12. ACHIEVING THE NEW FISCAL TARGETS

KEY ISSUES

- The task of restoring Queensland to financial strength is enormous, and will require adjustments to revenue, as well as both recurrent and capital expenditure.
- The First Stage of the fiscal task will require a combination of immediate revenue and expense measures to achieve a fiscal surplus in 2014-15. Options for revenue measures to contribute to the fiscal task are limited, reflecting the small number of broad based revenue sources available to the State, and the subdued revenue outlook.

  It is likely therefore that a major part of the adjustment burden will need to be borne by the expenditure side of the budget, particularly recurrent expenditure. This is where much of the structural imbalance in the budget originated.
- The Second Stage of the fiscal task will not be achieved through revenue and expenditure measures alone, although some longer term reform measures may assist. Reductions in debt of $25-30 billion between 2015-16 and 2017-18 will only be possible through careful utilisation of the balance sheet, including utilisation of the proceeds of asset sales.
- A range of revenue and expenditure options, both for the First Stage and the Second Stage of the adjustment process, is presented for further consideration by Government.

12.1. OVERVIEW OF FISCAL REPAIR TASK

Section 11 outlined the Commission's recommended fiscal strategy to restore Queensland to financial strength. The fiscal repair task is enormous.

Either expenditure (both recurrent and capital) needs to be wound back or revenues need to be dramatically boosted, so that the accumulation of further debt is arrested.

However, given the relatively narrow State tax base and the heavy reliance on Australian Government payments, there are limited prospects to boost revenue. It is likely therefore that a major part of the adjustment burden will need to be borne by the expenditure side of the budget, particularly recurrent expenditure. This is where much of the structural imbalance in the budget originated.

This section outlines a possible range of measures that could be considered to meet the fiscal targets outlined under the First Stage and Second Stage of the fiscal strategy.

The First Stage is to stabilise debt and return to a fiscal surplus by 2014-15. Second Stage measures, which are targeted at long term structural issues, will assist with the reduction in government debt required to restore the AAA credit rating and achieve a debt to revenue ratio of 60% by 2017-18.

12.2. ANNOUNCED POLICIES OF THE CURRENT GOVERNMENT

12.2.1. Cap growth in employee expenses at 3%

The Government has announced some measures to contain growth in recurrent expenditure.

The key policy announcement taken by the Government has been to cap growth in General Government employee expenses at 3% until the end of 2015-16, at which time it will be reviewed. Estimated growth in employee expenses at the time of the MYFER and in the May 2012 forward estimates update is shown in Table 12.1 below.

Table 12.1
Annual growth in employee expenses

	2012-13	2013-14	2014-15	2015-16
MYFER - Employee expenses annual growth (%)	3.4	4.4	5.1	na
May 2012 employee expenses annual growth (%)	3.1	3.9	4.6	3.3

Source: 2011-12 MYFER and Treasury

These figures do not reflect any of the policies to be implemented by the current Government. The estimated employee expenses growth in the table reflects what was estimated would occur under the policies of the previous Government.

As outlined in Section 3, the estimated growth rate for employee expenses in both the MYFER and the Treasury May 2012 forward estimates are significantly less than actual outcomes since 2000-01. While the previous Government had a 2.5% public sector wages policy, it had neither announced nor implemented any measures to deliver this outcome. In the absence of any announced measures, it is likely that employee expenses would continue to increase on the basis of previous annual increases of 8% to 9% per annum, rather than the 3% to 5% estimated in the forward estimates.

The current Government has a stated policy of capping growth in employee expenses at 3%. The Government has also indicated that it will support this policy with legislative changes. It is the robustness of those changes which will determine whether the outcome is successfully achieved.

In its election policy statement, *Costings and Savings Strategy*, the Government has indicated that savings generated from the 3% cap on employee expenses will be used to offset the cost of the Government's other election commitments. The overall impact of the election commitments is expected to be broadly neutral on the fiscal balance across the forward estimates period.

