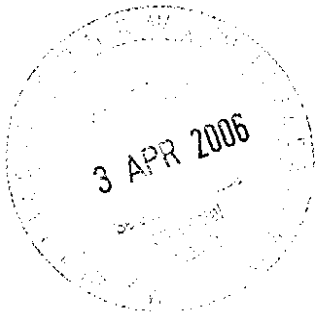
Queensland Government



Queensland **Health**

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Emailed 29.4.06

Mr I Holland
Secretary
Senate Committee on Mental Health
Parliament House
CANBERRA ACT 2600

Dear Mr Holland

I refer to your letter dated 3 March 2006, regarding the Senate Committee on Mental Health - Questions.

As indicated in my letter dated the 2 August 2005, I am happy to provide you further detail in relation to the questions asked by the Committee.

Funding Commitments

1. **The Queensland government submission reported funding commitments to expand mental health services and facilities, including:**
   - **30 transitional accommodation places for people with mental illness**
   - **Programs targeted at preventing suicide in high risk groups; and a research grant of $175 000 to the Australian Institute of Suicide Research and Prevention**
   - **$43.6 million over four years to provide integrated response to people with dual diagnosis, and are homeless**
   - **$6.9 million allocated to non-government organisations and some research institutions for providing mental health services to the community.**

   Please provide a progress report on these funding commitments

   In addition to the funding commitments identified, information is also provided on further mental health funding allocations which were subsequent to, and not included in, the Queensland Government submission.

   Suicide prevention

   The Queensland Government Suicide Prevention Strategy is continuing to be implemented throughout the State.

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Through the *Reducing Suicide: Queensland Government Suicide Prevention Strategy 2003-2008* and *Reducing Suicide: Action Plan 2003*, the Queensland Government allocates $2 million recurrently to support suicide prevention activities within Queensland.

The majority of this budget, until June 2006, is directed towards the Queensland Health Early Intervention Program (suicide prevention). There are 19 Full time equivalent (FTE) Early Intervention Project Officer (EIPO) positions attached to this program. The program is currently being externally evaluated and the findings from the evaluation will enable the Queensland Government to enhance services that target high-risk groups.

Additionally, Queensland Health allocates $340,000 annually to fund six Indigenous Life Promotion Officer positions in Wujul Wujul, Yarrabah, and Hopevale. In addition, $280,318 has been allocated for a two year Suicide Prevention Coordinator position in Hopevale, until September 2007.

Queensland Health has also recently committed to an Australian Research Council Linkage Project. It is collaborating as an industry partner with the Australian Institute of Suicide Prevention and Research (AISRAP), and other industry partners to undertake a three year research study into *Preventing suicide: A psychological autopsy study of the last contact with a health professional before suicide.* The findings from this project will enable Queensland Health and other relevant stakeholders to further enhance responses to people presenting with suicidal ideation.

The *Suicide in Queensland 1999 – 2001: Mortality Rates & Related Data* report is the latest in a series of biannual reports produced by AISRAP from the Queensland Suicide Register (QSR). The QSR is a comprehensive and sophisticated suicide database funded by Queensland Health since 1990 for the purpose of maintaining and disseminating Queensland mortality data covering all age groups across the life span. Queensland Health provides $175,000 annually to AISRAP to maintain the QSR to produce the biannual reports. These reports inform government and community planning and resource allocation in the area of suicide prevention.

AISRAP is one of two centres worldwide which is designated as a World Health Organisation Collaborating Centre for Research and Training on Suicide Prevention. The World Health Organisation START (Suicide Trends in At-Risk Territories) study involves 22 countries from the Western Pacific Region, and will contribute to constructing national databases on suicidal behaviours, both fatal and non-fatal. The study will develop intervention programs for suicide attempters and self-harmers; make trans-cultural comparisons utilising psychological autopsy investigations; implement longitudinal evaluations; and help develop national strategies.

Homeless and Transitional Housing Initiatives

The homeless initiative aims to address the complex health needs of people with mental illness and/or substance abuse problems who are homeless and is to be provided in five locations of high need (namely Brisbane, Townsville, Mt Isa, Cairns and Gold Coast). Services will include specialist mental health, general health, and drug and alcohol intervention to assist homeless people who are sleeping in public spaces, squats and other improvised dwellings. The service will be provided through mobile clinical outreach teams

(Homeless Teams) with a capacity to visit individuals at locations which may include parks or shelters.

The transitional housing initiative involves the establishment of treatment support and rehabilitation services for people with mental illness who are unable to be discharged from hospital due to a lack of adequate support and/or suitable accommodation. Discharge without this level of support places these people at high risk of homelessness. The initiative is being implemented in Brisbane and Townsville and aims to establish 30 transitional accommodation places.

Funding for these initiatives has been distributed to the relevant health service districts and recruitment to the Homeless Teams is progressing. In addition:

- A state-wide strategic planning and evaluation framework is being developed to facilitate future planning.
- Work has been undertaken in relation to the development of models of service delivery, including interstate visits to examine existing homeless programs.
- Two research and training positions are being established to ensure appropriate evaluation and to support Homeless Teams in identifying and meeting training needs.

In terms of securing transitional accommodation, 14 units are currently under contract in Brisbane and two units are under contract in Townsville.

Non-government organisations

The allocation of $6.9 million to non-government organisations represents the level of funding allocated to the non government sector in 2005/06. This level of funding is further enhanced by funding directed to the non government sector through Project 300, which is administered by Disability Services Queensland.

In light of the valuable role played by the non government sector in supporting people who live with a mental illness, Queensland Health is to increase funding to the non government sector by $5 million in 2006/07. This increase in funding is part of the announcements made in the Queensland Government's mini-budget on 25 October 2005.

