Oaths Act 1867

Statutory Declaration

I, **Dr Aaron Groves** of c/- Level I, 131 Leichardt Street Spring Hill, Brisbane, solemnly and sincerely declare that:

1. I make this statutory declaration in response to the Requirement to Give Information in a Written Statement issued by the Honourable Margaret Wilson QC, Commissioner, Barrett Adolescent Centre Commission of Inquiry dated 18 January 2016.

Introduction

Identify the positions and appointments (permanent temporary or acting) you held in Queensland Health (QH), or other positions you held for the calendar years 1999-2015

2. I am the Chief Psychiatrist in the Department for Health and Ageing in the State of South Australia. I commenced in that role in February 2015.

3. Between May 2013 and February 2015, I held a number of positions in the Department of Health and the Mental Health Commission in Western Australia. In 2013, I was employed as a Consultant Psychiatrist at the State-wide Specialist Aboriginal Mental Health Service and as a Consultant Psychiatrist at the Mother And Baby Unit at the Women and Children's Health Service in WA. In May 2013 I was also employed as the State Clinical Planner for the Mental Health Commission. In June 2014, I was employed as the Clinical Director of the Adult Mental Health Program, North Metro Area Health Service.

4. Between 2005 and April 2012 I was employed by Queensland Health. I was appointed to the role of the Director of Mental Health (Qld) (**DMH**) in September 2005. I was also appointed to undertake the role responsible for state mental health planning. This role had various titles between 2005 - 2012, including Director or Executive Director of the Mental Health Unit, Branch or Directorate, including the Mental Health Alcohol and Other Drugs Directorate.

5. I also undertook other roles for short periods in addition to the DMH role. These included:

   (a) a period as Deputy Director-General Division of the Chief Health Officer in 2009;

Witness Signature

Justice of the Peace / Commissioner for Declarations / Lawyer

(b) several occasions as Acting Chief Health Officer when the incumbent was on leave for short periods and for a longer period when the incumbent was off-line managing the Queensland Government's response to the H1N1 influenza pandemic in 2009; and

(c) the role of Executive Director, Queensland Mental Health Commission Transition Team (**QMHCTT**) between October 2011 and April 2012.

6. Between 1999 and 2005, I held various roles in the Western Australian Department of Health. These are outlined in my curriculum vitae.

Supply details of your curriculum vitae, including qualifications and experience

7. I attach a copy of my Curriculum Vitae. This forms exhibit **AG-1** to my statutory declaration.

Responsibilities

The Commission understands that you held the position of Director of Mental Health in Queensland from 2005 to April 2012. Please explain whether that is correct, and if it is, explain the responsibilities and functions (highlighting differences) of:

- **That position as the Director of Mental Health (Qld) (DMH); and**
- **The position of Executive Director, Mental Health, Alcohol and Other Drugs Branch (ED)**

8. As set out above I performed the functions of the role of the DMH role in Queensland from 2005 to April 20012.

9. The DMH is a statutory role. The position is created by the *Mental Health Act 2000* (Qld) ('**MHA**'). The Governor of Queensland appoints the person undertaking this role. A copy of the statutory requirements of the DMH role is attached and marked exhibit **AG-1A**.

10. The function of the DMH is to fulfil the statutory responsibilities set out in the MHA. The powers and functions of the DMH are largely outlined in Chapter 3 of the MHA, though there are other powers and functions throughout that Act.

11. These responsibilities included, amongst others, the declaration of high secure units and authorised mental health services and overseeing compliance with legislative requirements relating to involuntary treatment for mental health patients (i.e. both involuntary treatment orders and forensic orders).

12. The role of the Executive Director, Mental Health Alcohol and other Drugs Directorate (**ED**) within Queensland Health is a separate role.

13. The person in this position has responsibility for the policy, planning, reform and performance reporting of the delivery of mental health services in Queensland and providing advice about mental health services to the Director General of Queensland Health and the relevant Minister.

14. In Queensland, at the time I was appointed, the roles of the ED and the DMH were combined into one appointment. The view, within Queensland Health, was that it was best for the purposes of accountability that the same person be responsible for each role. It also allowed for everything relating to mental health to be supervised from one point with one person having overall responsibility for the delivery of mental health services in Queensland.

The Commission understands that during some or all of the period from 2005 to April 2012 you held the position of Executive Director for Mental Health Planning (Qld). If so, please explain the responsibilities and functions of that role and its relationship with the positions of DMH and ED (including highlighting the differences)

15. There was no position titled Executive Director Mental Health Planning in the period 2005-2012. This planning function was undertaken as part of the role of ED.

The Commission understands that from time to time (in the period 2005 to April 2012) you performed the role of Chief Health Officer for Queensland. Please explain whether that is correct, and, if so, the approximate times you did so and the responsibilities and functions you performed in that role.

16. As set out above I did perform the role of Chief Health Officer for Queensland on occasions. I cannot now recollect the precise dates when I performed this role in an acting capacity apart from the period between April and October 2009.

17. The responsibilities and functions that I performed in that role included a very wide range of responsibilities which included Alcohol, Tobacco and other Drugs policy, legislation and prevention, Drugs of Dependence monitoring, Medicines Regulation, Cancer Screening Services, Environmental Health, Injury Prevention, Population Health, Planning Public Health Act compliance and associated functions, Health Promotion and Prevention, Communicable Disease control, Health Surveillance, Health Protection, Aero Medical Retrieval, Emergency Management and Mental Health Policy and Planning.

Please identify any other position you held with QH in the period 2005 to 2012, and the roles and responsibilities of those positions.

In addition, I undertook the role as outlined in paragraph 19.QMHC

The Commission understands that you were taken "off-line" and transferred to a position as the leader of a team to establish the (then) proposed Queensland Mental Health Commission (QMHC). Please explain if that is correct and, if so, please explain:

- **The responsibilities and functions of the new role;**
- **Any roles you relinquished or altered as a result of assuming that new role;**
- **The person or persons who assumed any of your former roles (or parts of those roles) and any related adjustment of roles.**

18. In around October 2011, I attended a meeting that included Mr John Bradley, Director General, Department of Premier and Cabinet, Ms Linda Apelt, Director General Department of Communities and Dr Tony O'Connell, Director General Queensland Health. At the meeting I was informed the Cabinet had agreed that morning to the establishment of a Mental Health Commission. At the conclusion of the meeting I was asked whether I would undertake the role of planning the establishment of the proposed QMHC.

19. I became the Executive Director of the QMHCTT and, with a small team of staff, led the transition process from October 2011 until April 2012.

20. The role as Executive Director of the QMHCTT included to:

(a) analyse existing models of Mental Health Commissions;

(b) consider these within the Queensland governance structures;

(c) undertake broad consultation on proposed and possible models;

(d) prepare advice to the independent Ministerial Advisory Committee for this task;

(e) prepare reports on progress to the Health Reform Chief Executives' Officers, Committee (that consisted of the Chief Executives of the Departments of Premier and Cabinet (Chair), Health, Communities and Queensland Treasury) that oversaw the process; and

(f) prepare a report for Cabinet with recommendations.

21. After the Queensland Government had considered and approved the model, the Executive Director of the QMHCTT was to commence the process of establishing the role of Commissioner and the transition to the commencement of the Commission.

22. Between October 2011 and April 2012 I relinquished my role as ED. Dr William Kingswell undertook that role from October 2011.

23. I retained the statutory role of DMH however I discharged that role with the assistance of Dr Mohan Gilhotra who was delegated a number of responsibilities under the MHA and undertook most of the statutory responsibilities as my appointed delegate DMH from October 2011 until April 2012.

What were the reasons for the creation of the QMHC and why was it considered necessary for Queensland? What was envisaged as its role and compare and contrast the proposed role of the Queensland Mental Health Commissioner (QMHC Commissioner) with the role of the DMH? How did they differ?

Queensland Mental Health Commission

24. The reasons for the creation of the QMHC were said to include the need to:

(a) act as a strong advocate for mental health consumers and families;

(b) improve the coordination, effectiveness and performance of mental health services;

(c) ensure resources are deployed to where they are most needed;

(d) develop a strong evidence base to support Government's investment;

(e) promote greater transparency in the allocation of resources;

(f) bring a greater independent focus on mental health;

(g) include greater involvement of people with a lived experience of mental illness within decision making; and

(h) allocate funding and ensure that the Queensland Government's funding commitment to mental health was maintained in accordance with the Government's determination that mental health was a social policy priority. A more comprehensive list of reasons for the creation of the QMHC would have been included in the Cabinet submission supporting that proposal. As at the time of making this statutory declaration, I was not able to have access to that Cabinet submission.

[redacted] ....

Witness Signature **Justice of the Peace / Commissioner for Declarations / Lawyer**

25. The proposed role of the QMHC Commissioner was much broader than that of the DMH. It was proposed, in the model agreed by the Government at that time, that the Commissioner would:

    (a) head a department that would hold the total Government funding for mental health;

    (b) be responsible for planning;

    (c) determine how funding would be used to purchase services;

    (d) report on the performance of this service system; and

    (e) undertake a range of other functions related to mental health policy, planning and engagement as outlined in the previous paragraph.

26. Neither the DMH role nor the ED role had held the entire Queensland Government budget for mental health during the period 2005-2012.

27. The QMHCTT was given a short time to develop the QMHC concept. The expectation was that the team would complete the work in 6 months and provide an interim report to Cabinet by January 2012. The interim report was considered and adopted by Cabinet.

28. In my various roles between 2005 and 2012, and from documents I perused and conversations that I had with Queensland Health employees (which I am not now able to particularise) I came to be aware of a widely-held belief in the mental health sector that general hospital and health services often utilised money that had been earmarked for mental health services. There was, therefore, interest in some parts of Government in developing the QMHC as a separate entity to, amongst other things, hold a budget for mental health and administer that budget for mental health purposes. This model would help ensure that Queensland Health services did not reallocate funding set aside for mental health services and apply it elsewhere. That was a key feature of the model that was agreed by the then Government (Bligh Government) in January 2012. This model was based on the Western Australian model and what we considered to be improvements to that model.

29. As the Executive Director of QMHCTT, I reported to the Health Reform Chief Executives' Officers, Committee about the progress of the QMHCTT on a regular basis.

30. The QMHCTT and I consulted widely. I cannot remember how many consultation sessions we held across the state. We also received thousands of public submissions.

The submissions fell into two main categories. The first included people who welcomed the idea of the QMHC having its own budget. The second group thought that the funds should stay with Queensland Health.

31. From information provided to me at the time, I formed the view that senior officers within Queensland Health did not agree with the proposal of taking mental health funding away from the Department and transferring it with the QMHC.

32. Senior officials within the Department of Communities on the other hand took a different view and did not object to that Department parting with some of the funding allocated to it for mental health purposes and placing it with the QMHC.

33. To resolve potential issues arising from these potentially contradictory positions, the team reported to the Deputy Director-General of the Department of Communities and not to Queensland Health. The QMHCTT consisted of staff seconded from Queensland Health and the Department of Communities.

34. From conversations with Queensland Health officers at the time (the precise particulars of which I am now unable to recollect) I came to understand that Queensland Health briefed its Director-General to not support several aspects of the model, however, that did not stop the then Minister for Health from endorsing and signing the submission that went to Cabinet.

35. The proposal went to Cabinet in around January 2012. An event was arranged for the Premier who announced the QMHC model. The next day however the Premier called an election and much of the progress halted, in line with the caretaker conventions of Government. The Newman Government was elected in March 2012. The Newman Government implemented a QMHC model which differed from the model that we had recommended. I did not meet anyone from the new Government so I cannot say why the model changed.

Are the QMHC's functions as set out in section 9 of the *Queensland Mental Health Commission Act 2013* consistent with the work of your team?

36. The QMHC's functions are set out in section 11 of the *Queensland Mental Health Commission Act 2013.*

37. Whilst many of these functions are consistent with the work undertaken by the QMHCTT, they differ in a number of important aspects.

38. Importantly, the Bligh Government had decided that the QMHC would hold the mental health budget and purchase services. That feature was not retained in the *Queensland Mental Health Commission Act 2013.* My team had recommended a

model whereby the QMHC would be independent from Government. Under the current model, the QMHC must follow ministerial directions. Further, the statutory role of the DMH would reside within the QMHC (but not within the role of the QMHC Commissioner).

Was it contemplated that the QMHC Commissioner would be, at least to some extent, independent of the Government? If so are sub-sections 13 (1) and (2) of the *Queensland Mental Health Commission Act 2013* consistent with that and/or consistent with the work of your team

39. The Bligh Government's view was that the QMHC was to be independent of the Government (within the bounds of how any Queensland Government entity can be truly independent of Government).

40. The QMHCTT had not recommended that the QMHC Commissioner be subject to the direction of the Minister with a requirement to comply with those directions.

41. In that respect, sub-sections 13 (1) and (2) of the *Queensland Mental Health Commission Act 2013* are not consistent with the concept of an independent Commissioner or the recommendations of the QMHCTT.

What role, did you envisage, would the QMHC and the QMHC Commissioner have in overseeing the implementation of the Queensland Plan for Mental Health 2007-2017 (QPMH)?

42. The QMHCTT recommended to the Bligh Government that the QMHC should take the key role in overseeing the implementation of the Queensland Plan for Mental Health 2007-2017 (**QPMH**). The QPMH forms exhibit **AG-2** to my statutory declaration.

Queensland Plan for Mental Health

Were you involved in the development of the QPMH? If so, can you explain your involvement in the development of the QPMH and the significant features of the QPMH.

43. I was involved in the development of the QPMH.

44. The development of the QPMH should be seen in the following context:

National Mental Health Strategy

(a) Australia has had a National Mental Health Strategy (**NMHS**) since 1991. The strategy has been agreed by State, Territory and Commonwealth Governments and is the basis of national mental health reform;

(b) The NMHS is comprised of a group of documents, which together outline how each jurisdiction is to participate in mental health reform;

(c) The NMHS includes:

(i) a national policy and its subsequent revision;

(ii) four national mental health plans (as well as one COAG national plan in 2006);

(iii) funding agreements between the Commonwealth and the States; and

(iv) a series of associated documents, policies, plans and frameworks;

(d) The NMHS has produced a number of National Mental Health Plans;

(e) The 1st National Mental Health Plan (exhibit **AG-3** to this statutory declaration) covered the period 1992 to 1998.

(f) The 2nd National Mental Health Plan (exhibit **AG-4** to this statutory declaration) covered the period 1998 to 2003.

(g) The 3rd National Mental Health Plan (exhibit **AG-5** to this statutory declaration) covered the period 2003 to 2008.

(h) The 4th National Mental Health Plan (exhibit **AG-6** to this statutory declaration) covered the period 2009 to 2014.

(i) Planning at a jurisdictional level (e.g. at the Queensland level) ought to occur within the framework of the NMHS which sets out the respective roles and responsibilities of the Commonwealth and State Governments in the provision of mental health services. As part of this, the States provide a range of hospital and specialist services many of which are based in community settings.

(j) One of the goals of the NMHS was that each jurisdiction would invest its mental health resources in a manner that was consistent with the NMHS. A National Mental Health Report was published on a regular basis and amongst other things the Report would compare each jurisdiction's mental health expenditure and whether the expenditure was consistent with the national strategy. The last report in this series is the National Mental Health Report 2013 which reports outcomes up to and including the 2010-2011 Financial year. This report is exhibit **AG-7** to this statutory declaration. That report shows that Queensland has historically had low Mental Health funding. In

1993, Queensland ranked sixth amongst states and territories. By 2007 - 08 it had fallen to second last. By 2011, however it had risen again such that Queensland was only $2 per capita below the National Average State spending on Mental Health. Of particular importance, Queensland had the second highest spending on Child and Adolescent Mental Health Services, only fractionally less than the ACT.

(k) In 2009, the Fourth National Mental Health Plan proposed the development of a National Mental Health Service Planning Framework (**NMHSPF**) that described the optimal level of all components of a mental health system to guide jurisdictional planning as this had not been developed prior to that time.

(l) In 2010, the Commonwealth Government funded a project led by NSW in partnership with Queensland to develop the NMHSPF. The first phase of this project was concluded in late 2013 and an estimator tool was shared with each jurisdiction to be used as the basis of "field testing" at a jurisdictional level to determine its strengths and weaknesses in a real environment. This tool was made available to States in October 2013 to inform State Mental Health Planning.

(m) From documents available to me in my current role, I am aware that the tool has been used in at least four States to help identify shortcomings in the tool and to inform state planning. The recently released WA State mental health plan is based on the NMHSPF. As part of the development of the Fifth National Mental Health Plan, the Commonwealth has convened a series of experts to review the NMHSPF and to update it to take into account errors that have been identified and to make changes based on advice for jurisdictions who have used the tool as the basis of their planning. This group is due to complete its work in 2016. I am not aware that the current version of the NMHSPF has been formally endorsed by all jurisdictions until this research is finalised.

Queensland Mental Health Planning

45. Queensland was one of the first states to release a comprehensive mental health plan at the beginning of the NMHS.

46. In 1996, Queensland released its mental health plan, known as the Ten Year Mental Health Strategy for Health in Queensland (**Ten Year MHSQ**). A copy of the Ten Year MHSQ is exhibit **AG-8** to this statutory declaration.

47. When I commenced with Queensland Health in September 2005, the Ten Year MHSQ was in its final year of implementation.

48. Queensland Health proposed to develop a new plan to build on the progress of the Ten Year MHSQ.

49. In April 2006, I was asked by the then Director General of Queensland Health to lead the development of a new plan. This plan became known as the QPMH.

50. During 2006, much of my time was spent developing the QPMH. Most of the planning process was completed by the end of 2006. During this time and in the lead up to the release of QPMH, there was considerable National Mental Health activity in Queensland with the implementation of the Third National Mental Health Plan and the development and implementation of the COAG National Action Plan on Mental Health 2006-2011 (**COAG NAP**). A copy of the COAG NAP is exhibit **AG-9** to this statutory declaration.

51. During 2006, as part of having as wide an involvement of the sector as is possible in the development of the QPMH, I established a number of expert groups to provide advice that would be considered for inclusion in the QPMH. This included a group who considered the broader Child, Adolescent and Youth mental health needs.

52. This group's report is often referred to as the Queensland Child and Youth Mental Health Plan 2006-2011. A copy of this plan is exhibit **AG-10** to this statutory declaration.

53. This report was developed by the Child and Youth Mental Health sector in parallel with a number of other subgroups who developed similar reports on different specialised areas of mental health. Together these formed one part of the process for consideration of the clinical components of the QPMH.

54. The report was considered at that time as the best available advice about the future of how the services of the Barrett Adolescent Centre (**BAC**) should be provided within a more comprehensive, extensive and evidence informed model of service for Children and Youth.

55. The recommendations in the report concerning the BAC were important in the final decision to recommend the relocation of BAC.

56. During the planning process, consideration of the mix and ranges of services to provide on the site of The Park Centre for Mental Health (**The Park**) into the future was also considered.

57. My role was to oversee all aspects of the development of the QPMH including consultation, costing and preparation of documents for approval by the Queensland Government.

The Commission understands that the QPMH was a "whole-of-Government" plan rather than a QH plan. Please explain if, and to what extent, that is correct and the reasons for and ramifications of that difference.

58. The QPMH was originally intended to be a Queensland Health plan, that is, with a focus on how health services would be reformed in relation to mental illness.

59. However, during 2006, all Australian Governments agreed to the COAG NAP.

60. This resulted in the Queensland Governments' approach changing such that the new ten-year plan was to be developed from a whole-of-Government perspective rather than solely from a Health perspective. This expansion of the scope had no impact on the Queensland Health component of the QPMH.

61. This approach meant that a range of Queensland Government Departments, most notably, Department of Communities, Disability Services Queensland, Departments of Housing, Education, Child Safety, Employment and Emergency Services all considered the way in which they would commit resources to improving the mental health of Queenslanders.

62. This approach was quite different from the 1996 Ten Year MHSQ, which had its primary focus almost entirely on Queensland Health and how it would deal with mental health services as opposed to a whole-of-Government approach across numerous Government departments.

63. The Ten Year MHSQ was ahead of its time as one of the most detailed, researched and evidence based mental health planning documents in Australia.

64. The QPMH built on that initial work and was the first to publish benchmarks for nearly all areas of mental health.

65. NSW had previously published and planned around its planning tool known as Mental Health – Clinical Care and Prevention Model, and this had estimated very similar levels of resource requirements as those outlined within the QPMH. I do not have a copy of this planning tool.

66. In my view, there was significant investment in mental health services in the first half of the 1996 Ten Year MHSQ including the re-development of the Wolston Park Hospital to The Park. However, there had not been the same degree of investment in the second part of the 1996 Ten Year MHSQ. Consequently, by the end of the Ten Year MHSQ, Queensland had one of the lowest per capita expenditures on mental health in Australia.

67. It was a primary intention of that plan to move acute services away from The Park in line with the agreed national decision to mainstream mental health services. Mainstreaming refers to the relocation of acute mental health services away from stand-alone psychiatric hospitals to general hospital sites.

