EXHIBIT 729

First Evaluation Report
July 2011

Queensland Plan for Mental Health 2007-2017

Improving mental health for Queenslanders

Queensland Government

EXHIBIT 729

EXHIBIT 729

Document history

Version	Date	Comments	Status
0.9	17/8/2010	Draft Baseline Report	Draft
0.91	7/4/2011	Draft First Evaluation Report presented to Mental Health Plan Implementation Steering Committee and Executive Director, Mental Health Alcohol and Other Drugs Directorate (MHAODD)	Draft
1.0	28/7/2011	First Evaluation Report incorporating final changes	Final

EXHIBIT 729

Foreword

Since the commencement of the *Queensland Plan for Mental Health 2007-2017*, our mental health system has been changing. We are delivering more services, with improved facilities, with more staff, and renewed focus on reform.

For any organisation, a major increase in activity can be consuming, which is why it is important to keep a disciplined focus on our original goals. It is also important to understand where we are succeeding, and where we are not.

For these reasons, in June 2009, I endorsed an evaluation framework for the *Queensland Plan for Mental Health 2007-2017*. The framework was then provided to Cabinet in August 2009 and received favourable mention in *the Auditor-General's Report to Parliament No. 2 for 2009: Health service planning for the future*.

The evaluation framework sets out five core questions regarding the Plan: (1) Was the funding expended in the intended way? (2) To what extent has the infrastructure and capacity of the mental health sector increased? (3) Has the quality of the mental health service system improved? (4) Have the initiatives impacted on people living with a mental illness? and (5) Has the mental health of the community improved?

By continuing to ask ourselves these questions, we can ensure that our resources and efforts remain aligned to our goals, and also understand how our efforts are improving the system. This first evaluation report aims to start providing answers to these questions, outlining baseline performance and initial progress as the Plan commenced (2007-08 to 2009-10).

The information presented in this report shows that we have progressed well in establishing the infrastructure for the plan. However, in some areas, progress is less clear. This is expected. Changes in outputs and outcomes take time to emerge, while in some cases, systems that we use to measure progress have themselves been modified, making it more difficult to detect shifts over time. This means that, in many areas, we will need to wait for future reports to better assess our progress.

Change and reform can be complex; understanding the effects can be no less difficult. However, this report provides a solid foundation for better understanding where we have succeeded, and for ensuring we do not lose sight of our original goals.

In presenting this report, I wish to thank staff across Queensland Health and the Department of Communities who understand the need for the evaluation, and who contributed valuable information, expertise and time.

Dr Aaron Groves

Executive Director
Mental Health Alcohol and Other Drugs Directorate
July 2011

EXHIBIT 729

Executive Summary

The first evaluation report shows that there have been a number of achievements in the implementation of the Queensland Plan for Mental Health. In particular, significant infrastructure has been established, providing support of future reform. This includes

- Meeting targets for the allocation of funds provided under the Plan;
- Increasing mental health staff per 100,000 population by 11 per cent to 47.2 FTE, towards the 2016-17 target of 70 FTE mental health staff per 100,000 population ;
- Between 2007 and 2009, decreasing the clinical vacancy rate for community mental health services from 12 per cent to 4 per cent, whilst from 2008 to 2009, decreasing the mental health clinical vacancy rates across all service settings from 6 per cent to 3 per cent**;**
- Commissioning five new beds in the Sunshine Coast and refurbishing 8 extended treatment beds in Townsville ; and
- Implementing a a state-wide clinical information system, the Consumer Integrated Mental Health Application (CIMHA

The evaluation highlights areas of focus required to maintain momentum of current initiatives, including the delivery of 146 additional mental health beds, and to continue improvements to the quality of services provided, such as increasing rates of community mental health contact following discharge from acute mental health inpatient units.

It should be noted that some indicators were affected by the introduction of CIMHA during 2008-09. The data model underpinning the new system is a modification from the model implemented in the legacy applications, and its adoption effectively sets a new baseline for reporting of many indicators from 2009-10.

EXHIBIT 729

Key Findings

The following key findings have been grouped under their respective key evaluation questions.

Was the funding expended in the intended way?

- Funds for the first three years of the Plan have been allocated within expected levels and most initiatives are on track to be allocated by the established target dates:
  - 38 per cent of the $17.9 million allocated on activities related to Priority 1;
  - 56 per cent of the $428.5 million allocated on activities related to Priority 2;
  - 58 per cent of the $110.3 million allocated on activities related to Priority 3;
  - 64 per cent of the $4.7 million allocated on activities related to Priority 4; and
  - 77 per cent of the $70.8 million allocated on activities related to Priority 5.
- Funding allocated to establish additional mental health positions, enhanced by efficiencies and additional funding from other sources, has been utilised to create an additional 531 FTE;
- Five new aged care extended treatment beds (located in the Sunshine Coast) and eight refurbished extended treatment mental health beds (located in Townsville) have been commissioned. A number of projects are nearing completion, including the Princess Alexandra Hospital's Community Care Unit and High Security Unit.

To what extent has the infrastructure and capacity of the mental health sector increased?

- Progress in the development of the state-wide Mental Health Literacy strategy has seen a total of 13,593 persons trained in Mental Health First Aid;
- 20 new Service Integration Coordinator positions have been established and recruited. Memorandums of Understandings have been signed with seven Queensland government agencies. Fourteen out of 17 sites have commenced accepting referrals;
- The number of mental health consumer and carer worker positions have increased to 22.1 FTE, from 11.6 FTE prior to the commencement of the Plan. These workers have commenced accessing a number of professional development programs developed by Queensland Health Mental Health Alcohol and Other Drugs Directorate to assist them to perform their roles;
- 4,654 Queensland Health staff have participated in some form of mental health training offered through the Queensland Centre for Mental Health Learning;
- The rate of mental health staff per 100,000 population has increased by 10 per cent from 42.6 (prior to the Plan) to 47.2 FTE per 100,000 population. This increase is relatively small, despite more significant increases in absolute staffing levels, as a result of rapid population growth over the period;
- The rate of mental health beds per 100,000 population has decreased from 33.8 in 2006-07 to 31.5 in 2009-10 reflecting strong population growth, and slower than expected delivery of capital projects.

Has the quality of the mental health system improved?

- Between 2007 and 2009 the clinical vacancy rate for community mental health services decreased from 12 per cent to 4 per cent, whilst from 2008 to 2009 mental health clinical vacancy rates across all service settings decreased from 6 per cent to 3 per cent;
- Since the commencement of the Mental Health Intervention Project in 2006-07, training has been undertaken with 6,804 police officers, 1,860 ambulance officers and 787 Queensland Health staff;

EXHIBIT 729

- Responses from the 2009 staff satisfaction survey reveals that among mental health staff 'individual distress' was desirably low, and 'peer support', 'workplace health and safety' and 'multidisciplinary team support' were all desirably high. In addition, measures of 'employee engagement' and 'clinical communication' were also rated favourably by the majority of work units surveyed.
- Engagement and consultation with the non-government sector is underway to identify a range of output and outcome measures which will be formalised in the next round of service agreements. It is expected that data collection from the non-government sector will commence in 2011.
- There has been a desirable decrease in the rate of readmission to acute inpatient care (within 28 days of discharge) from 17.1 per cent in 2007-08 to 15.6 per cent in 2009-10.
- The proportion of separations from acute mental health inpatient units with post-discharge community contact declined from 52.1 per cent to 43.8 per cent from 2007-08 to 2008-09. However, in 2009-10, the proportion increased to 45.7 per cent.

Have the initiatives impacted on people living with a mental illness?

- The overall proportion of consumers achieving 'statistically significant improvement' in clinical outcomes was more pronounced among consumers discharged from hospital compared to consumers discharged from ambulatory care and finally consumers in ongoing ambulatory care. This is an expected result – evidence in other jurisdictions demonstrates that inpatient care delivers more pronounced improvements, notwithstanding that consumers may remain symptomatic at discharge.

Has the mental health of the community improved?

- The proportion of the Queensland population reporting 'high' and 'very high' levels of psychological distress has decreased by 19 per cent and 26 per cent respectively. While this is desirable, this may be more closely linked to improving economic conditions between reference periods (2005 and 2008).

EXHIBIT 729

Contents

EXHIBIT 729

EXHIBIT 729

List of Figures

List of Tables

EXHIBIT 729

Appendices

EXHIBIT 729

Acronyms

ABS	Australian Bureau of Statistics
ATODS	Alcohol, Tobacco and Other Drug Services
CALD	Culturally and linguistically diverse
CATI	Computer Assisted Telephone Interviewing
CCWN	Consumer and Carer Network
CIMHA	Consumer Integrated Mental Heath Application
COAG	Council of Australian Governments
CSTDA	Commonwealth-StateTerritory Disability Agreement
DSQ	Disability Services Queensland
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
FTE	Full time equivalent
HASP	Housing and Support Program
HoNOS	Health of the Nation Outcome Scales
HP	Health Practitioner
K-10	Kessler Psychological Distress Scale
KEQ	Key Evaluation Question
LSP	Life Skills Profile
MH	Mental Health
MHEC	Mental Health Establishments Collection
MHIP	Mental Health Intervention Program
MHPPEI	Mental Health Promotion Prevention and Early Intervention
MHRT	Mental Health Review Tribunal
MHSO	Mental Health Service Organisation
MO-index	Measurement of Outcome Index
NCRA	Non-consumer related activity
NGO	Non-government organisation
NMDS	National Minimum Data Set
NOCC	National Outcomes and Casemix Collection
OESR	Office of Economic and Statistical Research, Queensland Treasury
OU	Outcome Unit
POS	Provision of Service
PPEI	Promotion, prevention and early intervention
QAS	Queensland Ambulance Service
QCMHL	Queensland Centre for Mental Health Learning
QH	Queensland Health
QHAPDC	Queensland Hospital Admitted Patient Data Collection
QPS	Queensland Police Service
RRP	Resident Recovery Program
SDQ	Strengths and Difficulties Questionnaire
TRP	Transitional Recovery Program

EXHIBIT 729

Introduction

Queensland Plan for Mental Health 2007-2017

In June 2008 the *Queensland Plan for Mental Health 2007-2017* (the Plan) was released outlining the priorities for the reform and development of mental health care in Queensland over the next ten years. The Plan establishes a strategic framework and vision for the development of a more responsive system of services to better meet the needs of people who live with a mental illness.

The activities contained in the Plan revolve around five key priority areas (Table 1~~Table 1~~~~Table 1~~), with the overall aim being to facilitate access to a comprehensive, recovery-oriented mental health system that seeks to improve the mental health of Queenslanders. It is expected that increasing the infrastructure and capacity of the mental health sector will lead to improvements in the quality of the mental health care system for mental health consumers, carers and mental health practitioners.

Table { SEQ Table * ARABIC }: Priorities for reform

PRIORITY 1 Promotion, prevention and early intervention	Strengthen collaborative action to: • Build individual and community resilience and wellbeing; • Effectively target key risk and protective factors; and • Facilitate early intervention in known high risk groups for mental illness.
PRIORITY 2 Integrating and improving the care system	Enhance and develop the continuum of clinical mental health treatment and care for consumers, families and carers. This system will promote resilience and recovery.
PRIORITY 3 Participation in the community	Build capacity to assist and support people with mental illness to live full and meaningful lives in the community.
PRIORITY 4 Coordinating care	Facilitate the linkage of a range of services to provide an integrated system of care to consumers, families and carers.
PRIORITY 5 Workforce, information quality and safety	Enhance and strengthen the capacity of services to provide high quality, safe and evidence-based mental health care.

EXHIBIT 729

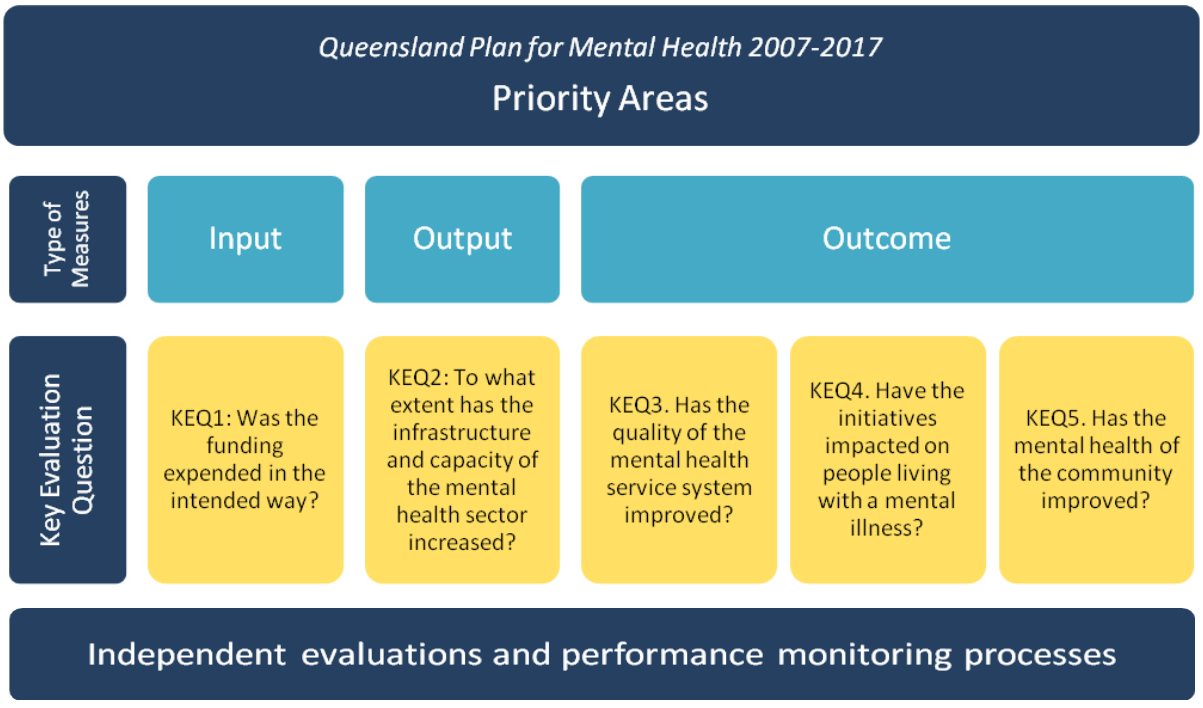
Evaluation framework

The evaluation framework for the Plan was developed under the auspices of the Mental Health Plan Implementation Steering Committee, and was endorsed by the Executive Director, Mental Health Alcohol and Other Drugs Directorate in July 2009. The framework aims to:

- justify the significant investment that has been made in the Queensland mental health system;
- monitor the implementation of the Plan;
- contribute to future mental health service planning, policy development and research; and
- open the mental health system to public scrutiny from peers, stakeholders and the broader community.

Figure 1~~Figure 1~~~~Figure 1~~ provides a summary of the evaluation framework, including the five key evaluation questions that have been developed to assess progress towards achieving the vision of the Plan.

Figure { SEQ Figure * ARABIC }: Evaluation Framework Summary for the Queensland Plan



for Mental Health 2007-2017

The Plan identifies a range of initiatives aimed at achieving a number of different outcomes, and it is not feasible to comprehensively evaluate each initiative and outcome within this evaluation framework. The indicator set utilised for this evaluation framework reflects a smaller number of input, output and outcome measures that can be used to answer the identified evaluation questions.

Determining how to appropriately answer the evaluation questions presents a challenge as the health system has traditionally focused measurement on its inputs and outputs and has only recently begun to identify the outcomes and impact of its activities. Subsequently, for some priority areas the number of input and output indicators is greater than indicators of outcomes. However, some of these measures should be considered preliminary and will be refined and replaced as more appropriate and informative indicators are available.

EXHIBIT 729

Results

The results of the initial evaluation have been grouped under the key evaluation question to which they apply, and to support alignment to the Plan they have also been grouped under their respective priority area.

Was the funding expended in the intended way?

Since 2007-08, over four State Budgets, funding of over $632 million has been invested in the Plan, representing a significant effort by government to improve the mental health system in Queensland. The funding has been allocated to provide inputs for infrastructure and human resources to develop and support a number of initiatives across the five priority areas under the Plan.

Progress in allocation of Plan funding

An audit has been undertaken to determine progress in allocation of funds across each of the five priorities. Figure 2~~Figure 2~~~~Figure 2~~ summarises the progress in allocation of funds from each budget, defined as the proportion of funding allocated under the Plan on each priority. As at 30 June 2011, 90 per cent (or $573 million out of $632 million) of announced plan funding has been allocated. Funds have been allocated within expected timeframes, with remaining funds ( )Table 2 on track to be fully allocated by the established target dates. Table 2 provides a summary of remaining allocations from announced plan funding.

Figure { SEQ Figure * ARABIC }: Progress in allocation of announced funds on activities related to priority areas, as at 30 June 2011

Priority area	Allocation by year ($m)				Allocated to 30 June 2011	
	2007-08	2008-09	2009-10	2010-11	($m)	Proportion
Promotion, prevention and early intervention	1.7	2.6	2.5	3.8	10.6	100%
Integrating and improving the care system	54.7	77.9	109.4	138.7	380.6	100%
Participation in the community	18.6	26.3	31.0	30.7	106.6	100%
Coordinating care	0.0	1.4	1.6	1.7	4.7	100%
Workforce, information, quality and safety	15.8	20.4	18.6	16.0	70.8	100%
Overall	90.7	128.6	163.0	190.9	**573.3**	**100%**

Table { SEQ Table * ARABIC }: Remaining allocations for announced funds, as at 30 June 2011

Priority Area	Purpose of allocation	2011-12 ($m)	2012-13 ($m)	2013-14 ($m)	Total ($m)
Integrating and improving the care system	Operational funding for new inpatient beds (1)	47.9			47.9
Participation in the community	Housing and Support Program (2)	1.5			1.5
Participation in the community	Time out housing initiative (3)	**2.2**			**2.2**
Promotion, prevention and early intervention	Stigma Reduction (4)	**2.5**	**2.4**	**2.4**	**7.3**
Overall		**54.1**	**2.4**	**2.4**	**58.9**

Note 1: Reflects 2008-09 operational funding for new inpatient beds. $47.9 million to be allocated in 2011-12 as planned.
Note 2: Reflects 2008-09 funding for Housing and Support Program. $1.5 million to be allocated in 2011-12 as planned.
Note 3: Reflects 2009-10 funding for Time-Out House initiative. $2.2 million to be allocated 2011-12 as planned.
Note 4: Reflects 2010-11 funding for stigma reduction. $7.3 million to be allocated from 2011-12 as planned.
Note: Totals may not add due to rounding.
Source: Mental Health Plan Implementation Unit, Mental Health Alcohol and Other Drugs Directorate (Queensland Health) budget documents and Community Mental Health Branch (Department of Communities) budget documents.

EXHIBIT 729

Priority Area: Integrating and improving the care system

Progress in commissioning additional inpatient beds

The Plan commits $121.55 million toward expanding the range of acute and extended treatment beds by providing 270 new, upgraded or redeveloped acute and extended treatment beds that meet contemporary standards. This will result in an overall increase of 146 new beds across the Queensland. This indicator is a measure of input and is defined as the proportion of new beds commissioned out of the 146 new beds[1] announced and funded under the Plan.

A substantial amount of planning, coordination and effort is required before a new inpatient bed can be commissioned or an existing bed can be upgraded. As a result a considerable amount of lead-in time is required before new or refurbished beds can be realised. As at 30 June 2010, five new aged care extended treatment mental health beds announced under the Plan have been commissioned at the Sunshine Coast. In addition, eight extended treatment beds in Townsville have been refurbished. A summary of the program of capital works funded under the Plan is presented in Table A3~~Table A3~~~~Table A3~~.

Progress in establishing additional FTE positions

In the development of the Plan the need for additional clinical positions within the public sector community mental health services was clearly identified. To support the required enhancement, the Plan provided funding to establish a total of 456 new mental health FTE positions. As at 30 June 2010, an additional 531.2 FTE community mental health positions have been established (Table 3~~Table 3~~~~Table 3~~). It should be noted that this includes FTE directly funded under the Plan, as well as positions funded outside of the Plan, such as positions in Homeless Health Outreach Teams and Evolve Therapeutic Support Services, and positions established due the to efficiency in the allocation of resources across Mental Health Service Organisations (MHSOs).

Table { SEQ Table * ARABIC }: New community mental health positions (FTE) established, as at 30 June 2010

	Service type	FTE funded (number)	FTE established ((number)
Age specific	• Adult Case Management	22.0	62.7
	• Adult Acute Care	60.0	65.9
	• Child and Youth (including Evolve Therapeutic Services)	100.0	80.6
	• Older Persons	46.0	44.3
	• Mobile Intensive Treatment	25.0	27.4
	• Adult Consultation Liaison	18.0	15.8
Cross aged services	• Forensic	27.0	25.0
	• Leaders and Quality/Safety	20.0	43.2
	• Indigenous	13.0	11.3
	• Consumer Consultants	10.0	10.5
	• Service Integration	20.0	22.0
	• Primary Care	10.0	10.0
	• Administration Support	26.0	39.2
	• Butler Forensic	35.0	32.5
	• Specialist*	24.0	18.5
	• Homelessness Health Outreach	Na.	22.3
	TOTAL	**456.0**	**531.2**

* Specialist positions include Transcultural, Dual Diagnosis, Eating Disorders, Intellectual Disability & Sensory Impairment. See Table A4~~Table A4~~~~Table A4~~. Source: MHAODD Community Mental Health Services FTE Report

[1] An additional six acute beds have been funded in Mackay, increasing the number from the 140 identified in the Plan to 146 by 2011-12.

EXHIBIT 729

To what extent has the infrastructure and capacity of the mental health sector increased?

Priority Area: Promotion, prevention and early intervention

Mental health expenditure on promotion, prevention and early intervention (PPEI)

Promotion, prevention and early intervention (PPEI) is concerned with strengthening collaborative action to build individual and community resilience and wellbeing, effectively target key risk and protective factors and facilitate early intervention in known high risk groups for mental illness. Funds of $17.9 million were allocated for a range of activity including the establishment of the Queensland Centre for Mental Health Promotion, Prevention and Early Intervention (QCMHPPEI), provision of Mental Health First Aid training, development of a state-wide Mental Health Literacy Strategy, the Ed-LinQ state-wide initiative, and the Mental Health Stigma Campaign.

Total expenditure[2] on mental health services in Queensland increased by 23.5 per cent in nominal terms between 2007-08 and 2009-10 (Table A5~~Table A5~~Table A5). In each year, approximately 0.5 per cent was spent on PPEI. An issue has been identified with the data source for this indicator that was unable to be resolved. Accordingly, this indicator underestimates the total expenditure on PPEI activity. Efforts will be made to address this issue for future reports.

Development and implementation of a state-wide Mental Health Literacy strategy

A key component of the PPEI agenda in Queensland relates to the development of the Queensland Plan for Mental Health Literacy. To support this work a cross-sectoral mental health literacy working group has been formed and, as at 30 June2010, a discussion paper and operational plan is being progressed in respect of this work.

A key component of the literacy strategy relates to access to Mental Health First Aid (MHFA) training which involves: teaching people how to recognise symptoms of mental health problems; how to provide initial help; how to guide a person towards appropriate professional help and; how to provide comfort to a person experiencing mental health problems. As at 30 June 2010, 10,454 individuals have received standard MHFA training, 1,810 have received youth MHFA training and 1,329 have received Aboriginal and Torres Strait Islander MHFA training[3].

Development of the state-wide Ed-LinQ Initiative

The Ed-LinQ initiative is a state-wide program that supports child and youth mental health services, the education sector and primary health care to work collaboratively to enhance the early identification and treatment of mental health problems and disorders affecting school-aged children and young people. A key objective of this initiative is to develop and implement early detection and intervention with children and young people and includes enhanced consultation liaison, improved referral pathways and training for school support personnel and other key providers.

A governance structure has been established and engagement with relevant stakeholders has occurred. 12.6 FTE out of 13.6 FTE Ed-LinQ Coordinator positions have been established as at 30 June 2010. A state-wide cross-sectoral forum was held to develop a framework for the implementation and evaluation framework for the Ed-LinQ initiative. Further work is planned to finalise the Ed-LinQ Framework for Action, the evaluation framework and establishment of a workforce development strategy.

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[2] Any PPEI expenditure regarded by Queensland Health districts as directly related to the provision of mental health services is not reported separately and there is no specific category or general ledger account for reporting this expenditure.

[3] MHFA training was provided by a range of agencies, including Queensland Health. Individuals may have received more than one instance of training.

EXHIBIT 729

The Mental Health Intervention Project (MHIP)

The Plan highlights the Queensland Government commitment to improve responses to mental health crisis incidents requiring police or ambulance intervention. The Mental Health Intervention Program (MHIP) is an innovative, Australia-first program with joint government partnership. It aims to prevent or safely resolve incidents involving persons with a mental illness who are experiencing a mental health crisis. MHIP is a collaborative program involving staff from three participating Queensland Government agencies: Queensland Police Service (QPS), Queensland Ambulance Service (QAS) and Queensland Health. The program aims to improve relationships and cooperation between the three agencies. Each agency shares expertise and resources aimed at the prevention and safe resolution of mental health crisis situations.

MHIP commenced in January 2006. Queensland Health has established 14 specialist district positions as designated Mental Health Intervention Coordinators, which are focussed on a consultation and liaison model, information sharing and agency specific training with cross agency participation. QPS conduct First Response Officer training for their officers, which focuses on strategies, procedures and communication skills facilitated by police negotiators and include role plays and debriefings. QAS offer an on-line mental health training package for all paramedics.

