Coordination Model for each consumer:

(1) **a clinical care coordinator:** who could possibly be a Psychiatrist, Psychologist, GP, Case Manager from a Public Mental Health Service, a Mental Health Nurse working in General Practice and Psychiatry, an Allied Health Professional working in a Division of General Practice or Aboriginal Community Controlled Health Service.

(2) **a community support coordinator:** who could possibly be a support worker employed by a NGO who receives funding from Queensland Health, Disability Services Queensland or the Australian Government, Personal Helpers and Mentors, Indigenous Agencies, Community Housing and Employment Agencies.

The *Care Coordinators* are responsible for:

- determining eligibility for care coordination,
- establishing rapport and close contact with the consumers, carers and family members,

- developing a single care plan with clear outcomes, which is formulated in collaboration with the consumer and his or her family and carer,
- coordinating the respective roles and responsibilities of each agency in the care system,
- regularly monitoring and reviewing the quality of care provided and the success of everyone's involvement,
- ensuring that there is a balance between medical and social aspects of an individual's well being,
- providing the primary points of contact for the consumer, carer, family and participating service providers.

In most cases, it is expected that the consumer referred for care coordination will have a well documented history with a variety of service providers; the role of Care Coordinators will be to gather and review this history to avoid any excessive assessment process for the consumer.

Qualifications and Skills of Workers:

The Care Coordination approach will bring together a diverse skill-mix including people with professional and para-professional qualifications, lived experience, carer experience, and cultural competence.

Caseloads:

Based on contemporary evidence in mental health, assertive community treatment for consumers with serious and complex needs cannot be greater than 1:10-15. The Care Coordinators will need to test and monitor this caseload to determine the appropriate caseload for the Care Coordination Model.

Location and Governance:

The rollout of the Care Coordination Model should, wherever possible, align with the PHAMs demonstration sites and their overall progressive rollout in Queensland. The Model will also operate across the different agencies' boundaries to ensure that consumers have access to the full range of services that they may need to live successfully in the community.

Governance arrangements will need to be established and endorsed at both the state-wide and local level to ensure the successful implementation of the Care Coordination Model and priority access to a range of services for this client group. These governance arrangements need to be formalised through the development of state-wide Memorandums of Understanding (MOU) and Local Collaborative Agreements (LCA) between all the relevant agencies. They will clearly address information sharing provisions, including any consumer consent that may be needed.

State-wide MOUs should articulate shared objectives; commitment; investment; responsibility for outcomes; decision making and sustainability. Additionally they should support the development of LCAs and inform how they will operate and identify ways of overcoming local barriers.

LCAs should identify the aims and intended outcomes which are to be achieved by the Care Coordination Model, identify the client group, identify agreed assessment processes, commit agencies to give ***priority access*** to this client group, identify position/s in each agency that are primary contacts for the two Care Coordinators, and articulate annual performance review and outcome reporting.

Implementation process:

Implementation of the Care Coordination Model in Queensland will take into consideration the following factors:

- PHAMs locations in Queensland, particularly the demonstration sites.
- Availability of Public Mental Health Services, both inpatient and community.
- Availability of a range of Non-Government Agencies to provide a range of Community Support Services.
- Availability of GPs and/or Private Psychiatrists, particularly practices that engage Private Psychologists through the new MBS items or employ Mental Health Nurses of Allied Health Staff.
- Availability of other Social Support Agencies, particularly Housing, Employment and Respite Services.

Timeframes:

The establishment of Care Coordination for this client group is a priority for CoAG and will need to align with the rollout of both Queensland and Australian Government initiatives announced in the National Action Plan on Mental Health 2006-2011.

Key opportunities and/or risks:

CoAG, the Queensland CoAG Mental Health Group, the Queensland Mental Health Inter-Department Committee and other bilateral and multilateral inter-agency and inter-sector meetings, forums and committees provide unique opportunities to progress the implementation of the Care Coordination Model and for gaining commitment, support and sign-off at the various levels within government and externally.