68. At the time of the Ten Year MHSQ, there was evidence that people with certain attributes did not generally do as well in general hospital settings, and it was considered that they would do better to remain in specialised settings at that time, this included mental health consumers with forensic, psychogeriatric, intellectual disability, acquired brain injury and dual diagnosis aspects to their treatment and care needs.

69. I was not privy to any planning in relation to the BAC at the time of the preparation of the Ten Year MSHQ. I am not aware what plans had been made for what would become of the buildings and the service when the planning for the re-development of The Park occurred following the endorsement of the Ten Year MHSQ in 1996. There was to my knowledge no specific plan for the BAC in the Ten Year MHSQ. Page 30 of the Ten Year MHSQ notes that "the Barrett Adolescent Unit at the Wolston Park Hospital complex has 15 places to accommodate young people with serious mental disorders for medium lengths of stay". It makes no comment about the future of those services though it appears to envisage their continuation.

70. I was informed that during the period 2003-2006, there was particular scrutiny of the BAC as a list of concerns about the adequacy of the facility, its service model, staff training and support and overall safety issues were raised in the context of growing lengths of stay, more severe and complex patients and a growing waiting list.

The QPMH provided for a number of Queensland Government initiatives focused on expanding public mental health, including mental health services to people in acute, extended treatment facilities and community health. One of those initiatives was: *"$121.55 million to expand the range of acute and extended treatment beds by providing more than 140 new beds and to upgrade existing services to meet contemporary standards."* Please explain whether that initiative included a proposal to provide for the capital expense of a relocation of the BAC to another site. If that is correct, what were the reasons and factors influencing that proposal and what expertise was relied on in making that decision. Did that proposal to relocate subsequently become a proposal to relocate the BAC to Redlands.

71. The QPMH was approved in early 2008 and released in June 2008. The delay was due to the internal processes of Government approval but this did not lead to any delay in the implementation of the funded actions outlined in the QPMH.

72. The QPMH was initially considered in March 2007 for approval of its detailed costings. Once these were endorsed the QPMH was presented for formal endorsement and release by Government.

73. The funding to support the QPMH was announced in around May 2007, whilst the formal release of the QPMH occurred in June 2008.

74. The QPMH consists of five priority areas. The second of these priorities was "Integrating and improving the care system". This component of the QPMH described the investment by Government in Queensland Mental Health Services. It did not specifically detail the relocation of BAC however it did outline the capital works program that had been approved which included the relocation of the BAC.

75. One of the central features of the QPMH was the continuation of efforts to relocate and modernise services away from stand-alone psychiatric hospitals, which had commenced in 1996 under the Ten Year MHSQ.

76. The QPMH outlined that $121.55 million would be available to expand the range of acute and extended treatment beds by providing more than 140 new beds and the upgrade of existing services to meet contemporary standards.

77. The proposal consisted of 17 different capital works projects that were referred to at a later point as stage 1 of the QPMH Capital Works Program. One of these projects included the capital expense of the relocation of the BAC to an alternate site. As set out below, the site chosen for the relocation of the BAC was a site at Redlands.

78. In the process of developing the QPMH, Queensland Health reviewed existing services, the appropriateness of their built infrastructure and whether the associated service model was contemporary, and whether there was an overlap in the delivery of services across the state.

79. Queensland Health conducted a review of all capital infrastructure in mental health. A number of issues were identified throughout the State. An extensive list of projects for what was considered important new infrastructure as well as projects to modernise existing infrastructure was developed as part of the planning process.

80. Ultimately the capital projects funded in 2007 to be completed by 2012 were known as the Stage 1 MH Capital Works Program (**MHCWP**). One of the key new infrastructure projects funded as part of stage 1 MHCWP was the relocation of the BAC. In February 2011, an independent preliminary evaluation was undertaken of the Stage 2 Capital works required for the QPMH. I do not have a copy of that evaluation report. My recollection though is that the report concluded amongst other things a number of additional child and youth mental health facilities should be constructed.

Barrett Adolescent Centre and its services

81. From a planning perspective, Queensland Health endeavoured to set out the range of services that are required within each health service and those which are so specialised that they are likely to be either unique within a State or because of their specialised nature, most appropriate to be provided as a single state-wide service.

82. These "State-wide" services are only considered safe to operate as they have a low volume of cases each year and other services have a more limited experience with providing this type of service. It is critical that State-wide services have clear pathways into and out of the service and well developed relationships between them and local services that are also involved in providing treatment to the people who might need to access the service.

83. States with smaller populations may not have the justification for such services as the volume is too low to safely provide these separate services. Such State-wide services often included forensic mental health, services for people with eating disorders and services for people with co-morbidity in particular intellectual disability.

84. In addition, there are some types of service which whilst still considered clinically essential, are required so rarely that even having one national centre needs to be considered. Such National services include psychosurgery services.

85. A review into the BAC in 2003 by Professor Brett McDermott and Dr Jacinta Powell titled 'The Barrett Adolescent Centre Consultation on Aggression and Violence at the BAC' (**McDermott Review**) had outlined the types of problems that had developed at the BAC because of its relative isolation from mainstream Child and Youth Mental Health Services (**CYMHS**). The McDermott Review and other reviews had also identified that the Barrett facility itself (buildings and other infrastructure) was old and outdated and had become unfit for purpose. That is why a view had developed that the BAC had to be relocated to a new purpose built facility. A copy of the McDermott Review is attached and marked exhibit **AG-11**.

86. This was further reinforced by the Walter Review into the BAC conducted in 2009. A copy of the Walter Review is attached and marked exhibit **AG-12**. The relocation of the BAC and bringing it within a broader CYMHS was intended to both resolve many of the issues at the BAC as well as complement the services provided locally by CYMHS services.

87. At the time of the QPMH, the BAC was considered an example of a State-wide service for adolescents and youth who required much longer term treatment than could be provided within a generic CYMHS inpatient or community service. That is, it was

expected to provide an extended treatment approach for the very small number of young people who would require such a service.

88. However as noted above, the reviews of McDermott and Walters had raised concern about the model of service being provided and the manner in which the service linked to other CYMHS in the State.

89. I was of the view there was a clear need for a service for the group of adolescents with severe longstanding mental health problems that had not done well within the acute CYMHS service system. This group was often but not exclusively, characterised by having high levels of distress, behavioural disturbance, backgrounds that often involved high levels of complex trauma or deprivation or neglect, together with the possibility that they had also been in institutional care or for long periods or had lived out of home. It also consisted of a group who had been either non-responsive or only partially responsive to standard first line treatment approaches.

90. There was also a concern that in the absence of such a service, if such young people spent extended time in acute units, this reduced the overall availability of acute inpatient units for young people who required more support that could be provided by even intensive community based child and youth teams.

91. It was important that any relocated service needed to have a modern approach and be integrated within the CYMHS system rather than existing as a stand-alone service.

92. The average length of stay for an adolescent as an inpatient in an acute CYMHS unit is usually measured in days and weeks and not months. This is important as for some people longer lengths of stay are associated with the potential development of institutionalised behaviours and for others it can be associated with age regression.

93. Adolescents are at an important developmental stage of their life. Even those experiencing significant emotional and behavioural disturbance have an important need to be involved in making decisions about their life (this includes a wide range of things from deciding who are their friends, what they watch on television, remaining socially connected and what therapeutic or recreational programs they will undertake). The longer adolescents are kept away from home and friends the more likely unwanted effects can develop. This is one significant reason why the aim of child and youth inpatient services is to keep the length of stay to as short as is possible.

94. However, an important counter-balance to this need for autonomy is the need to have the young person in an environment where they can flourish but also remain safe. For many in the BAC group there were very high levels of self-harming and suicidal behaviours that could not be safely managed in short term treatment programs.

Therefore, an important goal was to maintain the young person in a safe setting often for a prolonged period, awaiting the benefit of the therapeutic program.

95. A significant proportion of the cohort of young people referred to a state-wide service such as the BAC has chronic or complex Post-Traumatic Stress Disorder. Often such youth have a background of significant trauma, neglect or deprivation that can contribute to them having marked difficulty regulating their emotions and behaviour. Consequently, they often also have difficulty with their peer group. Frequently, their peer group and friends do not understand the significant problems that the adolescent is facing and it takes some time before their problems can be understood. That some of these young people can rapidly move from appearing to be normal to a short time later self-harming means that their behaviour can be both very disturbing and disruptive to other young people around them.

96. The problem with some acute inpatient adolescent units is that they usually have a different focus and can miss the need to address the longer term issues concerning the trauma experienced by some of the adolescents who comprise the group referred to State-wide services such as the BAC.

97. At the time the QPMH was being finalised it was my advice that the BAC should be reformed to become the most important element of a broader approach to providing care to this group of young people with longer term treatment needs, and that the service model should include not only inpatient care but also community based and residential care. I supported the view that the BAC be relocated and its services enhanced.

98. From my experience, there are around 100 adolescents and youth in Queensland per year who experience the severity and complexity of mental illness that require specialised services like the BAC each year. Most of these young people will at some point get their care from local CYMHS services but require more intensive and longer term treatment than can be provided by these services, thus the need for a more specialist service integrated within that more generic CYMHS model. Amongst other components this includes a service which can provide 24 hour care 7 days a week, whether it is an inpatient like service or a more home like residential service.

99. Where such a service is not available the consequence is pressure on other parts of the mental health system and emergency departments. This seems particularly the case for the small group who are in the care of Child Protection departments or are in out-of-home care. For many in this group an intensive outreach approach and staff well-trained in Mentalization Based Therapy and Dialectic Behavioural Therapy are essential as this group of young people are often have the hallmarks of Borderline Personality Disorder. Access to a service where these young people are closely

supervised when at greatest risk, such as a highly specialised inpatient unit like the proposed re-located BAC, would be needed in a small number of cases.

100. Furthermore, it is in my view critical that all health care providers are expertly trained in providing services using trauma informed principles.

101. In Queensland, as you move away from the south-east corner of Queensland the problem gets worse. If you don't have access to a dedicated service like the BAC there may be no other service other than the paediatric units at hospitals, which usually cannot handle adolescents who are deliberately self-harming.

102. The QPMH had funding for implementing actions in the first four years of the plan as part of Stage 1 of the MHCWP, which included the development of adolescent inpatient units and day programs in regional centres. It was intended that consideration by Government of funding Stage 2 of the QPMH would result in a more comprehensive range of CYMHS throughout the State.

103. One difficulty that can arise in Queensland with trying to establish remote or regional child and youth mental health inpatient services is the need to recruit a child and youth psychiatrist. It is not considered clinically appropriate to operate a CYMHS inpatient service unless you have a child psychiatrist.

104. In summary, there were valid reasons to relocate and modernise the BAC and the site chosen was a site at Redlands.

In particular, what was the process which led to the decision to relocate the BAC to Redlands, and who were involved in that process and what were there roles?

105. The Mental Health Plan Implementation Team (**MHPIT**), which reported to me in my role as ED formed a subgroup to evaluate options for the replacement of the BAC. That subgroup considered a wide range of options. For the reasons contained in a detailed report prepared by the subgroup titled 'Report of the site evaluation subgroup' dated October 2008 (**Site Options Paper**) the team identified the Redland site as the preferred option. The Site Options Paper was provided by me to the CEOs of Metro South and West Morton Health Service Districts for their consideration and endorsement. A copy of the Site Options Paper is attached and marked exhibit **AG-13**.

106. The people involved in that subgroup are listed in the Site Options Paper at pages 6 and 7.

107. The reasons that formed the basis of the decision that the BAC should be relocated are outlined in the Site Options Paper.

Did that process involve:

- **any consideration of closing the BAC (as opposed to re-location of the BAC to Redlands)? If not, why not? If "yes", please give details.**
- **of any consideration of significant changes to the BAC Model of Service. If yes, please give details of the nature of, and rationale for, the changes countenanced.**
- **any consideration of the use of The Park as a centre for forensic mental health (or plans for its use as such)? If "yes" please give details.**

108. The relocation process did not consider the closure of the BAC. At that time, it was considered essential that there remain a service, which was able to provide treatment and care for adolescents and their families where an extended timeframe for providing these services was required. This was further set out in the Site Options Paper.

109. Extensive consideration was given to changing the model of service; it needed major revision as it was out-dated and insufficiently integrated with the broader CYMHS system in Queensland. I have addressed some of the key considerations in earlier paragraphs.

110. I believe a final model of service for what was going to become known as the Redlands Extended Treatment and Rehabilitation Service was endorsed by me. A description of the proposed model of service is outlined at pages 7 to 10 of the Site Options Paper.

111. The QPMH considered the nature and number of services that should remain at The Park site. In the medium term it was considered that The Park should be centred on the provision of forensic services, other sub-acute highly specialised services such as for those people with dual diagnosis (of intellectual disability) and for other non-clinical services such as research. It was not considered a suitable long-term viable option to retain extended treatment services for highly complex youth at The Park site.

112. This plan for The Park was in line with the previous Ten Year MHSQ, which had resulted in a major relocation of services off the campus associated with the development of a range of modern periods at the more contemporary service for people who had spent long periods of time at the hospital.

113. The majority of clinical services that would remain at The Park would be forensic mental health services but it was not considered the site would be an exclusive forensic precinct.

Under the Ten Year Mental Health Strategy for Queensland 1996 released in early 1997 (1996-2006 Plan):

- **What Mental Health Services were to be provided at The Park?**
- **Was there to be on-going development/redevelopment of The Park?**
- **Was it envisaged that some services which were provided at The Park at the commencement of the 1996-2006 Plan would cease to be provided there, and either be located to other site/s or replaced by other service model/s elsewhere? If so, please give details.**

114. This explanation is discussed elsewhere in my statutory declaration and in the Ten Year MHSQ.

Implementation of the QPMH

The QPMH was endorsed by the then Cabinet on 25 February 2008. (It was published in approximately July 2008.) The Commission understands that you then chaired a group within QH to oversee the process of implementation of the QPMH. Please explain if that is correct, and, if it is, explain the relevant group, its members, its role or roles and the steps it took.

Please explain the steps taken to implement the relocation of the BAC to Redlands

115. The QPMH was endorsed in February 2008, however more than $528 million in funding had been made available in May 2007 to commence the implementation of the plan.

116. The implementation was overseen by a steering committee that I chaired, the governance structure having been endorsed by the then Director-General of Queensland Health. The governance structure and terms of reference outline the membership of this committee and its functions, roles and responsibilities. As at the time of making this statutory declaration I have not had access to the terms of reference for this committee.

117. The QPMH Implementation Steering Committee formed a QPMH Capital Works Working Group (**CWWG**) whose role was to oversee all 17 Capital Works projects.

118. The Capital Works and Assets Management Branch (later renamed as the Health Infrastructure Branch) together with Project Services had responsibility for the procurement of all capital works projects as well as the project management for each of these projects.

119. The ED, through the MHPIT provided the mental health policy, planning and clinical systems advice as well as being the link to the QPMH Implementation Steering Committee for reporting purposes.

120. The CWWG then established Project Control Groups for each 17 projects, which worked in partnership with Health Service Districts especially their mental health staff, Service User Groups, Facility Advisory Groups, MHPIT and Health Infrastructure Branch staff to develop models of service, plan, design, and ultimately commission each of the capital projects. The BAC project was managed through this same project methodology.

121. The development of the Site Options Paper and the model of service for the relocated BAC to the Redlands site followed this same process.

In relation to the Queensland Government report entitled, 'QPMH 2007-2017 Four Year Report October 2011' prepared in October 2011 (Four Year Report) that examined the implementation of the QPMH:

- **What role did you have in the preparation of the Four Year Report?**
- **How and to what extent did the Four Year Report impact upon the future delivery of child, youth and adolescent mental health services in Queensland;**
- **Did the Four Year Report have any implications for the BAC in the delivery of the services offered by an adolescent extended treatment and rehabilitation unit? and**
- **Did the Four Year Report identify any child, youth and adolescent mental health facilities that had been built or were being developed pursuant to the 10 Year Plan?**

122. In October 2011, a report was prepared that examined the progress in implementation of the QPMH. This was known as the "Four Year Report" into the QPMH. A copy of the Four Year Report is exhibited to this statutory declaration and marked exhibit **AG-14**.

123. As DMH, I oversaw the provision of the content of this report, which had been prepared by the MHPIT, together with other Mental Health Alcohol and other Drugs Directorate and Queensland Health Staff. The report was ultimately approved by the then Director-General of Queensland Health.

124. The release of the Four Year Report had no clear impact on the future delivery of child, adolescent and youth mental health services in Queensland. It served the purpose of describing the progress in the context of other important developments such as the formation of the QMHC, the 10 year National Roadmap, National Partnership

Agreements funding, funding to respond to the natural disasters of the summer of 2010-2011 and the effects of the global financial crisis.

125. The release of the Four Year Report had no impact on the BAC or services offered by adolescent extended treatment facilities.

126. The Four Year Report outlined the overall status of capital projects, noting the completion of four (4) projects and the estimated completion of other capital projects by June 2012. It did not distinguish the progress of CYMHS facilities or any other types of facilities.

Redlands Ceases

The Commission understands that on 28 August 2012 (i.e. after you ceased your roles with QH) the then Health Minister approved a briefing note to this effect:

> ***"Recommendation***
>
> *That the Minister:*
>
> *Approve the planned strategy for the targeted rectification of the prioritised infrastructure issues and subsequent planning for 12 rural hospitals.*
>
> ***Note** the recommended $41 million funding strategy for 2012-2013 for the rural infrastructure rectifications from the Capital Program, of:*
>
> - Cessation of the Sunshine Coast Health Precinct and Caboolture Health Precinct projects;
> - Cessation of the Replacement Adolescent Extended Treatment Unit, Redlands project;
> - Deferral of the Townsville Medium Secure Rehabilitation Unit refurbishment project until 2013-2014.
>
> ***Note** that a further $10.58 million is being allocated from "Closing the Gap" funding.*
>
> ***Note** consultation will occur following approval of the recommended funding strategy.*
>
> ***Note** that the 2010 planning at 12 rural hospitals identified infrastructure issues.*
>
> ***Note** that the funding strategy identified within existing capital program with minimum expenditure for targeted prioritised infrastructure rectification to improve safety and functionality in the short term.*

***Note** that detailed planning will follow for medium and longer term solutions.*

***Note** that the funding strategy relates to cessation and/or deferral of projects for replacement/collocation of existing services and not service expansion."*

(emphasis added)

When you were employed by QH, did you become aware of any steps leading to that approval or become aware of the process involved or of any consideration of the consequences of that approval? That (approved) recommendation refers to consultation occurring "*following approval of the recommended funding strategy*". Did you become aware of any such consultation either before or after that approval? How did that consultation compare with the consultation under the QPMH?

127. Whilst I was employed by Queensland Health, I was not aware of any steps leading to this approval.

128. Whilst I was employed by Queensland Health, I did not become aware of the process or become involved in any process that considered cessation of the Redlands Adolescent Extended Treatment Unit.

129. Whilst I was employed by QH, I was not involved in any consideration of the consequences of cessation of the Redlands relocation project because the cessation of the Redlands project had never been considered during my employment.

130. I am not aware of the consultation that occurred either before or after the approval of the recommended funding strategy.

131. As I am not aware of the consultation I am not able to comment on how this consultation compares with that related to the QPMH.

Barrett Adolescent Centre

During the period 2005-2012, were there any plans to close the Barrett Adolescent Centre (BAC) (as opposed to plans to relocate the services that BAC offered to a new adolescent facility)? If so, please provide details of those plans and your involvement in, or knowledge of, those plans

132. I was not aware of any plans to close the BAC during the period September 2005-April 2012. If plans had existed at the local level, they would have been considered as part of the State Planning process that commenced in 2006. As stated earlier, the advice that arose from the report of the Child and Youth subgroup referred to as the Queensland Child and Youth Mental Health Plan 2006-2011 did not propose closure of

the BAC, rather it proposed enhancement of services within a better integrated range of CYMHS.

Before 1 July 2012:

- **What was the reporting structure for the BAC?**
- **To whom did the Clinical Director of the BAC report?**
- **What role did the DMH or the ED have in monitoring the delivery of mental health services from the BAC?**
- **Did the role change over the 2006-1 July 2012 period and, if so, please explain how it changed?**

133. Before 1 July 2012, the following relates to the BAC.

134. The BAC was a State-wide mental health service operated by West Moreton Health Service District (**WMHSD**).

135. Its management was through The Park.

136. The Clinical Director of the BAC, would have reported to the Executive Director of Mental Health (**ED, Mental Health**) at The Park, who ultimately reported to the CEO of WMHSD.

137. The DMH role in relation to the BAC was restricted to the statutory functions outlined in the MHA.

138. The ED role included monitoring and reporting on the performance of all mental health services including BAC.

139. The role of the DMH and ED did not change in any substantive way during the period 2006-2012.

Who held operational responsibility for the BAC during the 2006-2012 period? Who held financial responsibility for the budget allocated to the BAC in that period? What were the financial delegations?

140. Operational responsibility for the BAC sat with the WMHSD, and was delegated at the site level to the ED, Mental Health The Park.

141. Financial responsibility for the budget allocation sat within WMHSD.

142. I am not aware of the financial delegation schedule within WMHSD, for decisions associated with the operations of the BAC.