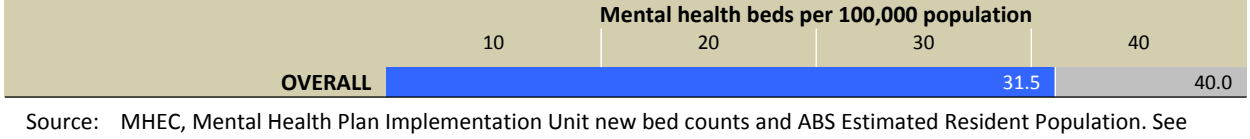
As at 30 June 2009, the 3-hour formal training program has been undertaken with 6,804 police officers, 1,860 ambulance officers and 787 Queensland Health staff. These figures do not include the number of 30-60 minute information sessions which were also delivered during the three year roll out as reliable data is not available. Further work will be undertaken to better identify and consistently capture MHIP activities which will inform the development of appropriate indicators.

Priority Area: Integrating and improving the care system

Inpatient beds per 100,000 of the population

Mental health services, including beds, need to be improved and expanded to meet the needs of a growing population. As at 30 June 2010, there were a total of 31.5 mental health inpatient beds per 100,000 of the population. This is 79 per cent of the 2016-17 target of 40 mental health inpatient beds per 100,000 of the population (Figure 3~~Figure 3~~~~Figure 3~~). As at 2009-10, the distribution of inpatient beds per 100,000 of the population were split evenly, with 15.8 and 15.7 beds per 100,000 of the population for acute and extended treatment respectively.

Figure { SEQ Figure * ARABIC }: Mental health beds per 100,000 population, as at 30 June 2010

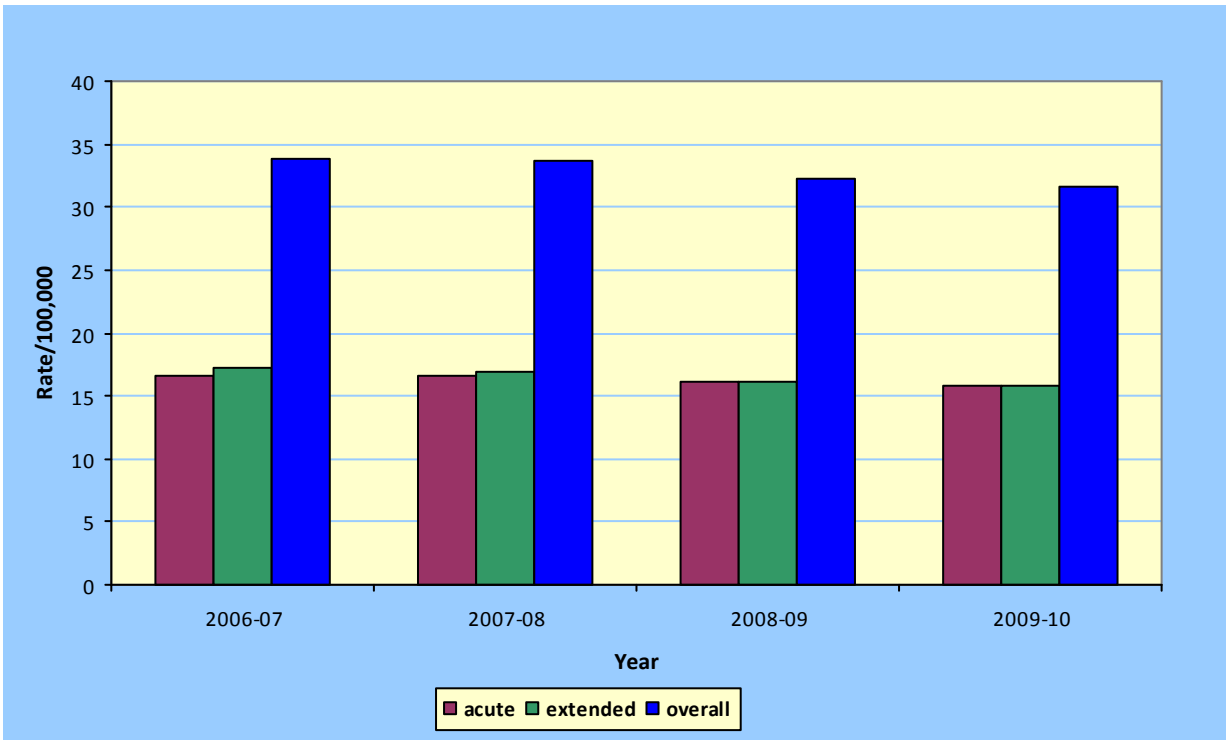


Source: MHEC, Mental Health Plan Implementation Unit new bed counts and ABS Estimated Resident Population. See Table A2~~Table A2~~~~Table A2~~ and Table A6~~Table A6~~~~Table A6~~.

Overall, the number of mental health beds per 100,000 of the population has decreased by 6.8 per cent between 2006-07 (prior to the commencement of the Plan) and 2009-10 (Figure 4~~Figure 4~~~~Figure 4~~).

EXHIBIT 729

Figure { SEQ Figure * ARABIC }: Inpatient beds per 100,000 of the population, as at 30 June 2010



Source: MHEC, Mental Health Plan Implementation Unit new bed counts and ABS.

This trend is likely, in part, to be a consequence of the development of new inpatient beds not keeping pace with a rapidly growing population in Queensland. These findings can also be attributed to the amount of lead-in time that is required to establish new beds as well as the consequences of unplanned delays involved in construction. Of the 146 new beds funded under the Plan, only five (one unit on the Sunshine Coast) has been delivered within original timeframes. These delays are predominantly the result of challenges associated with site acquisition and master planning.

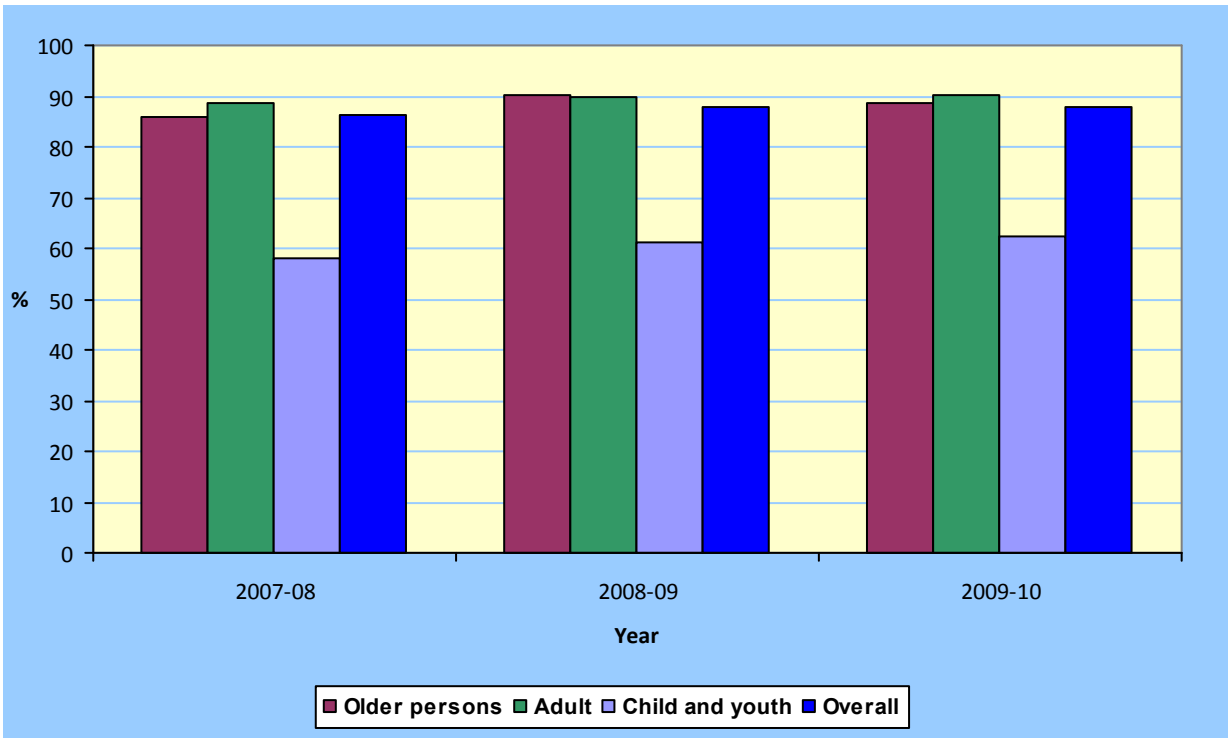
Acute bed occupancy for acute mental health inpatient units

Bed occupancy can be used as a proxy measure of the stress on acute inpatient mental health services, particularly regarding the capacity and functioning of these services. As evidenced above the growth in inpatient beds has not kept pace with population growth, which places additional pressure on inpatient units to be able to provide sufficient and appropriate services.

The proportion of notionally available mental health inpatient beds that are occupied varies across target populations, with adult services generally experiencing the highest occupancy, while occupancy in child and youth services is significantly lower. Over the period of the plan, the overall rate has remained steady at around 90 per cent (Figure 5~~Figure 5~~~~Figure 5~~), suggesting demand for mental health inpatient services remains strong.

EXHIBIT 729

Figure { SEQ Figure * ARABIC }: Average bed occupancy for acute mental health inpatient units, 2007-08 to 2009-10



Source: MHEC. See Table A9~~Table A9~~~~Table A9~~.

Mental health clinical staff per 100,000 of the population

The Plan identifies a target of 70 FTE clinical staff per 100,000 of the total population in community mental health services by 2016-17 (Figure 6~~Figure 6~~~~Figure 6~~). In making recommendations for service planning targets consideration was given to the prevalence of mental illness, existing occupancy and service utilisation rates in Queensland, planning parameters adopted by other jurisdictions and countries and cost and service utilisation modelling.

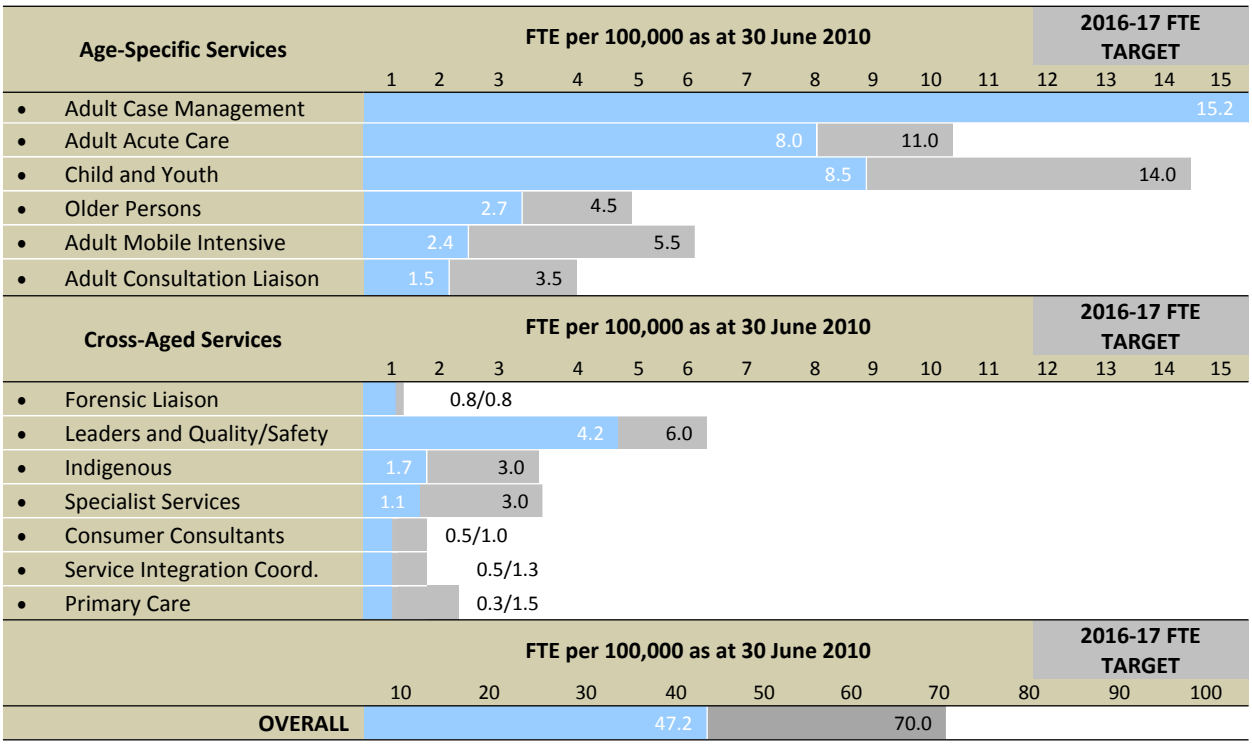
The benchmarks established for mental health service development in Queensland are consistent with the service components identified nationally and in planning literature. This overall target, split across age-specific and cross-aged services represents a best estimate of the level of resourcing needed to provide a comprehensive community mental health service[4].

Prior to the start of the Plan (2006-07) there were 42.6 FTE community mental health staff per 100,000 of the population (or 61 per cent of the 2016-17 target of 70 community mental health staff per 100,000 of the population). As at 30 June 2010, that had increased by 11 per cent to 47.2 FTE (or 67 per cent of the 2016-17 target).

[4] Mental Health Alcohol and Other Drugs Directorate Community Mental Health Services Full Time Equivalent (FTE) Report, June 2009.

EXHIBIT 729

Figure { SEQ Figure * ARABIC }: Mental health clinical staff per 100,000 of the population, as at 30 June 2010



Source: Mental Health Alcohol and Other Drugs Directorate Community Mental Health Services FTE Report, January 2010. See Table A7~~Table A7~~Table A7

Note: Specialist services refers to Trancultural Mental Health, Dual Diagnosis, Intellectual Disability & Mental Illness, Eating Disorder and Sensory Impairment services.

Indigenous mental health consumers with an identified Indigenous mental health worker/Indigenous Services officer

The Plan commits $5.15 million for the period 2007-2011 to employ additional Aboriginal and Torres Strait Islander mental health workers to provide assessment, treatment and care to people with a mental illness who are from an Aboriginal and Torres Strait Islander background. As at 30 June 2010, there were 11.3 FTE Indigenous mental health workers. These positions provide a unique and specialised role that functions within a broader holistic care model within the mental health system. This service ensures public mental health services have the capacity to deliver high quality, responsive care to Indigenous consumers, carers and families in a culturally respectful manner.

An initial step in monitoring the impact of this investment is to measure the proportion of service episodes involving Indigenous consumers where an Indigenous Mental Health worker or Indigenous Services officer is identified as an internal or external contact (Table 4~~Table 4~~Table 4). This information has only been readily available since the introduction of CIMHA in November 2008.

In 2008-09, there were 5,901 service episodes where a mental health consumer was identified as being Indigenous[5]. Of these, 0.6 per cent had an Indigenous mental health worker or Indigenous Services officer identified within the electronic clinical record. In 2009-10, this increased to 1.3 per cent. This baseline is low, indicating possible reporting issues, and suggesting improvement should be sought in this area.

[5] There are known issues associated with accurate identification of Indigenous consumers, therefore it is likely that the count is an under-estimation of the number of Indigenous consumers accessing mental health services in Queensland.

EXHIBIT 729

Table { SEQ Table * ARABIC }: Proportion of service episodes involving Indigenous consumers with an identified Indigenous Mental Health Worker or Indigenous Services Officer

Target Population	2008-09* Number of Service Episodes	2008-09* Number with Indigenous worker / officer	2008-09* Per cent	2009-10 Number of Service Episodes	2009-10 Number with Indigenous worker / officer	2009-10 Per cent
Adult	4215	36	0.9	5187	86	1.7
Child/Youth	1045	2	0.2	1446	6	0.4
Older persons	53	0	0.0	66	0	0.0
Forensic	588	0	0.0	525	1	0.2
Overall	5901	38	0.6	7224	93	1.3

Source: CIMHA.
Note (*): As CIMHA commenced on 17 November 2008, 2008-09 excludes data from 1 July 2008 to 16 November 2008.

Mental health consumers with an identified carer

The Plan outlines a commitment to enhancing the capacity of consumers and carers to be actively involved in mental health service planning and delivery. Carers provide an important level of support to consumers during their recovery. Ideally the indicator would measure the level of engagement and involvement of carers' in service delivery and planning. However the available data does not lend itself to measuring this activity and a first step in achieving this goal is to determine the extent to which consumers of public mental health services have an identified carer in their clinical record.

In 2008-09, consumers had an identified carer in 2.5 per cent of active community service episodes. In 2009-10, this increased to 5.1 per cent.

The proportions were relatively low and unexpected. However, it is likely to be a result of reporting issues as the mechanism for centrally identifying this information is relatively limited[6]. As a result the figures are likely to be an under-estimation of the number of service episodes with identified carers. Planned activity to support improved record keeping within central systems is likely to improve the accuracy of this data in future reports.

Table { SEQ Table * ARABIC }: Proportion of service episodes with an identified carer

Target Population	2008-09* Number of active service episodes with carer	2008-09* Per cent of active service episodes	2009-10 Number of active service episodes with carer	2009-10 Per cent of active service episodes
• General adult	381	1.4	724	2.1
• Child and Youth	578	7.4	1747	17.5
• Older Persons	24	1.3	61	2.5
• Forensic	5	0.2	7	0.3
TOTAL	988	2.5	2539	5.1

Source: CIMHA.
Note (*): As CIMHA commenced on 17 November 2008, 2008-09 excludes data from 1 July 2008 to 16 November 2008.

Consumers with an identified General Practitioner

Primary health care providers play an important role in the treatment and support of people with a mental illness. Seventy-seven per cent of people seeking help for a mental illness do so through

[6] The collection of this information is dependent upon a person being identified as having a carer role for a particular consumer. It is possible that a person who is a carer may be identified in the system as having a different role, such as friend or family member, and accordingly they would not be captured in this indicator.

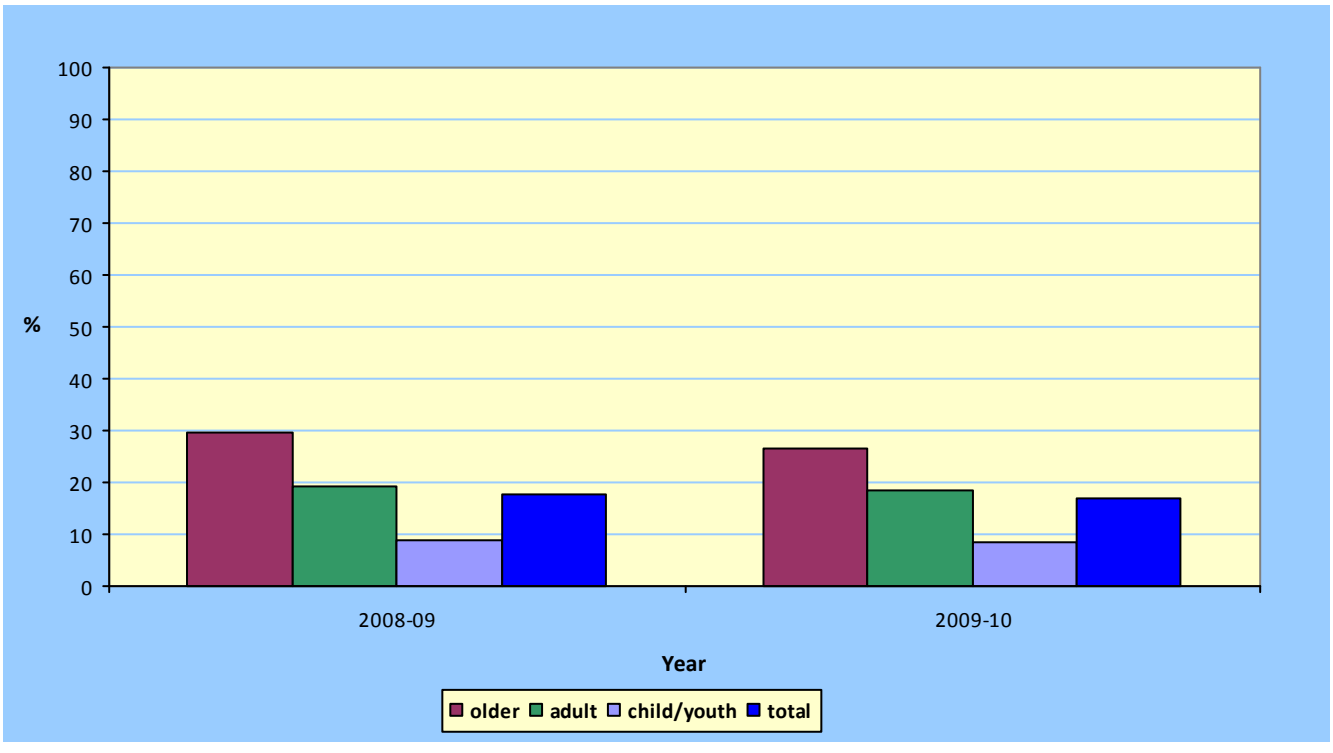
EXHIBIT 729

their General Practitioner (GP). When adjusted for attendance at multiple services, it is estimated that 38 per cent are treated by a GP only[7]. Liaison with GPs is critical in ensuring integrated, continuous and well co-ordinated mental health care. The identification and recording of information in relation to mental health consumers' GP, in clinical information management systems, is expected to promote appropriate communication and integrated care.

Ideally the framework would include an indicator of the level of collaboration between the primary mental health care and public mental health system, however an initial step is to measure proportion of service episodes where a GP is identified as a contact. Figure 7~~Figure 7~~~~Figure 7~~ shows that in 2008-09, 17.8 per cent of active service episodes included a GP as an external contact, remaining relatively steady in 2009-10 at 17.0 per cent. During both periods, service episodes for consumers from the older persons target population had the highest proportions of identified GPs (29.5 per cent and 26.7 per cent respectively).

Due to issues associated with the introduction of CIMHA (refer Appendix C: Methodology), minor changes in proportions between 2008-09 and 2009-10 should not be considered significant.

Figure { SEQ Figure * ARABIC }: Proportion of service episodes where a consumer had an identified GP



Source: CIMHA. See Table A8~~Table A8~~~~Table A8~~.

[7] Harris, M., Buckingham, B., Pirkis, J., Townsend-White, C. & Whiteford, H. (2006). Planning Estimates and Technical Notes: Queensland Mental Health Action Plan 2006-2011, Queensland Centre for Mental Health Research (unpublished).

EXHIBIT 729

Priority Area: Participation in the community

The Plan has committed $110.59 million for the period 2007-2011 for initiatives that increase access for support services and accommodation in the community for people with a mental illness. This includes:

- $35.64 million to purchase a range of accommodation and personal support services from the non-government sector, including new consumer-operated crisis prevention or respite places to provide short-term support to consumers; and
- $68.45 million to provide personal support to consumers moving into public housing, with the former Department of Housing allocated $40 million to provide up to 160 public social housing places for individuals accessing this program.

The majority of these initiatives are managed by the Community Mental Health Branch, Department of Communities which administers funding to non-government organisations (NGOs) to provide a range of services to assist the recovery of persons identified has having a primary psychiatric disability or mental illness.

Queensland Plan for the Mental Health Community Sector 2011-2017

Consultation for a *Queensland Plan for the Mental Health Community Sector 2011-17* has been undertaken. When the plan is finalised, it is expected that it will serve as a companion document to the *Queensland Plan for Mental Health 2007-17* and provide a road map for future enhancement of the mental health community services sector in Queensland, including how to enhance consumer and carer contribution and support, and outline what role the community mental health sector has in the coordination and integration of service responses to people with mental illness. The plan is also expected to articulate short, medium and long-term strategies for attracting and retaining a skilled and motivated workforce and strategies to build a strong and sustainable service delivery system.

As part of the preparation phase of the plan, a state-wide consultation process attracting 374 participants has occurred, including representatives from the mental health community sector; Queensland Health; consumers and carers, and other government and non-government agencies. 37 written submissions were also received from both individuals and agencies. Two pieces of research were also commissioned to inform the development of the plan including a Workforce and Training Needs Analysis and Planning Estimates Report. Further consultation was undertaken with members of the Mental Health Partnership Forum comprising: The Queensland Alliance, funded large and small non-government organisations (including Indigenous and Multicultural), consumers and carers, Queensland Health, FaHCSIA, and the Department of Communities. A Community Mental Health Summit was also conducted involving consumers, carers, NGOs, and other government departments.

Mental health expenditure on non-government organisations

The non-government and community sectors have a key role in providing non-clinical personal care and other flexible supports to people living with mental illness, families and carers. The Plan aims to enhance the non-government organisation (NGO) sector's capacity to provide non-clinical care and support for individuals with mental illness.

Total expenditure on mental health services in Queensland increased by 23.5 per cent in nominal terms between 2007-08 and 2009-10. In 2007-08, 6.3 per cent of total mental health expenditure was spent on NGOs that provide services to mental health consumers, rising to 6.5 per cent in 2009-10 (Table A5~~Table A5~~~~Table A5~~).