The Commission believes that the Government should have a policy on growth in employee expenses beyond the period of the current forward estimates. This is necessary to provide long term stability and certainty to both the public service and to the Government's medium term fiscal targets. The Commission therefore considers that the 3% cap on General Government employee expenses should remain until the ratio of Total Government debt to revenue has declined to 60% under the Second Stage of the fiscal strategy.

Recommendation

The Government retain the 3% cap on annual growth in employee expenses beyond 2015-16 and until the ratio of Total Government debt to revenue has declined to 60% under the Second Stage of the fiscal strategy.

12.2.2. Other discretionary savings already implemented

The Government has implemented measures to reduce discretionary expenditure in a number of areas, including on consultants, advertising, temporary and contract staff. This should assist with constraining growth in recurrent expenses across the forward estimates period.

12.3. MEASURES TO BE CONSIDERED UNDER THE FIRST STAGE OF THE FISCAL STRATEGY

12.3.1. Revenue

The Government has limited revenue options to assist in the fiscal adjustment task:

- almost half of the Government's total revenue is sourced from Australian Government grants over which the state has limited control
- the Government has few broad based revenue bases from which to raise revenue
- the Government has a commitment to retain Queensland's competitive tax status compared with other states.

However, the burden of the adjustment task should not fall entirely on recurrent expenses. A contribution from a limited number of broad based revenue measures would assist in sharing the burden of the adjustment task across the community and minimise the effects on interstate tax competitiveness.

While limited, the Government does have available to it a small number of relatively efficient revenue bases that could make a contribution to meeting the fiscal targets.

Possible revenue measures are outlined below.

12.3.1.1. Queensland budget deficit levy

The burden of the fiscal adjustment task is large and should therefore be spread as widely and as equitably as possible.

The fairest way to do this is to apply an adjustment on the broadest possible base.

The Commission recommends that the Government consider a general contribution to the deficit reduction task from the broad section of the community who are owners of either residential or commercial property.

A temporary deficit reduction levy applied to all rateable properties would raise approximately $200 million per annum for every $100 of levy.

By applying to all ratepayers, the amount of the levy would be minimised.

While the levy would apply at the same rate across all properties, irrespective of value, it will be progressive in that multiple property owners will pay the levy multiple times.

In its 1992-93 Budget, the Victorian Government introduced a $100 State Deficit Levy (*State Deficit Levy Act 1992*) on rateable properties to assist with reducing that state's high debt burden. The levy was in place for three years and was abolished from 1 July 1995 (*State Deficit Levy (Repeal) Act 1995*).

12.3.1.2. Land tax

Land tax is considered a relatively efficient tax base if applied broadly, as application of the tax usually has minimal effect on taxpayer behaviour and how land is used.

While the potential land tax base is broad in theory, it is applied narrowly through a series of exemptions and concessions. Broadening the land tax base by removing or reducing exemptions and concessions would remove current distortions in the application of land tax and improve the efficiency of the tax system.

Land tax is currently applied to individuals and businesses to total land holdings over a threshold amount, meaning a party that has multiple holdings under the threshold does not pay the tax.

An alternative would be to apply land tax to all parcels of land, with a general exemption for the principal place of residence.

12.3.1.3. Gambling taxes

In 2010-11, Queensland gambling revenue collections were $208 per capita compared with $242 in New South Wales, $296 in Victoria and $245 in South Australia. This is a weighted average of $263 per capita in these states. (Western Australia only has poker machines in its Casino which affects comparability of data.)

In its 2009 Relativities Update, the Commonwealth Grants Commission found that Queensland's gambling tax effort was 4% below the national average (including Western Australia).

Increasing Queensland's per capita tax take to the average of the other three states would have raised an additional $250 million in 2010-11.

12.3.1.4. Mining royalties

In its 2011-12 Budget, the NSW Government announced that it would increase royalties applied to the extraction of coal. The rate of royalty increase would be set to recover the estimated costs to the State Government of the Australian Government carbon tax, which will come into effect on 1 July 2012.