What were the "metrics" used to determine occupancy of the BAC for reporting purposes?

143. The 'metric' used to determine occupancy in the BAC between 2005 and 2012 for reporting purposes is termed Average Occupancy Rate. It is defined as the ratio between the actual bed days occupied and the available bed days, over a particular period of time, expressed as a percentage. In determining the actual occupancy, a bed is defined as occupied if the admitted person is in that bed at midnight, when the overnight census is completed. Admitted patients on leave from a unit overnight are not included for statistical purposes.

144. It is therefore possible for a unit to have the situation arise where a person is admitted in each of its beds (that is it has no bed available) but where some of those people are on leave from that bed at the time of the midnight census count meaning that the facility would have an occupancy rate of less than 100%. Inpatient units that have such practices can have low average occupancy rates over the reporting period but have been very busy during that time.

Were there any risks (such as risk of assault, or dangers to personal safety - physical or mental, or other risks) associated with the BAC being located on the grounds of The Park - Centre for Mental Health (The Park)? (i.e. adolescents being co-located with adult forensic patients or other adult patients admitted to secure facilities)

145. There is a potential risk associated with the BAC being located on the grounds of The Park Centre for Mental Health. However, in my opinion this risk is low and needs to be managed within the usual processes of managing any risks in a health service.

146. The Site Options Paper outlined consideration of the replacement BAC in consideration of principle 2, which related to undesirable persons.

147. By way of example, I am aware of a major private secondary school constructed immediately adjacent to a major stand-alone mental hospital in another state nearly two decades ago. The proximity of that school to that hospital which has over 150 patients, many in open wards, is much closer than the situation that arose for the BAC on The Park site. To my knowledge, there have been no reported incidents of assault or risk, danger or personal safety concerns. It has not been necessary in that case to consider relocation of either that school or the hospital.

To your knowledge, were any incidents reported between adult patients of The Park and adolescent patients of the BAC?

148. I am not aware of any incidents between BAC patients and other patients at The Park being reported to me. However, I expect that had such a risk been identified,

appropriate mitigation strategies would have been developed. Only if such mitigation of risk was not possible would such a situation been escalated for resolution.

During the planning, development and construction stages of the Extended Forensic Treatment and Rehabilitation Unit (EFTRU) located at The Park were there any risk implications identified for patients of the BAC? How did the opening of EFTRU impact upon the risk assessment and management of patients of the BAC?

149. I am not aware of the impact of the opening of EFTRU upon the risk assessment and management of patients at the BAC. The EFTRU opened after I left the roles of DMH and ED.

Financial Aspects

For the financial years:

- **Ended 30 June 2006;**
- **Ended 30 June 2007;**
- **Ended 30 June 2008;**
- **Ended 30 June 2009;**
- **Ended 30 June 2010;**
- **Ended 30 June 2011;**
- **Ended 30 June 2012;**
- **Ended 30 June 2013;**
- **Ended 30 June 2014;**

was the budget for the BAC within the responsibility of the Director General of QH, or the DMH, or the ED, or Children's Health Queensland, or West Morton Hospital and Health Service or some other entity? Did the financial responsibility for the BAC change over the 2006-2014 financial years? If so, please explain those changes.

150. As far as I am aware, and as noted earlier, during each of the financial years, from year ended 30 June 2006 through to year ended 30 June 2012, the budget for the BAC was the responsibility of the responsibility of the WMHSD (or its predecessor). At no time was the budget the financial responsibility of the DMH. I am not aware of the financial aspects concerning the years ended 30 June 2013 and 30 June 2014.

Prior to 1 July 2012, were their financial implications for a state-wide mental health service facility, like the BAC, being located within a Hospital and Health Service district where a Governing Council would oversee operational management?

151. There are financial implications of having state-wide services managed within a single Hospital and Health Service District (**HHSD**). The HHSD would be funded to take into consideration the provision of services to its local population as well as an additional amount that is required to operate the State-wide service.

152. It is, in theory possible for the HHSD and its governing council to undertake changes to aspects of the service that are not in line with either the state-wide planning considerations or the funding considerations for the service. It would be imperative that Queensland Health, as the system manager, would monitor compliance with service agreements and require corrective actions if this occurred.

153. Between 2005 and 2012, the WMHSD had a good track record, in my opinion of operating a number of State-wide mental health services in line with the expectations of the Corporate Divisions of Queensland Health as the funder and systems manager of health.

The Commission understands that, in the period 2006 to 2014, QH included a division which provided business advice, strategic financial policy, including budget forecasting and data analysis, financial and asset accounting (financial documents) which was, at least for some time, called the Finance, Procurement and Legal Services Division (FPL). Please explain if that is correct and, if so, to the extent you are able to answer these questions, did the FPL at any time (including the present) or some other division of QH, have, within its power or possession, financial documents which recorded:

- **The proposed capital allocation for the Redlands re-location of the BAC referred to above;**
- **The cancellation of that re-location pursuant to the approved briefing note referred to above;**
- **The re-allocation of those funds for the "targeted rectification of the prioritised infrastructure issues and subsequent planning for 12 rural hospitals" as referred to in the approved briefing note referred to above;**
- **The actual expenditure of the money previously allocated to the Redlands re-location;**
- **The associated recurrent expenditure for the Redlands re-location of the BAC;**
- **Re-allocation of the associated recurrent expenditure for the Redlands re-location of the BAC;**

And, if so, please identify those documents and their location. If you have a copy please attach a copy to your witness statement.

154. I am aware of the existence of a Division called the Finance, Procurement and Legal Service Division (**FPL**) within the Queensland Health Corporate Office.

155. I am not aware of what documents the FPL held in relation to the proposed capital allocation for the Redlands relocation. Such documents would probably have been shared between the Health Infrastructure Branch who managed the whole Capital Works program within Queensland Health and FPL.

156. I am not aware of being informed by either FPL or Health Infrastructure Branch of the precise nature of any procurement documentation that each kept in relation to the QPMH capital program.

157. I am aware that Health Infrastructure Branch kept comprehensive documentation together with Project Services on all aspects of the QPMH capital work program.

158. I am not aware any documentation held by FPL in relation to the BAC pursuant to decisions that were made after I had ceased carrying out the role of ED.

Please explain the financial document trail within QH for the Redlands re-location and the BAC and any alternative uses of the relevant funds. If you have any such documents, or can provide them, please do so.

159. In relation to the document trail within Queensland Health for the Redlands re-location, please see above.

160. I do not have any such documents.

Adolescent Extended Treatment and Rehabilitation Units

During your period of employment within QH, were any other alternative models of care for youth and adolescents suffering from severe and complex mental illness considered, particularly those who might otherwise be in need of extended and long-term treatment and care in an inpatient facility?

Was the need for Queensland to have an adolescent extended treatment and rehabilitation unit, such as the BAC ever considered during the period when you were responsible for overseeing the planning of mental health services in Queensland?

161. The consideration of alternative models of care for youth and adolescents suffering from severe and complex mental illness was considered during 2006 in the planning phase for the QPMH.

162. At the beginning of the planning for the QPMH, considerable effort was made by the Child and Youth subgroup of the State-wide Mental Health Network (which I chaired), to undertake the planning for what would be required over the following 10 years to develop a range of services that would cater for the mental health needs of people up to 18 years of age.

163. This planning process which fed into the decision making process for the final QPMH, considered the need for all types of services including the need for an adolescent extended treatment and rehabilitation unit.

164. Furthermore during the period 2006 to 2011, the Child and Youth subgroup of the State-wide Mental Health Network continued to oversee alternative models of mental health care for children, adolescents and youth.

165. To the best of my recollection, the need for Queensland to have an adolescent extended treatment and rehabilitation unit such as the BAC was not re-considered.

166. What was re-considered was the most appropriate model of service in particular linkage into the developing community and inpatient CYMHS throughout the State.

167. During that period considerable time was spent considering and getting agreement on the details of such a model within the context of all CYMHS.

168. During this time the need for an ongoing service for young people with severe and enduring treatment needs that could not be met by specialist community based CYMHS teams and who also could not be successfully managed within CYMHS acute inpatient units was confirmed. There was however considerable divergence of views about the precise nature of this service and how it would meet the needs of this small group of young people with the highest needs, yet also be integrated within the expanding range of new CYMHS services being developed under the plan.

169. However, the following were considered important features of the new model of service: clear admission criteria, clear referral pathways, a more modern approach to returning the young person to safe and nurturing environments, close attention to reducing the development of dependence and institutionalised behaviours, and collaborative treatment plans with the rest of the CYMHS sector.

Do you consider that an adolescent extended treatment and rehabilitation unit, such as the BAC, was required for Queensland?

170. I consider an adolescent extended treatment and rehabilitation service is required in Queensland that should include a unit capable of providing 24 hour (overnight care) in the most home-like manner possible.

In your view, what would constitute an appropriate model of treatment and care for youth and adolescents in Queensland suffering from severe and complex mental illness who need extensive and long-term treatment and care?

171. In my view an appropriate model of treatment and care for young people suffering enduring severe and complex mental illness and who need extensive and long-term treatment and care would require several elements. In the first instance it should be stated that the number of young people in Queensland between the age of 12 and 17 with a severe mental illness is approximately 8000 in any 12-month period. In addition, it should also be stated that the majority of these young people will get effective treatment and care from specialist CYMHS if they access them. The group who require an Extended Treatment and Rehabilitation Unit is a very much smaller number. As stated earlier the number who may require such a facility in any 12-month period is likely to be more like 100.

172. These young people typically have a range of complex problems. Not only do they have severe mental illnesses (many of which have been resistant to standard treatments) occurring at a time of considerable developmental challenges; they also frequently have a background of trauma, neglect, deprivation, co-morbid substance use disorders, other serious physical illness, histories of long periods in out-of-home care, especially foster arrangements that have failed. In addition, they have often been stigmatised, marginalised and discriminated against. Their families where they exist have usually exhausted all of their skills to keep the young person safe within their immediate environment.

173. Consequently, the range of services needed are extensive and need to be tailored to the specific individual needs of the young person, their family and any other carers involved with the person. A typical hospital environment as might be commonly understood, also represents problems. Any residential service that forms the key component of this cluster of specialised services needs to be built in an as home-like a manner as is possible. If, as is often the case, the young person's development has become seriously compromised or arrested then access on site or nearby to important educational, vocational and recreational services is essential.

174. Critically, highly trained staff with skills in Mentalization Based Therapy, Dialectic Behavioural Therapy and a range of other psychological treatments with close supervision and low caseloads is important. Clear treatment plans developed and shared with other agencies is critical. The facility would also need to have access to services that are shown to assist successful transition from the facility. In particular, the provision of assertive community treatment services (including hospital in the home), day programs that assist with acquisition of new social skills and assist development, short term overnight residential services (such as time out initiatives) if home care

arrangements are not able to provide the level of support to maintain safety as well as therapeutic foster care and residential care programs would in my view all be critical.

During the period when you were responsible for overseeing the planning of mental health services in Queensland, was the concept of community 'wrap around' services ever considered in the context of adolescents suffering from severe and complex mental illness who need extensive and long-term treatment and care? If so, what was meant by the expression 'wrap around' services and how was it considered and what was the outcome of the consideration?

175. The concept of community wrap around services was considered throughout the planning process and Queensland Government provided a substantial boost in funding under the QPMH for expansions of the community non-government mental health sector. This funding amongst other things helped expand the provision of community wrap around services. Consideration of wrap around services included people of all age groups and severity of mental illness and especially included adolescents and youth who needed extensive and long-term treatment and care.

176. The term "wrap around" or "wraparound" has various definitions but is usually used to refer to a process of intensive, individualized care management process for people with serious or complex needs. Wraparound as a concept was initially developed in the 1980s as a means for maintaining young people with the most severe emotional and behavioural problems in their own homes and community. During the wraparound process, a team of individuals who are most directly relevant to the well-being of the young person (e.g., family members, other natural supports, service providers and agency representatives) collaboratively develop an individualised plan of care, implement this plan, and evaluate the outcome.

177. A wraparound plan typically includes formal services and interventions, together with community services and interpersonal support and assistance provided by friends, kin and other people drawn from the family's social networks. The team involved in providing wraparound services convenes frequently to measure the plan's components against relevant indicators of success.

178. The process of engaging the family (where they are available), convening the team, developing the plan, implementing the plan, and transitioning the youth out of formal wraparound is typically facilitated by a trained case manager or "wraparound facilitator," sometimes with the assistance of a family support worker. The wraparound process, and the plan itself, is designed to be culturally competent, strengths based, and organised around family members' own perceptions of needs, goals, and likelihood of success of specific strategies.

According to the QPMH (page 7), in July 2007 responsibility for funding mental health support services contracted from the non-government sector was transferred from QH to Disability Services Queensland (DSQ). Please explain that new arrangement. What were the implications of this change for the delivery of youth and adolescent mental health support services to a young person turning 18 years of age?

179. In September 2006, under machinery-of-Government arrangements mental health was moved from the portfolio of the Health Minister to the Minister for Disability's Portfolio, as administered by Disability Services Queensland. Between September 2006 and April 2007, consideration of whether this change should proceed was considered within Government and throughout the affected mental health sector.

180. At the conclusion of that process, it was determined the funding to the non-government mental health sector together with the planning and administration of those funds would transition to Disability Services Queensland, but that planning, policy and funding to Queensland Health services would remain with the Minister for Health.

181. Under these arrangements, a new branch within Disability Services Queensland, the Mental Health Branch, was created to oversee the NGO sector in mental health and to work in close partnership with Queensland Health, in particular the Mental Health Alcohol and other Drugs Directorate. Under these arrangements the planning of services to young people needed a close relationship between Queensland Health and Disability Services Queensland to align clinical and non-clinical services.

In your opinion:

- **during the period you were employed at QH; and**
- **during the period April 2012 to the present; and**
- **as at the present time;**

was/is there appropriate alignment of services when a young person transitions from adolescent to adult mental health services once they turn 18 years of age? How is the alignment of services best achieved as a young person transitions to adult services? From your experience, is the age of 18 years and appropriate age for transition to adult services?

182. The alignment of services as an adolescent makes the transition from child services to adult services, once they turn 18, is a key concern throughout Australia. There is an inherent difficulty in any mental health system based on discrete programs and difficulties can arise at the interface between these programs. These include the use of different therapeutic approaches, different developmental frameworks, continuity of staff, re- development of therapeutic alliances, competing performance frameworks, differing philosophical approaches and levels of resources.

183. Queensland is no exception and it was a common concern that young people experienced great difficulty at a time they were also facing substantial developmental challenges. For this reason, there has been considerable policy debate on the merits of creating youth specific mental health programs that span the years from about 14 through to about 24. That is because the arbitrary cut off of 18 years is not an appropriate guide to transition person to adult mental health services. Whilst some States have created such youth programs it has not been without its own problems.

184. It is my opinion that this "transition period" was handled in a somewhat inconsistent manner across Queensland Health's regions, during the period of time I was employed by Queensland Health.

185. In many areas where there was a good range of CYMHS and adult services together with well-developed pathways between the services and clear understanding of the roles and responsibilities, the transitional problems were minimal. However, in a number of areas of Queensland, problems were very common and young people and their families often complained about this discontinuity of approach.

186. A number of new programs funded by the Commonwealth Government together with expanding State programs further compounded this issue, such that at times even mental health staff working in the youth mental health sector could become confused about precisely what a particular service might be able to offer at any point in time. This can add to the problems rather than rectify them as was intended.

187. I am not able to make an informed opinion about the alignment of services available to youth in Queensland after October 2011.

NMHSPF

The Commission understands that, in your employment with QH, you had some involvement with the development of the:

- **draft National Mental Health Services Policy Framework; and/or**
- **Drug and Alcohol Clinical Care and Prevention Modelling Tool.**

Please explain those resources and your involvement in them.

Does either (or both) of those resources have any implications for the allocation of Government funding and resources for the cohort of patients who accessed the BAC and, if so, what are those implications.

188. The National Mental Health Service Planning Framework (**NMHSPF**) is one of the most important recent developments under the NMHS. In 2008 and 2009, I held the roles of

Chair or Deputy Chair of the Australian Health Minister's Advisory Committee's (**AHMAC**) Mental Health Standing Committee (**MHSC**). This committee was given the task by all Health Ministers of developing the 4th National Mental Health Plan (**4th NMHP**).

189. In the early stages of the development of the 4th NMHP, together with a number of other State Mental Health Directors, I advocated for the development of the NMHSPF. In essence, after 17 years of agreed national mental health planning, Australia did not have a tool, which outlined the optimal mix of services that should exist to provide for the mental health needs of a particular area.

190. When all Health Ministers agreed to the 4th NMHP in September 2009, they agreed the development of the NMHSPF as one of the foundational actions of the plan (Action 16).

191. In 2010, the Commonwealth Government indicated to States and Territories that it would provide funding specifically for the development of the NMHSPF. NSW and Queensland put together a combined submission to the Commonwealth with NSW as the lead for the project, but with significant aspects of the plan to be undertaken by Queensland.

192. I was responsible for developing the Queensland part of this joint proposal, sought approval from the Director General of Queensland Health and then submitted the joint proposal.

193. In the middle of 2011, the Commonwealth convened a first meeting of the project in the offices of NSW Health Building in North Sydney, together with three other key Queensland Health staff who would be part of the project.

194. At that meeting it was also agreed the executive structure of the project to ensure the project could be delivered within the contract.

195. I attended a further meeting of the executive of the project by teleconference and conducting a meeting in Brisbane to consider the best way of ensuring Queensland could ensure it met its project deliverables.

196. Soon after this, I commenced the project to establish the QMHC and had no further direct involvement in Queensland's participation on the project.

197. In May 2013, I commenced the role as State Clinical Planner for the Western Australian Mental Health Commission (**WA MHC**). In this role I had access to the NMHSPF whilst it was still in its development phase, albeit the project was now well advanced.

198. In October 2013, I attended the final meeting of NMHSPF as one of the three members from the WA MHC. This meeting took the form of a workshop, which introduced the major products that forms the NMHSPF.

199. Following this meeting, the then WA Mental Health Commissioner was provided with a USB drive that contained all the project deliverables as well as a password-protected State-specific Estimator Tool, that could be used under strict conditions for the purpose of informing planning at a jurisdictional level. Together these materials are termed the draft NMHSPF. I have not attached a copy of the draft NMHSPF.

200. The draft NMHSPF contains the following resources: The Framework Document; the Taxonomy of Services; the Service Element and Activity Descriptions; the Complete set of Care Packages; the Technical Manual; and the Estimator Tool.

201. The draft NMHSPF is the intellectual property of NSW (with the Commonwealth having an un-restricted perpetual licence). It was NSW's intention, in sharing the draft with States, that the draft be used in the field as a way of providing important user feedback so that this could be used to refine the draft and ultimately lead to the development of a version for more widespread use once any inaccuracies had been rectified.

202. Between October 2013 and April 2014, I used the draft NMHSPF to provide the initial technical report for the WA MHC to provide to the Western Australian Minister for Mental Health to form the basis of that State's Ten Year Mental Health Plan. During the development of this report, a number of errors and issues with the draft were identified and I had further discussions with other planners who had used the draft NMHSPF.

203. A further version of the draft NMHSPF was provided to the WA MHC in early 2014 that contained some fixes to known problems with the first draft as well as some new functions within the Estimator Tool.

204. The WA plan was publically released in December 2015.

205. In July 2015, the Commonwealth indicated to States and Territories its intention to form a group of experts that would work with it and NSW to incorporate the feedback from users of the draft NMHSPF together with other experts to refine the draft NMHSPF into a second version.

206. I have been advised the Commonwealth has entered into a funded agreement with the Queensland Centre for Mental Health Services Research to undertake the next stage of consultation and further refinement of the NMHSPF. I am informed Professor Harvey Whiteford is leading this process. Professor Whiteford is considered one of the leading experts in the world on Mental Health Policy and Planning.

207. I am a member of both the expert group and the jurisdictional group that is considering the development of the updated NMHSPF. This project is expected to conclude its work in the middle of 2016.

208. I had no direct role in the development of the National Drug and Alcohol Clinical Care and Prevention modelling tool. I am however very familiar with the tool.

209. The implications of the draft NMHSPF to the allocation of Government resources and funding are currently still unclear. As noted earlier, the draft NMHSPF is still in its developmental phase. In certain areas the NMHSPF would appear to be very good at predicting the level of required resources.

210. However, in other areas, particularly where the level of resources is at an extremely low rate even for large populations the draft NMHSPF may not be as helpful. For example, in the outlining the characteristics of the framework, the following is stated… "the NMHSPF does not account for every circumstance or service possibly required by an individual or group, but allows for more detailed understanding of need for mental health services across a range of service environments" (page 13). That is the NMHSPF indicates to the planner "not all, but many".

211. The draft NMHSPF does however predict for a jurisdiction how many subacute bed-based services (residential and hospital or nursing home based) would be required. The BAC as a service type fits within this category, although as previously noted its model of service requires amendment.

212. Therefore using the draft NMHSPF, notwithstanding its limitations would indicate how many "beds" of this type are needed for young people who need this level and type of service.