Additional funding allocations

In total, the additional funding allocated to mental health services through the mini-budget, totals $201 million. The details of this funding are as follows:

- Community mental health services - In recognition of the need for increased capacity of community mental health services, $18 million per annum has been allocated to employ additional specialist clinical staff. This will address the need for improved assessment, treatment and continuing care for people with mental illness across the spectrum (ie. child, youth adult and older people), including specific services for people from Indigenous and Culturally and Linguistically Diverse communities. **Total commitment over 5 years: $90 million**
- Forensic mental health positions (Adult & Child and Youth Court Liaison, Adult and Child & Youth Forensic Community Outreach) - Funding of $3.16 million has been assigned to develop a system of coordinated specialised services, involving Court Liaison Services and Prison Mental Health Services, which are aimed at ensuring access to treatment and reducing the incidence of clinical relapse for people involved with the criminal justice system and minimise the likelihood of repeat offences. **Total commitment over 5 years: $15.8 million**

- Recurrent funding to address high pressure areas in mental health services including assistance for emergency departments with high mental health demand and acute inpatient services dealing with more than 100% occupancy
- Non-Government Mental Health Services - Non-Government support services are an essential component of a comprehensive system of care for people with serious mental illness. Investment of $25 million over five years will be provided to the NGO sector to enable non-government services to appropriately support people during recovery and reintegration into the community, and increase rehabilitation and employment opportunities available to people with mental illness. **Total commitment over 5 years: $25 million**

In addition to the increase in funding resulting from the mini-budget, I am also pleased to inform that Queensland Health has made further funding allocations in mental health which were started during 2005/06 and had not been reported to the Committee at the time of our previous submission. The details are as follows:

- Dual Diagnosis Positions - Funding of $1.1 million enabling an additional 13 clinicians to be employed in response to the increasing numbers of people presenting with mental illness and substance abuse problems. **Total Allocation: $1.1 million recurrently**
- Alternatives to Acute Admission - A comprehensive package has been provided to promote alternatives to acute hospital admission whereby people receive intensive support within their own homes or homelike environments. Under this initiative nine health districts has been provided $500,000 each to establish these services, which will include new mobile intensive treatment services, recovery support workers and improved transitional support for people with mental illness, their families and their carers during the risk period immediately after discharge from hospital. **Total Allocation: $4.5 million recurrently**
- Mental Health Intervention Positions with Queensland Police - A whole-of-Government initiative which commenced in 2005-2006 for the establishment of Mental Health Intervention Teams with the skills to de-escalate situations involving people with a mental illness and avert the development of crisis situations. This funding supports training of mental health clinicians across the State to work with trained police and ambulance officers to assist in preventing and safely resolving mental health crisis situations. Police and Ambulance services have received similar funding. The funding enables Queensland Health to support new clinical positions in emergency departments to provide short-term case management and follow up to people brought to hospital by police and ambulance officers who do not meet the criteria for treatment by a mental health service. **Total Allocation: $0.8 million recurrently**
- Child Safety Therapeutic Support Teams - State-wide establishment of at least nine multidisciplinary Mental Health Child Safety Therapeutic Support Teams targeting children and young people in the care of the Department of Child Safety. This involves a total of 125.75 Full Time Equivalent positions. Implementation has commenced with the piloting of the first three teams. These services will enhance mental health, behaviour support and participation in education for children and young people in the care of the Department of Child Safety. **Total Allocation: $0.9 million recurrently**

- *Beyondblue* - In recognition of the increasing impact of depression and related disorders on the Queensland community the State Government has increased funding of *beyondblue*: the national depression initiative from $280,000 to $3 million over five years. **Total allocation: $0.645 million annually for 5 years**

Queensland's Reform Initiatives

Project 300

2. **The Public Advocate – Queensland has particularly commended *Project 300* as a model of service integration (*Submission 303*, p.10). Project 300 brought together the state government departments of Housing, Disability Services and Health (Qld Gov *Submission 377*, p.20).**

The program has achieved positive results, with some full rehabilitation cases being recorded. What are the defining features of the model?

Initially the defining features of the model were the collaboration between the three government departments of Queensland Health, Disability Service Queensland (DSQ) and Queensland Housing working together to assist individuals to transition from Extended Treatment Facilities (ETF).

Queensland Health committed staff to work in the community to assist individuals with their medical supports and DSQ funded non-government service providers to assist with individuals with their disability support needs. Queensland Housing initially would prioritise these individuals to obtain housing with a focus on two bedroom accommodation.

A further defining feature of the model is the support provided by DSQ funded non-government organisations (NGO). In previous evaluations, it has been stated that the involvement of the non-government organisation support workers "...has been instrumental in the success of Project 300...". From the evaluation support workers provide "...practical help with financial matters, home making and community access." The support workers within the NGO's assist individuals with their own recovery process. The expertise and dedication of support workers helps individuals to develop skills and strategies that enable them to recover and sustain living arrangements within the community.

What accountability mechanisms are in place to ensure that all departments involved deliver tangible outcomes?

Initially a Memorandum of Understanding (MOU) between the three departments ensured all departments involved would be able to deliver tangible outcomes. Queensland Health also developed procedures and protocols to assist NGO's with transitioning individuals into the community and ongoing support.

Queensland Health and DSQ continue to have a MOU specifically relating to Project 300. Both departments review progress against the MOU, which also ensures that available funding is utilised to assist additional individuals to enter the program.

Queensland Housing and DSQ are negotiating a MOU relating to the provision of services to individuals with a disability, including individuals eligible for Project 300.

All individuals within Project 300 are supported through recurrent individual funding packages. NGO's acquit the funds to DSQ quarterly.

DSQ Support Facilitators monitor the outcomes of service provision for individuals and review funding packages as required.

Has an evaluation been done?

An evaluation of Project 300 has been ongoing since 1996. Progress reports have been provided at various intervals – 6 months; 18 months and three years. A five-year report is due in 2007.

Consistent positive feedback has been reported through the evaluation. The evaluation highlights the success of individuals transitioning from ETF facilities and remaining in the community, reduced admissions to acute care facilities, and where people have been admitted to acute care facilities, earlier discharge.

Evaluation reports have highlighted the reduction in Government expenditure as a result of individuals remaining in the community. The cost of an individual to remain with in a 26 Bed Acute Unit is $159,500 per annum ($437 per day). Currently individuals within Project 300 require approximately $52,000 per annum ($142 per day) to remain in the community.

What is the extent of non-government participation?

DSQ provides funding to NGOs who then support individuals through Project 300.

Evaluation reports indicate that the NGOs play a key role in the success of Project 300. The NGOs develop strong relationships with individuals and are able to provide a holistic model of support with all stakeholders. NGOs refer individuals to appropriate service providers such as Queensland Health's Community Mental Health agencies to assist with medical supports, or Commonwealth funded employment agencies.