The royalty increase in NSW will only apply to companies subject to the Australian Government Mining Resource Rent Tax (MRRT). The intended outcome is that the incidence of taxation will not increase since the royalties paid to the state will be netted off MRRT liabilities.

Prior to the decision in the NSW Budget, coal royalty rates in Queensland and NSW were broadly aligned. There is justification for Queensland to increase its royalty rates to align with the revised rates in NSW.

This would raise in the order of $100 million to $150 million per annum.

12.3.1.5. Transfer duty

Transfer duty is considered less efficient than land tax as it is imposed on transactions, rather than land itself and can therefore distort behaviour as to acquisition of property.

Transfer duty in Queensland has a progressive rate structure, with the rate of tax increasing with the value of the property sold.

An option to increase the progressivity of the duty would be to apply a premium transfer duty rate above the highest threshold (currently $980 000).

12.3.1.6. Compliance measures

As part of its revenue collection functions, the Office of State Revenue conducts annual investigation programs covering all revenue lines and as with all revenue offices adopts a risk based approach to allocating resources to greatest risks.

Lower compliance with laws imposing taxes and charges will arise for various reasons and can include changes in economic conditions, more sophisticated tax planning strategies by taxpayers as well as a decline in compliance activities relative to the number of transactions taking place.

For any revenue authority, investment in investigation activities should be reviewed on a regular basis in response to trends in taxpayer compliance and general economic and business conditions.

The Office of State Revenue has advised the Commission that for every dollar invested in investigation activities, a return to the revenue could be expected of between $4 and $5. Investigation of complex, serious evasion could yield up to $10 of revenue for each dollar invested.

The Commission recommends that the Government discuss with the OSR opportunities for additional revenue compliance and investigation activities, supported by a documented business case.

Furthermore, the Commission recommends that the Government consider additional measures to improve the recovery of outstanding or unpaid fees and fines, especially through the State Penalties Enforcement Register (SPER). To encourage greater revenue collection, the Government could give consideration to offering an amnesty on penalities for the non-payment of outstanding fees and fines.

12.3.1.7. Landholder duty

Landholder duty is applied where land is acquired by acquiring an interest in the owner rather than transferring the title of the land. Duty is applied on the value of all the Queensland landholdings of the landholder. The rate of duty is 10% of the transfer duty rate assessed on all the Queensland land of the landholder.

Options could be considered for increasing the rate of duty as a contribution to the fiscal repair task.

Recommendation

The Government examine revenue options to share the burden of the fiscal repair task under the First Stage of the fiscal strategy. The Government should focus on its broad revenue bases in the first instance. Addressing concessions and distortions in existing taxes could also provide a revenue contribution to the fiscal challenge. The Government should also discuss with the Office of State Revenue any opportunities it has identified to improve greater taxpayer compliance through additional investment in investigation and debt recovery activities.

12.3.2. Recurrent expenditure

The most important measure the Government can implement to contain the cost of recurrent expenditure is the announced 3% cap on growth in employee expenses. The most effective way to achieve the cap will be through legislation.

If the overall increase in employee expenses is to be held to 3%, any wage settlements in excess of 3% must be offset by commensurate downsizing of the workforce.

In addition to its cap on employee expenses, the Government should examine the current provisions for growth funding in the forward estimates, particularly in the health and education sectors. This growth funding is to support a further expansion of the public service beyond its current levels.

As well as employee expenses, there are a range of non-employee expenses that should be reviewed to achieve savings and efficiencies in the provision of government services. Several opportunities are available to identify and realise these efficiencies. These include:

- a systematic review of all baseline expenditure in departments and agencies to ensure expenditure is being undertaken consistent with the current Government's priorities

- identifying and scrutinising all discretionary government grants to ensure this spending is being allocated to highest priority recipients

- introduction of demand management tools to ensure government services are targeted to those most in need

- rigorous assessment of State contributions to National Partnership Agreements.