The risks associated with this approach include lack of clarity/agreement about the target group, and eligibility and exclusion criteria; the role of the different agencies/workers involved particularly the PHAMs; the assessment process and/or tools to be used; who is ultimately accountable; and the inability of participating agencies to prioritise this group for access to services.

Evaluation:

Develop an evaluation framework for the Care Coordination Model to capture process, impact and outcome indicators for reporting to all relevant agencies, including Queensland and Australian Government agencies and the Council of Australian Governments meetings. An evaluation framework needs to be developed at the commencement of the Care Coordination approach to ensure that appropriate data and information is captured to enable a robust evaluation of this approach and particularly the consumer outcomes achieved.

Assumptions:

Care Coordination will be equally available to people with serious mental illness and complex needs that are or are not in contact with formal public or private mental health services.

In most locations the PHAMs may be the best placed resource to undertake the role of the Community Support Coordinator, particularly because they may be in contact with people in the target group who are not accessing private and public mental health services.

PHAMs should introduce a new skill set to the Care Coordination Model which is in addition to the existing skills and knowledge contributed by clinical mental health service providers eg. Psychiatrists, Psychologists, Nurses, Social Workers and Occupational Therapists; and include people with para-professional backgrounds, lived experience, carer experience and Indigenous competence.

That each agency participating in the Care Coordination Model will provide priority access for this client group.

Author: Ivan Frkovic/Cathy Beck
Organisation: CoAG Mental Health Initiative
Mental Health Branch
Queensland Health
Telephone: 07 32340155
0488107526
E-mail: ivan_frkovic@health.qld.gov.au

Appendix 13 Care Coordination Memorandum Of Understanding

Council of Australian Governments
Care Coordination Model
(Queensland)

MEMORANDUM OF UNDERSTANDING

Between the

Queensland Government Agencies

Department of the Premier and Cabinet

Queensland Health

Department of Housing

Disability Services Queensland

Department of Communities

Department of Child Safety

Department of Education, Training and the Arts

Department of Employment and Industrial Relations

Queensland Police Service

Queensland Corrective Services

Department of Justice and Attorney-General

Department of Emergency Services

Table of Contents

1. INTRODUCTION

With the ever increasing complexity of mental health issues facing human services today, innovation and integration is becoming an invaluable commodity. As mental health services move more towards a holistic treatment process it becomes apparent that the spectrum of human services are required to work closer together with a shared goal.

The Council of Australian Governments (COAG) Care Coordination Model (Queensland) is a proactive approach to the provision of mental health services in Queensland Health. It aims to identify and respond to individuals with a severe and enduring mental illness and who also experience associated complex care needs that historically have "slipped through the gaps" of existing services. These individuals can be frequent users of multiple services within their community but never really receive a holistic service from any one service provider. The inconsistent nature of their contact, works to inhibit the individual from recovery of their illness. This progressively erodes their social and support network which results in significant isolation for the individual; further limiting their self management and obstructing their potential for recovery.

The Queensland Care Coordination Model aims to provide the individual with a more coordinated, client focussed, holistic and recovery focused model of care. The aim of the model is to link the eligible individual with appropriate clinical and non-clinical agencies and provide a tailored service for the individual to better meet their needs. It is expected that appropriate and consistent support will dramatically improve the lives of those who have largely been overlooked by current services and processes. It will provide the individual with two consistent coordinators to link with, instead of the myriad of services they historically "bounced" between.

Individuals with a mental illness often receive support for the psychiatric condition but their general health issues often go unaddressed. Care Coordination aims to maintain a clear focus on the physical and mental health needs of the individual as well as their psychosocial needs.

An advantage of the Queensland Care Coordination Model is recidivism will be reduced as these individuals become better equipped to deal with their issues, thus relieving some pressure on current services. Those issues for the individual that would historically have caused the repeated presentations to one or more organisations will now be addressed in the community. The individual will learn to better manage day-to-day situations. These skills will be transferable to crisis situations and ultimately the individual will respond, react and interact more appropriately.