3. **The submission notes that the cost of support packages under the initiative has reduced the service target from 300 to 270 clients (*Submission 377*, p. 20).**

What is the funding model for the project?

Funds are allocated to an individual but are paid to an NGO. DSQ assists individuals to link with an NGO of their choice.

When individual leaves the ETF, a non-recurrent allocation is provided to help them furnish their accommodation. An assessment of the individual's needs is also undertaken to determine the extent of support required. Recurrent funding is then provided to the NGO to enable them to provide the identified supports.

Payments are made to the NGO on a quarterly basis, based on a forecast of costs associated with the support needs of the person. The forecast is provided by the NGO with consideration to the wellness of the person at the time.

Over time, due to individuals progressing through their recovery process, their needs generally reduce. DSQ staff monitor funding expenditure and undertake reviews of the funding package with the individual and the NGO as indicated.

Recurrent savings identified through reductions in funding packages, or through people leaving the program (eg death), are reallocated to enable additional individuals to leave ETFs.

Following consultations with NGOs, DSQ is currently reviewing the funding model to ensure greater efficiency in the use of funds, and more flexibility to enable NGOs to respond to the changing and episodic needs of individuals.

Has there been an assessment of unmet need?

In 2001, Queensland Health requested ETF facilities across the state to assess the number of individuals within facilities that would be eligible for Project 300. Approximately 80 individuals were eligible at that time. Since that time DSQ has assisted an additional 56 individuals to enter the program utilising existing funds.

Queensland Health recently undertook further consultations to identify those people in ETFs who would be eligible for Project 300. They have advised that approximately 120 individuals would be eligible for discharge with Project 300 support.

Is the model sustainable? Is there capacity for the model to be extended, or do total costs preclude this?

This model of support has been sustained for nearly 10 years with minimal changes made to the program.

The funding required is significantly less than that required to sustain individuals in ETFs. Current average funding packages are approximately 50% less than DSQ provides for individuals with disabilities who require 24 hour support.

The reduction in support needs over time, and individuals leaving the program for a range of reasons, allows recurrent savings to be identified and existing funding to be reallocated. However, as the majority of individuals receive support for the duration of their lifetime, injections of new funding are required to respond to the needs of additional individuals accommodated in ETFs.

In 1999, the program supported approximately 180 individuals within the total budget allocation. The program currently supports approximately 220 individuals within that same budget allocation, although minor increases have been made through indexation.

It is anticipated that the review of the funding model which is currently occurring will further ensure sustainability of the model from a financial perspective.

Is there potential for national implementation of the model: what obstacles could be predicted?

This program has the potential to be implemented on a national basis for individuals with psychiatric disabilities and those with longer-term mental health issues, who also require similar disability-type supports during their illness.

Although the model currently responds to the needs of individuals within ETFs, it would be also be beneficial to individuals with psychiatric disabilities who often face constant readmissions to short-term acute facilities.

The model has been found to work in Queensland, despite the separation of responsibility between Queensland Health (which provides services to individuals with mental illness) and DSQ (which provides services to individuals with psychiatric disability as defined by the Disability Services Act 1992).

It is considered that the model may more readily be introduced in states where services to individuals with mental illness and psychiatric disability are provided by one department or one portfolio, allowing for more seamless service delivery.

4. **Other submitters have complained that Queensland's health and disability services operate in isolation (see, for example, Auspice support Group Australia, *Committee Hansard*, 4 August 2005, p. 50). The Queensland Government is devising an action plan to address this by building agency partnerships (*Submission 377A*, p.11).**

Can the government report progress in the development and design of the action plan? What will be the next steps to implementation?

The action plan identifies a broad range of strategies, many of which are already addressed in this correspondence. This includes, for example, initiatives relating to Project 300, the Memorandum of Understanding between Queensland Health and Disability Services Queensland, and initiative that relate to transitional housing, homelessness and people with dual diagnosis.

In addition, the action plan identifies other key areas such as collaboration between providers of primary health care and specialist mental health services, and the enhancement of consumer and carer participation. These areas are taking prominence within the State Health Services Planning process.

Criminal justice and corrective systems

5. **Queensland Health and Queensland Police Services have a comprehensive interagency strategy to address mental health needs (*Submission 377A*, p. 11)?**

Can the government provide more information about the Memorandum of Understanding between the services, and the operation of the Interagency Steering Committee (Submission 377A, p. 8)?

The Queensland Health and Queensland Police Service Memorandum of Understanding (MOU) establishes the general roles and responsibilities of both parties. The Terms of the Agreement include:

- To identify current and emerging issues and to develop strategies to improve service delivery through collaboration between the two Departments
- To continue to define and develop roles and responsibilities of each Department in regard to specific state-wide and local activities.
- To develop mechanisms which promote a culture of continuous improvement across the two Departments to facilitate the further development and communication of identified good practice, which will ensure that formal arrangements are sustainable over time

- To explore legislative and policy options to enhance information sharing
- To work in collaboration towards the development of protocols and procedures between the two Departments at the state-wide and district level for the prevention and safe resolution of mental health crisis situations
- To continue to improve knowledge, skills, attitudes and values of the respective staff of both Departments to ensure a coordinated system of care
- To continue the formal Interdepartmental Steering Committee process with senior representatives of both Departments to implement and monitor the terms of this agreement

The Inter-Departmental Steering Committee (IDC) is comprised of the Director of Mental Health (Chair), Assistant Commissioner of Police and senior Queensland Police Service and Queensland Health personnel. The IDC meets on a quarterly basis. Its function is to oversee the progression and implementation of the Terms of the Agreement provided in the MOU; in particular to:

- Identify current and emerging issues and develop strategies to improve service delivery
- Continue to define and develop roles and responsibilities of each department
- Identify and progress any changes which may be required as a result of legislative or policy changes
- Oversee the development and implementation of protocols and procedures for the prevention and safe resolution of mental health crisis situations
- Monitor the formal arrangements at a state-wide and Region/District level
- Advise on the development of a training strategy for the respective staff of both departments
- Assess the need for liaison and partnerships with other government, non-government and community agencies.

The Queensland submission reports that the Department of Corrective Services is now purchasing outpatient services from the Department of Health (Submission 377A, p. 8). Please provide more information about this initiative.