General

Outlined and elaborate upon any other information and knowledge (and the source of that knowledge) you have relevant to the Commission's Terms of Reference.

213. I have no further information relevant to the Commission's Terms of Reference to include in my Statutory Declaration.

Identify and exhibit all documents in your custody or control that are referred to in your witness statement

214. Except as set out above, I have identified and exhibited all documents referred to in my Statutory Declaration.

[redacted] ..... [redacted] .....

Witness Signature **Justice of the Peace / Commissioner for Declarations / Lawyer**

215. As the Commission is aware I ceased performing my roles at Queensland Health in April 2012. When I left Queensland Health I did not take any documents with me. In around 2013 I asked Queensland Health to make available to me, for other purposes, copies of all emails I sent and received whilst I worked for Queensland Health. Queensland Health provided me with a disc containing what it said constituted those emails however that disc was provided in a form that did not enable me to usefully retrieve or search any documents. In early 2016, Queensland Health made available to me certain documents that it says fell within the Terms of Reference of this Commission of Inquiry and the Requirement to Produce Documents issued to me by the Commissioner. I am not in a position to say whether I have received access to all relevant documents. Nevertheless, I would like the Commission to be aware that I have made this Statutory Declaration using my best endeavours to review the documents that Queensland Health has made available to me for the purposes of this Commission. If there are any other documents that the Commission would like me to consider, I would be happy to do so.

And I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

Taken and declared before me by Dr Aaron Groves at Adelaide in the State of South Australia this date of 21 January 2016

Before me:

Signature of authorised witness

Solicitor / Justice of the Peace

JP 12489

Vivien Marie Geaves

Signature of declarant

Dr Aaron Groves

EXHIBIT 58

GRA.020.001.0038

STATUTORY DECLARATION OF AARON GROVES

INDEX OF EXHIBITS

No	Document Description	Document Number	Page
AG-1	Curriculum Vitae of Aaron Groves	GRA.010.001.1482	3-11
AG-1A	Statutory Requirements of the Director of Mental Health – *Mental Health Act 2000*	GRA.010.001.1540	12-14
AG-2	Queensland Plan for Mental Health 2007-2017	QHD.020.001.2584	15-54
AG-3	National Mental Health Plan April 1992	GRA.010.001.1018	55-81
AG-4	Second National Mental Health Plan - 1998	GRA.010.001.0854	82-116
AG-5	National Mental Health Plan 2003 – 2008	GRA.010.001.1293	117-160
AG-6	Fourth National Mental Health Plan – An agenda for collaborative government action in mental health 2009-2014	GRA.010.001.0889	161-248
AG-7	National Mental Health Report 2013 – Tracking progress of mental health reform in Australia, 1993 – 2011	GRA.010.001.1045	249-456
AG-8	Ten Year Mental Health Strategy for Queensland - 1996	GRA.010.001.1253	457-496
AG-9	Council of Australian Governments National Action Plan on Mental Health 2006 – 2011	GRA.010.001.0977	497-537
AG-10	Queensland Health Child and Youth Mental Health Plan 2006 – 2011	WMS.9000.0001.00166 WMS.6000.0004.00253 GRA.010.001.1397	538-622
AG-11	Barrett Adolescent Centre Consultation on Aggression and Violence at the BAC –	PMG.001.002.062	623-671

[redacted]

Witness Signature

[redacted]

Justice of the Peace / Commissioner for Declarations / Lawyer

JP12489

Vivien Marie Greaves

	August 2003	WMS.1005.0001.00381 GRA.010.001.1491	
AG-12	2009 Review of Barrett Adolescent Centre (Final Report)	WMS.1001.0014.00248 GRA.010.001.1337	672-731
AG-13	Report of the site evaluation subgroup – Site Options Paper for the redevelopment of the Barrett Adolescent Centre – October 2008	QHD.020.001.1101	732-799
AG-14	Queensland Plan for Mental Health 2007-2017 Four Year Report – October 2011	QHD.020.001.0045	800-813

[redacted]
Witness Signature

[redacted]
Justice of the Peace / Commissioner for Declarations / Lawyer

JP 12489
Vivien Marie Greaves

CURRICULUM VITAE

AARON R GROVES
M.B. B.S. (UWA) FRANZCP

January 2016

PERSONAL DETAILS

Name Aaron Robert **GROVES**

Date of Birth

Address

Telephone Mobile: +

Email

Nationality Australian and Latvian citizenship

EDUCATION

QUALIFICATIONS

1984 M.B. B.S. (UWA)
Faculty of Medicine, University of Western Australia

1991 FRANZCP
Royal Australian New Zealand College of Psychiatrists
Melbourne, Victoria

MEDICAL REGISTRATION

General and Specialist (Psychiatry) Registration with
Australian Health Practitioners Registration Authority

EMPLOYMENT SUMMARY

South Australia

February 2015 - current	**Chief Psychiatrist** SA Health

Western Australia

June 2014 – December 2015	**Clinical Director, Adult Program,** North Metro Area Health Service; Mental Health
May 2013 – April 2014	**State Clinical Planner for the WA Ten-Year Mental Health Service Plan.** Western Australian Mental Health Commission;
Jan 2014 – December 2015	**Principal Clinical Planner** North Metro Area Health Service; Service Analysis Unit Department of Health (Western Australia)
Feb 2013- Dec 2013	**Consultant Psychiatrist** State-wide Specialist Aboriginal Mental Health Service;
Sep 2012- Sep 2103	**Consultant Psychiatrist (locum position)** Women and Newborn Health Service

Queensland

Sep 2005 - Aug 2012	**Director of Mental Health and Executive Director, Mental Health Alcohol and Other Drugs Directorate** Queensland Health
Oct 2011 - Mar 2012	**Executive Director, Queensland Mental Health Commission Transition Team** Queensland Health
Apr 2009 - Oct 2009	**Deputy Director-General** Division of the Chief Health Officer Queensland Health

Western Australia

Mar 2005 - Sep 2005	**Director, Division of Mental Health** Department of Health WA
Aug 2002 - Mar 2005	**Director, Office of Mental Health** Department of Health WA

Dec 2001 - Aug 2002	**Acting General Manager, Mental Health Division then Acting Director, Office of Mental Health** Department of Health WA
Dec 2001 - Jun 2002	**Chief Psychiatrist, Mental Health Division** Department of Health WA
Dec 2001	**Acting Deputy Director General, Health Care Division** **Acting Chief Medical Officer, Department of Health** Covering period of annual leave Department of Health WA
Jan 2000 - Aug 2002	**Director, Metropolitan Mental Health Service**
Jan 1999 - Jan 2000	**Deputy Chief Psychiatrist, Mental Health Division**
Apr 1996 - Jan 2000	**Director, Postgraduate Education and Training in Psychiatry, Department of Health**
Apr 1996 - Jan 2000	**On-call psychiatrist to King Edward Memorial Hospital for Women**
Oct 1993 - Current	**Private Psychiatric Practice (Aaron Groves Pty Ltd)** and **Private Consulting Practice (Tembay Holdings Pty Ltd)**
Oct 1993 - Jan 1996	**Sessional Psychiatrist, Mill Street Centre**
Jul 1992 - Oct 1993	**Consultant Psychiatrist** Armadale-Kelmscott Health Service 0.5 Armadale Lodge, 0.5 Armadale Clinic.
Dec 1990 - Jul 1992	**Clinical Director, Psychiatric Emergency Team**
Jan 1986 - Dec 1990	**Psychiatry Registrar, Psychiatry Training Program, WA Branch of RANZCP** Various Position as follows: 1986 Graylands Hospital; 1987 Bentley OAP; 1987 Warwick CAMHS; 1988 Royal Perth Hospital; 1989 Osborne Clinic; and 1990 Osborne Clinic (Elective Year).
Jan 1985 – Jan 1986	**Intern** Royal Perth Hospital

MEMBERSHIPS / POSITIONS HELD

1. National Committee Roles

- Member, Mental Health Drug and Alcohol Principal Committee (2015-present)
- Member, Safety and Quality Partnership Standing Committee (2015-present)
- Member Fifth National Mental Health Plan Working Group (2015-present)
- Member Fifth National Mental Health Plan Writers Group (2015-present)
- Member National Mental Health Service Planning Framework Jurisdictional Panel (2015-current)
- Member National Mental Health Service Planning Framework Expert Panel (2015-current)
- Chair, Mental Health Standing Committee (2008-2011),
- Deputy Chair, Mental Health Standing Committee, (2003-2008),
- Member, Mental Health Standing Committee (including its predecessor NMHWG 2001-2011),
- Chair, Mental Health Information Strategy Subcommittee (2002-2011),
- Chair, National Mental Health Activity Based Funding Task Group (2010-2011),
- Chair, Fourth National Mental Health Plan Executive group (2008-2009),
- Chair, Fourth National Mental Health Plan Writing group (2008-2009),
- Chair, Fourth National Mental Health Plan Implementation Plan Group (2009-2011),
- Chair, Fourth National Mental Health Plan Flagship 1 Implementation Group (2011-2012),
- Chair, Safety and Quality Partnership Subcommittee (2002-2007),
- Chair, National Suicide Prevention Working Group (2010-2011),
- Chair, Homelessness and Housing Taskforce of the NMHWG (2003-2005),
- Chair, National Research and Data Strategy Working Group of IGCD (2011),
- Co-Chair, National Perinatal Depression Working Group (2009-2011),
- Co-Chair, National Suicide Prevention Working Group (2009-2011),
- Deputy Chair, Cross Sectoral Working Group (2010-2011),
- Invited Expert, National Mental Health Information Development Expert Advisory Panel (2011),
- Member, National Standards Executive Committee (2006-2009),
- Member, National Standards Implementation Steering Committee (2008-2010),
- Member, Senior Officers Mental Health Working Group COAG (2011)
- Member, Intergovernmental Committee on Drugs (IGCD) (2010-2011),
- Member, Safety and Quality Partnership Subcommittee (2007-2011),
- Member, Joint Officer's Group/Multicultural Mental Health (2006-2011),
- Member, Expert Forensic group of NMHWG (2003),
- Member, NMHWG working party with AHWOC on MH Workforce (2005),
- Member, Working party of NMHWG to develop National Response Plan to Terrorist incidents (2006),

2. Queensland Government

2005- 2011	Queensland Government Suicide Prevention Strategy Executive Committee (Chair)
2005-2012	Queensland Health Mental Health Clinical Collaborative (Sponsor and Chair)
2005- 2009	Queensland Health *Achieving the Balance* Implementation Committee (Chair)
2006- 2008	Queensland Mental Health Plan Writing Group (Chair)
2006	Queensland Mental Health Senior Officers Group (Deputy Chair)
2006-2007	Queensland Department of Communities Board of Management (member)
2006-2008	HASP Tri-agency partnership committee (Co-Chair)

2006-2009	Queensland Mental Health Promotion, Prevention and Early Intervention Committee (Chair)
2006-2011	Queensland State-wide Mental Health Clinical Network (Chair)
2006-2011	Queensland COAG Mental Health Group (Deputy Chair and Acting Chair)
2007-2011	Queensland Health CHO ELT (member and acting Chair)
2007-2011	Queensland MHP Implementation Committee (Chair)
2008-2012	Queensland Mental Health Senior Executive Leadership Forum (Chair)
2008-2011	Queensland Health Mental Health Team Leaders Forum (sponsor)
2008-2011	Queensland Responsible Gambling Committee (member).
2008-2011	Queensland Clinical Senate (member)
2009-2011	Queensland Senior Mental Health Leaders Forum (Sponsor and Chair)
2009-2011	Clinical Informatics Committee (member)
2009-2011	Information Communication and Technology Executive Committee (ICTEC) (member)
2009-2011	Mental Health Clinical Audit committee (Chair)
2009-2011	Queensland Psychotropic Medication Advisory Committee (Sponsor)
2009-2011	Queensland Primary Mental Health Care Collaborative (member)
2009-2011	Activate: Mind and Body Project Executive Committee (Sponsor and Co-Chair)
2010-2011	Queensland Health Executive Management Team (member)
2010-2011	Queensland Government State Disaster Committee (member)
2011	Queensland Government Natural Disaster Community Recovery Committee (member and Chair of the psychosocial sub-committee)
2011-2012	Queensland Mental Health Reform Committee (Chair)

3. Western Australian Government

2013 - 2014	WA MHSP, Steering Committee; Technical Advisor
2013	WA MHSP, Mental Health Promotion and Prevention Consultative Group; Technical Advisor
2013	WA MHSP, Community Support Consultative Group; Technical Advisor
2013	WA MHSP, Community Clinical Consultative Group; Technical Advisor
2013	WA MHSP, Bed-Based Consultative Group; Technical Advisor
2013	WA Cultural and Clinical Reference Group; Chair
2003 - 2005	Member, WA Clinical Senate,
2002 - 2005	Chair, State Mental Health Clinical Network,
2002 - 2005	Chair, State Mental Health Executive Group,
2001 - 2005	Member, SAAP State Advisory Committee,
2001 - 2005	Chair, WA Psychotropic Drugs Sub-Committee,
2001 - 2005	Member, WA Therapeutic Advisory Committee,
2002 - 2005	Board member, WA Ministerial Council on Suicide Prevention
2001 - 2002	Member, WA State Homelessness Taskforce
1998 - 2000	Member, Criminal Law (Mentally Impaired Defendants) Review Board
1998 - 2000	Member, Mental Health Review Board

4. RANZCP

2012 – 2014	Western Australian Branch Committee, Chair
2012 – 2014	Bi-National Members Advisory Committee, member
2001 – 2003	Bi-National Ethics Committee, RANZCP
2001 – 2004	Shadow Examiner, Committee for Examinations, RANZCP
2001 – 2003	Chair, Boundary Transgressions and Professional Misconduct Project, RANZCP
2001 – 2003	Treasurer, WA Branch Committee, RANZCP
1995 – 2003	Member, WA Branch Committee, RANZCP
1997 – 2001	Honorary Secretary, Bi-National Continuing Education Committee, RANZCP
1997 – 2001	Member, Bi-National Continuing Education Committee, RANZCP
1999 – 2001	Member, Education and Training Review Project, RANZCP
1992 – 2000	Convenor, West Australian Branch Continuing Education Committee, RANZCP
1997 – 2001	College Congress Convenor's Committee,(Bi-National)

1997 – 2001 Member, Board of Practice Standards, (Bi-National)
1997 – 2000 Member, Committee for Training, (Bi-National)
1995 – 2000 Member, Maintenance of Practice Standards Committee, (Bi-National)
1998 – 2000 Chair, Taskforce on Boundary Violations Board of Practice Standards, (Bi-National)
1996 – 1999 Convenor & Chair Scientific Committee 34th RANZCP Congress Perth 1999
1991 – 1993 Member, WA Branch Committee, RANZCP

5. Other Organisations:

2015 – current Board Member of *beyondblue* the National Depression initiative representing SA
2011 - 2012 Commonwealth Department of Defence, Mental Health Advisory Group,
2004 - 2012 Board Member of *beyondblue* the National Depression initiative representing WA from 2004 until 2005 and then Qld from 2005 until 2012,
2007 - 2009 Inaugural Board member, Headspace Strategic Advisory Board,
2003 - 2006 Clinical Co-Chair of the National Institute of Clinical Studies (NICS) Mental Health Emergency Department Interface Community of Practice (COP) Project,
1997 – 2005 Overseas Qualification sub-Committee (Psychiatry) Medical Board of Western Australia, and
1999 – 2002 Chair, Overseas Qualification Sub-Committee (Psychiatry) Medical Board of Western Australia.

PRESENTATIONS, LECTURES, KEYNOTE ADDRESSES AND PUBLICATIONS

I have given numerous presentations, lectures and keynote addresses, at state, national and international levels on a range of topics over the past 15 years.

The mental health issues have included:

- Mental Health Planning, both state and national;
- Mental Health Inpatient Facility guidelines;
- Mental Health Promotion, Prevention and Early Intervention;
- Mental Health Reform, both state and national;
- National Mental Health Policy reform;
- Mental Health Community Sector planning and reform (Non-government sector);
- Mental Health Consumer, Carer and Family Participation Framework;
- Information sharing with families of people who live with a mental illness;
- Mental Health Safety Priorities, both state and national;
- Reducing Seclusion and Restraint;
- Reducing Medication error in mental health services;
- Primary Mental Health Care, including the QH/GPQ partnership and the primary mental health care framework;
- Mental Health and Intellectual Disability;
- Mental Health, Drugs and Alcohol (Dual Diagnosis) policy guidelines and reform;
- Mental Health Information Priorities and an arrays of sub-topics including; routine outcome measurement in public services, case mix, activity based funding, national minimum data sets, consumer self-report measures, and performance and benchmarking;
- Clinical Services Capability Frameworks;
- Models of Care in Mental Health;
- National Mental Health Standards for Mental Health Services;
- Employment initiatives in mental health services;
- The Housing and Support Program;
- The Mental Health Intervention Program;
- Recovery;
- Queensland *Mental Health Act 2000*;

- Queensland *Forensic Disability Act 2011*;
- Psychosocial aspects of disasters;
- Child and Youth Mental Health Services;
- National Survey of Mental Health and Wellbeing;
- Policy implications of the Survey of High Impact Psychosis (SHIP) study;
- Forensic Mental Health Services;
- Aboriginal and Torres Strait Islander mental health social and emotional wellbeing (SEWB);
- Rural and Remote mental health;
- Antidepressant medication guidelines;
- Antipsychotic guidelines;
- Breast milk/Plasma ratios for common antidepressant medications;
- Obsessive Compulsive Disorder;
- Perinatal Mental Illness;
- Neuropsychiatric aspects of streptococcal infections;
- Suicide Prevention;
- Mental Health First Aid; and
- Psychological First Aid; and

Non-mental health issues have included:

- Hendra Virus, clinical features and research implications;
- Health aspects of natural disasters;
- Cessation of cigarette smoking;
- Listeria infection and birth abnormalities; and
- Helicopter landing sites and safety.

I am able to provide further details if requested.

In 2012, I had the privilege of being invited to deliver the Stanley Wilkinson Oration to the Australian Orthodontics Society entitled " Mental Illness: Something to smile about".

I have published in peer-review journals in a range of areas most recently on the national policy aspects of the second NSMHWB and the SHIP as well as the development of planning estimates and clinical practice improvement payments for mental health services in Queensland.

In addition, I have had responsibility for the writing of a number of key policy or planning documents at both State and National Levels. This includes:

Queensland Mental Health Plan 2007-2017;
Queensland Mental Health Natural Disaster Recovery Plan 2011-2013;
Queensland Mental Health Workforce Plan;
Queensland Mental Health Safety Plan;
Queensland Mental Health Information Strategic Plan 2010-2014;
Queensland Care Coordination Model and Policy;
Queensland Primary Mental Health Care Framework;
Queensland Government Suicide Prevention Action Plan (unpublished);
Mental Health Act 2000 Resource Guide;
Mental Health Act 2000 Administrator Delegates Manual;
Health and Weapons – an information booklet: your rights and protections in relation to the Weapons Act 1990;
Forensic patient management policy and procedures;
Classified Patient Information Orders and Patient Information Register policy;
Policy for the operation of Limited Community Treatment Review Committees;
Queensland Clinical Services Capability Framework- Mental health module;
Queensland Health Forensic Mental Health Strategic Framework;
Information sharing between mental health workers, consumers, carers, families and significant others;

Queensland Health Policy Statement on Reducing and Where Possible Eliminating Restraint and Seclusion in Queensland Mental Health Services;
Queensland Health Policy, Service delivery for people with a dual diagnosis (co-occurring mental health and alcohol and other drug problems), referred to as the *Dual Diagnosis Policy;*
Queensland Health Dual Diagnosis Clinician Guidelines and Clinician Tool Kit;
Fourth National Mental Health Plan 2009-2014;
National Mental Health Information Priorities 2nd Edition;
National Action Plan for Perinatal Mental Health; and
National Safety Priorities in Mental Health: a national plan for reducing harm.