Key Stakeholders will come together to commit to a process where integrated service provision will enhance the quality of life for individuals within the target group. To undertake this approach the Care Coordination Model requires commitment to its philosophy and alignment to open communication and collaboration between all key stakeholders providing services to those in the target group. Collaboration will provide the individual with a more person-specific response meeting their needs far more appropriately. Information sharing will be paramount when providing planned intervention from the many, Commonwealth, State and non-Government agencies involved in the individuals support.

This Memorandum of Understanding (MOU) describes the relationship

BETWEEN

Queensland Government agencies, including

- Department of the Premier and Cabinet

- Queensland Health
- Department of Housing
- Disability Services Queensland
- Department of Communities
- Department of Child Safety
- Department of Education, Training and the Arts
- Department of Employment and Industrial Relations
- Queensland Police Service
- Queensland Corrective Services
- Department of Justice and Attorney-General
- Department of Emergency Services

Although representation from *Qld Alliance of Mental Illness and Psychiatric Disability Groups Inc.* and *General Practice Qld* are outside the scope of this MOU they have stated strong support to the principles, intent and administration of this document and how it will support improvement of the services for individuals with a mental illness via the implementation of Care Coordination.

2. PURPOSE

2.1 This MOU supports the Council of Australian Governments *(COAG) National Action Plan on Mental Health 2006-2011* and the successful implementation of Care Coordination, which was identified as a flagship initiative of the plan.

2.2 The purpose of this MOU is to define and improve the systems collaboration between Queensland government agencies in order to successfully implement the Care Coordination model as outlined in the *COAG National Action Plan on Mental Health 2006-2011*. The MOU formalises the commitment of departments to active participation in Care Coordination for the target group.

2.3 This MOU also will foster a culture of collaboration and cooperation between agencies in order to facilitate more timely and effective service to individuals in the target group who are moving through care coordination.

2.4 Greater flexibility between service providers will ensure that individuals in the target group will appropriately receive services across a range of clinical and community support services which are tailored to meet individual needs and assist them to live a meaningful life in the community; that is, a more coordinated and integrated approach from the identified agencies to their care and treatment.

2.5 This MOU will provide the basis to facilitate inter-agency collaboration at a local level which will commit agencies and organisations to actively participate in the operationalisation of Care Coordination for the target group.

2.6 This MOU denotes more than just a symbolic document it represents a practical framework for service collaboration.

2.7 This MOU is intended to work in conjunction with, and not derogate from or neutralise any other MOU that exists among the Queensland government agencies.

3. BACKGROUND

3.1 To ensure effective implementation of the *National Action Plan on Mental Health 2006-2011* endorsed by COAG on 14 July 2006, the Australian Government agreed to support a range of initiatives, the flagship initiative being the Care Coordination model with an emphasis on coordination and collaboration between government, private and non-government providers.

3.2 An estimated 5,000-10,000 people in Queensland with severe and complex mental health needs have been identified as falling through the gaps in service provision. Each jurisdiction has agreed to implement this initiative as a priority for *"Adults with a [severe] mental illness and complex care needs, including those with persistent symptoms and significant disability who fall through the gaps in the current service system, have lost social and family support networks and rely extensively on multiple health and community services for assistance to maintain their lives in the community"*.

3.3 Systems collaboration from Queensland government agencies will ensure that people in the target group receive a whole-of-government response across a range of clinical and community support services which are tailored to meet individual needs and facilitate a more coordinated approach to their care and treatment. Commitment to this MOU at a systems level will reduce duplication and service gaps; improve care planning and continuity of care across service boundaries.

3.4 It is acknowledged that all agencies have their own roles and responsibilities with regard to people with a mental illness and each department is committed to working in full cooperation to promote an integrated system of care to ensure effective and efficient delivery of services to meet the needs of the target group.

3.5 The framework outlined in this MOU is intentionally broad. Specific arrangements will be developed at a local level which will utilise local service components and reflect local requirements.