The Department of Corrective Services currently purchases minimal mental health services for people in correctional settings. A large proportion of the mental health services currently provided in correctional facilities are subsidised by Queensland Health. Following the release of the *Queensland Health System Review – September 2005*, Queensland Health initiated discussions with the Department of Corrective Services about possible transfer of all prison health services to Queensland Health.

In principle Queensland Health is supportive of the approach, however it will be important that this occurs in a staged manner to ensure minimal adverse impact on the existing Queensland Health service delivery system. Mental health services will be one of the first services considered for transfer. Queensland Health and Department of Corrective Services are currently planning for the transfer of prison mental health services in the context of Queensland Health's capacity to take on this additional service responsibility.

6. **The submission notes that treatment for released prisoners with substance abuse problems 'ideally' should be provided by community-based treatment services. (*Submission 377A*, p. 47).**

Is there dedicated funding or other support to foster development of appropriate services?

While there is no specific dedicated funding for prisoners following their release, these individuals have access to the network of drug and alcohol treatment services delivered by District Health Services throughout the State. The specific needs of this population are however well recognised and will be considered in the context of future planning and funding availability.

7. **Does Queensland have plans to develop new forensic mental health services or facilities for either male or female prisoners?**

Queensland Health will consider, as part of its current Health Services Planning process, the need for additional forensic mental health services and the need for a dedicated acute assessment and treatment inpatient unit for prisoners. This will be a component of the mental health services planning process and will ensure that Queenslanders have access to high quality and safe mental health services across the continuum of care.

Dual Diagnosis

8. **The Queensland Government has merged Mental Health Alcohol, tobacco and Other Drugs Services to better assist people with dual diagnosis (*Submission 337*, p. 16).**

How is the amalgamated department funded? Is the total amount of funding an increase? Can you report measurable improvements to service delivery since integration?

The *Achieving Balance: The Queensland Review of Fatal Mental Health Sentinel Events, March 2005* report resulted from a review of deaths occurring over a two year period (2002-2003) involving people with serious mental illness. The report included a recommendation to "Transfer the responsibility for alcohol and drug treatment services to mental health services" (Key Recommendation 3). This report was followed by the *Queensland Health System Review, September 2005* (Forster Review), which recommended a range of changes to Queensland Health structure and operation. The Department is currently considering the *Achieving Balance* recommendation, in light of the recommendations received in the Forster Review.

9. **At delivery level, a major obstacle to effective treatment of people with dual diagnosis has been the different treatment models used by mental health and drug and alcohol services.**

What strategies, structural and operational, has the government found effective in dealing with the challenges involved?

Queensland Health endorsed the *Dual Diagnosis Strategic Plan* in November 2003. The Plan promotes use of an integrated care approach and outlines seven key objectives and respective strategies that are widely considered to be essential for the establishment and sustained delivery of effective responses for people with a dual diagnosis by health services. The Plan builds on the existing capacity of health services rather than creating specialist, stand alone teams, recognising that responding to people with dual diagnosis is the core business of both mental health and alcohol, tobacco & other drug services. An overarching aim of the Queensland Health dual diagnosis strategic direction is to build the capacity of both mental health and alcohol, tobacco and other drug services to provide an integrated care approach to the problem of dual diagnosis.

A Queensland Health Dual Diagnosis Steering Committee has been established to facilitate enhanced integration of mental health and alcohol, tobacco and other drug services by health services. The Steering Committee meets on a regular basis and comprises state-wide representation of key stakeholders including mental health and alcohol, tobacco and other drug service clinicians and two dual diagnosis project officers (see below).

A recently endorsed Dual Diagnosis Project Plan includes the recruitment of two dedicated principal project officers to facilitate the integration of mental health and alcohol, tobacco and other drug services and the adoption and delivery of evidence-based practices for people with a dual diagnosis by district health services. A key role of the project officers is to enhance the knowledge, skills and expertise of mental health and alcohol, tobacco and other drug service staff in the delivery of evidence-based interventions through the development and delivery of training programs. A budget of $200,000 has been allocated for this purpose. The Dual Diagnosis Steering Committee oversees activities of the project officers and provides advice, support and expertise as required.

All alcohol, tobacco and other drug services provide screening for mental health problems and illness as part of the comprehensive alcohol and other drug assessment protocol. This includes use of psychometrically reliable and valid screening tools. The demographic and clinical features of clients are recorded on a state-wide data base.

Several initiatives have been established to improve services for people with a substance use problem and a mental illness, including:

- the appointment of Early Intervention Dual Diagnosis positions in five District Mental Health Services across Queensland for a trial period of two years with the purpose of developing appropriate and effective models of care which link mental health services, alcohol and drug services, primary health care settings and key settings such as emergency departments. A core element of the role of the nine Early Intervention Dual Diagnosis positions is to enhance the capacity of the Queensland Health service system to undertake early identification and treatment of people with a dual diagnosis. The benefits of earlier response to the problems faced by people with both mental health and substance use problems are well documented. These positions will be formally evaluated.

- Funding of three dual diagnosis early identification positions in Brisbane North, Cairns (indigenous focus) and a combined project between Sunshine Coast and Gold Coast with a focus on emergency departments. These positions have been finalised and final reports are to be reviewed.
- Funding of demonstration projects to establish services in selected areas of high prevalence including - Logan (Start Over & survive), Sunshine Coast Sunshine Coast Integrated Care Project), Prince Charles (ADIS Co-morbidity Enhancement) as well as a rural-regional multi-site initiative coordinated by University of Queensland (AimHi). Demonstration projects are also an important component of the dual diagnosis strategic approach, providing important learnings and evidence regarding the efficacy and appropriateness of various service models in the Queensland Health context.
- Funding of 13 positions in mental health services to drive the provision of integrated care and dual diagnosis initiatives at the local district level. These positions have been established in health service districts across the state including Redcliffe-Caboolture, Royal Brisbane Hospital, Royal Children's Hospital, The Prince Charles Hospital, Gold Coast, Logan-Beaudesert, Princess Alexandra, Toowoomba, West Moreton, Cairns and Townsville Health Service District.