EXHIBIT 729

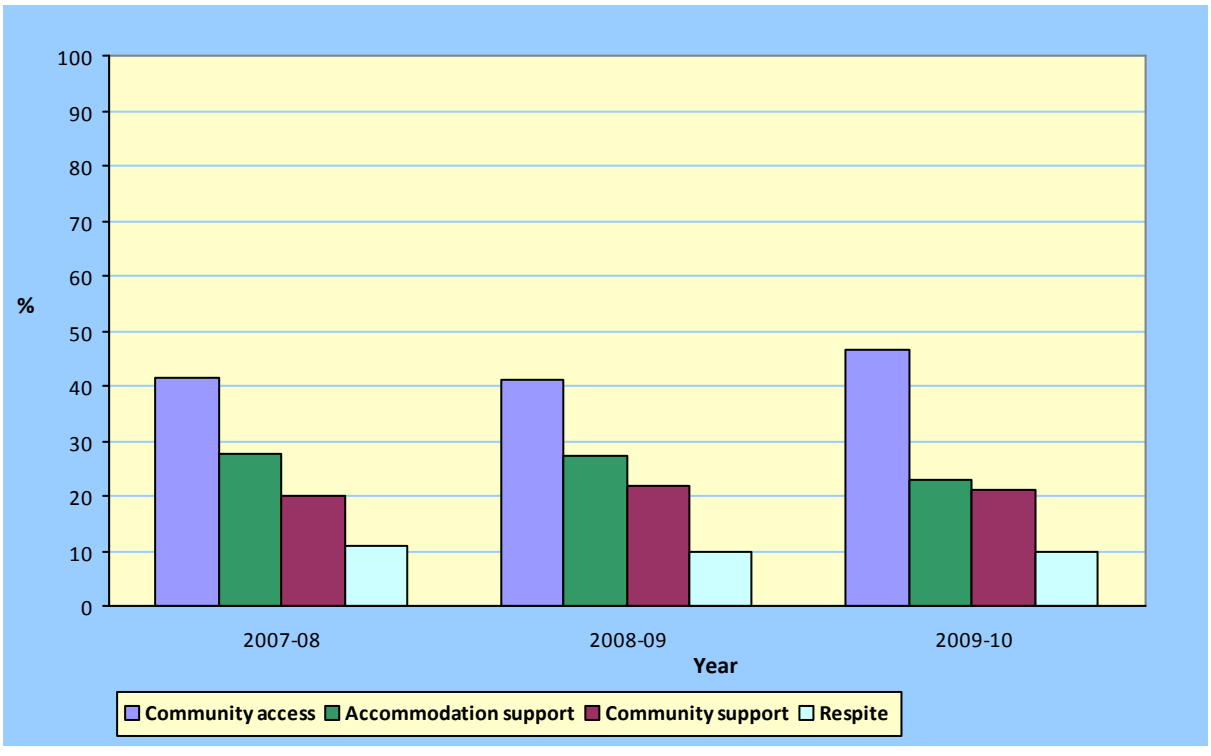
Queenslanders' accessing non-government support services for persons with a primary psychiatric disability or mental illness

The non-government and community sectors have a key role in providing non-clinical personal care and other flexible supports to people living with a primary psychiatric disability or mental illness, families and carers. The Plan aims to increase access to non-clinical recovery focused services[8] through the non-government sector.

The proportion of the Queensland population who accessed at least one type of NGO support service aimed at providing support to persons with a psychiatric disability or mental illness was 0.05 per cent (2,167 unique users) in 2007-08, increasing to 0.07 per cent (2,989 unique users) in 2009-10 (Table A11~~Table A11~~~~Table A11~~)..

Figure 8~~Figure 8~~~~Figure 8~~ highlights the different service types (Table A12~~Table A12~~~~Table A12~~) accessed by these consumers. Community access was the most utilised support service from 2007-08 to 2009-10. Accommodation support was the next most used service, followed by community support and respite.

Figure { SEQ Figure * ARABIC }: Distribution of usage of NGO community support services, 2007-08 to 2009-10



Source: Disability Services NMDS, formerly known as the CSTDA.

[8] Recovery focussed services are programs that focus on targeted psychosocial rehabilitation interventions that include: Links to vocational/employment support of meaningful occupation; Support to access community inclusion opportunities; Support to develop skills to self-manage mental and general health care; and Support to develop lifestyle skills that assist with maintaining a personally meaningful lifestyle and community tenure.

EXHIBIT 729

Accommodation and personal support

The Plan commits the Government to expanding the continuum of supported housing and accommodation available to people with mental illness in the community. In particular the plan identifies ten-year targets for the following programs:

- 15 places per 100,000 population for residential recovery programs;
- 35 places per 100,000 population for supported social housing;
- 35 packages per 100,000 population for support to people with a mental illness living in hostels and private homes; and
- 3 places per 100,000 population for crisis and respite services.

Transitional Recovery Programs

Transitional Recovery Programs (TRPs) provide new residential transitional recovery places to provide ongoing assessment, treatment and rehabilitation with the goal of assisting people to live successfully in the community. As at 30 June 2010 there were39 new TRP places, contributing to 0.87 places per 100,000 of the population (Table A2~~Table A2~~~~Table A2~~ and Table A13~~Table A13~~~~Table A13~~)

Supported housing places

Supported housing places are provided to support adults 18 years and over with a moderate to severe mental illness. To be eligible, these individuals must be currently or repeatedly accommodated in inpatient care, unable to be discharged due to homelessness or risk of homelessness, do not own property, rent privately or have social housing and have no recurrent disability services funding. As at 30 June 2010, there were 434 supported housing places, contributing an additional 9.70 places per 100,000 of the population (see Table A13~~Table A13~~~~Table A13~~). This figure does not include places in existence prior to the commencement of the Plan and therefore will be an underestimation of the total number of supported housing places.

Resident Recovery Program

The Resident Recovery Program (RRP) provides short to medium term recovery-oriented lifestyle support to people with a moderate to severe mental illness, for whom living in a boarding house or hostel is not conducive to their recovery. The support aims to assist with breaking the cycle of an individual moving through acute care facilities, boarding houses, hostels and homelessness. Recovery-oriented support includes: development of lifestyle skills that assist with maintaining a personally meaningful lifestyle and community tenure; support to develop skills to self-manage mental and general health care; improved access to social interactions and community inclusion; and links to vocational/employment support or meaningful occupation.

As at 30 June 2010, there were 1163 RRP places, representing 26 places per 100,000 of the population. This figure does not include existing places and therefore will be an underestimation of the total number of resident recovery program places

Consumer-operated crisis and respite services

Consumer-operated services are offered to adults 18 years and over who have a moderate to severe mental illness requiring crisis prevention support. These services, which are staffed by peer workers with substantial representation of consumers within management structures, provide a range of peer supports to mental health consumers aimed at reducing crises and the need for hospitalisation. The Program aims to deliver an individualised, flexible and responsive consumer-operated service that will assist consumers (people with mental illness) to develop self-management of personal

crises to reduce the need for hospitalisation. A ten-year target of 3 places per 100,000 of the total population has been set under the Plan.

As at 30 June 2010, there were 20 Consumer Operated Crisis and Respite Service places established, representing 0.45 places per 100,000 of the population. Lead-up work has focussed on the identification and purchase of suitable accommodation and training of staff, with additional services expected to commence in July 2010.

Priority Area: Coordinating care

Consumers with identified non-clinical government and non-clinical non-government services

An interagency action plan is required to better respond to the needs of people with a mental illness, their families and carers. The various elements of services provided to people with mental illness by organisations and services across sectors needs to be integrated in order to facilitate care. This indicator is a proxy measure of service integration and seeks to identify and report the proportion of public sector community mental health consumers who have identified non-clinical government and non-clinical non-government services.

This indicator is a measure of outcome and is defined as the proportion of service episodes where a public sector community mental health consumer had an identified non-clinical government (such as Department of Communities, Queensland Police Service, Teachers, Public Trustee and so on) and/or non-clinical non-government service representative (including supported accommodation and aged care providers). Due to limitations in the source data, it is not possible to distinguish between clinical and non-clinical roles of an Alcohol, Tobacco and Drug Services (ATODS) Officer (reported as 'other').

In 2008-09, 1.5 per cent of service episodes had a mental health consumer with an identified representative from at least one of the three agency groups listed above. In 2009-10, this increased to 2.6 per cent. Most of the identified representatives came from government-non clinical departments/agencies (1.0 per cent in 2008-09 and 1.8 per cent in 2009-10) (see Table A26~~Table A26Table A26~~). These results were lower than expected and point to potential reporting issues, although they are improving over time

Progress in the development of the state-wide Care Coordination initiative

Commitment to coordinated care for people with mental illness and complex needs is a priority. The Plan identifies the need for a collaborative approach to enable the various services to work together as inter-related parts of a single system of care. The Queensland Care Coordination Initiative is the key activity being progressed to address this priority. The Initiative is a state-wide program developed and implemented to better coordinate collaboration across government, private and non-government service providers. The Initiative targets consumers 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.

As at 30 June 2010, 20.5 FTE Service Integration Coordinator positions have been established and recruited. Engagement and consultation with stakeholders has resulted in the signing of Memorandums of Understandings with seven Queensland government agencies. Fourteen out of 17 sites across Queensland have commenced accepting referrals. A Referral Activity Collection Tool has been piloted and an evaluation of implementation of the initial implementation of the initiative has commenced. Future work will include development of local partnership agreements, collection and refinement of statistical data and expansion of the number of sites accepting referrals.

EXHIBIT 729

Priority Area: Workforce, information, quality and safety

Clinical training delivered within Queensland Health mental health staff is a key priority, with broad recognition that undergraduate training does not adequately prepare the mental health workforce. The skill requirements of novice practitioners are expanding at a rapid rate due to the increased acuity and complexity of presentations now seen in mental health service settings. Furthermore, traditional clinical training must be augmented with interdisciplinary clinical skills and a paradigm shift toward consumer centred and recovery orientated principles of care. There is also a number of non-clinical mental health staff within Queensland Health who play important roles in service delivery, and who also require access to mental health learning opportunities.

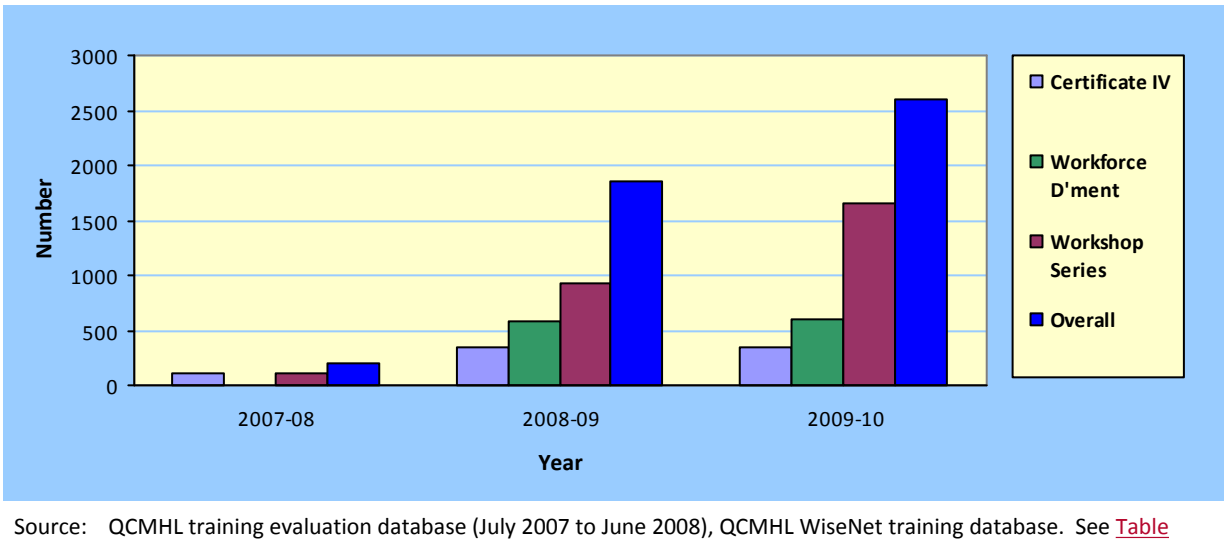
Mental health expenditure on training and development

The Plan identifies workforce development and training as key mechanisms to support workforce capacity to deliver quality mental health programs. Total expenditure[9] on mental health services in Queensland increased by 23.5 per cent in nominal terms between 2007-08 and 2009-10. Expenditure on mental health training and development was relatively steady during the same period, representing approximately 1 percent of total expenditure(Table A5~~Table A5~~~~Table A5~~). Due to limitations of the data source it is likely that this figure is an underestimate of the total expenditure on training and development activity.

Public mental health staff completing Queensland Centre for Mental Health Learning (QCMHL) training

The Queensland Centre for Mental Health Learning (QCMHL) provides a range of inter-disciplinary training programs that focus on the core requirements of Queensland Health mental health staff (knowledge, skills and attitudes) as articulated in the National Practice Standards for the Mental Health Workforce (2002). The primary aim of these training programs is to develop the level of workforce readiness within the Queensland Health mental health workforce (both clinical and non-clinical).

Figure { SEQ Figure * ARABIC }: Number of public mental health staff completing any of the QCMHL training units, 2007 to 2009



Source: QCMHL training evaluation database (July 2007 to June 2008), QCMHL WiseNet training database. See Table A16~~Table A16~~~~Table A16~~.

[9] Any training and development expenditure regarded by Queensland Health districts as directly related to the provision of mental health services is not reported separately and there is no specific category or general ledger account for reporting this expenditure.

Between 2007-08 and 2009-10, a total of 4,654 Queensland Health staff undertook at least one type of mental health training provided by the QCMHL[10]. Around 2,601 Queensland Health staff completed some form of mental health training during 2009-10 (Figure 9~~Figure 9~~~~Figure 9~~).

It is difficult to interpret what the numbers across time periods represent due to the changing numbers of mental health staff from one period to the next. At the time of writing this report, there was no accurate way to determine mental health staff headcount data. While mental health FTE data is available, this will not provide an accurate comparison figure as there may be more than one person against an FTE. Future development of this indicator will incorporate mental health staff headcount data in order to provide an accurate proportion of mental health staff completing training units.

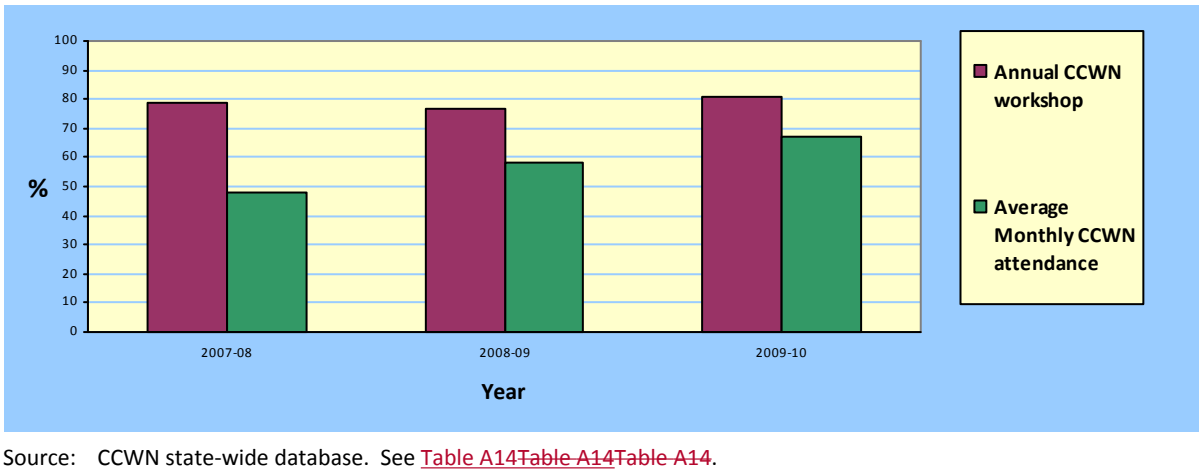
State-wide mental health consumer and carer professional development

The role of a Consumer and Carer Worker within Queensland Health mental health services has a primary focus on consumer, carer and family participation. The number of state-wide consumer and carer workers has steadily increased from 31 in 2007-08, to 43 in 2009-10.

A number of different professional development programs have been developed for consumer and carer workers aimed at improving the skill set and knowledge of the consumer and non-clinical carer workforce. These include state-wide monthly Consumer and Carer Worker Network (CCWN) meetings, an annual two-day state-wide CCWN workshop, a CCWN Skills Audit (to provide an opportunity for consumer and carer workers to identify and self assess both current and future skill requirements), an initial round of CCWN supervisee training (to help understand the role of supervision and to support them in accessing the state wide consumer and carer workers supervision program) and a CCWN state-wide orientation for consumer and carer workers (to establish a baseline skill set determined by the identified needs from the CCWN Skills Audit).

There is relatively good engagement and participation in the programs offered to the consumer and carer workforce (Figure 10~~Figure 10~~~~Figure 10~~), with around 80 per cent of the workforce attending the annual state-wide CCWN workshop, and increasing participation in the monthly CCWN meetings. The initial state-wide supervisee training and state-wide orientation were also well attended, with respective attendance of 22 and 24 workers.

Figure { SEQ Figure * ARABIC }: Proportion of consumer and carer workers accessing state-wide mental health consumer and carer professional development, education and training, including orientation, 2007 to 2009



Source: CCWN state-wide database. See Table A14~~Table A14~~~~Table A14~~.

[10] Excludes QCMHL training that was delivered to non-government organisations and other government departments.

EXHIBIT 729

Leadership Matters: Forum for Senior Mental Health Leaders

The Senior Leadership Forum gathers a cohort of senior decision makers from throughout the State to develop leadership skills and instigate initiatives for the implementation of the Plan. A senior leader occupies the highest point of decision making regarding the delivery of mental health services throughout the State. The Leadership Matters: Forum for Senior Leaders is held three times a year and attendees include Clinical Directors and Executive Directors of Mental Health Service Organisations and state-wide/specialty services, Directors of the Mental Health Alcohol and Other Drugs Directorate and Chairs of the Mental Health Clinical Clusters.

As at 30 June 2010, five Senior Mental Health Leadership Forums had been held (November 2008, March 2009, July 2009, November 2009 and March 2010), with an average of 77 per cent of senior leaders attending each forum.

Implementation of the Consumer Integrated Mental Health Application

Funding of $16.4 million was allocated to develop and implement the Consumer Integrated Mental Health Application (CIMHA) to amalgamate and enhance the functionality of three of the previous systems used to collection mental health information. The application went live on 17 November 2008 and although there have been issues associated with implementation which have had an impact on record keeping and utility of the data, subsequent developments has made a significant improvement to the system. Development of the application is ongoing to ensure it is able to meet the evolving needs of Queensland's mental health system.

Development of a mental health research policy and application of research for practice

Development of a strong research culture and agenda within mental health services will promote evidence based practice, service improvement and optimal outcomes for consumers. While there is currently a range of mental health research occurring within Queensland, this activity is generally uncoordinated, lacks effective links to policy and service development, and provides no clear pathway for the development of future researchers. Provision of a clear policy framework will ensure a systemic approach to investment and engagement in research activity within Queensland Health and support ongoing research capacity development.

The Mental Health Research Network was established in 2009 with broad representation from research leaders within Queensland Health and relevant research bodies. The Research Network has identified a range of areas of shared priority interest for collaborative attention, including information sharing, collaborative projects, and improving mechanisms to support research and researchers. A collaborative proposal to the National Health and Medical Research Council (NHMRC) for 2010 funding round was submitted and is awaiting determination. Future work will involve the identification, selection and development of relevant indicators which will inform progress on mental health research outcomes and will identify indicators that will provide a measure(s) on the effectiveness of applying research into practice.

EXHIBIT 729

Has the quality of the mental health service system improved?

Priority Area: Promotion, prevention and early intervention

Development and collection of appropriate data to inform future measures of outcome

In the development of the initial evaluation framework, the lack of appropriate measures to monitor and assess the outcomes of activity associated with Priority 1 was raised as an area of significant concern. Whilst comprehensive work to support development and collection of PPEI outcome measures has yet to be progressed, seven independent projects, operating under the auspices of PPEI have been completed or commenced. Evaluations of these projects will be used to facilitate the identification of possible data from where outcome measures can be developed.

Priority Area: Integrating and improving the care system

New clients accessing Queensland public mental health services

Access to public sector mental health services is an issue of significant concern to consumers, carers and the wider community. There is significant concern that the public sector mental health service system is inadequately responding to new people requiring care.

A 'new client' is identified as a consumer who has not had contact with any setting of a mental health service organisation within 365 days of their first contact (such as provision of service or admission) with any mental health service organisation within Queensland.

The proportion of 'new clients' accessing Queensland public mental health services has remained steady at approximately 60 per cent from 2007-08 to 2009-10 (Table A21~~Table A21~~~~Table A21~~).

It should be noted that data for this indicator was affected by the introduction of CIMHA in 2008-09. Data for the 2008-09 reference period was sourced from both legacy applications and the new information system. The use of statistical linkages to identify unique patients between multiple systems may have contributed to the decline in identified new clients. In addition, the data model underpinning the new system is a modification from the model implemented in the legacy applications, and its adoption effectively sets a new baseline for reporting from 2009-10.

Specialised community mental health care- Average treatment days per three month period

The majority of consumers receiving specialised clinical mental health care from Queensland Health access treatment in the community. Over the past two decades Australia has developed community-based treatment services, and seen the funding shift from inpatient based services to services in the community. The Plan continues the reform with substantial investment in developing evidence-based models of care to improve the delivery of care.

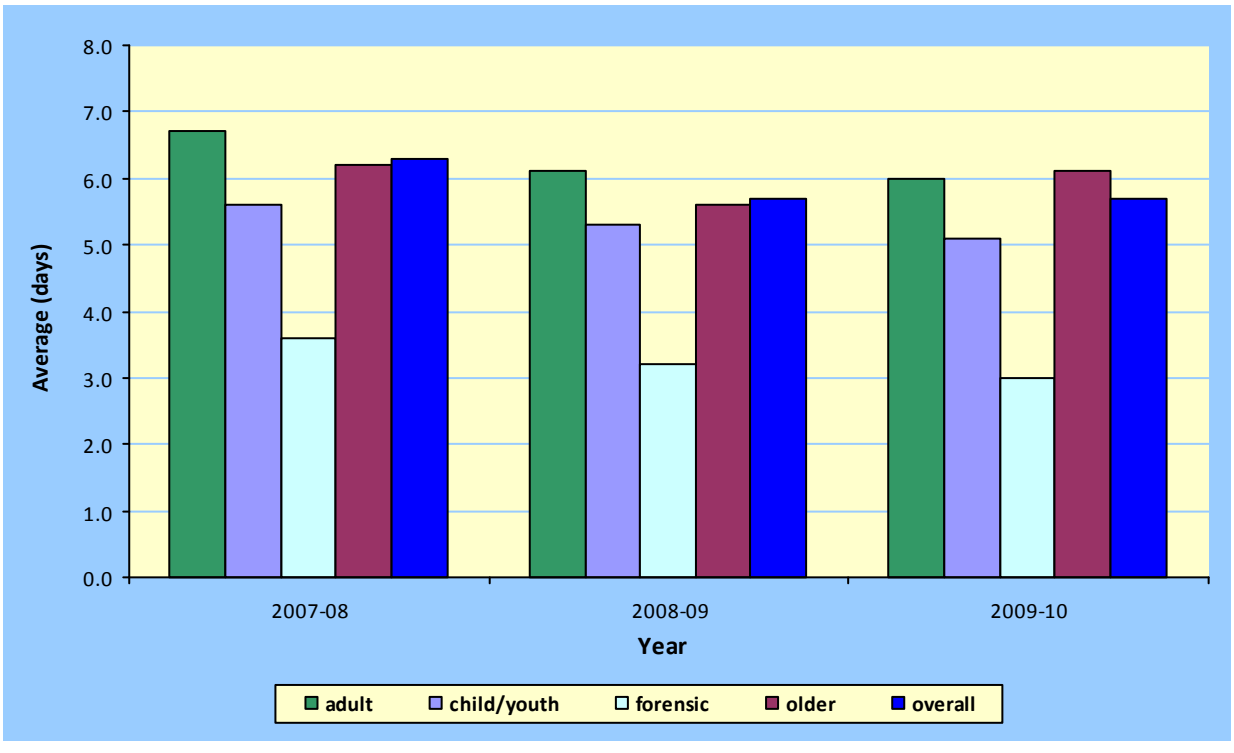
Despite the growth in understanding and sophistication of community mental health services the development of appropriate indicators to effectively capture the intensity and impact of treatment has not progressed. An interim measure of outcome is the average number of treatment days (defined as any day on which there is a service contact) provides an indication of the relative volume of care provided to people seen in ambulatory care. In 2009-10, consumers received an average of 5.7 treatment days per three-month period of community care. In other words, on average, there was a service contact for a consumer around once a fortnight.

EXHIBIT 729

Since the commencement of the Plan in 2007-08, the average number of treatment days per three month period of ambulatory care has remained steady at approximately 6 days.

It should be noted that the introduction of CIMHA in 2008-09 has affected data for this indicator. The data model underpinning the new system is a modification from the model implemented in the legacy applications, and its adoption effectively sets a new baseline for reporting from 2009-10.

Figure { SEQ Figure * ARABIC }: Average number of treatment days per three-month period by target population, 2007-08 to 2009-10



Source: CIMHA. See Table A24~~Table A24~~Table A24.