3.6 The intention of this MOU is not to undermine existing eligibility criteria for services that each agency has previously established. Enhanced access for individuals within the target group is to be determined by each agency in accordance with their existing services eligibility criteria.

4. DEFINITIONS

4.1 Unless a contrary intention is indicated, the meaning of the following terms contained in the body of this MOU will be defined below:

4.1.1 "MOU" refers to this Memorandum of Understanding.

4.1.2 "COAG" refers to the Council of Australian Governments.

4.1.3 the "Plan" refers to the *National Action Plan on Mental Health 2006-2011*.

4.1.4 the "Model" refers to the Care Coordination model which was endorsed by the Queensland COAG Mental Health Group

4.1.5 "agency" refers to the 12 Queensland government agencies identified in the introduction of this MOU.

4.1.6 "MH-IDC" refers to the Mental Health Inter-Departmental Committee, comprising of Queensland Government agencies identified in this MOU. The MH-IDC formalises collaboration between Queensland government agencies responsible for the mental health of the Queensland community.

4.1.7 "systems collaboration" refers to formal intersectoral collaboration between Queensland government agencies. Collaborative partnerships represent a shared purpose, contribution, commitment, shared goals and a high level of trust. It presents, at the highest level, a whole-of-government approach to mental health and integrated relationships between the wider health care system, non-government sector, and other support services provided beyond the health sector (e.g. housing, disability support, domiciliary care, income support, employment and training programs). Within this approach all government agencies coordinate their intervention at service delivery levels to ensure that all people identified in the target group have access to a range of services no matter the context where they may find themselves.

4.1.8 "mental illness" refers to a range of recognised, medically diagnosable illnesses that result in significant impairment of an individual's cognitive, affective or relational abilities.

4.1.9 "target group" refers to individuals 16 years or older with a severe mental illness and complex care needs who fall through the gaps in the current service system, have lost social and family support networks and rely extensively on multiple services for assistance to maintain their lives in the community.

5. TERMS OF THE AGREEMENT

5.1 All agencies agree that this MOU does not create any legal relations between them. However, the matters set out in this MOU are agreed in principle between the parties.

5.2 The MOU between the Queensland government agencies will commence on 2008 and shall continue for a period of two years unless earlier terminated in accordance with this agreement.

5.3 After expiration, parties may decide to dissolve, alter or renew the MOU in writing by mutual agreement. In the event that parties contemplate a successive MOU, negotiations with respect to such successive MOUs shall be limited to an identified period of time.

6. OPERATION OF MOU

6.1 The agencies acknowledge that exchange of information pursuant to this MOU may involve information that is confidential and/or subject to privacy laws. All Queensland Health permanent and temporary staff, volunteers or anyone being trained by Queensland Health facilities are bound by the confidentiality provisions under the *Health Services Act* 1991 and penalties apply for breaches of this legislation. Disclosure and exchange of client information will comply with the statutory or administrative instrument relevant to the participant agency. This includes, for example:

- *Health Services Act 1991* (as set out in the confidentiality requirements in Part 7)
- Information Standard 42A (Queensland Health) (as set out in the disclosure requirements in Information Privacy Principle 11)

6.2 Relevant information may be disclosed to another agency with the informed, voluntary, consent of the client. The agencies agree to the timely exchange of relevant information (for care and treatment of the individual), in accordance with the consent obtained. In the event the individual is unable to provide informed consent other mechanisms may need to be explored.

- *Health Services Act 1991* (as set out in the confidentiality requirements in Part 7)
- *Guardianship and Administration Act 2000*
- Information Standard 42A (Queensland Health) (as set out in the disclosure requirements in Information Privacy Principle 11)

6.3 In mental health crisis situations the parties will endeavour to ensure that their staff follow their respective agencies protocols for the prevention and safe resolution of mental health crisis situations.