Attachment 3

STATUTORY REQUIREMENTS OF THE DIRECTOR OF MENTAL HEALTH
MENTAL HEALTH ACT 2000

Providing an annual report to the Minister on the administration of the Mental Health Act 2000 ("the Act") under section 494 of the Act
Advising and reporting to the Minister on any matter relating to the administration of the Act on the Director's own initiative or on the request of the Minister if the matter is in the public interest under section 489 of the Act
Ensuring the protection of the rights of involuntary patients under the Act pursuant to section 489 of the Act including preparing a statement about the rights of involuntary patients under section 344 of the Act
Initiating investigations into aspects of the care of individual involuntary patients and appointing approved officers to carry out those investigations under Part 6 of Chapter 14 of the Act
Ensuring the involuntary admission, assessment and treatment of person complies with the Act pursuant to section 489 of the Act
Approving involuntary patients being absent from authorised mental health facilities under section 186 of the Act
Providing the interface between the health and criminal justice systems in relation to mentally ill patients and under Chapter 3 of the Act including: • Receiving information from the administrator of an authorised mental health service about a patient's detention as a classified patient and notifying the chief executive of justice about same under section 70 of the Act • Receiving report from an authorised doctor that a classified patient no longer needs to be detained for treatment in an authorised mental health service under section 74 of the Act • Receiving notification that a person has ceased to be a classified patient as a result of section 78 of the Act under section 79 of the Act • Approving continued detention of patient in a high security unit after they have ceased to be a classified patient under section 82 of the Act • Considering reports regarding mentally ill patients in custody and determining whether they are fit to face court or return to custody under Part 5 of Chapter 3 of the Act • Agreeing to detention of person in an authorised mental health service during trial under sections 102 and 104 of the Act • Receiving and giving notice of involuntary patients charged with offences under section 237 of the Act • Receiving report from the administrator of an authorised mental health service on the examination of involuntary patients charged with offences under section 239 of the Act • Considering referring to the Mental Health Court or Attorney-General an involuntary patients charged with offences where the mental illness is relevant to the offence under sections 240 and 241 and Parts 3 and 4 of Chapter of the Act • Receiving notice of the Mental Health Court's orders in relation to involuntary patients charged with offences under section 276 and for forensic patients under section 300 of the Act

• On receiving notice that a forensic order has been made in relation to a person under the Criminal Code following a jury finding, refer the matter to the Tribunal under section 301 of the Act
Facilitating the proper and efficient administration of the Act pursuant to section 489 of the Act
Promoting community awareness and understanding of the administration of the Act pursuant to section 489 of the Act
Declaring authorised mental health services, high security units and administrators under Part 2 of Chapter 13 of the Act
Appointing authorised mental health practitioners and approved officers under Chapter 13 of the Act
Appealing certain decisions made by the Mental Health Review Tribunal ("Tribunal") under section 320 of the Act and: • Receiving notice of appeals and decisions under Chapter 8 of the Act • Appearing at the appeal under sections 328 and 330 of the Act • Electing to become a party to the appeal under section 331 of the Act
Having right of appearance at Tribunal reviews under section 450 of the Act
Being a party to all proceedings in the Mental Health Court as a result of the definition of "party" in Schedule 2 to the Act
Ordering the transfer of forensic, classified and court order involuntary patients (including interstate) under Chapter 5 of the Act
Requiring reports from administrators of authorised mental health services about: • seclusions of patients in the health service under section 160 of the Act; • use of mechanical restraint of patients in the health service under section 147 of the Act
Reviewing the refusal of an administrator of an authorised mental health service to give agreement to the assessment of a patient and consider whether an assessment should be undertaken under section 55 of the Act
Receiving notice when: • a recommendation for assessment for a person is not made after the person's examination under a justices examination order or emergency examination order under sections 32 and 41 of the Act • an involuntary treatment order is revoked under section 123 of the Act
Giving approval for a classified patient to be provided limited community treatment under section 129 of the Act
Agreeing to the assessment of a person at a public sector mental health service under sections 53(1) and 55 of the Act
Approving the assessment of a young person or a person charged with a simple offence at a high security unit under section 53(2) of the Act
Agreeing to the treatment of a patient (except for classified patients) subject to an

involuntary treatment order in a high security unit under section 109 of the Act
Revoking involuntary treatment orders under sections 118 and 122 of the Act
Applying for review of the application of the treatment criteria to a patient under an involuntary treatment order under section 188 of the Act
Receiving various notices of review and decisions and requesting reasons for decisions from the Tribunal under Chapter 6 of the Act
Disclosing confidential information in accordance with section 531 of the Act

Queensland Plan
for Mental Health
2007-2017

Queensland Government

The Queensland Plan for Mental Health 2007-2017

Published by the Mental Health Branch,
Queensland Health, Queensland Government

ISBN 978-1-921447-22-8

June 2008

Marketing and Communication
Mental Health Branch
Queensland Health
GPO Box 48
BRISBANE Q 4001

An electronic version of this document is available at **www.health.qld.gov.au/mentalhealth**

Preferred citation: Queensland Government (2008), *Queensland Plan for Mental Health 2007-2017*, Queensland Government, Brisbane

Message from the Minister for Health

I am very pleased to present the *Queensland Plan for Mental Health 2007-2017*. The plan outlines priorities for the reform and development of mental health care over the next ten years.

The demand for treatment and support for people with mental illness continues to grow. Currently one in five adult Australians experience a mental illness in any one year. Depression is predicted to rise from the fourth to the second greatest cause of global disease burden over the next twenty years.

As part of the 2007-08 State Budget the Queensland Government committed a record $528.8 million over four years to improve Queensland's mental health system. This unprecedented level of funding, the largest investment in mental health in Queensland's history, reflects the Government's deep commitment to delivering a better quality of life for people who live with mental illness, their families and carers.

In 2008-09 a further $88.63 million has been allocated over four years to continue implementation of this Plan bringing the total Government commitment since July 2007 to $617.43 million.

The *Queensland Plan for Mental Health 2007-2017* provides a blueprint for reform and will inform future investment in mental health services across the State. The directions outlined in the Plan establish a framework for the development of a more responsive system of services to better meet the needs of people who live with a mental illness.

Public mental health services will continue to play a major role, with the contribution of other sectors involved in the delivery of mental health care clearly highlighted. There is a much stronger role for non-government organisations, and major contributions from all levels of government.

The *Queensland Plan for Mental Health 2007-2017* has been informed by extensive consultations undertaken with mental health consumers, carers, service providers and key stakeholders.

Five priority areas for action have been identified. These priorities position mental health services to be better able to respond to existing and future demand for care, by building on the strengths of the current system, developing an appropriate mix and level of services and implementing new and innovative approaches to consumer and carer needs.

The priorities are:

- promotion, prevention and early intervention
- improving and integrating the care system
- participation in the community
- coordinating care
- workforce, information, quality and safety.

Effective partnerships around mental health care are essential. Improving collaboration between the public sector, private sector, non-government organisations, other agencies and departments and the broader community to respond to the needs of people who live with a mental illness, their families and carers is a prime aspect of the *Queensland Plan for Mental Health 2007-2017*. The reform of mental health care over the next ten years relies on these partnerships and the participation of the broader community.

I look forward to working with you as we further develop and implement our vision for mental health in Queensland.

Stephen Robertson MP
Minister for Health

Contents

1. A vision for mental health

Throughout the world, mental disorders are common, affecting more than 20% of all people at some time during their lives. Mental health problems are universal, being experienced by people of all countries, by women and men of any age and socioeconomic status, and in urban and rural environments.

Mental disorders are the largest single cause of disability within Australia accounting for nearly 30% of the burden of non-fatal disease. In Queensland, it is estimated that 16.6% of the population is affected by mental disorders in any one year (further detail provided below).

A complex interplay of biological, psychological, social, economic and environmental factors influence mental health. This is true for all Queensland people, but has particular significance for some population groups, especially Aboriginal and Torres Strait Islander people who view social and emotional wellbeing holistically. Mental health status also influences access to various community resources and capacity to participate in society.

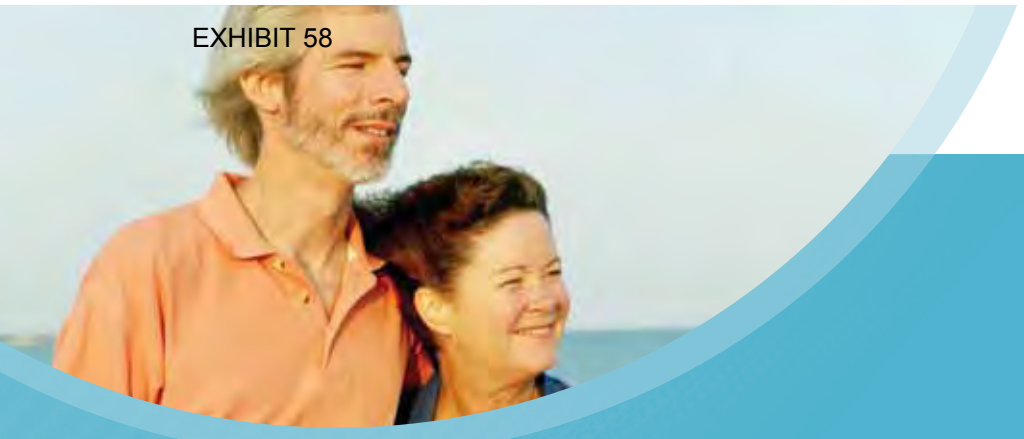
Meeting the mental health needs of Queensland's rapidly growing population poses challenges for governments, policy makers, researchers, service providers and communities. Queensland remains one of the fastest growing states in Australia with the population predicted to grow from 4 million to 5.6 million by 2026.

Mental illness in Queensland

- It is estimated that 16.6% of the Queensland population is affected by mental disorders in any one year (excluding dementia and alcohol and drug-related disorders, except where co-existing with another mental disorder).
- The figure rises to about 22% when alcohol and drug-related conditions are included.
- Anxiety-related and depressive disorders are the most prevalent, affecting approximately 7% and 6% of the population within any year respectively.
- Almost 2.5% of Queensland people experience severe mental disorders. About half of this group have a psychotic disorder and the remainder experience major depression or severe anxiety disorders and disabling forms of other disorders such as anorexia nervosa.
- Approximately 4.5% have a mental disorder of moderate severity, including depression, generalised anxiety disorder, post-traumatic stress disorder and panic disorder/agoraphobia.
- A further 9.6% have a disorder of mild severity and are at risk of recurring or continuing mental disorders.

Queensland Health, 2007*

** Australian and international sources have been used as Queensland-specific prevalence data of comparable coverage and quality are not available.*



While public mental health services in Queensland have undergone significant development in the last decade, there is a growing recognition that mental health is not solely the responsibility of the mental health treatment sector. Other sectors, in particular housing, disability and employment, play important roles in an individual's mental health and wellbeing, and on the broader social health of the community.

Each of these sectors together with education and training, child safety, police and emergency services, corrections and justice and community services, have a key role in maximising the mental health of Queenslanders.

The vision of the *Queensland Plan for Mental Health 2007-2017* is to facilitate access to a comprehensive, recovery-oriented mental health system that improves mental health for Queenslanders. The Plan aims to develop a coordinated approach that provides a full range of services that:

- promote mental health and wellbeing
- where possible prevent mental health problems and mental illness
- reduce the impact of mental illness on individuals, their families and the community
- promote recovery and build resilience
- enable people who live with a mental illness to participate meaningfully in society.

The mental health sector needs to build stronger partnerships with consumers, families, carers, and government and non-government services to achieve better outcomes for Queenslanders.

The delivery of recovery-oriented services is central to the Plan. Recovery is an emerging paradigm that has significant implications for people with a mental illness, families, carers and service providers. Recovery refers to a person's improved capacity to lead a fulfilled life that is not dominated by illness and treatment. The recovery approach does not focus on reduced symptoms or need for treatment alone, but on the person experiencing improved quality of life and higher levels of functioning despite their illness.

Recovery is an individual's journey toward a new and valued sense of identity, role and purpose outside the boundaries of mental illness. Recovery-oriented services assist an individual to live well despite any limitations resulting from their mental illness, its treatment, and personal or environmental conditions.

Recovery means that over time, individuals come to terms with their illness, learning how to accept and move beyond it. They learn to believe in themselves, identify strengths as well as limitations and find purpose and enjoyment in their lives, despite their illness. Services supporting individuals with mental illness have to focus on the potential for growth within the individual and acknowledge that individuals with mental illness are active participants in the recovery process.

Recovery acknowledges that having a mental illness does not necessarily mean life long deterioration. People with a mental illness are recognised as whole, equal and contributing members of our community, with the same needs and aspirations as anyone else. As a result, when working to facilitate recovery, the basic elements of citizenship need to be considered, such as ability to live independently, form social relationships and access employment opportunities. In doing this it is important that all relevant stakeholders adopt and are supportive of recovery-oriented service provision.

Sharing Responsibility for Recovery: creating and sustaining recovery-oriented systems of care for mental health. Queensland Health, 2005

People living with mental illness can and do recover to live productive lives in their communities. Recovery emphasises the need for a comprehensive community-based service system that works to address the full impact of mental illness. The improvement of mental health treatment services in isolation will not address all the issues related to the support of people with mental illness and their recovery.

There is growing recognition that a whole-of-government, whole-of-community approach is necessary to reduce the prevalence and impact of mental health problems and mental illness. The *Queensland Plan for Mental Health 2007-2017* brings together the sectors that impact on the mental health of individuals, their families, carers and communities.

The Plan recognises that a range of sectors including housing, education, training, employment, community support, health, corrections, justice, disability, police, emergency services and child safety have important roles to play in promoting mental health and reducing the impact of mental health problems and mental illness. A stronger role is envisaged for the non-government sector as a key partner in delivering comprehensive community based care and support.

Working collaboratively, these sectors have an important role to play in promoting the mental health and wellbeing of the general population, and assisting with the recovery of those experiencing mental health problems and mental illness.

> *"The vision of the Queensland Mental Health Plan 2007-2017 is to facilitate access to a comprehensive, recovery-oriented mental health system that improves mental health for Queenslanders."*

EXHIBIT 58

2. Achievements to date

The Queensland Government is building a better mental health system by improving the quality, range and access to mental health services. In October 2005, as part of the *Health Action Plan*, $201 million was allocated over five years to boost mental health services in Queensland. Beginning in July 2006 this funding was used to:

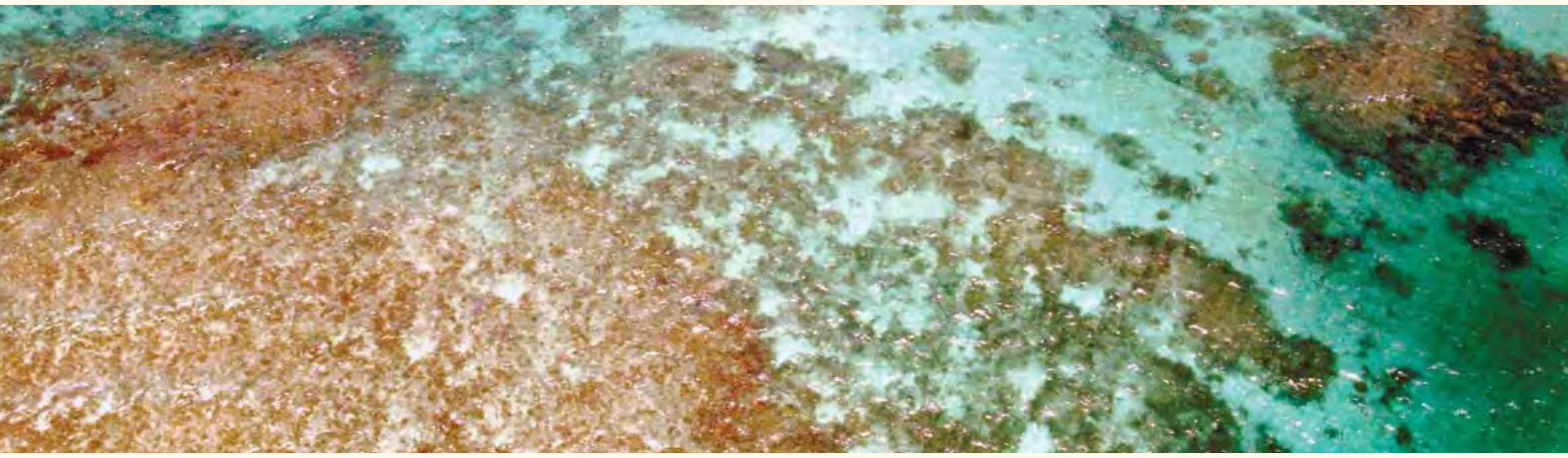
Increase mental health service capacity throughout Queensland

- Across Queensland, 193.5 new positions were established at a cost of $18 million per year. These new positions have increased access to community mental health services for people with mental illness by reducing waiting times and case loads.
- Forensic mental health services were expanded to improve services to people with mental illness who have been in contact with the criminal justice system. Specialised community forensic and court liaison services were enhanced with an additional 27 positions at a cost of $3.16 million per year. This included the creation of the position of Director of Forensic Mental Health Services to provide statewide leadership and oversight of forensic mental health services.
- Additional funding of $11.62 million per year was provided to assist in reducing pressure on existing services by increasing resources in Emergency Departments, acute inpatient treatment settings and other areas of significant demand.

Build the capacity of the non-government sector to support people with mental illness in the community

- Funding to community organisations was increased by $5 million per year, including grants to 18 non-government organisations across Queensland to provide independent living skills and social support services to people with mental illness living in the community.

In recognition of the substantial social and economic impact of mental illness on individuals, families and the wider community, the Queensland Government committed to the Council of Australian Governments (COAG) *National Action Plan on Mental Health 2006-2011* ('the NAP') as part of the continued reform of mental health services in Australia. The initial commitment of $366.2 million announced in July 2006 included the $201 million provided under the *Health Action Plan* and a range of other mental health-specific initiatives funded within Queensland Health and other government departments.



In addition to the *Health Action Plan* enhancements previously listed, major initiatives funded in the initial COAG commitment include:

- the Housing and Support Program as a collaborative service initiative between the Department of Housing, Queensland Health, Disability Services Queensland and the Department of Communities. This program provides coordinated social housing, clinical treatment and non-clinical support to enable people with moderate to severe mental illness and psychiatric disability to live successfully in the community. The program included a $20 million capital investment from the Department of Housing with clinical and disability support services funded by Queensland Health and Disability Services Queensland. A total of 80 supported social housing places were provided in 2006-07.
- development of service delivery hubs in a range of locations to provide integrated services to people in high areas of need. These included Early Years Service Centres, Blueprint for the Bush Service Delivery Hubs and Indigenous Domestic and Family Violence Counselling Services established by the Department of Communities. These hubs are designed to provide a comprehensive range of services, including mental health services, with a focus on children and families, rural communities, and Aboriginal and Torres Strait Islander people.

During 2006, Queensland Health also provided $640,000 to seven Divisions of General Practice across Queensland for the implementation of the 'Partners in Mind' framework. This approach, which has been agreed between Queensland Health and General Practice Queensland, will establish a better integrated primary mental health care sector.

The 2007-08 Queensland State Budget provided an additional commitment of $528.8 million over four years to expand the initial Queensland COAG mental health initiatives. This brings the total new investment in mental health by the Queensland Government to $895 million over the five years from 2006-11. This funding and the broad program of mental health reform are the focus of this Plan and are outlined in detail in Chapter 6.

These commitments will enable further development of the substantial network of District Mental Health Services, other government and non-government services in Queensland.

Currently the mental health inpatient system consists of more than 1,400 beds. During 2007-08, District Mental Health Services provided over 374,000 days of inpatient care. In addition, more than 2,000 staff were employed within community mental health services, and for the first time delivered more than 1.1 million occasions of services to Queenslanders with mental illness living in the community.

"The Queensland Government is building a better mental health system by improving the quality, range and access to mental health services."

3. Providers of mental health services in Queensland

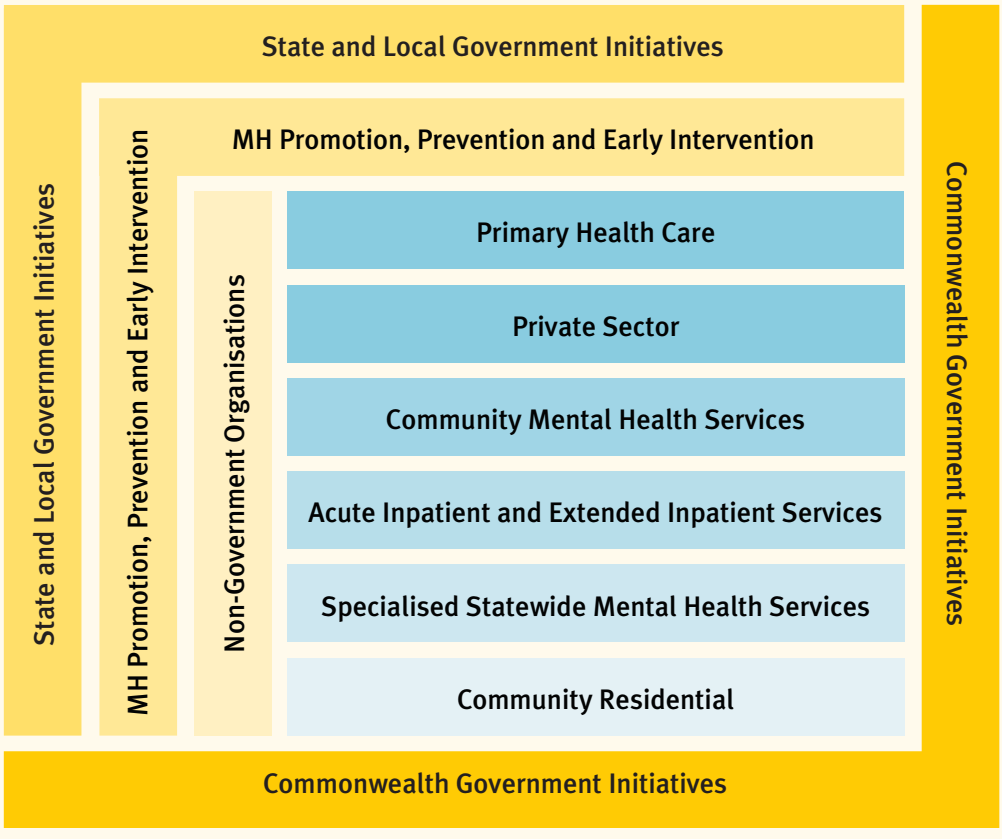
Mental health care in Queensland is delivered by a range of providers operating within and across different sectors. There are significant areas of interface between these sectors, as demonstrated in Figure 1.