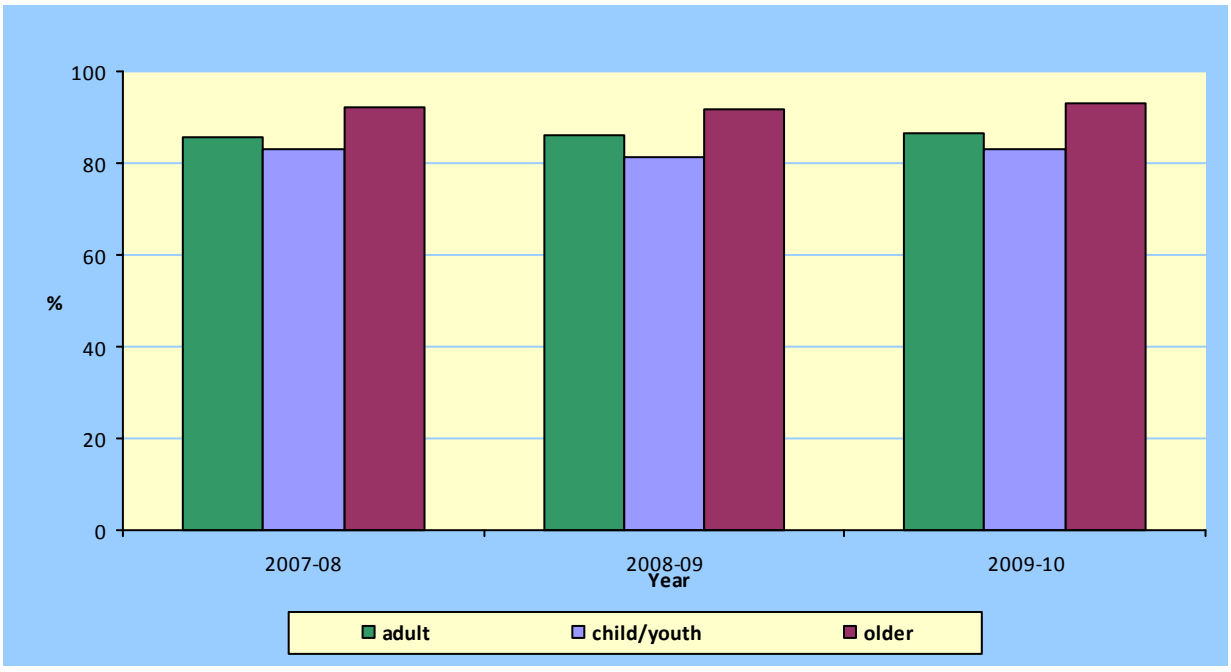
Local access to acute inpatient care

Acute inpatient mental health services aim to provide treatment that enables individuals to return to the community as soon as possible. Local access to appropriate services is a key principle underpinning the reform of the mental health system in Australia. This measure points to the degree to which persons living within a particular community who require acute inpatient treatment are in fact treated by the local service established to meet the area's needs.

Figure 12~~Figure 12~~Figure 12 shows that local access to acute inpatient care has remained high for all target groups since the commencement of the plan; above 80 per cent for the adult and child/youth target populations, and above 90 per cent for the older persons target population. This indicates that the catchments in place for each of the services are relatively appropriate (noting this indicator does not take into account unmet need).

EXHIBIT 729

Figure { SEQ Figure * ARABIC }: Local access to acute inpatient care by target population, 2007-08 to 2009-10

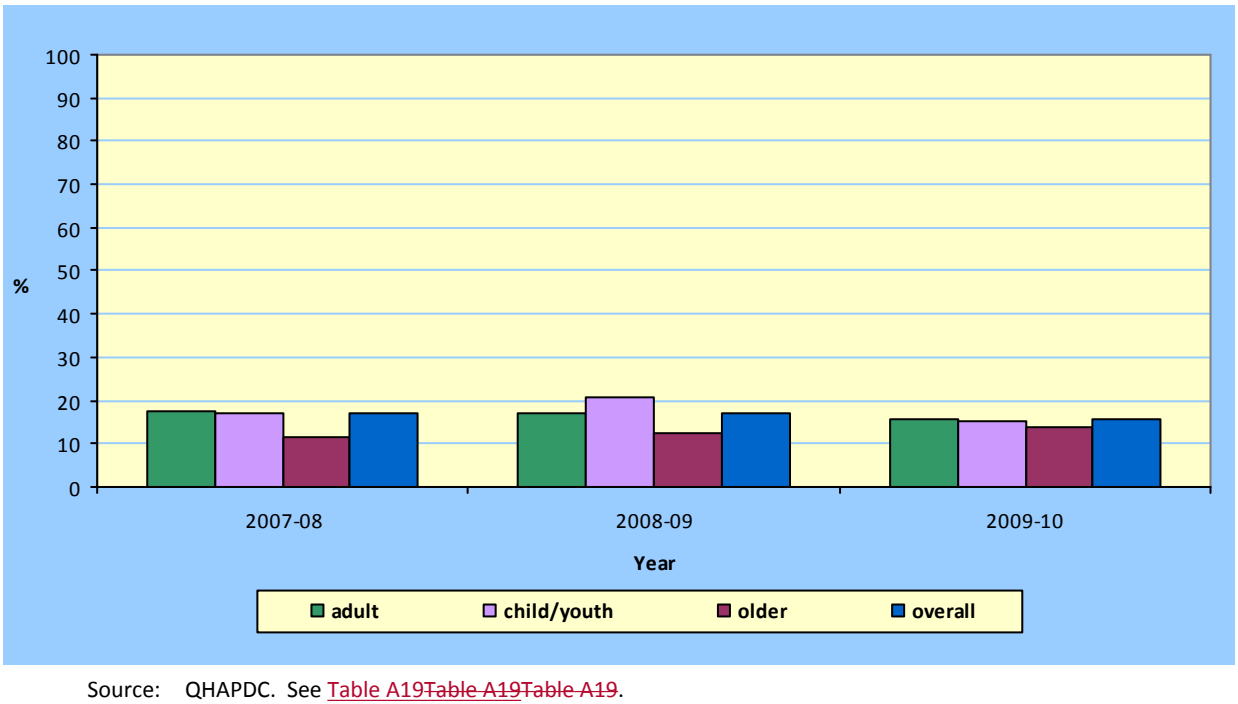


Source: QHAPDC. See Table A20~~Table A20~~~~Table A20~~.

28-day readmission rate to acute inpatient care

Unplanned admissions to a mental health service following a recent discharge may indicate that the inpatient treatment was incomplete, or that follow-up care was inadequate to maintain the person out of hospital. High levels of unplanned readmissions within a short time frame may reflect deficiencies in inpatient treatment and/or follow-up care and point to inadequacies in the functioning of the overall system. Since the commencement of the Plan in 2007-08, the overall 28-day readmission rate has decreased from 17.1 to 15.6 per cent (Figure 13).

Figure { SEQ Figure * ARABIC }: 28-day re-admission rate



Source: QHAPDC. See Table A19~~Table A19~~~~Table A19~~.

EXHIBIT 729

Consumer outcomes participation

Consumer self-rated outcome measures are one mechanism through which consumers and carers can be actively involved in treatment planning, decision-making and definition of treatment goals. The self-rated measures provide useful information about the way clients feel and how well they are able to cope with their usual activities and are an opportunity for consumers, carers and clinicians to track progress through comparison of ratings over time. Offering a self-rated measure can be useful for engagement as well as collaboration between consumers, carers and clinicians and can enrich treatment and care planning. Obtaining a consumer self-rated measure requires mental health services to have an adequate degree of engagement (both clinically and organisationally) with consumers to facilitate this process.

Collection occasions should occur at the commencement of a support episode (start), during a support episode (review), and at the end of a support episode (end).

In 2009-10, the proportion of collection occasions where a self-rated outcome measure was collected was 6.1 per cent (see Table 6~~Table 6~~~~Table 6~~). Although this is an improvement on the 2008-09 result of 4.9 per cent (see Table A25~~Table A25~~~~Table A25~~), this low proportion suggests improvement should be sought in this area.

Table { SEQ Table * ARABIC }: Proportion of collection occasions where a consumer self-rate outcomes measure was collected, 2009-10

Year	Target	Service Setting	Start collection occasion Per cent	Review collection occasion Per cent	End collection occasion Per cent	All Per cent
2009-10	Child/Youth	Acute Inpatient	32.1	1.4	7.8	16.2
		Community/Ambulatory	28.9	8.9	3.3	12.7
		Extended Treatment	25.0	73.3	0.0	36.8
		Overall	**29.3**	**8.7**	**4.0**	**13.1**
	Forensic	Community/Ambulatory	1.7	1.7	0.1	1.0
		Extended Treatment	7.9	6.2	0.0	5.7
		Overall	**1.9**	**5.6**	**0.1**	**1.7**
	Adult	Community/Ambulatory	3.3	6.4	0.8	4.0
		Extended Treatment	15.6	29.0	5.3	21.2
		Overall	**3.5**	**7.0**	**0.9**	**4.3**
	Older Persons	Community/Ambulatory	0.8	3.5	1.0	2.2
		Extended Treatment	0.5	5.0	0.0	2.2
		Overall	**0.8**	**3.6**	**0.9**	**2.2**
		Overall	**8.6**	**7.2**	**1.5**	**6.1**

Source: CIMHA. See Table A25~~Table A25~~~~Table A25~~.

EXHIBIT 729

Priority Area: Participation in the community

Progress in the development and collection of appropriate data to inform future outcome measures for the non-government sector

The Community Mental Health Branch, Department of Communities, is currently negotiating with the non-government sector to identify their outputs (service types) and output measures. These output measures will be formalised in the next round of service agreements. It is expected that service providers will supply information on a quarterly basis outlining their performance over the previous three months. With this information the Queensland Government will be able to define and inform future community mental health priorities. All new service agreements will be finalised by March 2011, with the expectation that data collection will commence in 2011.

Priority Area: Co-ordinating care

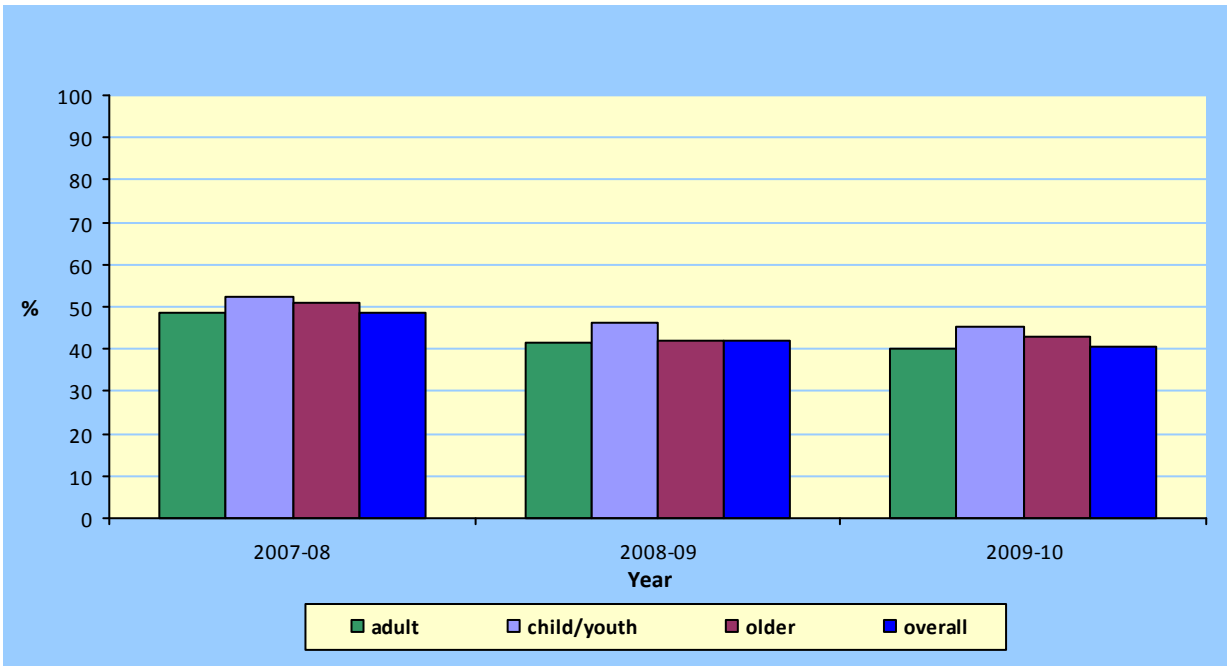
Pre-admission community care

Access to community based mental health services may alleviate the need for, or assist with improving the management of admissions to inpatient care. Public sector community mental health services involved with patients prior to hospitalisation could act to: support and alleviate distress during a period of great turmoil; relieve carer burden; avert hospital admission where possible; ensure that admission is the most appropriate patient option or commence treatment of the patient as soon possible where admission may not be averted.

Since the commencement of the Plan in 2007-08, the gross number of pre-admission community contacts has decreased by 12.6 per cent. Expressed a proportion of separations, it has declined by 8.1 percentage points. A decrease was reflected in all target populations (Figure 14~~Figure 14~~~~Figure 14~~). It is important to note that the indicator does not consider variations in intensity or frequency of contacts prior to admission, nor does it distinguish between indirect and face-to-face community contacts. The decline occurred principally during 2008-09, in conjunction with the introduction of CIMHA. The data model underpinning the new system is a modification from the model implemented in the legacy applications, and its adoption effectively sets a new baseline for reporting from 2009-10.

EXHIBIT 729

Figure { SEQ Figure * ARABIC }: Pre-admission community contact by target population, 2007-08 to 2009-10



Source: CIMHA and QHAPDC. See Table A22~~Table A22~~~~Table A22~~.

Post-discharge community contact

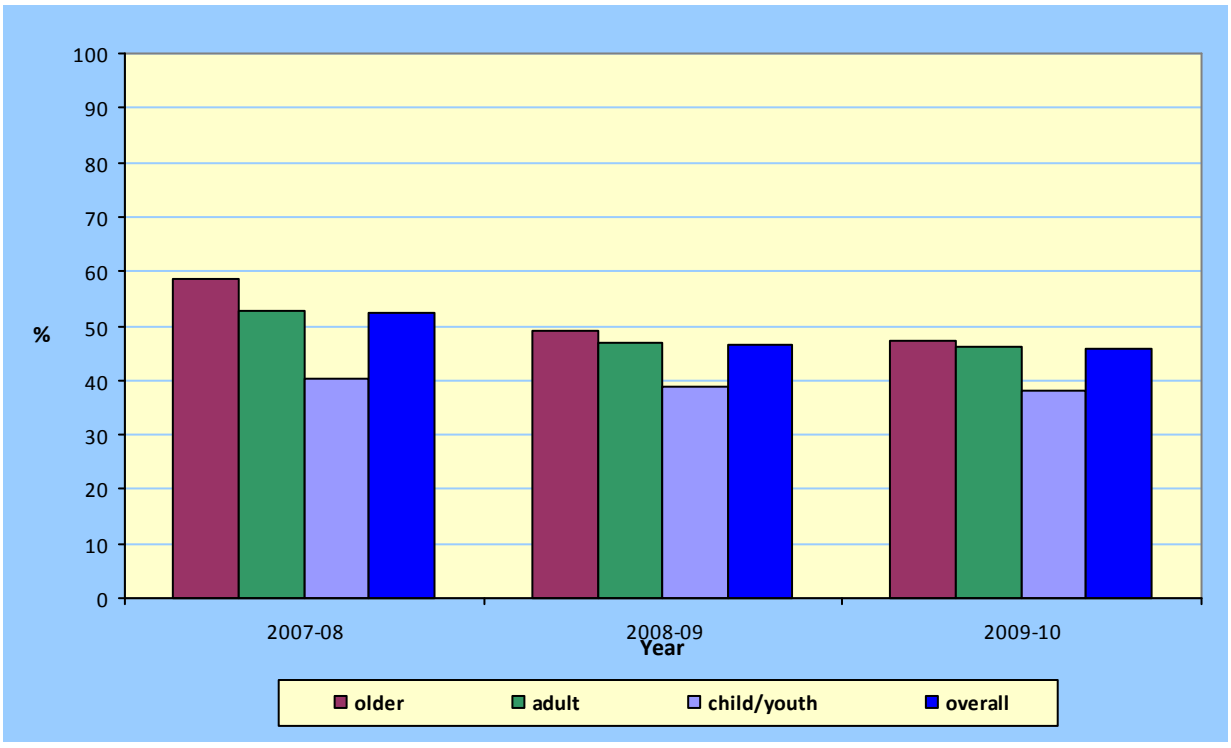
A responsive community support system for persons who have experienced an acute psychiatric episode requiring hospitalisation is essential to maintain clinical and functional stability and to minimise the need for hospital re-admission. It is expected that patients leaving hospital after a psychiatric admission with a formal discharge plan, involving linkages with community services and supports, are less likely to need early re-admission.

From 2007-08 to 2008-09, the proportion of separations with post-discharge community contact declined from 52.1 per cent to 43.8 per cent. However, in 2009-10, the proportion increased to 45.7 per cent (Figure 15~~Figure 15~~~~Figure 15~~).

It should be noted that the 2008-09 decline occurred in conjunction with the introduction of CIMHA. The data model underpinning the new is a modification from the model implemented in the legacy applications, and its adoption effectively sets a new baseline for reporting from 2009-10.

EXHIBIT 729

Figure { SEQ Figure * ARABIC }: Post-discharge community contact, in which the consumer participated, by target population, 2007-08 to 2009-10



Source: CIMHA and QHAPDC. See Table A23~~Table A23~~Table A23.

Priority Area: Workforce, information, quality and safety

Mental health service vacancy rates

An aim of the Plan is to improve the availability of a skilled mental health workforce. A key issue highlighted for the health sector is the ability to appropriately recruit and retain a skilled workforce. Vacancy rates are a measure of the impact of initiatives targeting recruitment and retention.

Community mental health vacancies against new positions under the Plan

Of total mental health FTE vacancies across all services, 88 per cent of new community mental health positions established under the Plan during the last three years have been filled. The overall vacancy rate for these positions has decreased since 2007 from twelve per cent to four per cent[11] in 2010. This suggests that recruitment initiatives are having a desired impact on retaining new mental health staff.

Overall FTE vacancies

Queensland Health collects a monthly snapshot of clinical vacancies[12] across the organisation (partitioned into medical, nursing and allied health positions). Vacancy numbers will invariably fluctuate throughout a 12-month period so the months of June 2008 and June 2009 and June 2010 were selected for comparative purposes.

In June 2008, there were a total of 246.1 FTE vacancies across all mental health clinical positions. This equates to 6 per cent of total clinical FTE positions. In June 2010, there were a total of 111.7 FTE vacancies across all mental health clinical positions. This equates to three per cent of total

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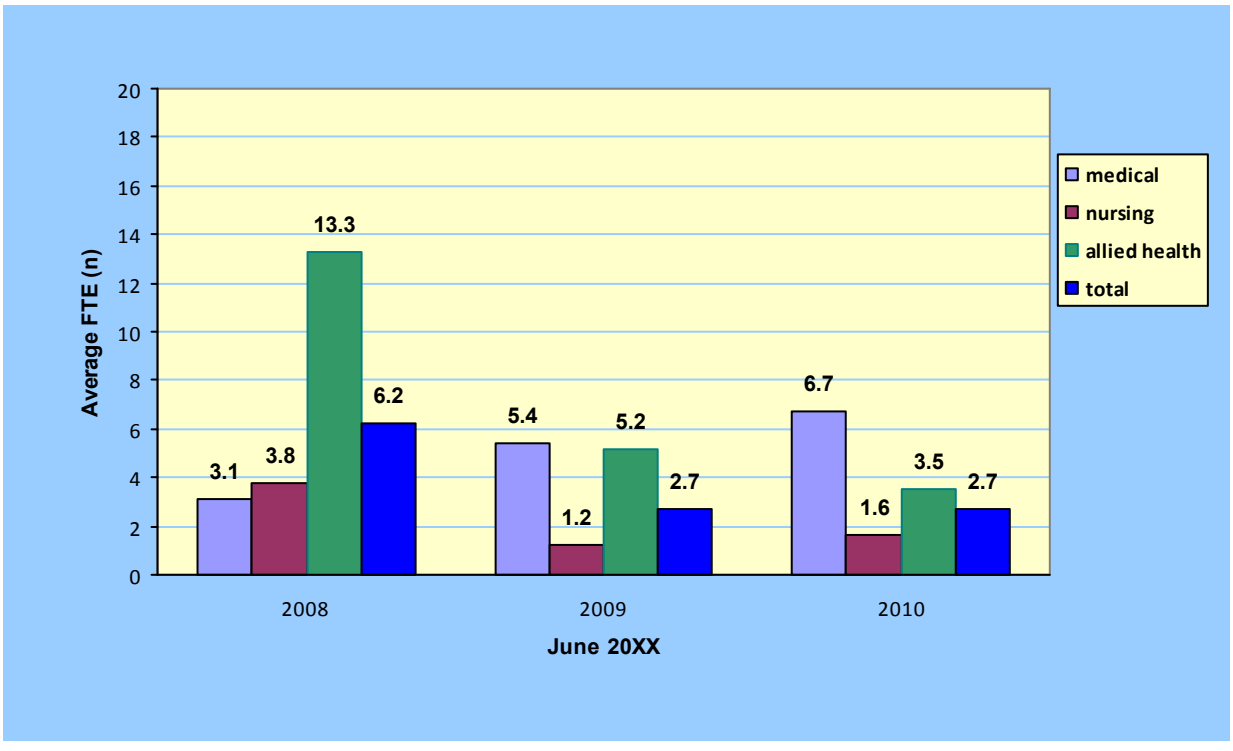
11 Source: Community Mental Health Services Full Time Equivalent (FTE) report, August 2010.

12 Administrative staff, project officers and non-clinical positions are excluded.

clinical FTE positions. Figure 16~~Figure 16~~Figure 16 shows a breakdown of vacancies in the periods by discipline. In June 2008, allied health positions had the largest vacancy rate (13.3 per cent of total FTE), followed by nursing (3.9 per cent of total FTE) and then medical (3.1 per cent of total FTE). In June 2010, medical positions had the largest vacancy rate (6.7 per cent of total FTE), followed by allied health (3.5 per cent of total FTE) and then nursing (1.6 per cent of FTE).

Figure { SEQ Figure * ARABIC }: Vacancy (FTE) rates at June, by position type

Source: Work For Us vacancy data and MHEC (FTE data). See Table A17~~Table A17~~Table A17~~.~~



'Unfilled' and 'unbackfilled' vacancies

Unbackfilled vacancies are only reported for nursing and allied health staff. There were 58.9 FTE unbackfilled vacancies in June 2008, which fell significantly to 8.5 by June 2009, then increasing to 15.6 in June 2010. Unbackfilled vacancies are only reported for nursing and allied health staff. This This means that, for those groups, in June 2008, unbackfilled vacancies represented one in four of all vacancies (25.5 per cent). In June 2010, they represented one in five of all vacancies (20.2 per cent).This suggests that, for these discipline types, relatively few vacancies are due to services' inability to fill positions vacated by staff who were on leave for longer than two months.

Critical vacancies

In June 2008, 8.2 per cent of the 246.1 FTE vacancies were considered critical[13]. In June 2009, this increased to 18.6 per cent of 115.6 FTE vacancies. However, in June 2010, this fell to 10.7 per cent of 111.7 FTE vacancies. Critical vacancies almost always occurred within the medical and allied health position types (rarely within nursing).

With the exception of medical vacancies, the average vacancy rate for mental health clinical FTE positions has either decreased or remained stable between June 2008 and June 2010. This suggests that the Plan is on track to deliver its goals to recruit and retain an adequate mental health

[13] A 'critical' vacancy is any permanently funded vacancy ('unfilled' or 'unbackfilled long term leave' only) which has caused, or is likely to cause, closure of services.

workforce. In addition, the majority of vacancies have been for unfilled vacancies rather than unbackfilled vacancies, suggesting that services are planning staff movements and leave relatively well.

Public sector mental health service staff satisfaction

The Plan's investment in the mental health workforce and activities to improve workplace culture and leadership is expected to have a flow on effect in increasing staff satisfaction across a range of individual, organisational and leadership measures, as well as lead to a decrease in the intentions of Queensland Health mental health staff to separate from the organisation. The Queensland Health Better Workplaces staff opinion survey was used to measure the level of mental health service staff satisfaction[14]. Statistical analysis is utilised to calculate an Outcome Unit (OU) score for each question and group of questions which then enabled responses to classified into one of five outcome bands: 'outstanding', 'commendable', 'middling', 'challenging' and 'adverse'. Results from the 2009 survey with a sample of staff from mental health services (Table A18~~Table A18~~~~Table A18~~) will be used as a baseline from which future comparisons can be made.

Overall strengths

There were four measures where all surveyed groups scored within the 'commendable' band. These four measures were 'individual distress', which was desirably low; and 'peer support', 'workplace health and safety' and 'multidisciplinary team support', which were all desirably high. Four out of the seven work units surveyed also scored 'employee engagement' and 'clinical communication' within the 'commendable' band.

Areas requiring improvement

Two measures, 'excessive work demand' and 'trust in the leadership of district executives' achieved the poorest ratings. Five of the seven work units surveyed scored 'excessive work demands' within the 'challenging' band. Four of the seven work units surveyed scored 'trust in the leadership of district executives/executives' within the 'challenging' band. While poor ratings were not universally endorsed across all work units surveyed, these two measures provide a baseline from where improvement is desired.

The Staff Satisfaction Survey also contained a number of items relating to experience and exposure to harmful behaviours, relationship with an immediate supervisor, career intentions, performance reviews and quality in the workplace (Table A18~~Table A18~~~~Table A18~~).