6.4 For disclosure of information not encompassed by the client's consent (eg. an emergency which places the personal safety of the client or others at risk), the agencies agree to provide information as soon as possible, in line with the requirements of the statutory/administrative instrument relevant to their agency.

7. GUIDING PRINCIPLES

7.1 The following principles will guide the relationship between the agencies in the agreements and arrangements covered by this MOU:

7.1.1 All processes are undertaken and managed with full agreement of the agencies at the commencement of the MOU;

7.1.2 The agencies agree to respect the ownership of any property rights of each other;

7.1.3 All agencies agree that the collaborative partnership between them is based on mutual respect, cooperation and shared principles to ensure that people with a mental illness receive a coordinated system of care; and

7.1.4 All agencies share an ongoing commitment to ensuring that services will be provided in a way which reflects the rights of people with a mental illness as proclaimed in the *Mental Health Statements of Rights and Responsibilities 1991*.

7.2 The agencies acknowledge and agree that in a mental health crisis situation involving clients of the target group and where there is risk to safety:

7.2.1 Relevant agencies should maintain the mental health needs of the person and carer, and the preservation of the person's rights and dignity as a primary consideration within the overall objective of ensuring the safety of all parties; and

7.2.2 The management of any such situation should be achieved by the relevant agency or agencies whilst maintaining the safety of the individual, staff and the public concerned and, where not able to be avoided, the imposition of minimum restriction upon the individual.

8. GENERAL ROLES AND RESPONSIBILITIES

8.1 The following outlines the general roles and responsibilities of each party to this MOU:

8.1.1 That agencies collaborate in the coordination and delivery of services to people identified in the target group;

8.1.2 That planning and service delivery be maintained so that those in the target group receive coordinated services that are appropriate to their needs;

8.1.3 That resources be committed to deliver coordinated and effective service responses to those in the target group;

8.1.4 That agencies monitor service provision to reflect the changing needs of individuals and communities and to ensure services is improved over time;

8.1.5 That agencies work in partnership to develop local level agreements and operational protocols and guidelines to achieve coordinated service delivery responses;

8.1.6 That agencies facilitate and actively support the implementation and monitoring of local level agreements;

8.1.7 That the Director-General of each agency be committed to the implementation of this MOU; and

8.1.8 That the Director-General of each agency nominate the officer who is represented on the IDC to act as a central point of contact and liaison between the agencies and to facilitate the initial implementation and ongoing adherence to this MOU. This role should be fully acknowledged in terms of workload allocation.

9. COOPERATIVE ARRANGEMENTS

9.1 In a spirit of cooperation between Queensland government agencies, the agencies agree as follows:

9.1.1 To identify current and emerging issues and to develop strategies to improve service delivery through collaboration between the agencies;

9.1.2 To continue to define and develop roles and responsibilities of each agency in regard to specific state-wide and local activities;

9.1.3 To develop mechanisms which promote a culture of continuous improvement across the agencies to facilitate the further development and communication of identified good practice, that will ensure formal arrangements are sustainable over time;

9.1.4 To explore legislative and policy options to enhance information sharing;

9.1.5 To continue to improve knowledge, skills, attitudes and values of the respective staff of departments to ensure a coordinated system of care for the target group; and

9.1.6 To continue the formal Mental Health Inter-Departmental Committee (MH-IDC) process with senior representatives of agencies to implement and monitor the terms of this MOU.

10. MONITORING AND REVIEW

10.1 The MH-IDC will provide the opportunity for each agency to monitor and review its service provision.

10.2 The MH-IDC will review progress against the *National Action Plan on Mental Health 2006-2011* after twelve months of this MOU coming into effect.

10.3 This MOU will be reviewed within 12 months of the date of its taking effect and thereafter annually on the anniversary of the initial review, or at such other earlier time as may be agreed by the agencies.

10.4 Progress on implementation of the Care Coordination model in Queensland will be reported to Cabinet as part of the MH-IDC's Annual Report to Cabinet.

11. RISK MANAGEMENT

11.1 Each agency will ensure that its employees will comply with their respective risk management policies and procedures in the course of carrying out its obligations under this MOU.