Consistent with the *QH Dual Diagnosis Strategic Plan*, mental health and alcohol, tobacco and other drug services in several health service districts have initiated the following activities:

- the establishment of dual diagnosis steering committees and working parties comprised of mental health and alcohol, tobacco and other drug service staff and key stakeholders
- the development of partnership agreements and memorandum of understanding between mental health and alcohol, tobacco and other drug services
- the creation and/or realignment of positions to coordinate dual diagnosis initiatives, foster the adoption of an integrated care approach and to drive the process of improved service delivery for people with a dual diagnosis
- the delivery of workforce development and training for respective services
- The development of clinical protocols and procedures, for example, clinical pathways, assessment protocols that include screening for respective conditions, etc.

Do you have programs to promote cross skilling among service staff?

As identified above, the development and delivery of a state-wide training program for service staff by the dual diagnosis project officers is planned to enhance the knowledge, skills and expertise of service staff in the delivery of evidence-based interventions for people with a dual diagnosis.

The Alcohol and Drug Training and Research Unit (ADTRU) provides state-wide training for Queensland Health staff. This Unit offers a range of seminars and workshops relevant to dual diagnosis. Examples of seminars and workshops include those focussed on interpersonal therapy, building relationships that engage change for complex clients, Introduction to dual diagnosis (2 day workshop), and Introduction to CBT (3½ days).

Consistent with the QH *Dual Diagnosis Strategic Plan*, mental health and alcohol, tobacco and other drug services in several health districts have undertaken initiatives that aim to increase the skills, knowledge and confidence of staff in respective treatment approaches and clinical interventions for application with clients with a dual diagnosis. Examples include:

- co-facilitation of training sessions relevant to the treatment and care of clients with a dual diagnosis. This training is organised at the local health district level.
- provision of clinical sessions or clinics on a regular basis at respective services.
- attendance at case conferences and case management meetings for dually managed clients.
- a clinical placement program (Cairns Health Service District) whereby staff from mental health and alcohol, tobacco and other drug services are based within respective health services for extended periods.

What clinical approaches are adopted to provide more comprehensive treatment for people with a dual diagnosis?

A range of clinical approaches have been adopted by health service staff for people with complex needs, including:

- Screening for substance use problems and dependence, and for mental health problems and disorders by mental health and alcohol, tobacco and other drug service staff respectively. All alcohol, tobacco and other drug services screen for mental health problems and disorders as part of the substance use comprehensive assessment. Some mental health services have also integrated substance use screening into their comprehensive mental health assessment.
- The delivery of mental health interventions for people with a mild-moderate mental health problem by alcohol, tobacco and other drug service staff. These services utilise a range of clinical approaches, including:
  - engagement and fostering of a therapeutic alliance
  - harm minimisation approach
  - cognitive-behavioural therapy
  - interpersonal therapy
  - supportive care
  - psychotherapy
  - pharmacotherapy
  - family therapy
- One health district facilitates a group program for people with a dual diagnosis that utilises dialectical behaviour therapy
- One health district is piloting an intensive (assertive) case management approach for people with serious mental illness and substance abuse or dependence
- The co-case management and care coordination of people with moderate-severe mental health or substance use disorders by mental health and alcohol, tobacco and other drug service staff

- The development of individual care plans with input from both the mental health and alcohol, tobacco and other drug sectors
- Service coordination and linkage with a range of health and welfare services in accordance with a client's identified needs (eg., housing, employment, sexual health, etc).

Youth Services

10. **A mental health service gap for the 16 to 25 year old age group has been widely reported. Professor Patrick McGorry of ORYGEN Research Centre advised there is 'tremendous resistance' to proposals for youth services for this cohort. State and territory governments are resistant to adding an extra service tier to existing three tier systems, comprising child and adolescent services, adult services and aged services (*Committee Hansard*, 7 July 2005, p. 8).**

Has Queensland plans to develop targeted youth services to target the unmet needs identified in the submission?

Over recent years increasing state and national policy focus has been placed upon the specific issues of providing quality, timely and developmentally appropriate mental health care to young people in the age range of 16 – 25 years. Informing this focus is the recognition that late adolescence has the highest prevalence of symptoms that may lead to a mental disorder, as well as high prevalence of actual mental health problems and disorders. Growing evidence of the long term and disabling individual, social and economic costs and consequences of undiagnosed and untreated mental health disorders in this age group highlights the importance of early diagnosis and treatment of young people with mental health problems.

Particular service delivery challenges relate to the 16 – 24 year age group. The structural arrangement of child and youth mental health servicing the age range between birth and 18 years, and the adult mental health system providing services to people over the age of 18 years is a significant issue. While services routinely exercise some flexibility in regard to age criteria, the two systems operate from distinct service provision paradigms. The appropriate entry point for people in the 16 to 25 age group can therefore be a complex issue.

Other barriers to access for young people have been well documented through research and consultation with young people. Some barriers relate to service factors (such as intake criteria and waiting lists) while others relate to developmental and other specific issues pertaining to young people. The scope of mental health treatment for this age group must take into account the formative nature of the various domains of the young person's life, all of which are highly vulnerable to the disabling impact of a mental illness. Therefore engaging young people in treatment (especially young people with complex and severe mental disorders) requires sensitive, creative and innovative approaches that transcend existing service boundaries and traditional models of service delivery.

In acknowledgement of the above issues, Queensland's service planning and development targeting this age group has involved a number of models and approaches. Specifically, a Youth Early Intervention Mental Health Program for 15-25 year olds was initially trialled and is now recurrently established in two high need catchments in the greater Brisbane metropolitan area. The aim of the Youth Early Intervention Program is to ensure that young people experiencing the early signs and symptoms of mental health problems receive early

treatment. The program focuses on building the capacity of a range of other government and non-government agencies to identify and provide more effective interventions for young people undertaking high risk taking behaviour or experiencing a wide range of adverse life events.

In addition, Early Psychosis Programs operate in various locations across the State including Brisbane and Townsville. Funding of the School Based Youth Health Nurse Program within secondary schools across the state is also aimed at the early detection and referral of young people at risk of or experiencing mental health problems and disorders.