Harmful behaviours

A high proportion of surveyed staff indicated that they knew 'how to report harmful behaviour', with between 87 per cent and 92.2 per cent agreeing or strongly agreeing with this statement. Fewer staff 'trusted the process for managing harmful behaviours', with between 37.5 per cent and 54.5 per cent agreeing or strongly agreeing with this statement. 'Experiencing harmful behaviours directed toward staff' was reported by between 27.3 per cent and 45.2 per cent of respondents. Between 20 and 50 per cent of managers/supervisors reported 'experiencing harmful behaviours from staff they manage'. Of those who experienced harmful behaviours and chose not to report it, the top reasons offered for not doing so were that they 'expected no action would be taken', 'the incident was not serious enough' or they 'dealt with the situation themselves'.

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[14] This survey, which is administered to one quarter of the entire workforce every six months, surveys two cohorts each year. Mental health services were identified based upon the establishment structure used within the survey. However, not all Health Service Districts separately identified their mental health service and as such these are not included in the results.

EXHIBIT 729

Career intentions

Between 18.2 per cent and 42.4 per cent indicated that they were 'considering leaving their job' between 9.1 per cent and 50 per cent indicated they were 'looking for a new job'. However, the majority (between 51 and 72.7 per cent) indicated a preference to 'remain with Queensland Health'. When asked to rate their reason(s) for leaving from a list of reasons, being 'unhappy with management', 'wanting career development', 'lack of recognition in the work area' and 'unfair treatment towards staff' were endorsed more often than other reasons offered.

Quality in the workplace

When asked to rate the most important things that need to be improved in their workplace, 'supervisory practices', 'manager-employee relationships', 'recognition for good work', 'openness of communication', 'efficiency and effectiveness' and 'availability of equipment' were endorsed by most of the work units surveyed. When rating the positive elements of their work area, 'relationship with co-workers', 'work satisfaction', 'work-life balance', 'openness of communication', 'focussed behaviour' and 'freedom from harassment' were most endorsed by most of the units.

Mental health patient safety plan

The Queensland Mental Health Patient Safety Plan 2008 - 2013 is structured around six key themes:

- reduction of suicide and self harm;
- reduction of aggressive behaviour in mental health settings, and the minimisation of the use of seclusion and restraint;
- best practice use of medication;
- safe transport;
- cultural safety of Aboriginal and Torres Strait Islander people; and
- safety of mental health services for consumers, carers and families.

It is critical that reasonably robust systems exist in all mental health services to support the recording of these events and to ensure that thorough analysis of such events occur in order to minimise recurrence of similar events.

On 1 July 2010, the Office of the Principal Advisor in Psychiatry, Mental Health Alcohol and Other Drugs Directorate took over responsibility for the governance of mental health patient safety in Queensland Health from the Patient Safety Centre. Infrastructure to support the development and identification of indicators to appropriately measure mental health patient safety has commenced.

Rate of seclusion

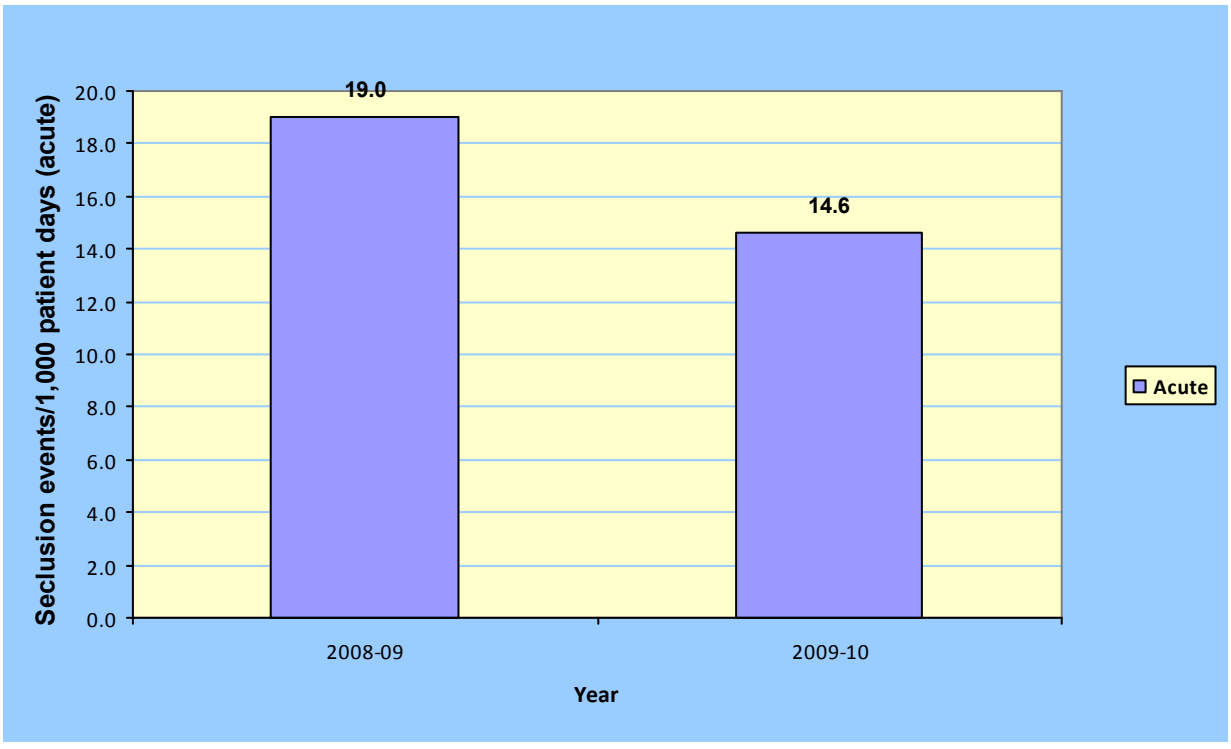
Under the *Mental Health Act 2000* seclusion is defined as the 'confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented'. High levels of seclusion are widely regarded as inappropriate treatment, and may point to inadequacies in the functioning of the overall systems and risks to the safety of consumers receiving mental health care. The use of seclusion in public sector mental health service organisations is regulated under legislation and/or policy of each jurisdiction.

The rate of seclusion is part of the National Mental Health Performance Framework and refers to the number of seclusion events per 1,000 patient days within mental health service organisations' inpatient services. Figure 17~~Figure 17~~~~Figure 17~~ shows that in 2008-09, there was an average of 19.0 seclusion events per 1,000 patient days in acute services, decreasing to 14.6 seclusion events per patient days in 2009-10. This reflects the Queensland Government's significant investments to reduce seclusion, and is consistent with national and state initiatives to investigate, reduce and, if possible, eliminate the use of seclusion.

EXHIBIT 729

Due to limitations identified with the data source at the time of printing, data for seclusion events for non-acute services was not available. Efforts will be made to resolve this in future reports.

Figure { SEQ Figure * ARABIC }: Average number of seclusion events in acute services per 1000 patient days, 2007-08 to 2008-09



Source: CIMHA and QHAPDC. See Table A27~~Table A27~~~~Table A27~~.

Compliance with public sector data collection requirements

Queensland is committed to the collection and utilisation of a range of information to support clinical practice, service development, evaluation and planning. This activity also supports national reporting requirements. In addition to hospital activity, which is coded from clinical files, there are two core collections which support mental health service delivery as well as state and national reporting requirements: the Outcomes and Casemix Collection and Mental Health Activity Data Collection.

Consumer outcomes presume a change over time in the person's health status and functioning. Gathering information about consumer outcomes therefore requires the measures to be used at regular intervals in the cycle of care. The introduction of the routine collection of the standardised clinical outcome measures included a set of nationally agreed rules that guide collection and reporting of data. In Queensland, these rules are articulated in the Queensland Outcomes Protocol. Table 7~~Table 7~~~~Table 7~~ shows the compliance with the Protocol.

EXHIBIT 729

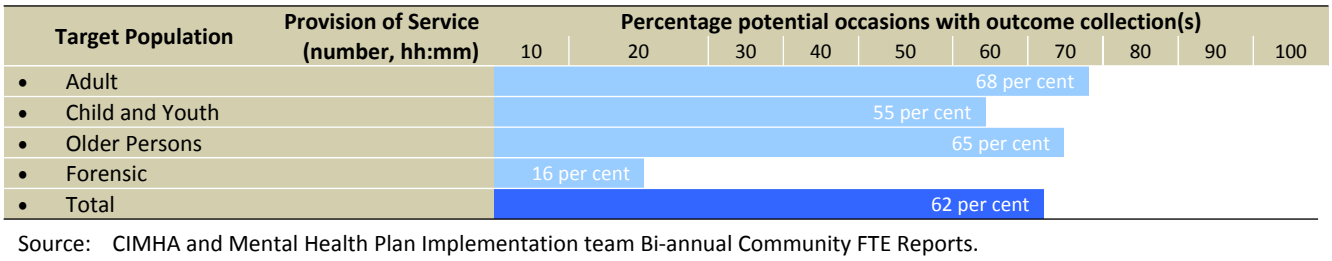
Table { SEQ Table * ARABIC } Proportion of collection occasions where a clinical outcome measure was recorded by clinicians, 2009-10

Year	Target	Service Setting	Start Collection occasion (Per cent)	Review Collection occasion (Per cent)	End Collection occasion (Per cent)	All Collection occasion (Per cent)
2009-10	Child/Youth	Community/Ambulatory	44.9	20.5	28.3	28.6
		Acute Inpatient	40.7	1.0	19.3	24.1
		Extended Treatment	25.0	80.0	0.0	39.5
		Overall	**44.3**	**19.8**	**27.1**	**28.3**
	Forensic	Community/Ambulatory	4.4	21.7	2.2	3.6
		Extended Treatment	22.2	10.3	32.3	14.2
		Overall	**5.0**	**11.7**	**3.3**	**5.1**
	Adult	Community/Ambulatory	28.3	42.8	26.5	33.9
		Acute Inpatient	51.0	6.7	38.0	42.0
		Extended Treatment	36.6	47.1	32.2	41.8
		Overall	**36.4**	**41.2**	**30.6**	**36.1**
	Older Persons	Community/Ambulatory	53.2	61.6	48.6	56.1
		Acute Inpatient	87.2	6.7	80.2	81.2
		Extended Treatment	66.7	30.9	39.6	44.4
		Overall	**58.5**	**58.8**	**51.1**	**56.5**
		Overall	**37.4**	**37.0**	**29.9**	**34.9**

Source: CIMHA. See Table A28~~Table A28~~~~Table A28~~

Figure 18~~Figure 18~~~~Figure 18~~ outlines the proportion of notional available FTE that is accounted for by clinically significant activity recorded in the electronic clinical record regarding community interventions (CIMHA). It is important to note that this figure should not be 100 per cent as CIMHA is not intended to capture data about all activities that clinicians undertake, but rather is focused on those activities directly related to the treatment and care of an identified consumer. Therefore this figure does not include travel and preparation time or time associated with tasks recorded as Non Consumer Related Activity (NCRA). In 2009-10 (the first full year of CIMHA operation), nearly 500,000 hours of clinical intervention was recorded in CIMHA, representing 62 per cent of available community/ambulatory clinical staff time.

Figure { SEQ Figure * ARABIC }: Mental Health Activity Data Collection participation, 2009-10



Source: CIMHA and Mental Health Plan Implementation team Bi-annual Community FTE Reports.

See Table A29: Total hours of community/ambulatory clinical interventions recorded as a proportion of total community/ambulatory clinical FTE hours~~Table A29: Total hours of community/ambulatory clinical interventions recorded as a proportion of total community/ambulatory clinical FTE hours~~~~Table A29: Total hours of community/ambulatory clinical interventions recorded as a proportion of total community/ambulatory clinical FTE hours~~

EXHIBIT 729

Have the initiatives impacted on people living with a mental illness?

Priority Area: Integrating and improving the care system

Queenslanders accessing clinical mental health care (public and private)

Access to public sector mental health services is an issue of significant concern to consumers, carers and the wider community. The issue of unmet need has become prominent since the National Survey of Mental Health and Wellbeing first indicated that a majority of persons affected by mental disorder do not receive treatment. The implication for performance indicators is that a measure is required to monitor population treatment rates and assess these against what is known about the distribution of mental disorders in the community. In the absence of the ability to accurately measure treatment rates the COAG National Action Plan on Mental Health has developed an interim measure which looks at the proportion of persons accessing clinical mental health care in Australia.

The latest available data is presented in Table 8~~Table 8~~~~Table 8~~. The table shows that, between 2006-07 and 2007-08 (the most recent year for which data is complete), the proportion of the Queensland population accessing care has increased, driven principally by increased provision of Medicare-funded mental health services. This likely reflects the Australian Government *Better Access to Mental Health Care* initiatives commenced in Nov 2006. It should also be noted that the decline in ambulatory care between 2007-08 and 2009-10 is the result of changes in reporting associated with the introduction of CIMHA (refer Appendix C – Methodology).

Table { SEQ Table * ARABIC } Proportion of the Queensland population receiving clinical mental health care across ambulatory, Queensland private hospitals and Medicare-funded mental health services, 2006-07 to 2008-09

Period	Ambulatory	Private hospital	Medicare-funded mental health services				
			Private psychiatrist	General practitioners	Clinical psychologists	Allied health	All MBS funded services
2006-07	1.8 per cent (72,856)	0.1 per cent (4,723)	1.2 per cent (50,006)	1.7 per cent (69,184)	0.1 per cent (4,774)	0.6 per cent (25,384)	2.8 per cent (116,029)
2007-08	1.8 per cent (75,541)	0.1 per cent (4728)	1.2 per cent (49,579)	3.1 per cent (131,957)	0.4 per cent (15,461)	1.3 per cent (57,320)	4.3 per cent (183,396)
2008-09	1.7 per cent (72,989)	Pending	Pending	Pending	Pending	Pending	Pending
2009-10	1.6 per cent (72,304)	Pending	Pending	Pending	Pending	Pending	Pending

Source: CIMHA; ABS Estimated Resident Population and COAG National Action Plan on Mental Health 2006-2011 Progress Reports. See Table A2: Queensland Population Statistics~~Table A2: Queensland Population Statistics~~~~Table A2: Queensland Population Statistics~~

Note 1: Data for 2007-08 (excluding ambulatory health services which is provided by Queensland Health) is preliminary and is subject to revision.

Change in consumers' clinical outcomes

Improvement in clinical outcomes, measured by a reduction in the severity of symptoms and improvements in functioning, is a core objective of mental health services. The implementation of routine mental health outcome measurement in Australia provides the opportunity to monitor the effectiveness of mental health services across services and jurisdictions. Identifying the comparative effectiveness of mental health services informs benchmarking between services and related service quality improvement activities.

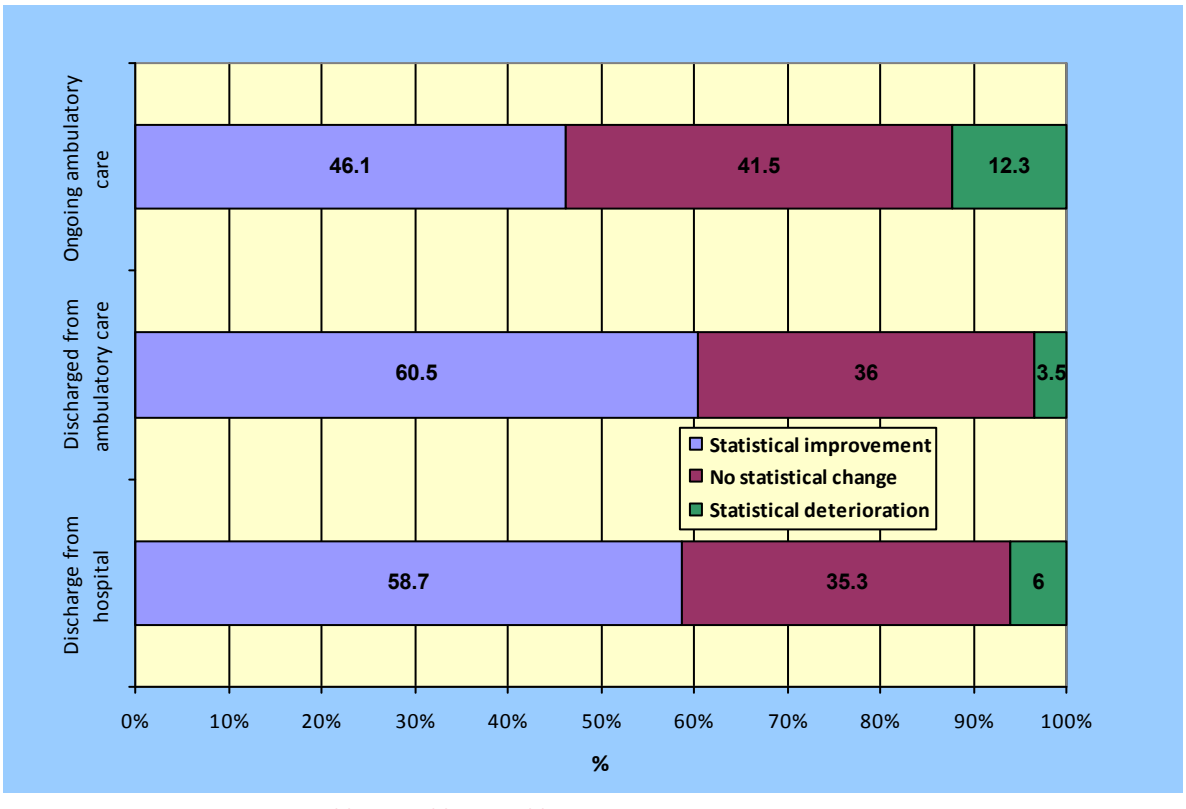
EXHIBIT 729

In this indicator, mental health settings refer to the following three cohorts:

- *Consumers discharged from hospital*: This group covers all people who were discharged from an acute psychiatric inpatient unit within the reference period.
- *Consumers discharged from ambulatory care*[15]: This group covers people who were discharged from an ambulatory care episode within the reference period
- *Consumers in ongoing ambulatory care*: This group covers people who have an 'open' ambulatory episode of care at the end of the reference period.

Data is currently only available from the period 2008-09 and 2009-10.

Figure { SEQ Figure * ARABIC } Change in clinical outcomes, child and youth, 2009-10

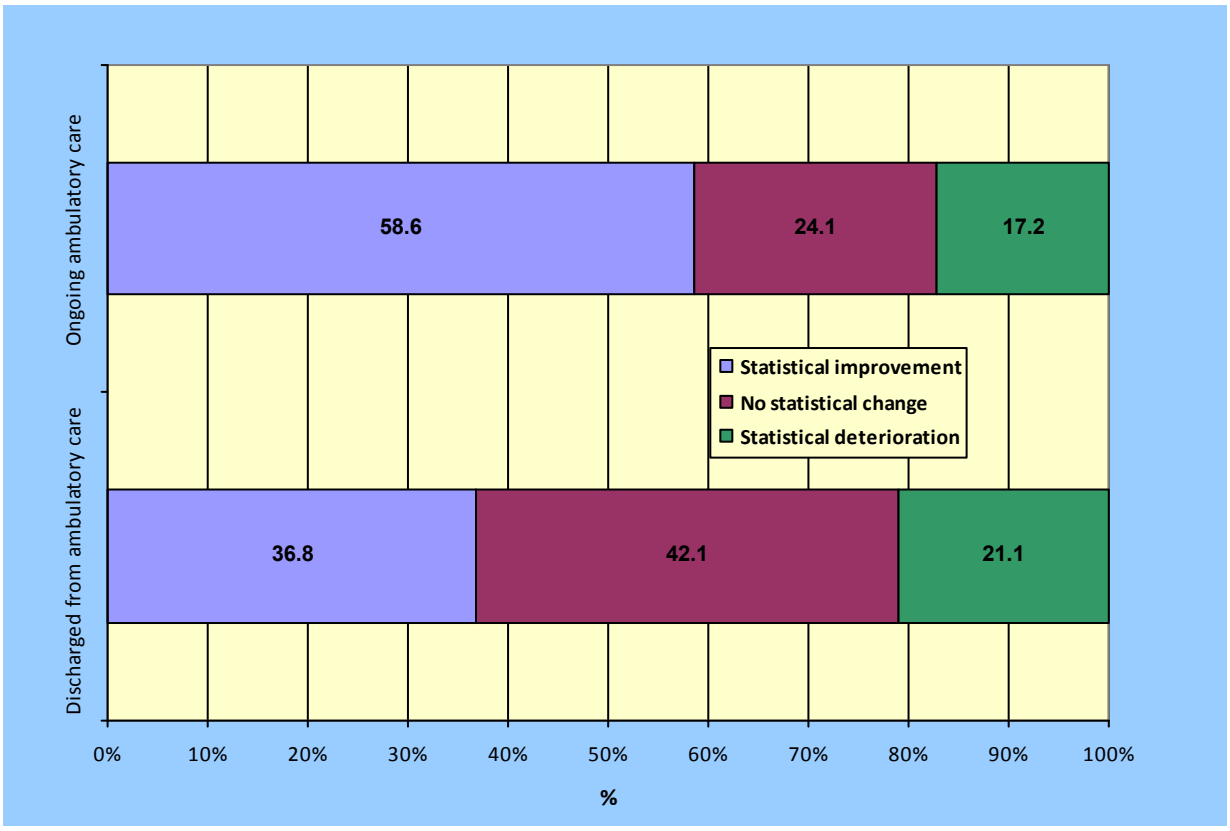


Source: CIMHA. See Table A30~~Table A30~~~~Table A30~~

[15] Ambulatory episodes that are completed because the consumer was admitted to hospital are excluded from the analysis.

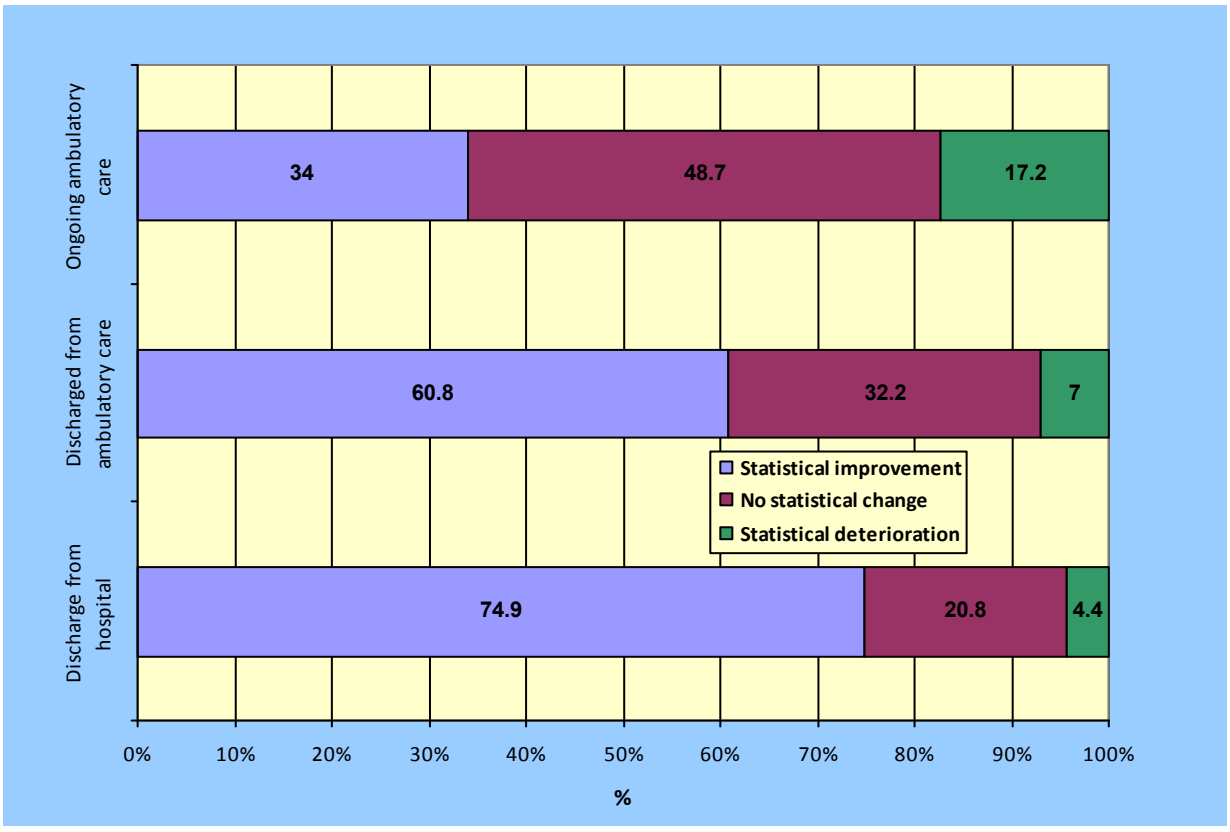
EXHIBIT 729

Figure { SEQ Figure * ARABIC }: Change in clinical outcomes, forensic, 2009-10



Source: CIMHA. See Table A30: Change in consumers' clinical outcomes~~Table A30: Change in consumers' clinical outcomes~~Table A30: Change in consumers' clinical outcomes.