11.2 This MOU in no way changes alters or affects any existing understanding, arrangements or established practice relative to insurance and/or indemnity.

12. COMMUNICATION

12.1 All agencies recognise that fluid internal communication is an integral component in ensuring that this MOU is filtered through to employees. All agencies are committed to timely dissemination of information in relation to this MOU to employees at all levels/districts/regions within the agency.

12.2 All agencies recognise that communication is a major component in facilitating systems collaboration. Each agency recognises the need for effective communication and consultation processes to assist in enhancing collaborative relationships to minimise duplication and increase the range and quality of services provided across the state.

12.3 The agencies acknowledge the benefits of open and candid communication between representatives of the agencies. The departments acknowledge the benefits of developing bilateral and multilateral working relationships between representatives of the agencies across all levels. In order to develop effective relationships between agencies and ensure broad uniformity of approach, the departments agree to the following:

12.3.1 Regular formal contact and communication shall be achieved through the Mental Health IDC and maintained for the purposes of coordinating the provision of appropriate services and support to people in the target group;

12.3.2 Provide information or clarification on mental health issues to a participating agency; and

12.3.3 Ensure that this MOU is filtered through to the lowest level in each agency (i.e. at the coalface).

13. VARIATIONS

13.1 Variations to the MOU may be negotiated at any time at the instigation of any agency.

13.2 Any proposed alterations shall be addressed through the Director-General of each agency.

13.3 Variations to the MOU must be made in writing and only with the mutual agreement of all agencies and attached to this MOU.

14. TERMINATION

14.1 An agency may not terminate this MOU except as follows:

14.1.1 Any agency becomes, either through reorganisation, disbandment, or pursuant to a government decision unable to carry on or otherwise discharge its obligations under this agreement;

14.1.2 By mutual agreement of the agencies;

14.1.3 Non compliance by any agency; or

14.1.4 Irreconcilable disputes.

14.2 If an agency fails to remedy any non-compliance of this agreement within 30 days of receiving notice of that non-compliance, the effected agency considering terminating their participation in the MOU must give 30 days notice to the other agencies in writing.

14.3 The respective rights of the agencies under clause 14.1 shall not be exercised unless the agencies respectively have engaged and concluded the dispute resolution mechanism provided in this MOU.

14.4 Where the MOU is terminated under clause 14.1, the agencies agree to provide all reasonable assistance and cooperation necessary to ensure a smooth transition.

15. DEFAULTS AND DISPUTE RESOLUTION

15.1 Where the dispute or alleged default arises under this MOU all agencies agree that they will take steps they believe reasonable to resolve the dispute/alleged default by mutual agreement, using the following procedures:

15.1.1 All agencies will undertake initial negotiation on the matter in dispute at the workplace level;

15.1.2 If the matter is not resolved at the workplace level, the matter will be referred for discussion between Executive Managers/Directors of the respective agencies;

15.1.3 If the matter remains unresolved at the Manager/Director level, the matter will be referred for discussion between the Director-General of the respective agencies; and

15.1.4 During the time when the agencies attempt to resolve the matter, the agencies continue to comply with the MOU.

16. NOTICES

16.1 Any notice or communication given under this MOU must be

16.1.1 In writing; and

16.1.2 Delivered, sent by ordinary prepaid post or sent by facsimile to the addressee's address or facsimile number (as the case may be) notified by the addressee from time to time.

16.2 A notice or other communication given under or about this MOU is taken to be received (as the case may be):

16.2.1 If delivered personally on the business date it is delivered;

16.2.2 If sent by ordinary prepaid post, 3 business days after posting; or

16.2.3 If sent by facsimile, when the sender receives confirmation that the facsimile has been transmitted to the addressee's facsimile number in its entirety.