12.3.2.1. Baseline department and agency budgets

At the time of each year's annual budget, total General Government recurrent expenditure is the total of:

- baseline expenditure, reflecting decisions on activities and priorities taken in previous budgets

- growth in baseline expenditures, reflecting demand for services and the impact of other economic parameters on government expenditure, such as inflation

- additional expenditure on new initiatives.

While new initiatives are generally subject to scrutiny during the budget process, there is no systematic scrutiny of baseline expenditure.

- Queensland Government expenditure is not accounted for on a program basis, which would allow Ministers to prioritise past expenditure decisions against new initiatives – the Commission's second Report will examine the role of program budgeting as a part of broader measures to improve budget reporting and accountabilities.

- When new expenditure initiatives are approved by Cabinet there has been no sunset clause or termination date for the activity – the spending therefore becomes part of the baseline budget and not subject to review.

- There has been no requirement for expenditure to be evaluated to determine whether it is achieving its intended outcomes – expenditure on activities continues without appropriate review or evaluation.

- The tendency over time for past expenditure decisions to become part of the base funding for government departments agencies, which is generally not examined during the budget process.

The systemic review of all baseline funding in agencies would highlight:

- what activities are being funded through the baseline budget

- whether these activities are consistent with the policy priorities of the current Government

- if the expenditure activities are consistent with the activities of the current Government, whether the expenditure is achieving its results at the lowest cost and represents optimum value for money.

12.3.2.2. Parameter growth funding

One example of baseline funding is formula driven provisions for expenditure growth across a number of functions, including health, education and communities. The parameter adjustments for allocations of growth funding have been embedded in the budget process for many years without review.

There are sound reasons to review the level of growth funding across the forward estimates:

- the increase in expenditure to date has been substantial and notwithstanding the decentralised nature of the State, Queensland per capita recurrent General Government expenditure is now higher than other states

- there should be an assessment of the outcomes from previous rapid increases in funding for additional employees prior to additional growth funding being committed

- the growth funding represents provisions for the employment of additional government employees in the future – it is not for the funding of current employees

- application of current growth funding parameters would be inconsistent with the Government's policy of a 3% cap on employee expenses (unless offsetting savings are made elsewhere).

12.3.2.3. Discretionary grants

Discretionary grants are made by departments and agencies from their general budget allocations. Departments and agencies are delegated the authority to allocate grants within general policy guidelines.

Expenditure on discretionary grants is not currently reviewed by Ministers during the budget process. The Commission considers that the Cabinet Budget Review Committee (CBRC) should review all grants on an annual basis as part of the budget process. Furthermore, consideration should be given to more efficient ways for the administration of grant programs, given the high overhead costs that can be involved in managing multiple and diverse payments.

12.3.2.4. National Partnership Agreements

At a time when Australian Government grants to Queensland are declining, the Australian Government continues to pursue policy development that will expose the State to increased financial risks. The National Disability Insurance Scheme is one such example.

There is a case for the Government to undertake an assessment of all current and planned National Partnership Agreements to determine whether any of these agreements will impose additional costs on the state above that which was expected at the time of the Agreement. This may be because of changes to the Agreement, or the expiry of Australian Government funding under the Agreement which may be required to be met by the state.

Where such financial risks occur, the state should seek to limit its exposure to what is currently factored into the forward estimates, or make savings where programs are not consistent with state priorities.

12.3.2.5. First Home Owner Grant

The First Home Owner Grant (FHOG) was announced by the Australian Government as part of the arrangements for the introduction of the GST in 2000. Eligible first home buyers can apply for a FHOG for either a new or established dwelling.

The purpose of the FHOG, when announced, was to compensate first home buyers for the estimated average increase in the price of housing on the introduction of the GST. It was not the purpose of the FHOG to provide an ongoing incentive for first home buyers to enter the housing market. This is evidenced by the FHOG being fixed in nominal terms ($7000) since it was introduced 12 years ago, apart from short term supplementation from the Australian Government as an economic stimulus. It had always been the intention that the real value of the FHOG would decline over time as a percentage of the price of a new home.