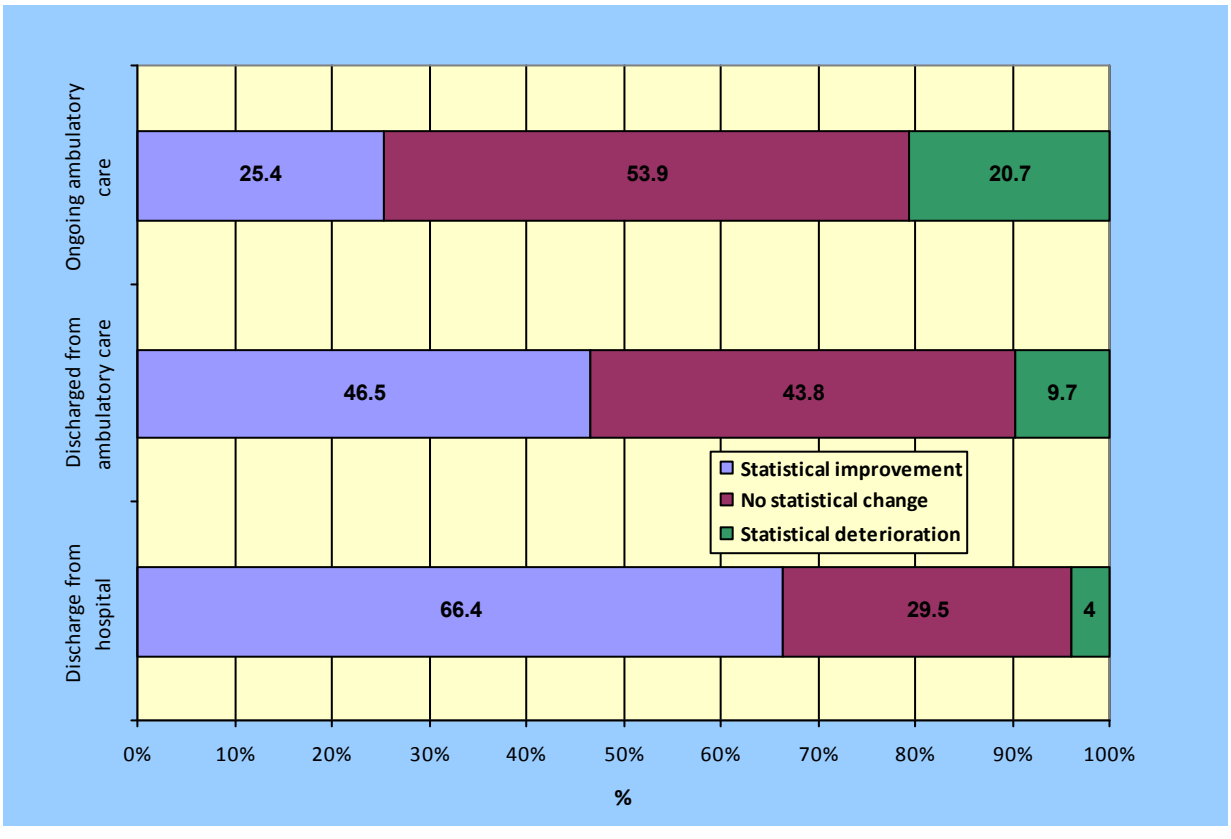
Figure { SEQ Figure * ARABIC }: Change in clinical outcomes, general adults, 2009-10



Source: CIMHA. See Table A30: Change in consumers' clinical outcomes~~Table A30: Change in consumers' clinical outcomes~~Table A30: Change in consumers' clinical outcomes.

EXHIBIT 729

Figure { SEQ Figure * ARABIC }: Change in clinical outcomes, older persons, 2009-10



Source: CIMHA. See Table A30~~Table A30~~~~Table A30~~

The overall proportion of consumers achieving 'statistically significant improvement' in clinical outcomes was more pronounced among consumers discharged from hospital compared to consumers discharged from ambulatory care and finally consumers in ongoing ambulatory care. This is an expected result; experience in other jurisdictions demonstrates that inpatient care delivers more pronounced improvements, notwithstanding that consumers may remain symptomatic at discharge. Ambulatory care covers a wider range of people with varying conditions, while illnesses for consumers in ongoing ambulatory care may be persistent or episodic in nature.

Among consumers discharged from hospital, those from the adult target population had the highest proportion of statistically significant improvement in clinical outcomes. Among consumers discharged from ambulatory care, those from the adult target population also had the highest proportion of statistically significant improvement in clinical outcomes. For consumers in ongoing ambulatory care, those from forensic target population had the highest proportion of statistically significant improvement in clinical outcomes, followed by consumers from the child/youth population.

Priority Area: Coordinating care

Consumer, carer and staff perceptions of mental health service provision

To clearly identify the scope of the impact of the Plan it is critical that the views of those at the receiving end of policy change - the consumers, carers and staff - are accessed and utilised as part of the monitoring and evaluation arrangements. A longitudinal project[16] is underway that seeks to obtain information on the perceptions of consumers, carers and staff to service provision at three

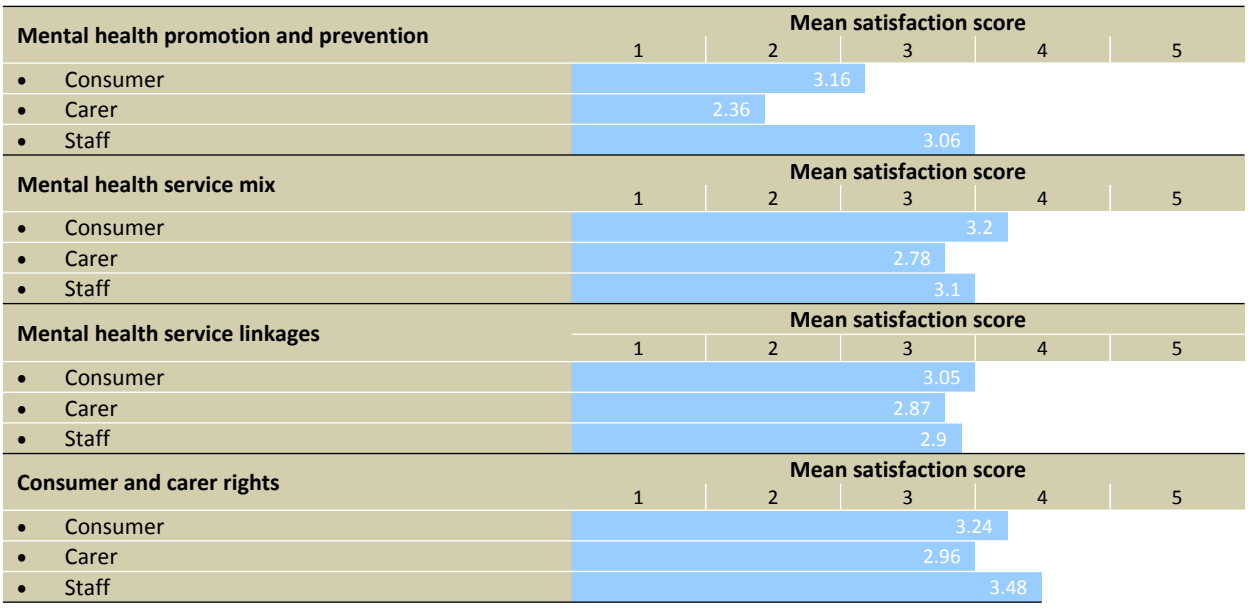
[16] Service Evaluation and Research Unit, The Park - Centre for Mental Health. *Consumer, carer and staff perceptions of service provision (Final Report - Phase 1)*, February 2010, (unpublished).

EXHIBIT 729

separate time periods during the life of the Plan: 2009 (baseline); 2013 (mid Plan) and 2018 (post-Plan).

Perceptions of service provision was assessed by asking a sample of consumers, carers and mental health staff to rate their level of agreement on a series of statements related to 11 separate domains of service provision that are applicable to the three groups of respondents. The results are summarised in Figure 23~~Figure 23~~~~Figure 23~~.

Figure { SEQ Figure * ARABIC }: Perceptions of mental health service provision, 2009



Source: Service Evaluation and Research Unit, The Park - Centre for Mental Health. *Consumer, carer and staff perceptions of service provision (Final Report - Phase 1)*, February 2010, (unpublished).

Promotion and prevention

Promotion and prevention is concerned with respondents' perceptions toward community awareness of mental illness and the ability to obtain help if required. Overall, the mean scale scores for consumers, staff and carers revealed a highly significant (p = 0 001) difference between the groups. While consumers and staff did not differ significantly from each other they were more positive about promotion and prevention efforts than carers were.

Service mix

Service mix is concerned with the variety or mix of services available in a given District. These services must be able to cater for individuals with a variety of needs including those that require acute and long-term care. An ideal service-mix would provide for continuity of care, so that consumers can move between services as their needs change. Differences in the mean scale scores between respondent groups were highly significant (p = 0.001). Carers rated service mix as being significantly lower than consumers and staff. All three respondent groups felt that there was a lack of support services for people with mental illness in the community, however agreed that mental health consumers were able to receive community-based care as an alternative to being admitted to hospital.

Service linkage

Service linkage is concerned with the degree to which people affected by mental illness have similar access to public housing, ambulance services and employment opportunities compared to other people in the community. The perception of being treated fairly by police was also assessed. All three respondent groups held similar views regarding service linkages. While the overall difference

between the groups was significant, the difference was modest (p = 0.03) with carers appearing to be less positive about service linkages compared to consumers and staff.

Consumer and carer rights

Consumer and carer rights is concerned with the ability of consumers and carers to influence the way in which their local mental health service operates, the degree to which the mental health service involves consumers in planning the treatment they receive, the degree to which carers are involved in treatment decisions that affect them, the degree to which consumers and carers are treated with respect and dignity by mental health professionals and the degree to which they are able to receive assistance in supporting their relative or friend with a mental illness. Differences in scale scores for the three groups were large and statistically significant (p = .001) with all groups differing significantly from each other. Staff tended to hold the most positive views of efforts to promote consumer and carer rights.

The remaining domains related to respondents' perceptions of mental health workers, mental health worker competence, mental health service received, safety, service quality, organisational commitment and therapeutic optimism provide only a single scale score from which no comparisons can be made. These scores will not be reported in this report but rather will form the baseline from which subsequent scores obtained in 2013 and 2018 surveys will be compared against (Table A31~~Table A31~~~~Table A31~~).

Qualitative responses

As part of the perceptions of service provision project, consumers, carers and mental health staff were given the opportunity to provide responses to two open-ended questions: (i) "What is currently missing from mental health services", and (ii) "What works well in mental health services generally". The top three comments made by consumers, carers and mental health staff on 'what's working well' and 'what's missing' are provided in Table 9~~Table 9~~~~Table 9~~.

EXHIBIT 729

Table { SEQ Table * ARABIC }: Perceptions of consumers, carers and staff on 'what works well in' and ' what is missing from' mental health services, 2009

Consumers	Carers	Staff
What works well in mental health services generally		
• Positive personal qualities of staff • Good care through a public mental health service • Good care through an NGO	• Carer involvement in consumer treatment • Positive personal qualities of staff • Services provided by NGO	• Team-based approach • Positive personal qualities of mental health staff • Good coordination between services
What is currently missing from mental health services?		
• Consumers not treated with respect • Insufficient staff-patient time • Lack of beds	• Carers not treated with respect • Lack of beds • Lack of genuine consumers and carer participation	• Lack of suitable accommodation in the community • Not enough staff • Lack of coordination between services

Source: Service Evaluation and Research Unit, The Park - Centre for Mental Health. *Consumer, carer and staff perceptions of service provision (Final Report - Phase 1)*, February 2010, (unpublished).

The project analysis categorised the negative experiences of respondents into interpersonal, staffing and structural issues.

- *Interpersonal:* A number of consumers and carers held the perception that they were not being treated with respect by staff and that staff lacked a genuine compassion and understanding of consumers.
- S*taffing*: A 'lack of staff' was a common perception among all respondents. The difficulties in meeting the demand for services and a lack of sufficient time to spend with consumers were reported by staff. Difficulties in gaining access to services or receiving a lower quality of care were reported by consumers and carers.
  A 'lack of continuity of care' due to frequent changes in staff was also reported as an issue by consumers and carers. Staff changes were seen to be a barrier to developing a therapeutic relationship, leading to frustration among consumers and carers.
- *Structural:* A perceived 'lack of coordination between services', a 'lack of opportunity for genuine participation for consumers and carers' and a 'focus on consumer privacy at the expense of information sharing with carers' were reported.

EXHIBIT 729

Has the mental health of the community improved?

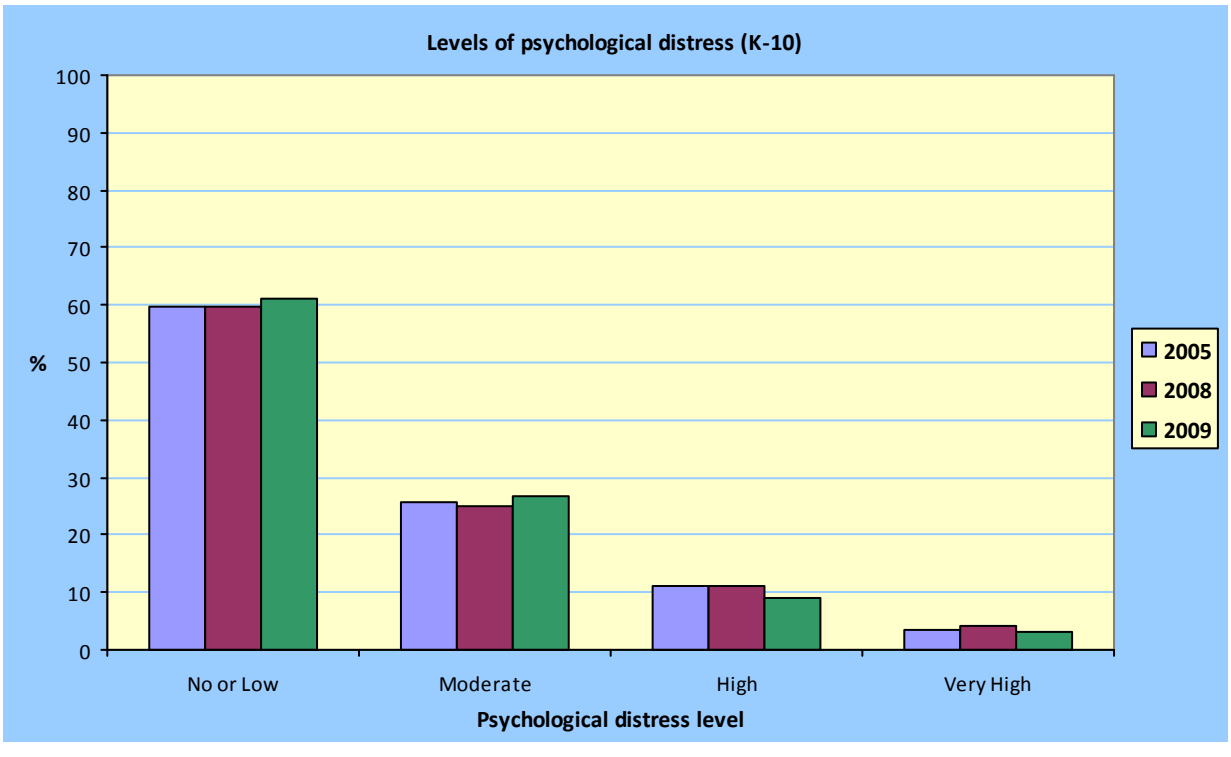
Priority Area: Promotion, prevention and early intervention

Psychological distress in the general community

Psychological distress has a major effect on the ability of people to work and manage their day-to-day activities. A promotion and prevention focus across all sectors of the community is required to address the growing burden of disease associated with mental health problems and mental illness. Mental health is intrinsic to good health and quality of life and as such is firmly placed within the broader public health and health promotion agenda. Positive mental health can be enhanced by effective population health interventions. Interventions that promote positive mental health are likely to be associated with a reduction in psychological distress. One measure of the prevalence of mental health in the population is the Kessler Psychological Distress Scale (K-10) which has been used to determine the level of psychological distress and likelihood of mental disorder in the community.

The K-10 was administered in Queensland on three separate occasions - the 2005 Queensland Omnibus Survey (25 May to 12 July 2005), the 2008 Queensland Omnibus Survey (10 June 2008 to 4 July 2008) and the 2009 Self-Reported Adult Health Status Survey (27 January to 7 March 2009). These population-based surveys utilised similar methodologies and are comparable in terms of their results. The proportion of the Queensland sample who reported having 'no or low', 'moderate', 'high' or 'very high' levels of psychological distress as measured by the K-10 is displayed in Figure 24~~Figure 24~~~~Figure 24~~.

Figure { SEQ Figure * ARABIC }: Queensland proportion reporting no/low, medium, high or very high levels of psychological distress



Source: 2005 Queensland Omnibus Survey, Questionnaire and Weighted Results, Statistical Analysis Unit, Health Statistics Centre, Queensland Health, February 2006. See Table A32~~Table A32~~~~Table A32~~.
Estimate of the Prevalence of Anxiety and Depressive Disorders in the Adult Queensland Population using Kessler Psychological Distress Scale, Mental Health Information Unit, Queensland Health, November 2008.

EXHIBIT 729

Queensland Health: Pollard G, White D, Harper C. 2009. Self-Reported Health Status: Queensland, 2009 Survey Report. Queensland Health Brisbane.

'No or low' levels of psychological distress as measured by the K-10 appeared to be the norm (approximately 60 per cent) across all survey administrations. 'Moderate' levels of psychological distress were around 25 per cent, increasing to almost 27 per cent in the 2009 survey. The proportion of those reporting 'high' levels of psychological distress was around 11 per cent, decreasing to 8.9 per cent in the 2009 survey. The proportion of those reporting 'very high' levels of psychological distress was between 3.5 and 4.2 per cent, decreasing to 3.1 per cent in the 2009 survey. Together these figures support a downward trend in the proportion of the population reporting 'high' or 'very high' levels of psychological distress as measured by the K-10.

EXHIBIT 729

Appendices

A: Indicator summary

Measures of input, output and outcomes are used to evaluate the Plan.

- Input measures are associated with the resources made available to a system (e.g. funding) to produce outputs and outcomes.
- Output measures are associated with services provided as a result of the inputs (e.g. number of training sessions delivered, delivery of clinical interventions).
- Outcome measures are associated with a change in behaviour, attitudes or conditions as a result of a specific activity (e.g. interventions, policies, training). Outcomes are not what happened, but rather are the consequence of the activity.

Table A{ SEQ Table_A * ARABIC }: Summary of indicators

KEQ	Indicator	Measure Type	
Priority Area One: Promotion, prevention and early Intervention			
1	Progress in allocation of funds under the Plan on activities related to Priority 1: Promotion, prevention and early intervention	Input	Percentage
2	Progress in the development and implementation of a state-wide mental health literacy strategy	Output	Qualitative
2	Progress in the development and implementation of the Ed LinQ Initiative	Output	Qualitative
2	Proportion of mental health expenditure on promotion, prevention and early intervention	Output	Percentage
2	Progress in implementation of the Mental Health Intervention Project (MHIP)	Output	Qualitative
3	Progress in the development and collection of appropriate data to inform future outcome measures for promotion, prevention and early intervention activity	Outcome	Qualitative
5	Psychological Distress (Kessler 10)	Outcome	Percentage
Priority Area Two: Integrating and improving the care system			
1	Progress in allocation of funds under the Plan on activities related to Priority 2: Integrating and improving the care system	Input	Percentage
1	Progress in commissioning specialised mental health inpatient beds funded under the Plan	Input	Percentage
1	Progress in establishing clinical Full Time Equivalent positions funded under the Plan	Input	Percentage
2	Inpatient beds per 100,000 population	Output	Rate
2	Clinical mental health staff per 100,000 population	Output	Rate
2	Proportion of consumers with identified General Practitioner	Output	Percentage
2	Acute bed occupancy	Output	Percentage
2	Proportion of Indigenous mental health consumers with an identified Indigenous mental health worker	Output	Percentage
2	Proportion of community mental health consumers with an identified carer	Output	Percentage
3	28-day readmission rate	Outcome	Percentage
3	Proportion of mental health consumers accessing local services	Outcome	Percentage
3	Proportion of new clients	Outcome	Percentage
3	Average treatment days per three-month community care period	Outcome	Rate
3	Consumer outcomes participation	Outcome	Percentage
4	Change in consumers' clinical outcomes	Outcome	Percentage
4	Population receiving clinical mental health care	Outcome	Percentage

EXHIBIT 729

KEQ	Indicator	Measure Type	
Priority Area Three: Participation in the community			
1	Progress in allocation of funds under the Plan on activities related to Priority 3: Participation in the community	Input	Percentage
2	Proportion of the Queensland population accessing non-government support services for persons with a primary psychiatric disability or mental illness	Output	Percentage
2	Types of community support services utilised by persons with a primary psychiatric disability or mental illness	Output	Percentage
2	Places per 100,000 population for Transitional Recovery Programs	Output	Rate
2	Places per 100,000 population for supported social housing	Output	Rate
2	Packages per 100,000 population to support people with a mental illness living in hostels and private homes	Output	Rate
2	Places per 100,000 population for Consumer Operated Crisis and Respite Services	Output	Rate
2	Proportion of public mental health expenditure on non-government organisations	Output	Percentage
2	Progress in the development of a Queensland Plan for the Mental Health Sector 2010-2017	Output	Qualitative
3	Progress in the development and collection of appropriate data to inform future outcome measures for the non-government sector	Outcome	Qualitative
Priority Area Four: Participation in the Community			
1	Progress in allocation of funds under the Plan on activities related to Priority 4: Coordinating care	Input	Percentage
2	Progress in the development of the state-wide Care Coordination initiative	Output	Qualitative
2	Proportion of public sector community mental health consumers with identified non-clinical government and non-government services	Output	Percentage
3	Pre-admission community contact	Outcome	Percentage
3	Post-discharge community contact	Outcome	Percentage
4	Consumer, carer and staff perceptions of mental health service provision	Outcome	Mean satisfaction
Priority Area Five: - Workforce, information quality and safety			
1	Progress in allocation of funds under the Plan on activities related to Priority 5: Workforce, information, quality and safety	Input	Percentage
2	Proportion of public sector mental health expenditure on training and development	Output	Percentage
2	Proportion of consumer and carer workers accessing professional development	Output	Percentage
2	Proportion of identified mental health leaders participating in the Leadership Matters: Forum for Senior Mental Health Leaders	Output	Percentage
2	Public mental health staff completing Queensland Centre for Mental Health Learning (QCMHL) training	Output	Number
2	Progress in the development of a mental health research policy and application of research for practice	Output	Qualitative
3	Mental health service vacancy rates	Outcome	Percentage
3	Public sector mental health staff satisfaction	Outcome	Outcome bands
3	Rate of seclusion	Outcome	Rate
3	Progress in the implementation of a mental health patient safety plan	Outcome	Qualitative
3	Compliance with public sector data collection requirements	Outcome	Percentage

B: Data tables

Table A{ SEQ Table_A * ARABIC }: Queensland Population Statistics

Series Name	2006-07	2007-08	2008-09	2009-10
• OESR Population Projections (Medium Series)	4,090,908 (2006 projection)	4,090,908 (2006 projection)	4,090,908 (2006 projection)	4,567,714 (2011 projection)
• ABS Estimated Resident Population (Cat 3101.0), December Quarter	4,132,015	4,228,290	4,349,529	4,472,957

Note: The ABS revises estimated resident population on a quarterly basis. The ABS population figures identified above are the most recent estimate as at the December quarter issue in the reference period.

EXHIBIT 729

Table A{ SEQ Table_A * ARABIC }: Capital works for the upgrade, redevelopment and commission of additional beds

Bed type	Target Population	Location	Number	Milestones	Next steps
Acute	General adult	Logan-Beaudesert	25	• Service Planning • Site Options Study • Project Definition Plan • Schematic Design • Design Development • Tender	• Construction • Indicative commissioning date of November 2011
		Caboolture	20	• Service Planning • Master Planning • Project Definition Plan • Schematic Design • Design Development • Tender	• Construction • Indicative commissioning date of January 2012
		Mackay	30 New and upgraded	• Service Planning • Master Planning • Progress towards Project Definition Plan	• Transferred to Mackay Hospital Re-development Project in April 2008 • Construction • Indicative commissioning date of April 2012
	Older Persons	Rockhampton	4 New	• Service Planning • Site Identification	• Subject to formal approval may be transferred to recently announced Rockhampton Hospital Redevelopment Project.
Community Care Unit	General adult	Logan-Beaudesert	16 New	• Service Planning • Land Acquisition • Project Definition Plan • Schematic Design • Design Development	• Tender • Construction • Indicative commissioning date of June 2012
		Bayside	20 New	• Service Planning • Land Acquisition • Project Definition Plan • Schematic Design • Design Development	• Tender • Construction • Indicative commissioning date of May 2012
		West Moreton	18 New	• Service Planning • Land Acquisition • Project Definition Plan	• Schematic Design • Design Development Tender • Construction • Indicative commissioning date of January 2013
		PAH	20 New	• Service Planning • Land Acquisition • Project Definition Plan • Schematic Design • Design Development • Tender	• Construction • Indicative commissioning date of June 2011
Extended Treatment	Secure	West Moreton	9 HS 5 HDU	• Service Planning • Site Options Study • Project Definition Plan • Schematic Design • Design Development • Tender	• Construction • Indicative commissioning date of April 2011
		Redcliffe-Caboolture	23	• Service Planning • Master Planning • Project Definition Plan • Schematic Design • Design Development • Tender	• Construction • Indicative commissioning date- January 2012

EXHIBIT 729

Bed type	Target Population	Location	Number	Milestones	Next steps
	Older Persons	Sunshine Coast	5	• Service Planning • Master Planning • Project Definition Plan • Schematic Design • Design Development • Tender • Construction • Commissioned June 2010	
Day program	Child and Youth	Toowoomba	8	• Service Planning • Master Planning • Project Definition Plan • Schematic Design • Design Development • Tender	• Construction • Indicative commissioning date August 2011
		Townsville	6	• Service Planning • Site Options Study • Project Definition Plan • Schematic Design • Design Development	• Tender • Construction • Indicative commissioning date- July 2012
Extended Treatment	Medium Secure	Townsville	Upgrade	• Service Planning • Project Definition Plan • Site Options Study • Schematic Design	• Design Development • Tender • Construction • Indicative commissioning date October 2012
	General adult	Townsville (Kirwan)	Upgrade	• Scope of Works • Construction • Commissioned July 2008	
	Forensic	West Moreton	20	• Service Planning • Design Development • Scope of works	• Construction • Indicative commissioning date of February 2012
	Youth	Bayside (replacing Barrett Adolescent Centre)	15	• Service Planning • Site Options Study • Land acquired adjacent to Redland Hospital • Project Definition Plan • Schematic Design • Design Development	• Design Development • Tender • Construction • Indicative commissioning date of October 2012

Source: Mental Health Plan Implementation Unit, Mental Health Alcohol and Other Drugs Directorate, Queensland Health, April 2011.