DIRECTOR-GENERAL SIGNATORIES:

Department of the Premier and Cabinet

_____
Director–General

Date:_____

Witness Name:_____

Signature:_____

Date:_____

Queensland Health

_____
Director–General

Date: _____

Witness Name:_____

Signature:_____

Date:_____

Department of Housing

_____
Director–General

Date: _____

Witness Name:_____

Signature:_____

Date:_____

Disability Services Queensland

_____
Director–General

Date: _____

Witness Name:_____

Signature:_____

Date:_____

Department of Communities

_____
Director–General

Date: _____

Witness Name:_____

Signature:_____

Date:_____

Department of Child Safety

_____
Director–General

Date: _____

Witness Name:_____

Signature:_____

Date:_____

DIRECTOR-GENERAL SIGNATORIES cont'd:

Department of Education, Training and the Arts

_____
Director–General

Date: _____

Witness Name:_____

Signature:_____

Date:_____

Department of Employment and Industrial Relations

_____
Director–General

Date: _____

Witness Name:_____

Signature:_____

Date:_____

Queensland Police Service

_____
Commissioner of Police

Date: _____

Witness Name:_____

Signature:_____

Date:_____

Queensland Corrective Services

_____
Director–General

Date: _____

Witness Name:_____

Signature:_____

Date:_____

Department of Justice and Attorney General

_____
Director–General

Date: _____

Witness Name:_____

Signature:_____

Date:_____

Department of Emergency Services

_____
Director–General

Date: _____

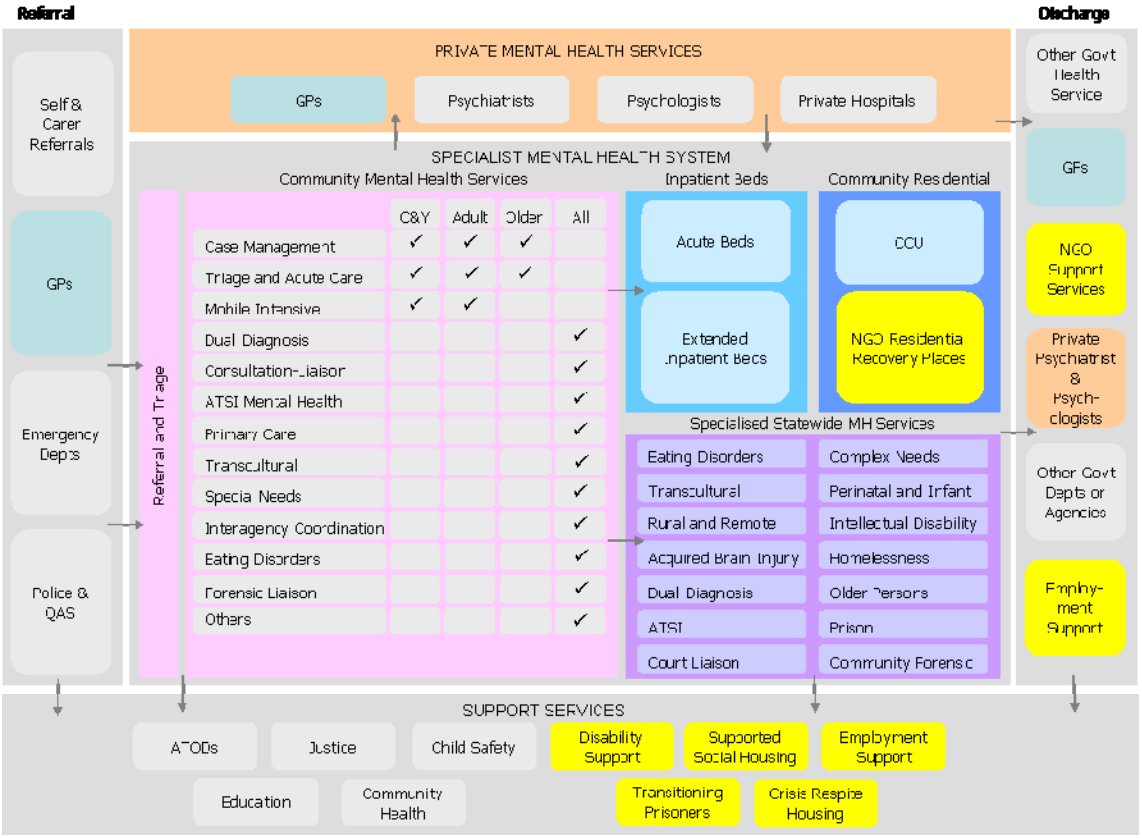
Witness Name:_____

Signature:_____

Date:_____

Appendix 14 Partners in Mind Framework
(tabled seperately)