The mental health treatment sector, supported by the broader health sector, has clear responsibility for delivery of a range of clinical assessment and treatment services. The mental health treatment sector includes both public and private providers.

They provide crisis response, acute, non-acute and continuing treatment services in inpatient and community settings.

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

Figure 1: Queensland Mental Health Service System



Public mental health services are provided in each of the 20 Queensland Health Service Districts. They deliver specialised assessment, clinical treatment and rehabilitation services to reduce symptoms of mental illness and facilitate recovery. These services focus primarily on providing care to Queenslanders who experience the most severe forms of mental illness and behavioural disturbance, including those who are subject to the provisions of the *Mental Health Act 2000*.

Public mental health services work in collaboration with primary health and private sector health providers. ***Primary health care providers*** include general practitioners, community health workers, nurses, allied health professionals, school health nurses, counsellors and community support groups. Their role includes assisting individuals with mental health problems and facilitating access to specialist public and private mental health services when required.

Private mental health services are delivered by psychiatrists, mental health nurses, clinical psychologists, social workers, occupational therapists and other allied health professionals with expertise in mental health care. They provide a broad range of services largely through office-based private practice and inpatient care within private hospitals, including dedicated private psychiatric hospitals.

Non-government organisations include not-for-profit community agencies, consumer, family and carer groups and other community-based services that provide a range of treatment, disability support and care services, which complement both public and private mental health services. Non-government organisations are the primary providers of psychiatric disability support for people with mental illness and play an important role in promoting and maintaining mental health and wellbeing.

All sectors, including public mental health services, other government agencies and non-government organisations are involved in identifying and intervening early with people who are at risk of developing mental illness and facilitating timely and effective recovery-oriented pathways to care. Key groups requiring particular attention in ***mental health prevention and early intervention*** include children of parents with mental illness, children and youth who have experienced, or are at risk of abuse/neglect, and young people displaying behaviour disturbances, and their families.

A safe environment, adequate income, meaningful social and occupational roles, secure housing, higher levels of education and social support are all associated with better mental health and wellbeing. Queensland Government departments are actively working together to deliver programs that aim to strengthen mental health and promote recovery, across the spectrum of interventions. Ensuring mental health services respond as effectively as possible to the needs of consumers, families, carers, and the broader Queensland community requires effective coordination and collaboration between these sectors and across the spectrum of interventions.

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

EXHIBIT 58

4. Purpose and scope of the Queensland Plan for Mental Health 2007-2017

The *Queensland Plan for Mental Health 2007-2017* provides a blueprint for reform of mental health care over the next ten years. It identifies interventions to be delivered by the different sectors to provide a system which is responsive to the needs of consumers, families and carers. This will reduce the burden of mental illness on individuals, families and the community. The Plan provides a framework which balances increases in the capacity of public mental health services against an expanded and strengthened role for non-government services and other areas of government. Collaboration and partnerships between these multiple stakeholders is pivotal in protecting the mental health of the Queensland community and supporting recovery for people living with mental illness.

Mission:
To provide a comprehensive, resilience and recovery-based mental health system across Queensland, with emphasis upon promotion, prevention and early intervention.

The scope of the *Queensland Plan for Mental Health 2007-2017* has been influenced by the framework provided by the *National Mental Health Strategy* and Queensland Government policies and plans including:

- *National Mental Health Policy 1992*
- *National Mental Health Plan 1993-1998*
- *Second National Mental Health Plan 1998-2003*
- *National Mental Health Plan 2003-2008*
- *Council of Australian Governments National Action Plan for Mental Health 2006-2011*
- *Mental Health Statement of Rights and Responsibilities (1991)*
- *National Standards for Mental Health Services (1996)*
- *National Mental Health Information Priorities 2nd Edition*
- *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000*
- *National Practice Standards for the Mental Health Workforce (2002)*
- *National Action Plan on Perinatal Mental Health*
- *Aboriginal and Torres Strait Islander Social and Emotional Well-being Framework 2004-2009*
- *Key Performance Indicators for Australian Public Mental Health Services (2004)*
- *National Safety Priorities in Mental Health: A National Plan for Reducing Harm (2005)*
- *Ten Year Mental Health Strategy for Queensland (1996)*
- *Queensland Forensic Mental Health Policy 2002*
- *Queensland Mental Health Strategic Plan 2003-2008*
- *Queensland Health Systems Review (Forster, 2005)*
- *Queensland Health Action Plan 2005*
- *Queensland Statewide Health Services Plan 2007-2017*
- *Queensland Health Strategic Plan 2007-12*
- *Queensland Health Disability Services Plan 2007-12*
- *Queensland Plan for Multicultural Health 2007-2017.*

The *Queensland Plan for Mental Health 2007-2017* also builds on the recommendations of two key reports. The first, *Promoting Balance in the forensic mental health system - Final Report - Review of the Queensland Mental Health Act 2000*. The Review was charged with examining the efficacy of provisions in the *Mental Health Act 2000* and administrative arrangements relating to victims, as well as assessing whether associated arrangements achieve an appropriate balance between community safety considerations and the provision of rehabilitation to forensic patients.

The Queensland Government Response to the Final Report - Review of the Queensland Mental Health Act 2000, details strategies to implement the Review recommendations.

The second, *Achieving Balance: The Report of the Queensland Review of Fatal Mental Health Sentinel Events,* is being implemented during the life of this Plan and will form the basis of the development of a mental health safety plan.

Planning parameters used in the development of the *Queensland Plan for Mental Health 2007-2017* were drawn from the information paper *Planning Estimates and Technical Notes for Queensland Mental Health Services*, prepared for the Mental Health Branch, Queensland Health.

EXHIBIT 58

5. Principles

The *Queensland Plan for Mental Health 2007-2017* articulates six principles to guide and support reform. Mental health intervention, care and service delivery across all sectors in Queensland should align with these principles.

Principle 1 – Consumer and carer participation

Consumers, families and carers are actively involved in all aspects of the mental health system

The mental health system will support active participation of consumers, families and carers in all aspects of activity including policy development and implementation, service planning and delivery, and research to ensure mental health care is oriented to meeting the specific needs of individuals.

Principle 2 – Resilience and recovery

The mental health system promotes resilience and recovery

Mental health care will be provided within an operational framework that promotes resilience and recovery.

Principle 3 – Social inclusion

The mental health system is community-oriented, comprehensive, integrated and socially inclusive

Consumers, their families and carers will have access to a comprehensive community-based system of treatment, care and support that promotes recovery and works in a positive manner to address the impact of mental illness.

Principle 4 – Collaboration and partnerships

Cooperation, collaboration and partnerships are key elements of the mental health system

The mental health system will operate through inter-sectoral cooperation, collaboration and partnerships with a range of stakeholders including consumers, families and carers.

Principle 5 – Promotion, prevention and early intervention

Promotion, prevention and early intervention are integral to the mental health system

Promotion, prevention and early intervention (PPEI) will occur at the population, group and individual level, to build individual and community resilience and wellbeing, effectively target key risk and protective factors, and facilitate early intervention.

Principle 6 – Evidence-based

Mental health care is evidence-based, prioritising quality and safety

High quality services will be accessible and responsive, informed by research and evidence of best practice, provided by a suitably skilled and supported workforce, and deliver improved outcomes to people living with mental illness, their families and carers, and the wider community.

The principles that underpin the *Queensland Plan for Mental Health 2007-2017* are in addition to the principles articulated within the United Nations *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care,* the *National Mental Health Strategy* and the Queensland *Mental Health Act 2000*.

These frameworks encompass fundamental rights and responsibilities for all people who have a mental illness, including the following:

- People with mental illness are entitled to respect for their basic human rights, confidentiality, and must be able to participate in decisions made about them.
- The specific cultural, religious and language needs of individuals must be respected.
- Treatment should only be provided where it promotes or maintains the person's mental health, and should impose the least restriction on their rights possible with due regard for the safety of the person and others.

6. The reform agenda – improving mental health for Queenslanders

Five priorities guide the reform of the mental health system. These priorities will inform the investment over the period 2007-2017. These priorities and the associated strategies are consistent with the COAG *National Action Plan for Mental Health 2006-2011*.

The needs of consumers, families and carers drive each of the priorities. The involvement of consumers, families and carers in these areas will be instrumental in achieving change. Strengthening the mechanisms through which consumers, families and carers can influence reform of the Queensland mental health system in meaningful and effective ways must occur within each priority and all aspects of activity.

The five priorities have application across the spectrum of intervention and cover both clinical and non-clinical aspects of care. All components of the system are necessary for the system to function effectively. Development of a detailed service model that identifies target levels of resources required for each service component is a key objective of the Plan, to ensure achievement of a balanced system over the next ten years.

These targets will be based on interpretation of trends in national and international planning and reflect best available knowledge at this point in time. The targets cover all components of priority areas and will be continually tested against experience as new services are developed. Ongoing developments in mental health care at the international and national level will be taken into consideration, in association with identification and analysis of local community needs.

The Queensland Plan for Mental Health 2007-2017
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 • facilitate early intervention in known high risk groups for mental illness.
PRIORITY 2 **Improving and integrating 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.

PRIORITY 1
Mental health promotion, prevention and early intervention

Strengthen collaborative action to:
- ***build individual and community resilience and wellbeing***
- ***effectively target key risk and protective factors***
- ***facilitate early intervention in known high risk groups for mental illness.***

Key actions
- Establish statewide leadership through the Queensland Centre for Mental Health Promotion Prevention and Early Intervention (PPEI)
- Improve mental health literacy and capacity in non-clinical workers in key government and non-government services
- Strengthen responses for perinatal and infant mental health
- Reduce suicide risk and mortality within Queensland communities, within identified high risk groups such as Aboriginal and Torres Strait Islander populations, rural communities, and young people

Promotion, prevention and early intervention (PPEI) activities are vital elements in reducing the burden of disease associated with mental health problems and illness, and managing future demand for mental health services. PPEI addresses the health and wellbeing of the entire population, including all levels of mental health need within the community, and requires the contribution of a wide range of government and non-government agencies. Strengthening partnerships with these agencies and building their capacity to effectively contribute to the mental health and wellbeing of all Queenslanders is a priority.

Development of strategic partnerships across the government and non-government sectors aimed at improving mental health literacy, reducing stigma and discrimination experienced by people affected by mental illness, and targeting risk and protective factors for the prevention of high prevalence disorders is essential. Building supportive and inclusive environments, and resilient individuals and communities are also important tasks in promoting mental health into the future. Public mental health services play an important role in mental health PPEI through partnerships focused on intervening early with high risk groups and delivery of recovery-oriented services.

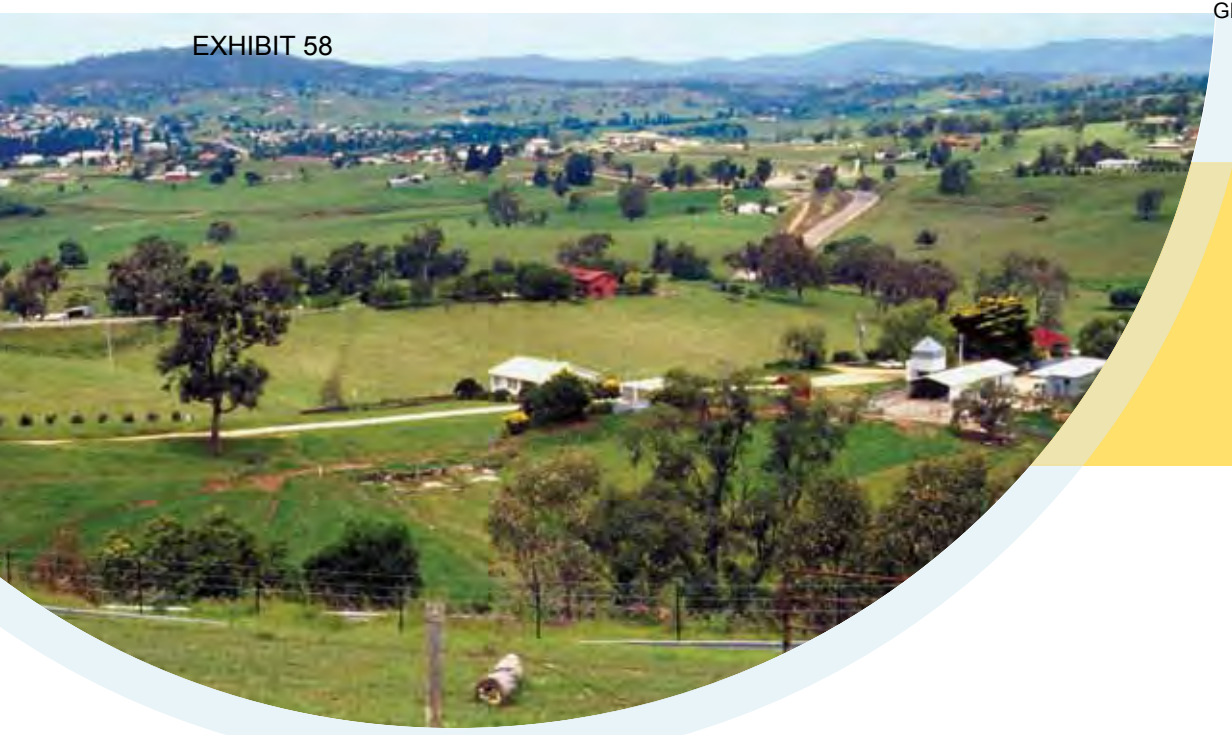
Actions for 2007-11

An additional $9.35 million will be provided over four years to support activities which will build mental health promotion, prevention and early intervention capacity.

The Queensland Government will implement initiatives focused on enhancing and promoting mental health and wellbeing, preventing mental illness and providing early intervention, including:

- $5.47 million to establish the Queensland Centre for Mental Health Promotion, Prevention and Early Intervention to lead the development and implementation of a statewide framework for mental health promotion, prevention and early intervention including:
  - establishing the *beyondblue* Queensland Chapter to engage with the National Depression Initiative to promote recognition and early access to treatment for depression
  - improving mental health literacy and access to mental health first aid training for non-clinical workers in key government and non-government services
  - raising community awareness about mental illness, and reducing stigma and discrimination
  - promoting the use of innovative technologies in mental health promotion activities.

- $2.91 million to support the ongoing development of cross-sectoral strategies, partnerships and agreements targeted at reducing suicide risk and associated mortality, including:
  - dedicated strategies to reduce suicide risk and mortality with a focus on specific high risk groups including Aboriginal and Torres Strait Islander populations, rural communities, and young people
  - development of a risk management framework for the detection and management of suicide risk
  - development of mechanisms to review all available information in relation to people who suicide in Queensland
  - increased capacity to follow-up people presenting to Emergency Departments with deliberate self-harm or attempted suicide.
- $0.97 million to establish a hub of expertise in perinatal and infant mental health to provide co-case management, consultation, liaison, and support to public mental health services and the broader community sector.
- Providing training to health workers in hospital, community health and primary health care settings on psychosocial risk assessment, screening and pathways into care consistent with the *National Action Plan on Perinatal Mental Health*.
- Establishing processes for the early detection and psychosocial support of children of parents with mental illness.
- Establishing collaborative processes and interdepartmental partnerships to improve mental health problems in children and young people within education, justice and child protection settings.
- Developing partnerships and increasing access to education and training initiatives to enhance the capacity of the aged care sector to prevent and intervene early in mental health problems and reduce social isolation.
- Developing and implementing early detection and intervention with children and young people including enhanced consultation liaison, improved referral pathways, and training for school support personnel and other key providers such as youth support coordinators, child safety workers, and youth justice workers.
- Establishing programs that build individual and community resilience and capacity, including those targeting Aboriginal and Torres Strait Islander populations, people from Culturally and Linguistically Diverse backgrounds, and other high risk groups.



Outcomes by 2011

These initiatives will strengthen the capacity to promote mental health and wellbeing and to prevent and minimise the risk of mental illness developing, especially in high risk populations. By 2011 the Queensland Government will have delivered the following outcomes:

- established a statewide framework for mental health promotion, prevention and early intervention
- implemented a range of targeted, evidence-based mental health promotion, prevention and early intervention programs across government, non-government and community sectors
- implemented models to ensure early detection of 'at risk' populations
- improved the capacity to build community resilience to mental illness
- improved the response to suicide risk behaviours and the management of suicide risk.

Outcomes by 2017

By 2017, the Queensland Government will have:

- delivered whole-of-population mental health PPEI initiatives across government, non-government, and community sectors
- improved community awareness, understanding and attitudes towards mental health and mental illness
- established collaborative, evidence-based, mental health and early intervention initiatives across the lifespan
- established collaborative, evidence-based mental health prevention and early intervention to targeted high risk groups
- implemented and evaluated a comprehensive approach to suicide prevention and suicide risk management
- developed collaborative initiatives to address the mental health needs of specific communities and targeted populations.

> *"Promotion, prevention and early intervention activities are vital in reducing the burden of disease associated with mental health problems and issues."*

EXHIBIT 58

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 promotes resilience and recovery.

Key actions

- Strengthen consumer, family and carer participation in mental health services
- Establish a statewide model of service to facilitate integrated service delivery across child and youth, adult, older persons, statewide and specialised mental health services
- Increase the capacity of community and inpatient mental health services to deliver high quality, responsive, consumer-focused care
- Build collaborative links with primary health and private sector providers to ensure effective links between services and efficient use of resources

Access to the right care and support at the appropriate time is important for people living with mental illness. A range of inter-connected clinical and community service options are required. These need to be responsive to the needs of people with mental illness, promote resilience and recovery, and facilitate positive outcomes.

Primary health, private and public mental health treatment services are all engaged in the delivery of assessment and treatment. Together they contribute to a spectrum of services required to meet the needs of people with mental health problems and mental illness. Close collaboration between providers will minimise the risk of duplication, service gaps and disconnections across the continuum of care.

The Plan focuses on fostering partnerships and improving linkages between services provided within and across the primary health, public and private specialist mental health sectors. It aims to improve access, support optimal care across all service levels and ensure effective use of specialised treatment resources. Innovative approaches to achieve improved continuity of care are proposed.

Actions for 2007-11

An additional $345.8 million will be provided over four years to further expand mental health treatment and service capacity across sectors.

Consumer and carer participation

The Queensland Government will implement initiatives focused on enhancing the capacity of consumers and carers to be actively involved in mental health service planning and delivery. This includes:

- $2.97 million to employ additional Consumer Consultants to provide support to consumers and to improve consumer engagement within mental health services
- developing a Queensland Government Consumer, Family and Carer Participation Policy
- establishing a statewide Consumer and Carer Coordinator position to coordinate consumer and carer service development initiatives and participation
- providing education and training to consumers, families and carers, mental health service providers and government and non-government staff to enable informed participation by consumers and carers in service delivery.

Primary and private sector mental health care
The Queensland Government will support the development of a coordinated framework for the delivery of primary and private mental health care. This includes:

- $3.24 million to employ additional Primary Care Liaison Coordinators to improve coordination of services between primary health care and public mental health service providers.
- $1.42 million to support the implementation of the 'Partners in Mind' framework and its integration with the Queensland Primary Mental Health Care Collaborative and community health services.
- establishing a forum for the public and private mental health sectors to collaborate and implement a plan for alignment of the two sectors with the aim of achieving a continuum of care for consumers moving between them. This would include communication protocols for access and reporting.
- delivering programs of collaborative care between general practitioners, other primary care providers and mental health professionals, particularly in rural and remote areas.

Public mental health care
The Queensland Government will implement initiatives focused on expanding mental health care. This includes:

- $37.78 million for 100 additional clinicians to provide child and youth community mental health services
- $9.44 million for 22 additional clinicians to provide adult community mental health services
- $18.7 million for 46 additional clinicians to provide older persons community mental health services
- $11.55 million for 25 additional clinicians to provide mobile intensive treatment services to consumers with complex needs living in the community
- $27.47 million for 60 additional clinicians to provide extended hours community-based emergency triage and brief acute treatment
- $9.63 million for 18 additional consultation liaison clinicians to support early assessment, treatment and referral of mental health consumers
- $10.5 million to employ 27 additional clinicians to provide tertiary statewide forensic services including, child and youth community forensic outreach, prison mental health, and court liaison services
- $5.7 million to employ 26 additional administrative staff to support clinicians working in community mental health services
- $15.32 million to expand district service and development capacity by establishing additional clinical leaders, supervisors and other staff to manage legislative, quality and safety activity.