Table A{ SEQ Table_A * ARABIC }: Establishment of new FTE positions

Age-specific programs	New FTE funded under the Plan	New FTE positions 2007-08	New FTE positions 2008-09	New FTE positions 2009-10	Total new FTE as at 30 June 2010	per cent as at 30 June 2010
• Child & youth	100	35.1	24.5	21.0	80.6	80.6
• Older persons	46	16.3	18.0	10.0	44.3	96.3
• Consultation Liaison	18	5.5	4.0	6.3	15.8	87.8
• Adult case management	22	37.8	3.0	21.9	62.7	284.9
• Mobile intensive treatment	25	13.0	3.5	10.9	27.4	109.6
• Acute care	60	50.4	8.0	7.5	65.9	109.8

EXHIBIT 729

Cross-aged programs	New FTE funded under the Plan	New FTE positions 2007-08	New FTE positions 2008-09	New FTE positions 2009-10	Total new FTE as at 30 June 2010	per cent progress as at 30 June 2010
• Indigenous	13	3.0	3.3	5.0	11.3	87.2
• Primary care	10	3.0	4.0	3.0	10.0	100.0
• Transcultural	4	0.5	3.5	0.0	4.0	100.0
• Dual diagnosis	7	0.0	2.0	2.0	4.0	57.1
• Intellectual Disability	3	0.0	3.0	0.0	3.0	100.0
• Eating Disorder	7	0.0	4.5	0.0	4.5	64.3
• Sensory Impairment	3	0.0	3.0	0.0	3.0	100.0
• Consumer Consultants	10	4.5	3.0	3.0	10.5	105.0
• Leaders & Quality & Safety	20	13.4	12.3	17.5	43.2	215.8
• Service Integration	20	0.0	19.5	2.5	22.0	110.0
• Forensics	27	12.5	5.5	7.0	25.0	92.6
• Administration support	26	15.0	10.5	13.7	39.2	150.8
• Butler Forensic	35	32.5	0.0	0.0	32.5	92.9
• HOTT	n.a.		10.8	23.5	22.3	n.a
Total	**456**	**242.5**	**145.9**	**154.8**	**531.2**	**119.1**

Source: Mental Health Alcohol and Other Drugs Directorate Community Mental Health Services FTE Report, 30 June 2009.
Note: Includes

Table A{ SEQ Table_A * ARABIC }: Total public sector mental health expenditure

	2007-08	2008-09	2009-10
Promotion, prevention and early intervention (PPEI)	2,443,026	2,004,323	3,055,271
Non-Government Organisations	39,435,575	46,099,722	50,253,667
Mental health training and development	6,503,252	6,058,189	6,504,016
Total mental health expenditure	630,213,601	688,450,395	778,137,056

Source: MHEC.
Note 1: Expenditure on PPEI excludes expenditure reported by mental health services as “direct” expenditure (expenditure deemed to be directly related to their program activities), and is likely therefore an underestimate. For instance, salary expenditure for an employee who undertakes PPEI in conjunction with other activities may be deemed to be direct expenditure and accordingly would be excluded.
Note 2: Expenditure on PPEI increased in 2009-10 due to the more accurate identification of expenditure by the Queensland Centre for Mental Health Promotion, Prevention and Early Intervention

Table A{ SEQ Table_A * ARABIC }: Mental health beds per 100,000 population

Setting	2006-07		2007-08		2008-09		2009-10	
	No. of beds	Rate	No. of beds	Rate	No. of beds	Rate	No. of beds	Rate
Acute	684	16.6	705	16.7	701	16.1	706	15.8
Extended Treatment	713	17.3	704	16.6	703	16.2	703	15.7
Overall	1397	33.8	1409	33.3	1404	32.3	1409	31.5

Source: National MHEC + new bed count and ABS Estimated Resident Population.

Table A{ SEQ Table_A * ARABIC }: Clinical mental health FTE per 100,000 population

Age-specific programs	2006-07 FTE	2007-08 FTE	2008-09 FTE	2009-10 FTE	2017 FTE target
Child and youth	7.81	8.57	9.02	8.52	14.00
Older persons	1.91	2.31	2.73	2.66	4.50
Adult consultation liaison	1.27	1.41	1.49	1.47	3.50
Adult case management	15.41	16.33	16.40	15.17	15.00

EXHIBIT 729

Adult mobile intensive treatment	1.97	2.29	2.37	2.36	5.50
Adult acute care	7.32	8.55	8.75	8.00	11.00
Cross-aged programs	**2006-07 FTE**	**2007-08 FTE**	**2008-09 FTE**	**2009-10 FTE**	**2017 FTE target**
Indigenous	1.61	1.68	1.75	1.67	3.00
Primary care	0.07	0.15	0.24	0.28	1.50
Transcultural	0.20	0.21	0.27	0.24	0.50
Dual Diagnosis	0.37	0.37	0.42	0.42	1.00
Intellectual Disability	0.01	0.01	0.09	0.08	0.50
Eating Disorder	0.08	0.08	0.25	0.22	0.50
Sensory Impaired			0.15	0.13	0.50
Consumer Consultants	0.28	0.39	0.47	0.48	1.00
Leaders and Quality/Safety	3.87	4.12	4.31	4.24	6.00
Service Integration Coordinators			0.48	0.48	1.25
Adult forensic liaison	0.39	0.83	0.83	0.74	0.75
Overall	**42.57**	**47.30**	**50.00**	**47.18**	**70.0**

Source: Mental Health Alcohol and Other Drugs Directorate Community Mental Health Services FTE Report, January 2010.

Table A{ SEQ Table_A * ARABIC }: Proportion of open services episodes with an identified GP

Target Population	2008-09		2009-10	
	Number of service episodes with identified GP	Per cent of open service episodes (per cent)	Number of service episodes with identified GP	Per cent of open service episodes (per cent
Adult	4852	19.4	6112	18.6
Child/Youth	640	9.0	765	8.5
Older persons	556	29.5	643	26.7
Overall	6048	17.8	7520	17.0

Source: CIMHA
Note: As CIMHA commenced on 17 November 2008, 2008-09 excludes data from 1 July 2008 to 16 November 2008.

Table A{ SEQ Table_A * ARABIC }: Average bed occupancy for acute mental health inpatient units

Target Population	2007-08 Beds occupied (accrued patient days)	2007-08 Available beds (days)	2007-08 Occupancy (per cent)	2008-09 Beds occupied (accrued patient days)	2008-09 Available beds (days)	2008-09 Occupancy (per cent)	2009-10 Beds occupied (accrued patient days)	2009-10 Available beds (days)	2009-10 Occupancy (per cent)
Adult	195,000	219,730	88.7	195,936	218,270	89.8	198,445	220,095	90.2
Child/Youth	11,031	18,980	58.1	11,642	18,980	61.3	11,804	18,980	62.2
Older Persons	15,975	18,615	85.8	16,817	18,615	90.3	16,513	18,615	88.7
Overall	222,006	257,325	86.3	224,395	255,865	87.7	226,762	257,690	88.0

Source: MHEC

Table A{ SEQ Table_A * ARABIC }: Proportion of community mental health service episodes with an identified carer

Target Population	2008-09*		2009-10	
	Service Episodes	Per cent	Service Episodes	Per cent
• Adult	656	2.1	601	2.2
• Child/Youth	790	9.9	1,151	15.9
• Older persons	33	1.7	27	1.5
• Forensic	8	0.3	9	0.5
Overall	1,487	3.4	1,788	4.7

Source: CIMHA.

EXHIBIT 729

Note (*): As CIMHA commenced on 17 November 2008, 2008-09 excludes data from 1 July 2008 to 16 November 2008.

Table A{ SEQ Table_A * ARABIC }: Proportion of Queensland population accessing non-government support services for persons with a primary psychiatric disability or mental illness

Support Service	2007-08		2008-09		2009-10	
	Persons	Services	Persons	Services	Persons	Services
• Accommodation Support	853	906	988	1,007	913	928
• Community Support	615	663	781	817	823	860
• Community Access	1,293	1,365	1,511	1,520	1,872	1,889
• Respite	299	364	277	371	294	393
Overall	2,167	3,298	2,570	3,715	2,989	4,070

Source: Disability Services NMDS, formerly known as Commonwealth-State/Territory Disability Agreement (CSTDA).
Note 1: Service user data are estimates after use of a statistical linkage key to account for individuals who received more than one service during the collection period. Totals may not be the sum of the components since individuals may have accessed multiple service types and service providers during the collection period.
Note 2: These figures are the total number of persons with a psychiatric disability or mental illness accessing non-government services during the reference period.

Table A{ SEQ Table_A * ARABIC }: Non-government organisation (NGO) Support Services as defined by the Disability Services NMDS (DS NMDS)

Support Services	Description
Accommodation support	Services that provide accommodation to people with a disability and services that provide support needed to enable a person with a disability to remain in their existing accommodation or to move to more suitable or appropriate accommodation (e.g. large/small residential or institution, hostel, group home, attendant care, in-home accommodation support, alternative family placement, other accommodation support).
Community support	Services that provide the support needed for a person with a disability to live in a non-institutional setting (e.g. therapy support, early childhood intervention, behaviour/specialist intervention, counselling, regional resource and support teams, and case management, local coordination and development).
Community access	Services designed to provide opportunities for people with disabilities to gain and use their abilities to enjoy their full potential for social independence (e.g. learning and life skills development, recreation/holiday programs, and other community access). New community mental health programs included under the new National Classification of Community Services and National Mental Health Minimum Data Set (NMHMD) have been counted in this service type.
Respite	Services which provide a short term and time limited break for families and other voluntary care givers of people with disabilities, to assist in supporting and maintaining the primary care giving relationship, while providing a positive experience for the person with the disability (e.g. own home respite, centre based respite/respite homes, host family/peer support respite, flexible respite and other respite).

Table A{ SEQ Table_A * ARABIC }: Accommodation and personal support places / packages per 100,000 of the population

	2007-08		2008-09		2009-10	
	Number	Places/ 100,000	Number	Places/ 100,000	Number	Places/ 100,000
Transitional Recovery Places	0	0	8	0.18	39	0.87
Supported housing Places	125	2.96	166	3.82	434	9.70
Resident Recovery Programs	0	0	908	20.88	1163	26.00
Consumer Operated Crisis and Respite Services	0	0	0	0	20	0.45

Source: National Classifications of Community Services and ABS.

EXHIBIT 729

Table A{ SEQ Table_A * ARABIC }: Proportion of consumer and carer workers accessing state wide mental health consumer and carer professional development, education and training, including orientation

	Average no. of CC workers	Average no. attending CCWN meeting	Annual CCWN workshop	CCWN orientation	CCWN supervisee training	CCWN skills audit
2007-08	31	15 (48%)	24 (79%)	n.a.	n.a.	16 (52%).
2008-09	37	21 (58%)	28 (77%)	n.a.	22 (60%).	16 (44%
2009-10	43	29 (67%)	35 (81%)	24 (56%)	n.a	n.a

Source: CCWN state-wide database.

Table A{ SEQ Table_A * ARABIC }: Mental Health Leaders participating in the Senior Mental Health Leadership Forum

Forum	2008	2009	2010
• November 2008	48/55 (87.3%)	X	X
• March 2009	X	42/55 (76.4%)	X
• July 2009	X	43/55 (78.2%)	X
• November 2009	X	44/55 (80.0%)	X
• March 2010	X	X	40/62 (64.5%)
Average as at 30 June 2010			217/282 (76.9%)

Source: Mental Health Leadership Forum Database, Mental Health Plan Implementation Team, Queensland Health, Mental Health Alcohol and Other Drugs Directorate.

Table A{ SEQ Table_A * ARABIC }: Number of public mental health staff completing any QCMHL training units

	2007/2008	2008/2009	2009/2010
Certificate IV in Mental Health Work			
Undertake Case Management	7	64	7
Utilise Specialist Communication Skills to Build Strong Relationships	25	20	90
Work Within a Legal and Ethical Framework	12		15
Facilitate Co-Operative Behaviour	10	6	6
Respond Holistically to Client Issues	15	5	14
Provide Brief Intervention		8	14
Work Effectively with Culturally Diverse Clients and Co-Workers	11	26	7
Assess and Respond to Individuals at Risk of Self-Harm or Suicide		78	5
Provide Support Services to Clients			20
Orientation to Mental Health Work	20		41
Provide Non-Clinical Services to People with Mental Health Issues			17
Provide Interventions to Meet the Needs of Consumers with Mental Health and AOD Issues		107	87
Work with Other Services			17
Implement and Monitor OHS Policies and Procedures for a Work Place	1	25	14
Total Certificate IV in Mental Health Work	**101**	**339**	**354**
Workforce Development Programs		One	
Mental State Examination		205	235
Case Management			95
Provide a brief intervention			22
Suicide Risk Assessment and Management		104	141
Orientation to Mental Health Practice		58	29
Working Holistically		106	
Legal and Ethical Issues in Practice		117	77

EXHIBIT 729

Total Workforce Development		**590**	**599**
Workshop Series			
Mental Health Educator Development		91	51
Critical Components of Risk Assessment & Management for the Mental Health Practitioner		585	1125
Mental Health Assessment and Capacity 2 Day			91
Capacity Assessment 1/2 Day			96
Mental Health Clinical Supervision Training Program Supervisor Training	103	179	159
Mental Health Clinical Supervision Training Program Supervisee Training		65	104
Mental Health Clinical Supervision - Supervising Supervisors			22
Total Workshop Series	**103**	**920**	**1648**
Overall	**204**	**1849**	**2601**

Source: QCMHL training evaluation database (July 2007 to June 2008), QCMHL WiseNet training database (July 2008 to December 2009).
Note: Columns with an 'x' indicates the program was either not offered or was under development.

Table A{ SEQ Table_A * ARABIC }: Mental health FTE vacancy rates by position and vacancy types

Position Type		Medical	Nursing	Allied Health	Overall
	Total FTE	503.8	2514.1	1005.3	4023.1
	No. unfilled FTE	15.4	64.1	107.7	187.2
	Per cent unfilled	3.1	2.5	10.7	4.7
	No. unbackfilled FTE	n/a	32.4	26.5	58.9
Jun-08	**Per cent unbackfilled**	n/a	1.3	2.6	1.5
	All forms vacant FTE	15.4	96.5	134.2	246.1
	Per cent all forms vacant	3.1	3.8	13.3	6.1
	Critical Vacancies	5.0	1.0	14.1	20.1
	Per cent critical vacancies	32.5	1.0	10.5	8.2
	Total FTE	519.1	2613.1	1080.0	4212.2
	No. unfilled FTE	28.0	27.8	51.3	107.1
	Per cent unfilled	5.4	1.1	4.8	2.5
	No. unbackfilled FTE	n/a	3.5	5.0	8.5
Jun-09	**Per cent unbackfilled**	n/a	0.1	0.5	0.2
	All forms vacant FTE	28.0	31.3	56.3	115.6
	Per cent all forms vacant	5.4	1.2	5.2	2.7
	Critical Vacancies	14.0	0.0	7.5	21.5
	Per cent critical vacancies	50.0	0.0	13.3	18.6
	Total FTE	514.1	2502.4	1082.3	4098.7
	No. unfilled FTE	34.5	30.2	31.4	96.1
	Per cent unfilled	6.7	1.2	2.9	2.3
	No. unbackfilled FTE	n/a	9.6	6.0	15.6
Jun-10	**Per cent unbackfilled**	n/a	0.4	0.6	0.4
	All forms vacant FTE	34.5	39.8	37.4	111.7
	Per cent all forms vacant	6.7	1.6	3.5	2.7
	Critical Vacancies	1.0	2.0	9.0	12.0
	Per cent critical vacancies	2.9	5.0	24.1	10.7

Source: Work For Us vacancy data and MHEC (FTE data).
Note 1: Temporary vacancies were included in the 'All' vacancies up until May 2008. From May 2008 onwards the temporary filled vacancies were removed from the 'All' vacancies and reported on separately. Please also note that medical vacancies are only reported on unfilled positions for Mental Health Data. The medical data is collected in a different format to the Nursing and Allied Health and is not broken down in the same way as Nursing and Allied Health

EXHIBIT 729

Note 2: Queensland implemented a new payroll system during 2009/10 which resulted in a modification to the methodology used to calculate FTE. This caused the total FTE recorded for June 2010 and ongoing years to reduce.

Table A{ SEQ Table_A * ARABIC }: Staff satisfaction survey - 2009

MEASURE	Overall Finding	March 2009 cohort				October 2009 cohort		
		Site 1 (n=421)	Site 2 (n=71)	Site 3 (n=104)	Site 4 (n=104)	Site 5 (n=11)	Site 6 (n=52)	Site 7 (n=191)
Individual Outcome								
• Quality of Work Life	Neutral	2.27 M	3.98 M	-0.14 M	-7.0 M	-0.79 M	0.28 M	2.60 M
• Individual Morale	Neutral	1.47 M	4.01 M	0.49 M	-1.23 M	0.94 M	1.42 M	1.75 M
• Individual Distress (negative scores desirable)	Positive	-12.61 C	-11.22 C	-12.86 C	-9.92 C	-12.59 C	-10.06 C	-13.59 C
Organisational Climate								
• Workplace Morale	Neutral	2.24 M	6.07 M	2.22 M	1.27 M	4.77 M	-1.79 M	2.51 M
• Supervisor Support	Neutral	4.62 M	5.92 M	6.24 M	1.35 M	12.18 C	4.03 M	7.02 M
• Participative Decision Making	Neutral	-4.33 M	1.63 M	0.16 M	-1.64 M	1.48 M	-3.88 M	0.35 M
• Role Clarity	Neutral	8.34 M	5.78 M	7.93 M	7.76 M	8.0 M	7.72 M	9.02 C
• Peer Support	Positive	11.9 C	15.35 C	13.48 C	15.33 C	18.57 C	11.31 C	11.7 C
• Appraisal & Recognition	Neutral	-1.78 M	-0.47 M	-1.23 M	-3.99 M	6.65 M	-1.71 M	1.79 M
• Professional Growth	Neutral	-2.81 M	0.37 M	0.13 M	-3.34 M	5.17 M	-1.09 M	5.64 M
• Goal Congruence	Neutral	3.6 M	4.37 M	6.95 M	3.16 M	10.49 C	1.93 M	4.49 C
• Workplace Distress (negative scores desirable)	Neutral	5.42 M	8.06 M	8.52 M	14.78 C	8.82 C	12.47 C	6.03 M
• Excessive Work Demands (negative scores desirable)	Negative	2.76 M	9.78 Ch	10.89 Ch	19.23 Ch	12.72 Ch	9.9 Ch	4.08 M
Trust in Leadership								
• Immediate Supervisor	Neutral	6.73 M	9.54 M	9.06 C	2.91 M	8.23 M	6.45 M	8.45 M
• Senior Management	Neutral	-5.13 M	2.75 M	4.06 M	-6.18 M	7.66 M	-5.91 M	-1.24 M
• District Executive/Executive	Negative	-13.67 Ch	-12.9 Ch	0.89 M	-9.18 Ch	-7.32 M	-9.81 Ch	-6.73 M
Organisational Management Practices								
• Workplace Health and Safety	Positive	13.5 C	21.33 C	19.65 C	15.23 C	24.44 C	15.18 C	19.04 C
• Work Area Management Practices	Neutral	-0.82 M	-0.92 M	2.37 M	-3.36 M	6.65 M	-1.04 M	2.17 M
• Support for Managing Others	Neutral	6.05 M	5.84 M	6.26 M	5.26 M	n.a.	9.20 C	4.07 M
• Employee Engagement	Positive	5.14 M	11.22 C	8.12 M	5.84 M	9.65 C	10.08 C	10.4 C
Clinical Work								
• Clinical Management Practices	Neutral	0.88 M	-1.13 M	5.52 M	-1.24 M	6.90 M	4.48 M	4.08 M
• Multidisciplinary Team Support for Patient Care	Positive	16.31 C	16.46 C	21.68 C	15.06 C	23.19 C	14.62 C	17.34 C
• Clinical	Positive	9.47	7.84	12.35	6.43	18.44	11.83	7.59

EXHIBIT 729

MEASURE	Overall Finding	March 2009 cohort Site 1 (n=421)	Site 2 (n=71)	Site 3 (n=104)	Site 4 (n=104)	October 2009 cohort Site 5 (n=11)	Site 6 (n=52)	Site 7 (n=191)
Communication		C	M	C	M	C	C	M
Immediate Supervisor								
• Mutual trust (agree/strongly agree)		57.9%	61.9%	54.8%	50.9%	36.4%	63.5%	51.3%
Harmful behaviours								
• Know how to report harmful behaviours (agree/strongly agree)		86.9%	88.6%	91.3%	90.4%	90.9%	92.2%	90.4%
• Trust process for managing harmful behaviours (agree/strongly agree)		42.3%	44.3%	50.0%	37.5%	54.5%	43.1%	43.9%
• Have experienced harmful behaviours directed toward self in the past 6 months		34.4%	28.2%	34.6%	45.2%	27.3%	48.1%	40.3%
• Have experienced harmful behaviours from staff I manage or supervise during the past 6 months		29.1%	20.0%	28.6%	25.9%	50.0%	33.3%	25.5%
Career intentions								
• Considering leaving job		40.9%	39.44%	41.4%	44.2%	18.2%	34.6%	42.4%
• Looking for new job		27.3%	22.5%	28.9%	25.0%	9.09%	50.0%	31.9%
• Would remain with QLD Health if decided to leave current job		66.9%	70.4%	59.6%	50.9%	72.73%	53.85%	71.2%
Performance								
• Had a performance plan		54.9%	36.6%	43.3%	42.3%	81.8%	46.2%	70.7%
• Conducted a performance plan[17]		56	6	7	17	0	6	42
Reasons for considering leaving current job (top 3)								
• Unhappy with management		23.0%	19.7%	18.3%	24.0%	18.2%	25.0%	24.1%
• Career development		18.5%	21.1%	20.2%	24.0%	18.2%	X	19.8%
• Lack of recognition in work area		15.4%	18.3%	17.3%	22.0%	27.3%	15.4%	21.5%
• Unfair treatment towards staff		X	X	X	X	X	17.3%	X
Quality in Workplace								
Five most important things that need to be improved								
Supervisory practices		9.3%	10.6%	7.9%	10.2%	9.4%	11.5%	9.0%
• Manager-Employee relationships		8.4%	X	X	X	9.4%	X	7.3%
• Recognition for good work		8.2%	11.2%	11.6%	9.4%	X	8.4%	8.4%
• Openness of communication		8.1%	X	7.7%	X	X	8.0%	9.0%
• Availability of equipment		7.1%	8.8%	9.6%	8.9%	X	X	X
• Efficiency and effectiveness		X	8.2%	8.5%	9.1%	X	7.3%	8.2%
• Chances to advance		X	9.4%	X	X	X	X	X
• Work-life balance		X	X	X	7.9%	X	X	X
• Clarity of expectations		X	X	X	X	9.4%	X	X
• Fair treatment		X	X	X	X	9.4%	X	X
• Relationship with co-workers		X	X	X	X	13.2%	7.3%	X
Five best things about my work area								
• Relationships with co-workers		15.7%	15.5%	14.6%	19.6%	X	14.3%	11.9%
• Work satisfaction		8.9%	8.9%	X	7.1%	X	X	8.5%
• Work-life balance		8.6%	10.3%	X	7.9%	8.3%	12.3%	8.9%
• Openness of communication		7.3%	7.0%	X	X	8.3%	X	7.2%
• Freedom from harassment		6.7%	9.6%	8.3%	6.5%	X	X	X
• Chances to advance		X	X	X	X	13.9%	X	9.2%
• Fair treatment		X	X	8.8%	X	X	6.4%	X
• Focussed behaviour		X	X	6.9%	7.9%	8.3%	9.1%	X
• Availability of equipment		X	X	6.6%	X	19.4%	9.1%	X

Source: Queensland Health Better Workplaces Survey.

[17] It is difficult to determine what proportion of persons authorised to conduct a performance plan actually conducted a performance plan as the number of authorised persons are not provided in the Staff Satisfaction Survey. Using the number of respondents as the denominator will result with misleading information as not all these respondents are authorised to conduct a performance plan.

EXHIBIT 729

Table A{ SEQ Table_A * ARABIC }: Readmissions within 28 days of original admission

	2007-08			2008-09			2009-10		
	No.	Total separations	Per cent	No.	Total separations	Per cent	No.	Total separations	Per cent
Adult	2,095	12,045	17.4	2,124	12,410	17.1	1,932	12,279	15.7
Child and Youth	138	816	16.9	194	936	20.7	143	929	15.4
Older Persons	73	644	11.3	84	672	12.5	104	745	14.0
Overall	**2,306**	**13,505**	**17.1**	**2,402**	**14,018**	**17.1**	**2,179**	**13,953**	**15.6**

Source: QHAPDC.
Note 1: Overall numbers will be greater than the sum of the individual target population numbers because persons who move between the different target populations within the reference period will be counted more than once.