Appendix 15 Queensland Mental Health Service System and Specialist Service Descriptions



Public mental health services provide a range of specialist mental health services across the lifespan:

- Mental Health Services for Children and Adolescents and Youth aged 0-18.
- Adult Mental Health Services for people aged over 18.
- Older Persons Mental Health Services aged 65 and over.

These services are offered on an outreach basis in the community or within inpatient (residential) settings across a wide range of locations. The various types of programmes are detailed below.

Community Mental Health Services

The enhancement of ambulatory or community mental health service is a significant component of the mental health reform agenda. This is driving increased reported community activity, and is aimed at decreasing both reliance and pressure on hospital based mental health care across this State. Community Mental Health Services include the following:

- *Emergency, Crisis and Acute Care Responses*

Manage emergency mental health assessment, interface between the community, the private and the public health system and provide referral and advice to local services.

- *Continuing Care and Case Management*

Provide treatment over the course of illness and facilitate access to and co-ordination of delivery of the range of services necessary to meet the individual needs of a person with a mental illness, both within and outside the mental health service.

- *Mobile Intensive Treatment*

Provide intensive long-term case management, treatment and support to people with enduring needs and assertive outreach to very vulnerable and disabled people living in the community with severe mental illness, enduring disability and complex needs.

Inpatient or 'Bed Based' Treatment and Care

- *Acute Inpatient*

Provide short-term intensive treatment, medical management, and 24 hour per day clinical support on a voluntary and involuntary basis to reduce symptoms, stabilize functioning and promote sufficient recovery to allow effective treatment in a community based setting for child and adolescent, adult and older persons.

- *Extended Treatment and Rehabilitation*

Provide medium to long-term clinical treatment, supervision and rehabilitation services for people with a serious mental illness and psychosocial disability.

- *Extended Treatment & Rehabilitation - Community Care Units*

Provide medium to long-term clinical treatment, supervision and rehabilitation services for people with a serious mental illness and psychosocial disability within a community setting.

- *Dual Diagnosis Extended Treatment*

Provide extended inpatient care to people with a mental disorder and concomitant intellectual disability and who exhibit aggressive or violent behaviour, which makes them unmanageable in an integrated mental health service.

- *Medium Secure*

Provide intensive treatment and rehabilitation to people, who require care within a higher level of security to ensure the safety of themselves and/or the community.

- *High Security*

Provide intensive treatment and care to people detained under the provisions of the Mental Health Act 2000 who present a serious risk to the safety of others and cannot be managed in a less secure environment.

- *Acquired Brain Injury Extended Treatment*

Provide treatment and care for people with acquired brain damage and associated mental disorders and/or severe behaviour problems.

- *Psychogeriatric Extended Treatment*

Extended inpatient services for older people provide care for people aged 65 years and over who require both specialist psychiatric and aged care and who cannot be cared for in any other setting.

Specialist Services

Specialist services are provided to target the following areas:

- Community Forensic Mental Health Services
- Homelessness Health Outreach Teams
- Mental Health Services for Indigenous People
- Therapeutic Mental Health Child Safety Teams
- Consultation Liaison Mental Health Services
- Targeted Mental Illness, Alcohol and Drug services
- Alternatives to Admission services
- Mental Health Services for People from Culturally and Linguistically Diverse Backgrounds (CALD)
- Eating Disorders Outreach Service

Deafness and Mental Illness