In terms of future planning, Queensland continues to be strongly influenced by the key principles of providing services that are acceptable and accessible to young people, and which minimise disruption to the young person's life and social, educational and vocational functioning. The preferred model continues to centre on key youth sector partnerships including generalist youth health services, non-government services, general practitioners, and educational facilities. Under this model specialist mental health services would primarily be providers of resources and consultancy aimed at containing episodes and maintaining key networks.

11. **The Queensland submission reports growing service demand among young people with drug induced psychosis and youth with co-occurring disorders in tourist areas (*Submission 377*, p. 4). The committee has heard that NGOs and community health services struggle to provide adequate services on the Gold Coast, for example. (*Submissions 533, passim*, and *Submission 321*, p. 8)**

What is the Queensland government doing to address the increasing service demand on the Gold Coast and in other tourist areas?

Are there particular mental health service issues arising due to the needs of international visitors?

Queensland Health is aware of the rapid population growth in the Gold Coast area as well as other areas in which population growth is expanding as a result of tourism or people relocating as part of their retirement. These areas include; the Wide Bay Area, the Darling Downs, the Far North particularly around Cairns and whole South East Corner of Queensland.

Queensland Health has commenced the process of developing a State-wide Health Service Plan that will address the needs of all Queenslanders, but will enable Area Health Services to plan for the needs of populations which are expanding rapidly.

Specifically, the needs of the Gold Coast have been recognised by Queensland Health, so as part of the funding announcements contained with in the mini-budget during 2005/06, with a total additional commitment to mental health services on the Gold Coast of $1.6 million. Further service expansion to the Gold Coast and other areas of high population growth will be made as part of the State Health Service Plan.

Long Stay Detox Beds

12. **The Gold Coast Drug Council runs a residential program called the Mirikai Residential Therapeutic Community Programme which targets youth with co-occurring disorders, a growing high needs group. At the hearing on the gold Coast (2 February 2006) it told the Committee:**

> **In 2004/05 the Mirikai Residential Therapeutic Community Programme bed cost was @$21,000 p.a. Other states such as Victoria and New South Wales have bench marked their costs for particular client beds, with the cost of an equivalent bed in New South Wales and Victoria running @ $30,000 per year, with this funding including a component related to complexity. Queensland Health have repeatedly confirmed that they do not intend to benchmark costs for specific services or to provide financial incentives for specific client groups. Without financial recognition for the complexity of clients supported, it may simply not be possible to provide the environment and staff to deliver these services safely into the future (GCDC *Submission 533*, p. 9).**

What considerations are driving the government's response on benchmarking of costs for specific services?

In recognition of the valuable services provided by the non-government sector, Queensland Health provides funding assistance for the provision of alcohol and drug treatment services throughout the State. Queensland Health has advocated for and awarded general funding increases over the years to funded agencies in recognition of cost imposts, as well as provide one-off funding to agencies to assist with minor capital works, information technology enhancements and staff development.

In relation to funding for residential alcohol and drug treatment services, otherwise known as rehabilitation programs, Queensland Health does not fund beds as such. Funding has been awarded to agencies over the decades through historic funding grants to offset some of the costs associated with providing services. Queensland Health does not use a benchmark or set formula or unit cost per bed day as such for the non-government sector as each organisation/service/ project is assessed on a case by case basis, taking into consideration:

- historical funding grants awarded by Queensland Health to offset some of the costs associated with staffing and operational costs for core services;
- any new funding awarded by Queensland Health for specific initiatives or services;
- other sources of income such as funding grants awarded to agencies for services directly from the Australian Government, local councils, other state government departments;
- projected client income as all agencies charge between 70 – 80% of client's Centre Link payments to offset costs associated with food and lodging.

For new services, non-government organisations submit a budget for their particular model of service and itemise the staffing requirements, capital works and operational costs, whilst factoring in existing infrastructure and other sources of income (such as client rent), which may offset some of these costs. As these aspects differ between different organisations, different levels of funding have been provided.

Does the government have a long-term plan, or view, about the utilisation and funding of community-based tertiary beds for complex cases?

Queensland Health has a long-term commitment to the non-government sector providing alcohol and drug residential treatment programs and recognises that a comprehensive approach is needed to address the complex issues underlying substance abuse. Queensland Health's commitment to community-based services is evident in the recent provision of significant funds to expand the availability of alcohol and drug treatment services in North Queensland with the addition of 50 new residential drug treatment beds (20 each in Cairns and Townsville and 10 in Mackay) to help those people who are actively working through the difficult issues that led to substance abuse. Funding for the new residential drug treatment services was awarded to agencies following an advertised tender process. These services were funded for staff and operational costs to provide 20 beds to support the Drug Court expansion as well as provide 30 beds to clients presenting for treatment from the general community.

Queensland Health is a key partner in the coordination and provision of a range of treatment services to support the Police Diversion Program, Drug Court Pilot Program, Illicit Drugs Court Diversion Program and soon to be trialled Queensland Magistrates Early Referral into Treatment (QMERIT) program. This suite of programs provide a comprehensive and integrated range of strategies that target offenders at various points in the criminal justice system, including arrest, pre-sentence/plea and post-sentence, and aim to differentiate clients on the basis of their offending history. The non-government sector has been a key partner in providing a range of treatment services to support these initiatives.

Future opportunities for the non-government sector will be available to provide services to support the QMERIT program as it is rolled out to various locations throughout Queensland. An advertised tender process will be undertaken at each stage of the QMERIT roll-out, depending on the final locations of the program and the mix of services required. Services may include the need for a number of residential alcohol and drug treatment services and this will require an advertised tender process where non-government agencies will be able to submit their proposals and be evaluated on the mix of services offered, and the comparative cost and quality of the proposed service model against other providers offering similar services.

13. **The committee has been told that Queensland Health has no dedicated detoxification long-stay beds on the Gold Coast and that a submission for dedicated beds in a proposed new hospital has been made by Gold Coast ATODS (Background information provided to the committee, 18 January 2006).**

Does the government plan to improve services to people with dual diagnosis include establishing dedicated long stay wards for complex cases in hospitals?

I have previously identified the way in which services to people with a dual diagnosis will be improved in the short term. This includes the additional 13 positions dedicated assisting people who have a dual diagnosis.

The Government has also made an additional investment as part of its Alcohol Demand reduction strategy to 14 Aboriginal and Torres Strait Islander Communities, where alcohol is having a profound effect on the social and emotional well-being of those communities.