Table A{ SEQ Table_A * ARABIC }: Number of separations delivered to local residents

	2007-08			2008-09			2009-10		
	No.	Total separations	Per cent	No.	Total separations	Per cent	No.	Total separations	Per cent
Adult	11229	13134	85.5	11686	13582	86.0	11788	13589	86.7
Child and Youth	698	839	83.2	773	953	81.1	788	950	82.9
Older Persons	700	759	92.2	697	759	91.8	811	872	93.0
Overall	**12627**	**14732**	**85.7**	**13156**	**15294**	**86.0**	**13387**	**15411**	**86.9**

Source: QHAPDC.

Table A{ SEQ Table_A * ARABIC }: Proportion of new clients accessing Queensland public mental health services

	2007-08		2008-09		2009-10	
	Number of new clients	Proportion of total (%)	Number of new clients	Proportion of total (%)	Number of new clients	Proportion of total (%)
Overall	46,775	61.3	42,126	57.1	42,323	57.7

Source: CIMHA and QHAPDC.

Table A{ SEQ Table_A * ARABIC }: Pre-admission community contacts

	2007-08			2008-09			2009-10		
	No.	Total separations	Per cent	No.	Total separations	Per cent	No.	Total separations	Per cent
Adult	5,851	12,048	48.6	5,157	12,421	41.5	4,953	12,290	40.3
Child and Youth	338	647	52.2	433	936	46.3	423	929	45.5
Older Persons	327	644	50.8	282	672	42.0	318	745	42.7
Overall	**6,516**	**13,339**	**48.8**	**5,872**	**14,029**	**41.9**	**5,694**	**13,964**	**40.8**

Source: CIMHA and QHAPDC.

EXHIBIT 729

Table A{ SEQ Table_A * ARABIC }: Post-discharge community contacts (consumer participated)

	2007-08			2008-09			2009-10		
	No.	Total separations	Per cent	No.	Total separations	Per cent	No.	Total separations	Per cent
Adult	6370	12045	52.9	5498	12410	44.3	5681	12279	46.3
Child and Youth	328	816	40.2	353	936	37.7	354	929	38.1
Older Persons	377	644	58.5	312	672	46.4	351	745	47.1
Overall	**6698**	**12861**	**52.1**	**5851**	**13346**	**43.8**	**6035**	**13208**	**45.7**

Source: CIMHA and QHAPDC.

Table A{ SEQ Table_A * ARABIC } Average number of treatment days per three month period of ambulatory care

Target Population	2007-08 Average number of treatment days (standard error)	2008-09 Average number of treatment days (standard error)	2009-10 Average number of treatment days (standard error)
Adult	6.7 (±0.02)	6.1 (±0.02)	6.0 (±0.02)
Child/Youth	5.6 (±0.03)	5.3 (±0.03)	5.1 (±0.03)
Forensic	3.6 (±0.03)	3.2 (±0.03)	3.0 (±0.03)
Older persons	6.2 (±0.07)	5.8 (±0.06)	6.1 (±0.06)
Overall	**6.3 (±0.02)**	**5.8 (±0.02)**	**5.7 (±0.02)**

Source: CIMHA and legacy systems.

EXHIBIT 729

Table A{ SEQ Table_A * ARABIC }: Proportion of collection occasions where a consumer self-rate outcomes measure was collected

	Target	Service Setting	Start			Review			End			All		
			Potential collections	Actual collections	Per cent	Potential collections	Actual collections	Per cent	Potential collections	Actual collections	Per cent	Potential collections	Actual collections	Per cent
2008-09*	Child/ Youth	Acute Inpatient	586	184	31.4	362	0	0.0	581	47	8.1	1,529	231	15.1
		Community/ Ambulatory	4,144	1,070	25.8	6,903	525	7.6	3,693	168	4.5	14,740	1,763	12.0
		Extended Treatment	8	2	25.0	1	0	0.0	9	0	0.0	18	2	11.1
		Subtotal	4,738	1,256	26.5	7,266	525	7.2	4,283	215	5.0	16,287	1,996	12.3
	Forensic	Community/ Ambulatory	1,164	3	0.3	32	0	0.0	932	0	0.0	2,128	3	0.1
		Extended Treatment	40	7	17.5	487	17	3.5	38	0	0.0	565	24	4.2
		Subtotal	1,204	10	0.8	519	17	3.3	970	0	0.0	2,693	27	1.0
	Adult	Community/ Ambulatory	16,625	447	2.7	20,001	860	4.3	14,895	85	0.6	51,521	1,392	2.7
		Extended Treatment	217	29	13.4	860	173	20.1	199	10	5.0	1,276	212	16.6
		Subtotal	16,842	476	2.8	20,861	1,033	5.0	15,094	95	0.6	52,797	1,604	3.0
	Older Persons	Community/ Ambulatory	999	7	0.7	1,748	63	3.6	884	6	0.7	3,631	76	2.1
		Extended Treatment	122	0	0.0	415	17	4.1	109	0	0.0	646	17	2.6
		Subtotal	1,121	7	0.6	2,163	80	3.7	993	6	0.6	4,277	93	2.2
		Overall	**23,905**	**1,749**	**7.3**	**30,809**	**1,655**	**5.4**	**21,340**	**316**	**1.5**	**76,054**	**3,720**	**4.9**
2009-10	Child/ Youth	Acute Inpatient	1,012	325	32.1	513	7	1.4	1,011	79	7.8	2,536	411	16.2
		Community/ Ambulatory	6,650	1,923	28.9	13,002	1,153	8.9	6,086	202	3.3	25,738	3,278	12.7
		Extended Treatment	12	3	25.0	15	11	73.3	11	0	0.0	38	14	36.8
		Subtotal	7,674	2,251	29.3	13,530	1,171	8.7	7,108	281	4.0	28,312	3,703	13.1
	Forensic	Community/ Ambulatory	1,603	27	1.7	60	1	1.7	1,347	1	0.1	3,010	29	1.0
		Extended Treatment	63	5	7.9	418	26	6.2	61	0	0.0	542	31	5.7
		Subtotal	1,666	32	1.9	478	27	5.6	1,408	1	0.1	3,552	60	1.7
	Adult	Community/ Ambulatory	25,967	854	3.3	38,758	2,470	6.4	24,030	204	0.8	88,755	3,528	4.0
		Extended Treatment	385	60	15.6	1,078	313	29.0	393	21	5.3	1,856	394	21.2
		Subtotal	26,352	914	3.5	39,836	2,783	7.0	24,423	225	0.9	90,611	3,922	4.3
	Older Persons	Community/ Ambulatory	1,535	13	0.8	3,033	106	3.5	1,518	15	1.0	6,086	134	2.2
		Extended Treatment	213	1	0.5	278	14	5.0	199	0	0.0	690	15	2.2
		Subtotal	1,748	14	0.8	3,311	120	3.6	1,717	15	0.9	6,776	149	2.2
		Overall	**37,440**	**3,211**	**8.6**	**57,155**	**4,101**	**7.2**	**34,656**	**522**	**1.5**	**129,251**	**7,834**	**6.1**

Source: CIMHA.

Note (*): As CIMHA commenced on 17 November 2008, 2008-09 excludes data from 1 July 2008 to 16 November 2008.

EXHIBIT 729

Table A{ SEQ Table_A * ARABIC }: Proportion of community mental health consumers with non-clinical government, non-clinical non-government and 'other' service representatives

Agency Type	2008-09*		2009-10	
	Number	Per cent	Number	Per cent
• Government (non-clinical)	391	1.0	895	1.8
• Non-government (non-clinical)	162	0.4	355	0.7
• Other (Alcohol, Tobacco & Drug Services Officer)[1]	29	0.1	35	0.1
Overall	582	1.5	759	2.6

Source: CIMHA.

Note 1 Alcohol, Tobacco and Drug Services may be provided by a government or privately owned department, agency or facility and also involve the provision of clinical or non-clinical care. The current system does not distinguish between source and type of service provided.

Note 2 (*)As CIMHA commenced on 17 November 2008, 2008-09 excludes data from 1 July 2008 to 16 November 2008.

Table A{ SEQ Table_A * ARABIC }: Seclusion events per 1000 patient days

Service Type	2008-09			2009-10		
	Seclusion events	Patient days	Seclusion events/1000 patient days	Seclusion events	Patient days	Seclusion events/1000 patient days
• Acute inpatient	4,096	215,967	19.0	3,167	217,435	14.6
Overall	4,096	215,967	19.0	3,167	217,435	14.6

Source: CIMHA and QHAPDC.

EXHIBIT 729

Table A{ SEQ Table_A * ARABIC }: Collection occasions where a clinical outcome measure was recorded by clinicians, 2008-09 to 2009-10

	Target	Service Setting	Start			Review			End			All		
			Potential collections	Actual collections	Per cent	Potential collections	Actual collections	Per cent	Potential collections	Actual collections	Per cent	Potential collections	Actual collections	Per cent
2008-09*	Child/ Youth	Acute Inpatient	586	261	44.5	362	0	0.0	581	119	20.5	1,529	380	24.9
		Community/ Ambulatory	4,144	1,618	39.0	6,903	1,017	14.7	4,141	1,311	31.7	15,188	3,946	26.0
		Extended Treatment	8	2	25.0	1	0	0.0	9	0	0.0	18	2	11.1
		Subtotal	4,738	1,881	39.7	7,266	1,017	14.0	4,731	1,430	30.2	16,735	4,328	25.9
	Forensic	Community/ Ambulatory	1,164	20	1.7	32	18	56.3	1,208	6	0.5	2,404	44	1.8
		Extended Treatment	40	14	35.0	487	63	12.9	40	22	55.0	567	99	17.5
		Subtotal	1,204	34	2.8	519	81	15.6	1,248	28	2.2	2,971	143	4.8
	Adult	Community/ Ambulatory	16,625	3,913	23.5	20,001	7,680	38.4	16,351	3,374	20.6	52,977	14,967	28.3
		Inpatient	8,496	3,897	45.9	1,027	66	6.4	8,504	2,897	34.1	18,027	6,860	38.1
		Extended Treatment	217	102	47.0	860	280	32.6	201	67	33.3	1,278	449	35.1
		Subtotal	25,338	7,912	31.2	21,888	8,026	36.7	25,056	6,338	25.3	72,282	22,276	30.8
	Older Persons	Community/ Ambulatory	999	361	36.1	1,748	906	51.8	940	271	28.8	3,687	1,538	41.7
		Inpatient	166	114	68.7	8	0	0.0	170	89	52.4	344	203	59.0
		Extended Treatment	122	80	65.6	415	76	18.3	116	33	28.4	653	189	28.9
		Subtotal	1,287	555	43.1	2,171	982	45.2	1,226	393	32.1	4,684	1,930	41.2
		Overall	**32,567**	**10,382**	**31.9**	**31,844**	**10,106**	**31.7**	**32,261**	**8,189**	**25.4**	**96,672**	**28,677**	**29.7**
2009-10	Child/ Youth	Acute Inpatient	1,012	412	40.7	513	5	1.0	1,012	195	19.3	2,537	612	24.1
		Community/ Ambulatory	6,650	2,984	44.9	13,002	2,666	20.5	6,822	1,932	28.3	26,474	7,582	28.6
		Extended Treatment	12	3	25.0	15	12	80.0	11	0	0.0	38	15	39.5
		Subtotal	7,674	3,399	44.3	13,530	2,683	19.8	7,845	2,127	27.1	29,049	8,209	28.3
	Forensic	Community/ Ambulatory	1,603	70	4.4	60	13	21.7	1,698	38	2.2	3,361	121	3.6
		Extended Treatment	63	14	22.2	418	43	10.3	62	20	32.3	543	77	14.2
		Subtotal	1,666	84	5.0	478	56	11.7	1,760	58	3.3	3,904	198	5.1
	Adult	Community/ Ambulatory	25,967	7,338	28.3	38,758	16,607	42.8	26,448	7,000	26.5	91,173	30,945	33.9
		Inpatient	14,490	7,396	51.0	2,088	140	6.7	14,478	5,501	38.0	31,056	13,037	42.0
		Extended Treatment	385	141	36.6	1,078	508	47.1	397	128	32.2	1,860	777	41.8
		Subtotal	40,842	14,875	36.4	41,924	17,255	41.2	41,323	12,629	30.6	124,089	44,759	36.1
	Older Persons	Community/ Ambulatory	1,535	817	53.2	3,033	1,868	61.6	1,608	782	48.6	6,176	3,467	56.1
		Inpatient	219	191	87.2	15	1	6.7	217	174	80.2	451	366	81.2
		Extended Treatment	213	142	66.7	278	86	30.9	212	84	39.6	703	312	44.4
		Subtotal	1,967	1,150	58.5	3,326	1,955	58.8	2,037	1,040	51.1	7,330	4,145	56.5
		Overall	**52,149**	**19,508**	**37.4**	**59,258**	**21,949**	**37.0**	**52,965**	**15,854**	**29.9**	**164,372**	**57,311**	**34.9**

Source: CIMHA.

Note (*): As CIMHA commenced on 17 November 2008, 2008-09 excludes data from 1 July 2008 to 16 November 2008.

EXHIBIT 729

Table A{ SEQ Table_A * ARABIC }: Total hours of community/ambulatory clinical interventions recorded as a proportion of total community/ambulatory clinical FTE hours

	2008-09*			2009-10		
	Estimated available community/ ambulatory staff time (hours)	Duration of ambulatory/ community interventions recorded (hours)	Proportion of available hours recorded (per cent)	Estimated available community/ ambulatory staff time (hours)	Duration of ambulatory/ community interventions recorded (hours)	Proportion of available hours recorded (per cent)
Child/Youth	103,410	59,197	57.2	185,194	101,042	54.6
Forensic	27,412	4,380	16.0	48,928	7,912	16.2
Adult	292,751	186,966	63.9	530,047	361,201	68.1
Older Persons	22,903	13,667	59.7	42,782	27,726	64.8
Overall	446,476	264,210	59.2	806,951	497,881	61.7

Source: CIMHA and Mental Health Plan Implementation team Bi-annual Community FTE Reports.
Note 1 (*):As CIMHA commenced on 17 November 2008, 2008-09 excludes data from 1 July 2008 to 16 November 2008.
Note 2: Community/ambulatory staff hours for 2008-09 has been estimated on a pro-rata basis, at 58.3 per cent of the total for 2008-09.

EXHIBIT 729

Table A{ SEQ Table_A * ARABIC }: Change in consumers' clinical outcomes

	Target population	Service setting	Statistically significant improvement		No statistically significant change		Statistically significant deterioration		Total
			Number	Per cent	Number	Per cent	Number	Per cent	
2008-09*	Child/Youth	Discharged from hospital	69	72.6	23	24.2	3	3.2	95
		Discharged from ambulatory care	192	57.8	123	37.0	17	5.1	332
		In ongoing care	227	40.5	257	45.8	77	13.7	561
		Subtotal	488	49.4	403	40.8	97	9.8	988
	Forensic	Discharged from ambulatory care	4	100.0					4
		In ongoing care	1	20.0	4	80.0			5
		Subtotal	5	55.6	4	44.4			9
	Adult	Discharged from hospital	1103	76.9	276	19.2	56	3.9	1435
		Discharged from ambulatory care	533	56.2	337	35.5	78	8.2	948
		In ongoing care	853	25.0	2041	59.8	519	15.2	3413
		Subtotal	2489	42.9	2654	45.8	653	11.3	5796
	Older Persons	Discharged from hospital	37	57.8	22	34.4	5	7.8	64
		Discharged from ambulatory care	50	53.2	39	41.5	5	5.3	94
		In ongoing care	81	21.7	220	59.0	72	19.3	373
		Subtotal	168	31.6	281	52.9	82	15.4	531
		Overall	**3150**	**43.0**	**3342**	**45.6**	**832**	**11.4**	**7324**
2009-10	Child/Youth	Discharged from hospital	88	58.7	53	35.3	9	6.0	150
		Discharged from ambulatory care	573	60.5	341	36.0	33	3.5	947
		In ongoing care	701	46.1	631	41.5	187	12.3	1519
		Subtotal	1362	52.1	1025	39.2	229	8.8	2616
	Forensic	Discharged from ambulatory care	7	36.8	8	42.1	4	21.1	19
		In ongoing care	17	58.6	7	24.1	5	17.2	29
		Subtotal	24	50.0	15	31.3			48
	Adult	Discharged from hospital	2185	74.9	607	20.8	127	4.4	2919
		Discharged from ambulatory care	1453	60.8	770	32.2	168	7.0	2391
		In ongoing care	2391	34.0	3424	48.7	1210	17.2	7025
		Subtotal	6029	48.9	4801	38.9	1505	12.2	12335
	Older Persons	Discharged from hospital	99	66.4	44	29.5	6	4.0	149
		Discharged from ambulatory care	173	46.5	163	43.8	36	9.7	372
		In ongoing care	169	25.4	359	53.9	138	20.7	666
		Subtotal	441	37.2	566	47.7	180	15.2	1187
		Overall	**7856**	**48.5**	**6407**	**39.6**	**1914**	**11.8**	**16186**

Note(*) As CIMHA commenced on 17 November 2008, 2008-09 excludes data from 1 July 2008 to 16 November 2008.

EXHIBIT 729

Table A{ SEQ Table_A * ARABIC }: Perceptions of service provision of consumers, carers and mental health staff - baseline 2009

Domain Perceptions of…	Consumer (n=296) Mean	Carer (n=101) Mean	Mental Health Staff (n=215) Mean
• Promotion and prevention	3.16	2.36	3.06
• Service mix	3.24	2.78	3.10
• Service linkages	3.05	2.87	2.90
• Consumer and carer rights	3.24	2.96	3.48
• Mental health workers	3.80	3.90	n.a.
• Mental health worker competence	3.64	n.a.	n.a.
• Mental health service received	3.52	n.a.	n.a.
• Safety	3.40	n.a.	n.a.
• Service quality	n.a.	3.13	n.a.
• Organisational commitment	n.a.	n.a.	5.14 [a]
• Therapeutic optimism	n.a.	n.a.	58.8 [b]

Source: Service Evaluation and Research Unit, The Park - Centre for Mental Health. *Consumer, carer and staff perceptions of service provision (Final Report - Phase 1)*, February 2010, (unpublished).
a: Responses rated on a seven point scale (1=strongly disagree to 7= strongly agree).
b: Responses rated on a seven point scale (1=strongly disagree to 7= strongly agree) but the total score is used ranging between 10 and 70.

Table A{ SEQ Table_A * ARABIC }: Queensland proportion reporting no/low, medium, high or very high levels of psychological distress

Level of psychological risk	2005[1]		2008[2]		2009[3]	
	Per cent	95 per cent CI	Per cent	95 per cent CI	Per cent	95 per cent CI
• No or Low	59.7	(57.1 - 62.3)	59.7	(57.3 - 62.2)	61.2	(59.4 - 63.0)
• Moderate	25.6	(23.4 - 27.9)	25.0	(22.6 - 27.4)	26.7	(25.1 - 28.4)
• High	11.2	(9.5 - 13.3)	11.1	(9.3 - 12.8)	8.9	(7.9 - 10.0)
• Very High	3.5	(2.5 - 4.8)	4.2	(3.3 - 5.3)	3.1	(2.6 - 3.8)

Source: 2005 Queensland Omnibus Survey, Questionnaire and Weighted Results, Statistical Analysis Unit, Health Statistics Centre (formerly Epidemiology Services Unit, Health Information Branch), Queensland Health, February 2006. The 2005 survey was benchmarked to population counts from the 2003 Estimated Residential Population figures. There were 1,846 responses to the survey, giving a response rate of 70.1 per cent.
Estimate of the Prevalence of Anxiety and Depressive Disorders in the Adult Queensland Population using Kessler Psychological Distress Scale, Mental Health Information Unit, Queensland Health, November 2008. A total of 2002 completed surveys were obtained giving an overall response rate of 46.6 per cent.
Queensland Health: Pollard G, White D, Harper C. 2009. Self-Reported Health Status: Queensland, 2009 Survey Report. Queensland Health Brisbane. Benchmark population data was obtained from the Estimated Resident Population for Queensland 2007; based on results from the 2006 Census of Population and Housing conducted by the ABS. There were 6881 responses to the survey, giving a response rate of 56.7 per cent.

EXHIBIT 729

C: Methodology

Data identification

A range of performance measures were identified following wide consultation with mental health clinicians from across Queensland Health Mental Health Services. Through repeated consultation with stakeholders and reference working groups, measures were reduced in number and refined. This resulted in a list of 50 indicators that will be used to assess progress. These indicators will be reviewed over time to determine their ongoing utility.

Data collection

Relevant key performance measures were collected from existing data sources, including the CIMHA, QHAPDC databases, Queensland Mental Health reports and Mental Health Alcohol and Other Drugs Directorate and Department of Communities' in-house databases. Independent projects aligned with the five priority areas identified in the Evaluation Framework will be evaluated independently by the respective project managers. The results of these evaluations, when available, will be used to inform the overall evaluation.

Data analysis

Descriptive statistics such as percentage and percentage rate change and trends (where sufficient years of data are available) will be used to demonstrate the level of progress towards achieving outcomes specified in the Plan.

Reference Period

- Generally, indicator data will be reported on a financial year basis or when it is part of a planned collection cycle (e.g. every three years for the K-10);
- Where data for an indicator is qualitative in nature or consists of a progress update, a snapshot as at end of financial year (30 June) will be used as the reference period.

Reporting Level

Unless otherwise specified, data will be reported at a state-wide level.

Disaggregation

- Target population: A number of outcome indicators have been partitioned by mental health target population to determine whether certain populations are more or less responsible for the overall results found for a particular indicator. This information will assist to identify areas of mental health service provision that may require investigation and/or further investment of resources. The target populations used in this report refer to four population groups primarily targeted by a specialised mental health service.
- General Services: principally target the general adult population (≥18 - <65 years) but may provide services to children, youth or the aged. General services, therefore, are those services that are not primarily specialist child and youth, older persons, or forensic services. General mental health inpatient services include hospital units, in which the principal function is the provision of some form of specialised service to the general adult population, including dual diagnosis, medium secure and Acquired Brain Injury.
- Older Persons Services: principally target the aged population (65+ years). Classification of services in this population requires recognition by the governing authority of the special focus of

the service on aged persons. This service category does not include the treatment of older people by general services.

- Child and Youth Services: principally target children and youths (≥0 - <18 years). Classification of services in this population requires recognition by the governing authority of the special focus of the service on children and youths. For smaller regional services this may be the appointment of staff to specifically work with children and youths within a broader mental health team.
- Forensic services: principally assess, treat and care for mentally disordered individuals whose condition have led them to commit criminal offences or make it likely that they will offend in the future if not adequately treated or contained. Forensic services also include all prison-based services. In Queensland, high secure inpatient services should be reported as Forensic.

Limitations

- The most fundamental of the limitations is the limited use of objective sources of data from which progress can be measured against;
- It is not feasible to comprehensively evaluate each initiative and outcome of the Plan, due to the large range of initiatives;
- Wherever possible, the evaluation aims to utilise data that is available in existing systems. Data is more readily available in the public mental health sector and the indictors tend to reflect the bias in available data; and
- There are a number of limitations of performance indicators which must be considered in the interpretation of the results. These include:

    - Difficulty in identifying how much of the change is due to the initiatives of the Plan;
    - Potential difficulty in establishing clear relationships between actions and achievement of desired outcomes; and
    - Performance indicators are only as reliable as the data they are based upon.
    - Considerations
    - Reform of the public mental health care system commenced prior to the adoption of the current Queensland Plan for Mental Health 2007-2017. As a consequence of earlier efforts in reform it is possible that performance measured against indicators may reveal improvements prior to 2007-08, the first year of the Plan.

Data Quality

It is acknowledged that there are limitations and issues associated with the collection of data utilised to construct key performance indicators, including the variable level of quality and entry of data in the source systems. Consideration must be given to the variable quality of the available data sources, in particular expenditure data. The Mental Health Alcohol and Other Drugs Directorate is implementing a range of initiatives aimed at enhancing the quality of a range of data, which in turn will improve the accuracy, consistency, and utility of the reported information.

Caveats

- 2009-10 data is preliminary and subject to change.
- Expenditure data: The amount of expenditure refers to what is reported by districts and may not represent total expenditure.
- Public sector mental health service staff satisfaction - 'Better Workplaces' staff opinion survey: At present, results across cohorts cannot be combined to provide a single annual figure due to different sample sizes involved and different time periods used which could affect the reliability of findings. Development of this indicator will involve providing calculations that allow for a single score across cohorts.

EXHIBIT 729

Reporting issues - CIMHA

- Queensland Health began operation of a new recording system called the CIMHA on the 17th November 2008. Unexpected results reported in indicators may be due to reporting issues related to the new application, changes in business processes associated with record keeping (such as ability to record more than one intervention per provision of service).
- The system replaces and incorporates three legacy systems that previously operated independently. As a result, the data model underpinning the new system is modified from the model implemented in the legacy applications. Accordingly, results should be treated cautiously for indicators that rely on data that was previously collected in the legacy system(s) and is now collected in the CIMHA. For these indicators, variations between 2008-09 and 2009-10 may be an artefact of the changed data model. Where appropriate, 2009-10 should be regarded as a new baseline (the first full year of the CIMHA's operation).