Mental health services to people receiving care in acute, extended and community mental health settings will be improved by providing:

- $121.55 million to expand the range of acute and extended treatment beds by providing 140 new beds and to upgrade existing services to meet contemporary standards. This is in addition to the services being provided as part of the development of the new Gold Coast, Sunshine Coast and the Queensland Children's Hospitals.

- standardised service models and protocols for core public mental health service functions, including entry criteria, case management and inter-sectoral collaboration.
- protocols for inter-hospital transfers and referrals to Queensland Health Service Districts providing specialist services.

Mental health services to people in **rural and remote** areas will be improved by providing:

- $2.36 million to develop a service model for rural and remote mental health services in collaboration with the Centre for Rural and Remote Mental Health Queensland, and to develop innovative mechanisms to improve recruitment, retention and development of mental health staff in rural and remote areas
- Programs developed in collaboration with the Centre for Rural and Remote Mental Health Queensland and the Queensland Centre for Mental Health Promotion Prevention and Early Intervention to promote mental health and prevent the development of mental health problems in rural and remote communities.

Mental health services to people from an **Aboriginal and Torres Strait Islander** background will be improved by providing:

- $5.15 million 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
- a specialist hub of expertise to provide leadership and oversight of development of service models, workforce and partnerships in collaboration with the Centre for Rural and Remote Mental Health Queensland. The specialist hub will provide support to Aboriginal and Torres Strait Islander workers in the development and delivery of clinical services.

Mental health services to people from a **culturally and linguistically diverse** background will be improved by providing:

- $1.8 million for additional clinicians to provide transcultural mental health services. These clinicians will help to improve the capability of mental health services to respond to the needs of people with a mental illness from a culturally and linguistically diverse background.
- programs to increase mental health literacy and reduce stigma and discrimination in culturally and linguistically diverse communities.
- support to the Queensland Transcultural Mental Health Centre in implementing the mental health components of the *Queensland Plan for Multicultural Health 2007-12*.

“Access to the right care and support at the appropriate time is important for people living with mental illness.”

Mental health care for people who have a co-existing mental illness and **drug and alcohol problem** will be improved by providing:

- $2.92 million to establish dual diagnosis coordinators to facilitate the provision of coordination between mental health and drug and alcohol services, and to provide training and skill development for mental health services
- statewide guidelines for mental health services to ensure routine screening of all consumers for drug and alcohol problems and the provision of brief therapeutic interventions.

Initiatives are being progressed by Queensland Health, the Department of Justice and Attorney-General, and the Mental Health Review Tribunal to improve management of **people with mental illness who commit serious offences** and to increase support for victims of violent offences committed by people who are found of unsound mind or unfit for trial under the *Mental Health Act 2000*.

Initiatives include:

- $0.8 million to improve community and stakeholder understanding of the forensic mental health system as part of the recommendations from the Review of the *Mental Health Act 2000* by developing mental health literacy materials, culturally targeted resources and a media professionals' package.
- $29.18 million to enhance clinical services for adult forensic mental health consumers and to improve risk management practices. Funding will:
  - establish 35 additional positions
  - improve specialist and district based forensic services and increase the number of Indigenous mental health workers
  - provide risk management training and monitor and report on compliance with forensic mental health policy and legislation.
- $10.24 million to establish a statewide Victim Support Service and a Victim Information Register.
- $13.34 million to improve the forensic legal processes related to the Mental Health Court and the Mental Health Review Tribunal.

There will be ongoing liaison with Queensland Corrective Services in relation to victims of serving sentence prisoners. The benefits of Queensland Health providing ongoing support, liaison and service provision to offenders with mental illness is acknowledged. This cross departmental relationship is essential to the continued health and wellbeing of offenders accessing health care within any Queensland Corrective Services centre.

The Queensland Government will improve the provision of mental health services to people who have **complex mental health** needs by providing:

- $0.97 million to employ additional positions to boost the capacity to coordinate services for people with complex needs related to intellectual disability and mental illness
- $2.71 million to establish positions to build capacity to provide assessment and treatment for people with eating disorders in the community
- $1.12 million to establish positions to enhance the capacity to provide assessment and treatment for people with mental illness and a visual or hearing impairment
- additional funds to Disability Services Queensland to employ clinicians to provide services for people with an intellectual disability and mental illness, as part of the response to the recommendations of the Hon. W.J. Carter's review and resulting report *Challenging Behaviour and Disability: A Targeted Response*.

Outcomes by 2011

These initiatives will enhance service delivery and expand the range of services provided to meet the needs of a growing population. By 2011, the Queensland Government will have delivered the following outcomes:

- Improved consumer and carer representation at all levels of mental health activity and decision making.
- Implemented a coordinated framework for the delivery of primary, private and public mental health services.
- Expanded community public mental health services with the employment of additional clinical staff across child and youth, adult and older person services in the community. By 2011 the number of clinical staff employed in community public mental health services is expected to increase by 21%. This increase will mean that there will be 48 full time staff per 100,000 of the total population. This represents an estimated progress of up to 68% towards achievement of a ten year target rate of 70 full time equivalent staff per 100,000 population.
- Expanded access and capacity to deliver specialist mental health care services for people within special populations or with complex needs.
- Expanded and improved the infrastructure of hospital and community based inpatient services towards a ten year target of 40 beds per 100,000 total population for acute and extended inpatient services.

Outcomes by 2017

By 2017, the Queensland Government will have:

Public mental health services

- increased effective consumer, family and carer participation in public mental health services
- provided effective consumer and carer advisory systems
- facilitated cross-sector care for consumers, families and carers
- established a consistent model of service provision for the delivery of mental health services
- expanded the capacity of community mental health services
- provided sufficient mental health inpatient beds that reflect contemporary standards and population needs
- improved access and entry to mental health care for consumers, families and carers
- improved capacity to provide comprehensive mental health care to children and young people aged 15-25
- improved capacity to respond to mental health needs of older persons
- improved capacity to provide mental health services to people in rural and remote areas
- improved capacity to respond to the mental health needs of Aboriginal and Torres Strait Islander people
- increased capacity to deliver Forensic Mental Health Services
- provided effective models of mental health service delivery to people with a mental illness and drug and alcohol problems (dual diagnosis)
- provided culturally appropriate responsive services to people from culturally and linguistically diverse backgrounds
- strengthened delivery of consultation-liaison services across Queensland
- provided a continuum of care for people with eating disorders

- strengthened local capacity to provide specialist mental health care to people who are deaf and/or blind
- strengthened local capacity to provide specialist mental health care to people with intellectual disability
- strengthened local capacity to provide specialist mental health care to people with acquired brain injury
- strengthened local capacity to provide specialist mental health care to people with severe mood disorders
- expanded capacity to respond to people with mental illness who are homeless.

Primary Care

- developed planning and leadership for cross-sector primary mental health care
- strengthened partnership processes between primary, private, public and non-government providers of mental health care.

Private Sector Mental Health Care

- engaged private, primary and community sectors in local-level planning with public mental health services
- established greater collaboration between private psychiatrists, primary care services and public mental health services.

"The Plan focuses on fostering partnerships and improving linkages between services provided within and across the primary health, public and private specialist mental health sectors."

EXHIBIT 58

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

Key actions

- Increase access to non-clinical recovery-focused services delivered through the non-government sector
- Expand access to supported housing and accommodation services for people with mental illness
- Increase capacity of Government agencies to support recovery of people with mental illness across a range of services

People living with mental illness require a range of services to strengthen their community engagement and improve quality of life. Stable housing, income support, education and employment are all vital for recovery, and require access to a range of government and non-government services.

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. Close partnerships will be required between Queensland Health, Disability Services Queensland and other government agencies, to ensure availability of the range of services required by people with mental illness within the community.

Actions for 2007-11

An additional $98.09 million will be provided over four years to develop and implement programs that will increase access to community based services. These include:

Accommodation and personal support

The Queensland Government will expand the continuum of supported housing and accommodation available to people with mental illness in the community. Disability Services Queensland will purchase non-government sector services to provide non-clinical personal support and accommodation to mental health consumers and their families. Initiatives include:

- $35.64 million to purchase a range of accommodation and personal support services, including:
  - new residential recovery places to provide ongoing assessment, treatment and rehabilitation with the goal of assisting people to live successfully in the community
  - additional personal support packages to provide non-clinical support to people with varying levels of psychiatric disability living in the community in hostels, boarding houses, or in their own homes.
  - Additional places for consumer operated crisis and respite services to provide short-term accommodation, up to a maximum of three months, for those in need of respite, or emergency and crisis support.
  - Non-clinical personal support for people with a mental illness transitioning from corrective facilities to accommodation in the community.
- The Department of Housing, Disability Services Queensland and Queensland Health will expand the Housing and Support Program:
  - $40 million to provide additional housing places for people with a severe mental illness who have moderate to high support needs. Eligibility criteria will require the person to be homeless or in acute

or extended treatment facilities, eligible for social housing and unable to maintain current housing arrangements without adequate support.
- $22.45 million to provide non-clinical personal support to people with a severe mental illness who have moderate to high support needs and are living in social housing. Personal support services may include assistance with activities of daily living and practical support to access programs and services, which help to maintain optimal mental health functioning and promote recovery.

Vocational rehabilitation

The Queensland Government will support the implementation of initiatives to improve the engagement of people with a mental illness in vocational rehabilitation and employment, including:

- developing, implementing and evaluating a model of vocational rehabilitation which collocates an employment specialist within a mental health service
- establishing initiatives to foster the increased involvement of people with a mental illness in training, educational and employment readiness opportunities
- collaborating with non-government sector organisations to develop and provide a range of consumer-run vocational rehabilitation programs.

"People living with mental illness need a range of services to strengthen their community engagement and improve quality of life."

Interagency coordination

The Queensland Government will support cross-sector collaboration to:

- develop and implement a strategic plan for the mental health non-government sector in Queensland, which enhances workforce capacity and infrastructure, service quality and review, and research, evaluation and outcome reporting
- develop and implement local cross-agency operational protocols and guidelines; local partnership agreements; and cross-agency education and professional development initiatives
- continue to implement and develop the Mental Health Intervention Program to improve collaborative responses between the Queensland Police Service, Emergency Services and public mental health services.

Outcomes by 2011

Investment of funds will improve the range of care and support for consumers living in the community. By 2011, the Queensland Government will have delivered the following outcomes:

- provided and maintained an expanded range of non-clinical personal support and accommodation aimed at assisting people with a mental illness to live a meaningful life in the community
- improved inter-sectoral collaboration in the delivery of programs to assist people with a mental illness to live and participate in the community.

Outcomes by 2017

By 2017, the Queensland Government will have:

- strengthened the capacity of non-government organisations to deliver a range of quality mental health services that promote recovery
- expanded the range of community-based supported housing and accommodation options for people with mental illness
- expanded non-government sector services for consumers, carers and families
- strengthened non-government capacity and government services in the criminal justice system
- increased vocational rehabilitation for people with mental illness
- improved access to education, training and employment opportunities for people with mental illness
- increased understanding of mental illness in non-government and government employees
- expanded mental health initiatives for police, mental health and emergency services.
- expanded cross-government capacity to provide a coordinated statewide mental health and psychosocial disaster response and enhanced participation in the community recovery response.
- improved the capacity of the non-government sector to deliver a range of mental health services in the community, towards a ten year target rate of:
  - 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
  - 3 places per 100,000 population for crisis and respite services.

> *"The Queensland Government will expand the continuum of supported housing and accommodation available to people with mental illness 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

Key actions

- Strengthen partnerships and collaborative initiatives between Government agencies to address mental health service priorities
- Establish Service Integration Coordinators to improve service integration across government and non-government providers
- Implement processes at the local level to support collaborative, coordinated care across government and non-government agencies and improve outcomes for people with mental illness and complex care needs

Commitment to coordinated care for people with mental illness and complex needs is a priority. The various elements of service provided to people with mental illness by organisations and services across sectors need to be integrated to ensure the best outcomes are achieved. A collaborative approach will minimise the risk of people of all ages including youth, falling through gaps in the service system and allow the various services to work together as inter-related parts of a single system of care.

Actions for 2007-11

$4.77 million in funds will be provided over four years to strengthen the capacity to coordinate care for consumers with complex needs living in the community. This funding will support the establishment of Service Integration Coordinator positions across Queensland.

Service Integration Coordinator positions will be responsible for:

- improving care planning, communication and continuity across agencies
- overseeing processes for linking core service needs
- ensuring efficient utilisation of resources.

Queensland government agencies will work in partnership to develop coordinated responses to disasters to minimise psychological impact and facilitate community recovery, including increasing the availability of training and professional staff development.

In addition an Interagency Action Plan for an integrated human services framework to better respond to the needs of people with mental illness, their families and carers will be developed. Initially this plan will focus on people who are at risk of, or are experiencing social exclusion.

Outcomes by 2011

Investment of funds to support these initiatives will improve the coordination of care and support for consumers living in the community. By 2011, the Queensland Government will have delivered the following outcomes:

- improved capacity for people with a severe mental illness to successfully live in the community
- improved access to a range of support services and care for people with a severe mental illness in the community
- improved capacity for effective inter-sectoral collaboration to assist people with mental illness to access appropriate support and care in the community

- reduced the number of people with severe and persistent mental illness and psychiatric disability who currently fall through the gaps in service provision
- improved the degree to which people with a mental illness are socially included and able to participate in the community.

Outcomes by 2017

By 2017, the Queensland Government will have:

- established governance of mental health across sectors, and other levels of government
- strengthened capacity for cross-sector collaboration between providers of mental health care at the local level.

"The various elements of service provided to people with mental illness by organisations and services across sectors needs to be integrated."

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

Key actions

- Increase availability of a skilled mental health workforce
- Improve access to mental health service information, including information on consumer perceptions of care, to inform service evaluation and planning
- Improve delivery of safe, high quality care through effective quality improvement processes
- Increase access to evidence from research to inform mental health service delivery and development

The capacity to provide high quality services is essential to the delivery of a contemporary mental health care system, and relies on the use of evidence-based care to produce measurable improvements for consumers, carers and families. The quality agenda focuses on workforce development, information management, quality and safety initiatives, and research development. These are essential to the delivery of high quality care into the future.

Actions for 2007-11

An additional $70.82 million will be provided over four years to expand and develop the mental health workforce to ensure the provision of high quality, safe public mental health services, and to continue developing mental health research and information management capacity. This funding includes $43 million from the Queensland Government to replace Commonwealth funded projects expiring in 2007-08.

Workforce development

The Queensland Government will implement initiatives focused on developing workforce capacity to deliver mental health programs. This includes:

- $2.41 million to develop and implement a range of strategies to recruit mental health staff. These include undergraduate marketing initiatives, targeted scholarships and incentives for people to enter the mental health workforce.
- $3.06 million to provide a range of ongoing support to assist with retaining mental health staff. This includes orientation programs and supervision models for allied health and nursing.
- $0.69 million to improve workplace culture and leadership, including programs to provide support to professional supervisors and team leaders.
- $0.67 million to provide staff training and education through the Queensland Centre for Mental Health Learning including implementation of recovery training for mental health staff.
- $0.46 million to provide support to develop the non-government sector workforce.
- Additional positions in the Queensland Centre for Mental Health Learning to improve risk assessment and management skills as part of the implementation of the recommendations from the Review of the *Mental Health Act 2000*.

- Enhancing the statewide role of the Queensland Centre for Mental Health Learning in the provision of mental health training initiatives for staff, consumers, family, and carers across public, private and community sectors.
- Developing a Workforce Development and Innovation Plan, which is consistent with the *National Practice Standards for the Mental Health Workforce*, including:
  - development of Clinical Practice Guidelines
  - development of standardised multidisciplinary training and education curriculum and modules based on the *National Practice Standards for the Mental Health Workforce*, for delivery by specialist educational units.

Information management

The Queensland Government will support the further development of Queensland Health information management systems to support quality mental health service delivery and reform. This includes:

- $16.4 million to establish the Consumer Integrated Mental Health Application (CIMHA), which will enhance access to clinical and service information needed to support service delivery and evaluation
- $2.16 million to more effectively utilise information in clinical practice, service planning and policy development
- $1.2 million to establish and maintain a data reporting repository
- developing and implementing strategies to improve access to mental health information
- implementing routine reporting of key performance indicators to guide service improvement activities and facilitate performance monitoring
- building infrastructure to enable the linking of mental health data sets at the client and service levels to better inform planning, funding, evaluation and development of models of best practice
- developing a health planning model for mental health based on prevalence and service utilisation data.

> *"The quality agenda focuses on workforce development, information management, quality and safety initiatives, and research development"*

Quality and safety

The Queensland Government will continue to develop and improve quality and safety systems in collaboration with consumers, carers and families, government and non-government service providers. This work will include:

- the development and implementation of a comprehensive Quality and Safety Plan which is aligned to *National Standards for Mental Health Services* and is consistent with the *National Safety Priorities in Mental Health: the National Plan for Reducing Harm*
- establishment of a system of clinical audit that engages services in ongoing review and quality improvement
- finalisation of implementation of the key recommendations in:
  - *Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events (2005)*
  - *Promoting balance in the forensic mental health system – Final Report – Review of the Queensland Mental Health Act 2000.*

Mental health research

The Queensland Government will continue to support mental health research and particularly, the application of research to clinical practice. This includes:

- $0.77 million to develop a statewide framework for mental health research which supports the translation of evidence and innovation into improved day-to-day services for consumers, their families and carers
- collaborating with appropriate research bodies
- exploring increased funding for scholarships that promote the translation of evidence into practice.

Outcomes by 2011

Investment of funds to support workforce development and the provision of quality and safe mental health services will improve services for consumers, carers and their families. By 2011, the Queensland Government will have delivered the following outcomes:

- developed sustainable mechanisms to recruit and retain an adequate mental health workforce
- improved workforce development and support to ensure ongoing capability of mental health staff to deliver services
- developed and maintained effective leadership support for professional supervisors and operational leaders
- improved the use of information by clinicians and organisations in day-to-day clinical practice and service improvement initiatives
- developed and maintained the appropriate technology, infrastructure and resources to support mental health information management
- implemented and maintained effective quality and safety systems to ensure proactive identification of safety risks
- developed strategic links between the mental health workforce in public mental health services and the non-government sector workforce.

Outcomes by 2017

By 2017, the Queensland Government will have:

Workforce development

- developed and implemented a range of innovative recruitment and retention strategies for public mental health services
- developed and implemented new roles and new ways of using the skills and expertise of the mental health workforce
- engaged key stakeholders in mental health workforce planning and development.

Information management

- provided relevant and timely information to consumers, carers, mental health service providers and the community
- provided appropriate information and support to inform quality mental health service delivery and reform
- provided the technology, infrastructure, and resources that meet Queensland's mental health information needs
- established a quality and safety governance structure for mental health care across Queensland
- enhanced safety and minimised harm to consumers, the mental health workforce and the broader community
- engaged mental health stakeholders in quality and safety systems.

Research

- established statewide mechanisms to ensure that all key stakeholders contribute to, and benefit from mental health research.

7. Conclusion

The *Queensland Plan for Mental Health 2007-2017* sets a broad agenda to guide the reform and development of mental health services across the State, providing strategic and operational direction to mental health services. The Plan informs development, delivery and investment in mental health services.

It outlines a staged approach to reform and looks to the future as Queensland progresses towards a genuinely collaborative and supportive mental health system. Progressive implementation of the Plan will see Queensland establish a broader base for mental health intervention, while simultaneously moving towards a stronger focus on promotion and prevention, as well as establishing a consumer-driven, recovery-focused service delivery system.

Implementation of the *Queensland Plan for Mental Health 2007-2017* will be overseen by the Mental Health Interdepartmental Committee. The Director of Mental Health will be responsible for coordinating regular reporting that will be detailed in Queensland Health's Agency Service Delivery Statement , the annual Queensland Health Performance Report and a report to Cabinet.

An evaluation framework is being developed that considers progress towards identified goals and objectives at multiple levels:

- at the individual level in regard to the outcomes for consumers and carers, and the delivery and achievements of specific programs
- at the organisational and resource management level
- at the state level in regard to systems development, coordination and collaborative achievements
- within the National COAG evaluation framework.

This Plan will remain current for ten years. It will be reviewed and updated every two years. The benefits and outcomes of initial reforms will assist in shaping further mental health improvements in Queensland throughout this period.

> *"The Queensland Plan for Mental Health 2007-2017 sets a broad agenda to guide the reform and development of mental health services across the State."*

Feedback and contact details

We welcome your feedback on the *Queensland Plan for Mental Health 2007–2017*.

Please send feedback to mhb@health.qld.gov.au

or you can contact:

The Director
Mental Health Branch
Queensland Health
GPO Box 48
Brisbane Q 4001

Further copies of the *Queensland Plan for Mental Health 2007–2017* are available:

- electronically, on the Queensland Health internet site at www.health.qld.gov.au/mentalhealth
- printed copies available by telephoning 1800 989 451.