The development of any dedicated long stay beds for complex cases will be considered as part of the State Health Services planning process.

Rural and Remote

14. **Queensland Health has recently initiated a collaborative project to develop an operational policy and associated interagency guidelines for the emergency transport of mentally ill persons from rural and remote areas (*Submission 377A*, p. 59)**

Can the government report progress on this proposal?

In recent years, Queensland Health, in partnership with the Queensland Ambulance Service and the Royal Flying Doctor Service, has made considerable progress in the development of a coordinated response to the many complex issues involved in the transport of patients. This partnership, which falls under the umbrella of the *Queensland Emergency Medical System* (QEMS), aims to utilise local knowledge and resources to address transport issues through a state-wide support network.

Queensland Health is currently finalising standard operating procedures which relate to the emergency and non emergency transport of people with a mental illness from rural, remote and regional areas of Queensland. These mental health specific guidelines complement existing emergency and non emergency transport infrastructure and processes covered by the Queensland *Inter Facility Transports Operational Guidelines.*

15. **The submission reports plans for the establishment of a Queensland Centre for Rural and Remote Mental Health (QCRRMH) to coordinate services for rural and remote populations. The centre will be developed by a collaborative partnership between Queensland Health, the Royal Flying Doctor Service, industry partners such as Comalco, two major universities, and Indigenous Community Health Services with the support of the Commonwealth Office of Rural Health and Commonwealth Mental Health Branch (*Submission 377A*, p. 65).**

What process brought about the partnership?

How will the stated objectives, including 'enhancing service delivery, education and training, policy and program development, research, and the innovative use of information technology' be funded?

To what extent will the Centre concentrate on service provision to Indigenous communities?

The relative disadvantage of rural and remote residents in Queensland is reflected in data of health status and health service utilisation, including mental health service provision. The Centre for Rural and Remote Mental Health – Queensland (CRRMH-Q) project is an initiative which has already established partnerships between community, corporate, Indigenous, non-government and government organisations that are directed towards better coordination of existing services and development of new approaches to addressing unmet mental health needs of this population.

The proposal to establish the CRRMH-Q was brought about by an initial feasibility study and Discussion Paper funded by Mental Health Branch in 2004. Recommendations were then presented to 24 representatives of potential funding bodies and partners, resulting in the proposed innovative model for governance and organisation structures (a limited consortium and an incorporated joint venture with Queensland Health to be a partner in the formation of a company). The third and current phase in development is the CRRMH-Q Implementation Project which submitted a preliminary business plan in 2005 and which received in principle support from Queensland Treasury on 10 March 2006. A formal application for Queensland Health to be a partner in the formation of a company which will facilitate and manage the Centre is now being developed by Mental Health Branch.

The funding model for the Centre is yet to be finalised. However, one of the key reasons for potentially establishing a company is to form a separate legal entity to attract and receive Commonwealth Government funding. The Commonwealth Department of Health and Ageing and Queensland Health have committed $280 000 per year for 3 years and $500 000 per year for 3 years respectively. Other partner organisations are currently considering the value of their contributions (in-kind and other) which are to be included in the establishment documents.

Given the high representation of Indigenous peoples in rural and remote locations, and the high incidence of mental health problems in Indigenous communities, Indigenous peoples have been identified as a priority population. The CRRMH - Q Implementation Committee has conducted four workshops to canvas priorities for action on Indigenous issues. The Centre will facilitate the development of programs to address social and emotional wellbeing and mental health needs across the spectrum of mental health interventions.

16. **The Queensland Government reports developments in Indigenous mental health in support of this, community governance legislation has been reformed and a Community Governance Improvement Strategy implemented to assist Indigenous community Councils to enhance their accountability, functions and compliance requirements.**

What were these changes and what will they effect?

What support will be provided for their implementation and how will they be enforced within community settings?

The *Community Governance Improvement Strategy (CGIS)* is a major initiative under the Government's *Meeting Challenges, Making Choices Strategy* to build capacity and strengthen the standard of corporate governance of Aboriginal Shire Councils, with some components being offered to Island Councils and to Aurukun and Mornington Shire Councils as appropriate. The CGIS is delivered through the Community Governance Branch (CGB) of Local Government Collaboration Division in the Department of Local Government, Planning, Sport and Recreation (DLGPSR).

CGB has taken a broad approach in the delivery and implementation of the CGIS. This has involved providing direct services to Indigenous Councils; forming partnerships with a range of government and non-government agencies and individuals to deliver services and advice to Indigenous Councils; and working with a number of key stakeholders to better inform CGB and others concerning issues impacting on Indigenous Councils. CGB has a network of management consultants in its Cairns and Brisbane office that work directly with Aboriginal Shires and Island Councils under the CGIS.

The CGIS assists Aboriginal Shires to meet new responsibilities under the *Local Government (Community Government Areas) Act 2000,* which was enacted on 1 January 2005.

The objectives of the Act include to:

- constitute Aboriginal Councils as local governments under the *Local Government Act 1993* (LGA);
- apply most of the LGA to the Councils;
- provide additional legislative provisions to deal with the unique needs and circumstances of Aboriginal communities, including providing the Councils with the ability to establish local service committees and create electoral divisions based on Indigenous social groups.

One of the key elements of the CGIS is the development of Performance Development Plans (PDP) which have been negotiated with all Aboriginal Shires and most of the Island Councils by CGB management consultants. As part of the PDP process, the Councils have identified areas which required improvement and/or enhancement of their business/financial systems. As part of these shared responsibility agreements, DLGPSR has agreed to fund some of these identified activities. PDP's will be negotiated annually with all Councils.

Another key component of the CGIS is the Councillor Training Program (CTP), which comprises two streams: Corporate Governance (focussing on organisational development); and Innovative Leadership (focusing on personal development). Councilors and Chief Executive Officers from Aboriginal Shires and Island Councils can choose to undertake the accredited Certificate IV in Local Government Administration or a non accredited course under the CTP which is being delivered by Registered Training Organisations.

The DLGPSR have formed a partnership to pilot the delivery of the Council Employees Accredited Training (CEAT) program; a professional development training program for administrative staff working in Aboriginal Shires and Island Councils throughout Queensland. The initiative seeks to build the capacity and skills of administration staff to enhance their future career choice.