EXHIBIT 58

EXHIBIT 58

NATIONAL MENTAL HEALTH PLAN

APRIL 1992

ENDORSED BY HEALTH MINISTERS SUBJECT TO COMMONWEALTH FINANCIAL CONTRIBUTION

CONTENTS

1. PREAMBLE

Mental disorders and mental health problems are prevalent, extensive, affect all ages and social groups and can often result in chronic and major disability. The cost of mental disorder is significant in economic and social terms for individuals, their families and the community as a whole. In this context it is important to continue to improve the quality of mental health services and to improve their coordination with each other and other public goods and services to reduce the level of functional impairment arising from mental disorder.

The National Mental Health Plan provides specific strategies to assist in the implementation of the National Mental Health Policy. The Plan builds on the significant reform already undertaken in the organisation and delivery of mental health services throughout Australia. The Plan is to be read in conjunction with the National Mental Health Policy 1992.

The Plan reflects the results of consultation over several years with consumers, States and Territories, and the Commonwealth Government. As such it represents both a joint understanding and a national agreement on ways to develop and improve mental health services.

The broad aims of the Plan are to encourage a national approach to mental health policy and service delivery; to strengthen the impetus for reform of mental health services; and to provide a mechanism for addressing agreed priority issues.

The development of the Plan acknowledges that a higher priority together with a national focus is required in order to continue to improve services, and, in particular, to address micro-economic reform issues. Notwithstanding these strategies, it is intended that States/Territories will continue to address the broad range of mental health service planning and service development issues.

The Plan has been developed in the context of the following goals:

- customer service, including improvements to program effectiveness by meeting the needs and expectations of those who use public mental health services;
- sound administration, including improvements which advance public interest, accountability, responsiveness to mental health needs and the protection of rights; and

- economic efficiency, including improvements which advance allocative and productive efficiency and ensure service effectiveness.

2. SCOPE OF THE PLAN

The Plan refers to the provision of health services to people with mental disorders and mental health problems within the authority and responsibility of the Commonwealth Department of Health, Housing and Community Services, and the States and Territories Health Departments.

The Plan is intended to address the needs of people with mental disorders through the provision of specialised mental health services integrated within themselves and with mainstream health services and coordinated with other service areas such as accommodation. A Key priority of the Plan is the upgrading of services to people with serious mental disorder.

The Plan encompasses the whole system of mental health service delivery, both public and private. State Governments will be reporting on progress within the public sphere for accountability purposes. Mechanisms for obtaining a complete picture of mental health services in Australia will be explored over the life of the Plan.

The ambit of the Plan does not include matters more properly covered by existing Commonwealth/State arrangements/Agreements, such as the Commonwealth/State Disability Agreement and the Commonwealth/State Housing Agreement. It is noted that both these Agreements have responsibility for providing non-discriminatory services to the community, including people who have a mental disorder or mental health problem.

The Plan addresses a range of issues fundamental to the planning and delivery of mental health services in Australia. It identifies critical steps for the reform of services with a focus on the following areas:

- structural and system reform;
- standards;
- consumer rights;
- data;
- legislation; and
- resource priorities.

The Plan also clarifies Commonwealth and State Government roles and responsibilities as a basis for a national approach to mental health reform.

Operation of the Plan

The Plan commences on 1 January 1993, subject to the Commonwealth Minister and a State/Territory Minister having signed an Agreement prior to that date.

The Plan will terminate in respect of all parties at the end of a five year period from the first date the Plan commences operation.

A review of the Plan and progress in achieving strategies will be undertaken by the Commonwealth, States and Territories commencing 1 July 1995 and to be completed by 1 January 1996.

A summary of the activities under the Plan to be initiated in the five years is provided at Attachment A.

IT IS AGREED AS FOLLOWS:

3. MAINSTREAM SERVICES

The delivery and management of specialised mental health services from within mainstream health services is vital for the promotion of quality of services and equity of access.

This means that acute inpatient psychiatric care, preferably and where feasible, will be provided from within a general hospital. There should be a close link between community mental health services and psychiatric inpatient services. Non-acute care in psychiatric facilities, such as for some people with chronic mental disorders who have seriously disturbed behaviour, may be located separately. These facilities should be integrated with other components of the specialised mental health service and have strong links with wider health service. Case management systems facilitate continuity of care across service components according to individual need.

While the integrated network of mental health services should be managed and delivered from within mainstream health services, such as through area/regional administration, a separate identifiable program budget is necessary for purposes of accountability.

Significant progress has been made in most States towards linking and locating mental health services with mainstream health services. The co-operation of both general hospital administrators and health care providers has assisted in making these changes.

The following strategies aim to further the development of mental health services by improving service quality, improving access, and reducing the stigma associated with mental health problems and mental disorders:

Strategies

Within the life of the Plan the States/Territories will:

- bring the management of State operated mental health services into the same management structure as general health services,
- expand community based mental health services;
- locate or co-locate acute inpatient mental health services with mainstream inpatient services, and where possible, co-locate community mental health services with general community health services;

- increase the proportion of admissions to acute psychiatric units based in general hospitals, compared to all acute psychiatric admissions in a State/Territory; and

- establish or maintain a separate program budget for mental health services which covers relevant services provided in general hospitals, psychiatric hospitals and the community.

Within the life of the Plan, the Commonwealth will:

- incorporate all psychiatric hospital services as a component of any renegotiated Medicare Agreement.

4. INTEGRATION

Integration refers to the maintenance of a network between components of specialised mental health services, including crisis, assessment, acute and long term care and treatment and rehabilitation and domiciliary care services within mainstream health services. The network can be coordinated through area/regional management.

In an integrated system the consumer has access to services according to individual need in the least restrictive environment. Case management is an important means of achieving integrated service delivery for the individual, so ensuring continuity of care and preventing people from falling through the gaps between services.

Multi-disciplinary clinical teams working in an integrated system ensure the consumer benefits from continuity of care, which is particularly important for those with chronic mental disorders who will make use of multiple services over time.

Strategies

Within the life of the Plan the States/Territories will:

- establish or maintain integrated mental health services throughout Australia, covering the full range of specialised mental health services; and

- introduce and expand case management systems across the different parts of the mental health service.

Within the life of the Plan the Commonwealth and the States/Territories will:

- develop quality assurance programs, in consultation with relevant professional organisations, in all components of the range of services within a specialised mental health service network.

5. INTERSECTORAL LINKAGES

Positive mental health outcomes are facilitated by coordination of a range of services. The Plan seeks to enhance access of people with mental disorders to these other services. It is recognised that this can be most effectively achieved through collaboration and co-operation between health and other government agencies providing related and/or support services.

To assist in achieving equity of access, agencies providing services such as housing, social support, income security, employment and training should ensure their services are provided in a non-discriminatory manner to people with mental health problems and mental disorders.

Strategies

Within the life of the Plan the Commonwealth and the States/Territories will:

- establish joint pilot projects with other government agencies to assist people with mental disorders to live in the community. For example, projects could be established with government agencies responsible for accommodation or for children/youth services;
- seek a review of other government agency guidelines with a view to enhancing access of people with mental disorder to their services by 30 April 1993;
- establish ongoing communication mechanisms with all relevant agencies, including the non- government sector; and
- consider the issues relating to the Pharmaceutical Benefits Scheme and the delivery of mental health services.

6. SERVICE DEVELOPMENT AND MICROECONOMIC REFORM

A. Reform and Incentive Contracts

Subject to appropriate conditions being agreed between the States and Territories and the Commonwealth, reform and incentive contracts are proposed to support projects/measures which will encourage innovation and accelerate mental health reform. Funding will be for specific projects which can be substantially achieved within the life of the Plan.

Commonwealth funds are not intended to be used to replace, or lead to a reduction in, existing recurrent State/Territory expenditure on mental health.

As agreed by Commonwealth and State/Territory Ministers, a component of any money provided by the Commonwealth will be allocated to the States/Territories on a per capita basis, with an agreed floor for Tasmania, Northern Territory, and the Australian Capital Territory. The remainder of any allocation will be for innovative projects of national significance. Proposals of national significance will be considered by the AHMAC Working Group (see Section 15).

Strategies

The Commonwealth Government will seek to provide funds for the Commonwealth and States/Territories to assist initiatives in the following priority areas:

- develop initiatives and service models which improve integration and continuity of care for people with mental disorders;
- develop integrated community based mental health services to provide alternatives to separate psychiatric facilities;
- facilitate the collection and publication of a national mental health data set, service standards and performance indicators;
- upgrading specialised psychiatric facilities for those who are appropriately placed in such facilities; facilitating the mainstreaming of acute psychiatric services into general hospitals; and the development of community residential and support facilities;
- promote applied mental health research;
- develop models which provide effective services for those people with mental disorder identified as having special needs for mental health services.
- continuing training for health professionals involved in the delivery of mental health services (eg training of staff for new roles outside institutional settings); and
- implement and evaluate pilot preventive projects, and conduct surveys to measure the prevalence of mental health problems and mental disorder.

B. Workforce Issues

The following strategies are put forward in the context of microeconomic reform and are designed to assist in the more equal distribution of mental health personnel throughout rural and urban areas, and improved mix of these personnel across hospital and community mental health services, the maintenance of clinical and service standards, and the improvement of efficiency in service delivery. The provision of mental health services as part of mainstream health services increases the importance of these issues, as health professionals in general hospitals are increasingly involved in the delivery of mental health services.

Strategies

Within the life of the Plan the Commonwealth will:

- establish a committee to consider a range of policy issues relating to the mental health work force, reporting by October 1993. The committee would operate under the auspices of the AHMAC Working Group on Mental Health (see Section 15) and would include representatives from the Commonwealth Government, one with financial expertise, one with clinical expertise and one from a rural area. The committee would:
  - examine barriers to a more equitable distribution of mental health professionals between urban and rural areas and between the private and public sectors (including review of rights of private practice for salaried public psychiatrists, and access to acute inpatient facilities by consultant psychiatrists) and to an improved mix of personnel across hospital and community services;
  - examine the impact of existing funding arrangements for medical practitioners and specialists, and recommend changes as appropriate, with particular reference to the Medicare Benefits Schedule (MBS); and
  - examine and report on the continuing training needs of existing personnel in mental health services.

7. LEGISLATION

Mental health legislation differs between States/Territories, particularly in the criteria for compulsory treatment. The differing legislation produces considerable practical and legal difficulties in transporting patients for treatment across borders.

The following strategies will assist in meeting commitments under the United Nations Resolution 98B (Resolution on the Protection of Rights of People with Mental Illness), and the National Mental Health Statement of Rights and Responsibilities adopted by the Australian Health Ministers in March 1991. The adoption of these strategies will provide a framework for progressive development of nationally consistent legislation.

Strategies

Within the life of the Plan the States and Territories will:

- develop, as soon as possible, State/Territory legislation consistent with the United Nations Resolution;
- ensure, as soon as possible, that all mental health legislation incorporates the principles agreed by Health Ministers in the National Mental Health Statement of Rights and Responsibilities;
- identify cross border anomalies by 1 July 1993; and
- by 1 July 1995 to have in place administrative and legislative arrangements which facilitate the transfer of people with mental disorders across State/Territory borders.

8. MONITORING, SERVICE STANDARDS, DATA AND PERFORMANCE INDICATORS

The development of national service and clinical standards is aimed at improving the quality and efficiency of service delivery and care. Other strategies are intended to monitor progress across Australia towards meeting the objectives of the National Mental Health Policy and the strategies of this Plan. They should improve the quality and availability of specific mental health data.

Strategies

Monitoring

Within the life of the Plan the Commonwealth and the States/Territories will:

- introduce an annual system of reporting progress in implementing the National Mental Health Policy and the National Mental Health Plan through the production of a National Report on Mental Health in November of each year, commencing in 1993. State/Territory and Commonwealth Governments will provide agreed data, the Commonwealth shall collate this data, for publication as a National Report on Mental Health by the Commonwealth Department of Health, Housing and Community Services.

The National Report should give priority to outlining progress and performance on:

- consumer rights strategies and consumer input
- strategies to achieve mainstreaming and integration
- reform and incentives initiatives (subject to agreement)
- legislation reform and resolution of cross boundary anomalies;
- introduction of service standards(from 1996)
- initiatives for carers
- special needs groups
- expenditure and service utilisation data
- benchmark data (from 1993)
- quality assurance programs
- activities of the AHMAC Working Group on Mental Health, and
- national performance indicators.

- establish national performance indicators of progress towards the achievement of National Mental Health Policy objectives which will be reported on by October 1992, and will be included in the 1993 National Report on Mental Health, and in subsequent Reports.

Standards

Within the life of the Plan the Commonwealth and the States/Territories will:

- establish a Working Party on Mental Health service standards under the auspices of the newly established AHMAC Working Group, to develop and agree to national service standards, and to introduce national mental health service standards across Australia; and

- foster and encourage the development and adoption of clinical practice standards.

Data

Within the life of the Plan the Commonwealth and the States/Territories will:

- agree on a national mental health data strategy, consistent with privacy considerations, incorporating a national mental health services minimum data set by 1 October 1992 and to publish benchmark data by 1 September 1993.

9. CONSUMER RIGHTS AND CONSULTATION

The following strategies aim to provide an ongoing mechanism for consumer input into mental health policy decision making processes, particularly in relation to the implementation of the National Mental Health Plan, and to build on those statements outlined in the Mental Health Statement of Rights and Responsibilities endorsed by Health Ministers in March 1991.

Strategies

Within the life of the Plan the Commonwealth and the States/Territories with;

- each establish or maintain a mental health consumer advisory committee which is representative of the range of mental health consumers and carers. Such an Advisory Committee shall provide advice, including to both the relevant Minister and Chief Executive Officer of the Agency.

Within the life of the Plan the Commonwealth and the States/Territories will:

- appoint by 1 January 1993 either a primary consumer or a primary carer to a National Consumer Advisory Group. There should be a minimum of four primary consumers on this Advisory Group. If there are less than four primary consumers, the Commonwealth, in consultation with the States/Territories, shall arrange for the appointment of additional primary consumer representatives. The chair of the Advisory Group shall be appointed by the Commonwealth in consultation with the States/Territories, and funds for the operation of the Advisory Group will be provided by the Commonwealth;

- that the Chair and Deputy Chair of the National Consumer Advisory Group be formal members of the AHMAC Working Group on Mental Health (see Section 15);

- pursue wider consultation strategies with the community and consumers and relevant organisation, such as the Consumers Health Forum and professional bodies;

- the AHMAC Working Group (see Section 15) shall consult regularly with the National Consumer Advisory Group; and

- the National Consumer Advisory Group would cease to exist after the cessation of the Plan.

10. SPECIAL NEEDS GROUPS

People of all ages with a mental disorder, and their carers, should have the same access to the range of public and private health care and community services enjoyed by other member of the community. It is important that mental health services are planned and delivered in a manner which is sensitive to the needs and expectations of different groups in the community.

It is recognised that some groups in the community have special needs, and an underlying principle is that the mental health service system should be responsive to the varying needs of particular groups. The emphasis given to special needs groups will depend on the particular requirements of States/Territories and may change over time. In some cases these groups will require specific programs within the mental health service. In this regard, the policy acknowledges the recommendations of the National Aboriginal Health Strategy and the National Women's Health Strategy.

Strategy

Within the life of the Plan the States/Territories will:

- report on the development of the most appropriate service models to meet the service requirements of identified special needs groups across different regions.

11. ROLES OF CARERS AND ADVOCATES

The contribution of domiciliary carers and advocates in supporting and caring for people with mental disorders in the community is recognised as an integral component of community care. The Mental Health Statement of Rights and Responsibilities outlines in detail the rights and responsibilities of carers and advocates.

Strategies

Within the life of the Plan the Commonwealth and States/Territories will:

- enhance education and training programs to meet the specific needs of people caring for those with mental disorders to assist them in their task;

- ensure that effective support services, such as respite services, are made available to carers on an area/regional level. (These services will be provided by a number of different types of agencies, including those funded through the Commonwealth/State Disability Agreement); and

- ensure that there is increased availability of, and accessibility to, a range of advocacy services (including self advocacy and system advocacy) by consumers and carers. These services may be provided by a number of different agencies including those funded under the Commonwealth/State Disability Agreement.

12. FINANCIAL ACCOUNTABILITY

In contrast with specific accountability measures outlined in the Section on Microeconomic Reform, this Section addresses broad accountability and outcome measures.

Strategies

Within the life of the Plan the Commonwealth and the States/Territories will:

- report publicly in the National Report on Mental Health in each year on annual expenditure on specialise mental health services and on indicators of their performance; and

- a comprehensive range of outcome measures, including efficiency and effectiveness measures, should be progressively developed; reporting on agreed outcome measures should commence in the 1993 National Report.

13. EVALUATION

An evaluation of the Plan will be conducted at the end of three full years of operation, and will be part of an ongoing evaluation process over the life of the Plan. This should not preclude amendments to the Plan before that time, particularly in relation to the implementation of specific strategies to address the objectives of the National Mental Health Policy.

Strategies

The Commonwealth and the States/Territories agree that:

- evaluation of the Plan will occur three years after the commencement of the Plan; and

- findings of the evaluation to be considered by Health Ministers in April 1996.

14. NATIONAL ROLES AND RESPONSIBILITIES

State Government roles and responsibilities:

a. administer, fund and organise specialised public mental health services;

b. plan for a comprehensive mix of mental health services, including the establishment of service delivery systems which ensure effective networks of care are fostered;

c. manage the redirection of resources within mental health services to reflect national policies and responsiveness to local need and circumstances;

d. ensure linkages at the State, area/regional and service delivery levels, of mental health services and other general health and community care services; and

e. fund mental health research and evaluation.

Commonwealth Government roles and responsibilities

a. finance and administer some programs, consistent with current and revised Medicare arrangements where the nature of the service entitlement or program does not vary between States/Territories, and it is more efficient for administration to be national, that is , Medicare Benefits and Pharmaceutical Benefits;

b. ensure people with mental health needs are not discriminated against in gaining access to general health, community support, accommodation, employment, training and other programs which are the responsibility of the Commonwealth Government;

c. fund mental health services for veterans;

d. subject to agreement, provide financial incentives to accelerate the pace of organisational and service enhancement reforms in mental health services, particularly in relation to institutional reform;

e. provide funding for, and foster the development of , mental health research and service evaluation;

f. in consultation with the States/Territories, seek to ensure an adequate supply of high quality mental health personnel through funding of the Higher Education and Training systems; and

g. act as a clearing house for information relating to significant developments in mental health service delivery.

Proposed Joint Commonwealth/State/Territory roles and responsibilities

a. participate in the development, implementation and monitoring of the National Mental Health Policy;

b. establish mechanisms and processes for ensuring national consumer rights and service standards are being satisfied;

c. maintain and develop the quality of mental health professionals through training and mutual recognition of qualifications; and

d. promote the development of nationally consistent mental health legislation.

15. AHMAC WORKING GROUP ON MENTAL HEALTH

To ensure that ongoing priority is accorded to mental health issues the following strategy is proposed

Strategy

- The AHMAC Working Group on Mental Health will continue to:
  - provide a forum to monitor progress on the implementation of the Plan;
  - consider, and recommend on agreed substantive mental health reform issues consistent with the Policy and report to AHMAC as required;
  - subject to agreement, consider demonstration proposals under the reform and incentive component of the Plan and make recommendations to the Commonwealth Minister;
  - establish time-limited working parties to address specific issues;
  - consult regularly with the National Consumers Advisory Group and with other relevant organisations and individuals as required, for example the Consumers Health Forum and the Royal Australian and New Zealand College of Psychiatrists; and

- it is anticipated that the Working Group will cease to exist after the cessation of the Plan.

The Working Group will comprise representatives from each State and Territory and the Commonwealth who have endorsed the Plan, and the Chair and Deputy Chair of the National Consumer Advisory Group.

It is envisaged that the Working Group will meet not less than once a year. The Commonwealth will provide Secretariat support to the Working Group.

The Group will report in the National Report on its activities, commencing in November 1993.

16. DEFINITIONS (in alphabetical order)

Advocate
A person who has been given the power by a consumer to speak on her or his behalf, who represents the concerns and interests of the consumer as directed by the consumer, and provides training and support to enable consumers to better represent themselves.

Case Management
The mechanism of ensuring access to and coordination of the range of services necessary to meet the identified needs of a person within the integrated mental health service. Persons with mental disorder requiring case management are usually living in the community and have long term needs necessitating access to health and other relevant community services.

Carer
A person whose life is affected by virtue of his or her close relationship with a consumer, or who has a chosen and contracted caring role with a consumer.

Clinical Indicator
A measure of clinical management and outcome of care.

Commonwealth Minister
The Minister of State of the Commonwealth for the time being responsible for the administration of this Plan for the Commonwealth and includes the Commonwealth Minister or other member of the Federal Executive Council acting on behalf of, or for the time being, acting for such Minister.

Consumer
A person utilising, or having utilised, a mental health service.

Continuity of care
Integration and linkage of components of treatment and care across health service agencies according to individual need.

Governments
Includes all Australian State Governments, the two Territory Governments, the Commonwealth Government and local Governments.

Integration/integrated mental health services
A network of specialised mental health services within the general health service system which includes acute care, long stay, crisis, assessment, treatment, rehabilitation, specialised residential and housing support services, and domiciliary care services. The network can be coordinated through area/regional management and through the operation of case management across services.