The CGB has also entered into a partnership with the Indigenous Community Volunteers (ICV) which is an independent not for profit organisation established to assist Indigenous communities and organisations to build capacity through linking them with skilled volunteers and promoting skills transfer. Under this project, an ICV project officer will be dedicated to assisting the Councils by providing skilled volunteers, through ICV projects, that are capable of transferring skills to the Councils.

The CGIS is almost halfway into its implementation period of 4 years and further elements of the strategy will be progressively implemented over the next 2 years.

17. **The Queensland Government reports that Indigenous Environmental Health workers have been funded by Cape York communities under a trial environmental health initiative.**

What was the nature and timeframe of the trail program and what were its objectives?

How was it funded?

Will the program be continued, and/or implemented in other areas?

The trial environmental health program in the Cape was established to fund and train environmental health workers in each 13 communities across the Cape. Environmental health workers are employed by the community council and are responsible for monitoring environmental health issues in their community and coordinating action in response to identified problems. They address such issues as waste management, drinking water, housing conditions, hygiene, vector control, animal management and emergency management.

The program has been expanded to cover all deed of grant in trust communities (DOGIT) across Queensland, with funding provided on a permanent basis. Funding is provided through the Department of Local Government, Sport and Recreation, and is linked to the usual state funding arrangements for these communities. Queensland Health (through the population health units) provides support to the environmental health workers through community visits, workshops and training.

Queensland Health, in conjunction with Department of Natural Resources and Mines, and the Department of Primary Industry has also established an animal management program. This program provides funds to each community to employ an animal management worker, and develop infrastructure. The purpose of the program is to assist DOGIT communities manage domestic and feral animals in the areas covered by the community. It is being rolled out over the period from 2005-2007.

National Consultation and Coordination

18. **The National Co-Morbidity Taskforce ceased to function as a specialised co-morbidity forum a year ago.**

Does the Queensland Government consider that the taskforce should be reinstated?

Would the Queensland Government support the establishment of another mechanism for information sharing and coordination of policy approaches?

Another suggestion was that the body could coordinate national funding of research into mental health reform. Would you support that approach?

Does the government consider that a Mental Health Commission like that established in New Zealand would be beneficial?

The Queensland Government does not have a position on whether the National Co-Morbidity Taskforce should be reinstated. Whilst the role of the taskforce was valued by Queensland Health there remain mechanisms in place that allow for information sharing and coordination of policy approaches.

Queensland does not support the proposition that "the body", presumably meaning the National Co-Morbidity Taskforce, should coordinate national funding of research into mental health reform. There are a number of bodies that would be better placed to perform this function. Queensland supports the National Mental Health Working Group of AHMAC in its role in overseeing National Mental Health Reform and supports its recent approach to the National Health and Medical Research Council in relation to its role in supporting research activities in health.

Queensland does not support the establishment of a Mental Health Commission like that established in New Zealand, but would look forward to further discussions about mechanisms that could be put in place to support the better accountability of mental health reform in Australia.

Other Matters

Adoption and Mental illness

19. **Queensland is the only state that does not have a post-adoption resort centre and retains options for the birth parent of an adoptee to prevent access to information or contact. The Coordinator of Origins Incorporated reports serious consequences for adoptees (*Committee Hansard*, 4 August 2005. pp. 33-34)**

Can the government explain its position: why does Queensland remain out of step with developments in this area in other states?

The legislation governing adoptions in Queensland is over 40 years old and reflects the social values about families and children of the 1960s. While the *Adoption of Children Act 1964* has been amended on numerous occasions, it has not been comprehensively reviewed. To ensure adoptions in Queensland are governed by contemporary legislation, the Queensland Government is undertaking a comprehensive review of the adoption legislation. The Queensland Government is awaiting the Australian Government's response to the House of Representative Inquiry into inter-country adoption which has recommended sweeping reforms to the adoption process prior to releasing a draft Bill for a four month public consultation process.

The type and level of post adoption support services that will be provided by the Queensland Government, either directly or indirectly, is being considered as part of the review of the adoption legislation. Queensland presently operates a Local and Post Adoption Unit within the Department of Child Safety that provides identifying information to people who apply and are not blocked by an objection from another party. Queensland also operates a mailbox facility to assist people in communicating with the other party to their adoption.

Matter of Ms Christina Hoi Yan Wong

20. **Ms Wong, a young medical doctor and psychiatrist, was deregistered for five years after a Queensland medical tribunal decision in 2002. Ms Wong reported inaction on the part of Queensland Health, despite the fact that government initiated independent examination of her case by Dr Jonathon Phillips, had exonerated her (*Committee Hansard*, 4 August 2005, p. 48).**

Can the government report any developments in Ms Wong's case?

Queensland has a Mental Health Review Tribunal which rules on involuntary treatment decisions. Should the body, or some other, have a capacity to review decisions – such as that by the Medical Board – which are allegedly discriminatory and are based on judgements about someone's mental health?

Queensland does not wish to make any further comments in relation to Ms Wong's case. The Mental Health Review Tribunal is established to determine issues relating to the *Mental Health Act 2000*. It is not our view that it should have any role in reviewing the decisions of the Medical Board.

Queensland Health strongly supports the role of the Medical Board in determining the registration of Medical Practitioners in Queensland. It does not believe the decisions made by that Board would be based on discrimination on the basis of someone's mental health.

Multiple Diagnoses and the Prison Population.

21. **At the Gold Coast hearing (2 February 2006) the Mental Health Association of Queensland referenced a state-wide research paper commissioned by Queensland Health (p. 49, *Committee Hansard*).**

The Committee was subsequently informed by Mr Compton that the paper examined multiple diagnoses, including "mental illness, intellectual disability etcetera whilst in the prison population" and may be accessible through Queensland Health.

Could you provide the Committee with a copy of the aforementioned research paper?

The research paper referred to by the committee has not been published and Queensland Health does not believe it is of a standard that it could be published by Queensland Health. If the Committee wishes to obtain a copy, it may wish to contact the author directly.

Should officers of your Department require further information Queensland Health's contact is Dr Aaron Groves, Director Mental Health, on telephone (07) 3234 0607.

Yours sincerely

Uschi Schreiber
Director-General
26 / 03 /2006