After initial funding of the FHOG by the Australian Government, the cost of the grant is now funded directly by the states.

Removal or restriction of the grant to purchases of new homes could be considered.

Recommendation

In addition to the 3% cap on employee expenses, the Government review all other aspects of General Government recurrent expenses to ensure baseline recurrent expenditure is consistent with government policy and is delivering optimum value for money.

12.3.3. Capital expenditure

12.3.3.1. Prioritisation of capital expenditure

As outlined in Section 8, there has been a significant increase in infrastructure expenditure in Queensland over the last six years, following a period of under investment.

Against this very high level of investment, the Government needs to ensure that only the highest priority projects receive funding across the forward estimates period, consistent with a rigorous evaluation of business cases for all projects. Business cases should include not only realistic estimates of capital costs, but also whole-of-life costs such as operating and maintenance costs over a period of at least 20 years, (or the life of the assets, if shorter).

12.3.3.2. Total asset management

Given the previous levels of capital investment in Queensland, the Government should also ensure there is rigorous scrutiny of future expenditure. This is necessary to ensure additional investment is justified and that future capital expenditure plans include estimates of ongoing operation and maintenance costs.

Asset management within government is typically characterised by two features:

- a cycle of high peaks and deep troughs, where a period of underinvestment is followed by a surge in investment, often in excess of what is required
- a failure to actively manage the existing capital stock, particularly with regard to replacement and repair, leading to the creation of a backlog of investment and maintenance that must be undertaken in a short period.

To ensure efficient management of the Government asset stock in the future, active management of assets is necessary.

The components of this active asset management requires each department and agency to have:

- an up to date register of all its physical assets
- a total asset management plan for the acquisition, maintenance and replacement of its asset over time.

Recommendation

The Government actively manage its forward program of capital expenditure to ensure expenditure is appropriately prioritised across the forward estimates and based on rigorous business case evaluation, including whole-of-life costs. The Government to consider what asset management strategies are required to ensure the efficient acquisition, maintenance and replacement of assets.

12.3.4. Balance sheet management

In addition to active management of new capital expenditure, the Government will also need to actively manage its balance sheet, to ensure that public assets are achieving an appropriate return for the community.

The Queensland Government does not have a consolidated list of all its property holdings.

Preparation of such a list is a matter of urgency so that the Government can determine:

- the size and location of its property holdings
- whether there is property that is surplus to requirement
- a strategy for maximising the use and return on its property holdings.

The Queensland Government continues to operate commercial business operations in direct competition with private businesses operating in open and competitive private markets. These government businesses are providing services principally to internal government clients, and there is no justification as to why these services cannot be sourced directly from commercial private operators.

Examples of these businesses include Q-Fleet, Q-Build, Goprint, CITEC and Queensland Shared Services. In the Australian Government and other states, many of these services are sourced directly from the private sector.

Queensland, as with other states, has contracted private sector managers to operate some government service delivery, such as corrective service facilities.

Other examples include private construction and operation of public housing assets

Private sector management will not be appropriate in all instances (for example, in the more decentralised parts of the state). There is also a need for high level contract management skills within government.

An examination of experiences in other states – both positive and negative – may highlight further opportunities for greater private sector management of government assets and delivery of business services to government.

The Commission considers that the Government should review all commercial business units, with a view to determining the most cost effective forms of service delivery. Further analysis of these issues will be presented in the Commission's subsequent Reports.

Recommendation

The Government examine its current holding of physical and commercial assets and implement measures to maximise the return on those assets for the benefit of the community.

12.4. MEASURES TO BE CONSIDERED UNDER THE SECOND STAGE OF THE FISCAL STRATEGY

As well as measures that could be considered in the short term, the Government should also ensure that forecast long term trends in expenses and revenues are consistent with the debt reduction objectives under the Second Stage of the fiscal strategy. The Government should address any long term structural issues in budget expenses and revenues that are inconsistent with the Second Stage targets.

12.4.1. Revenue

Payroll tax is one the Government's broadest tax bases and if applied broadly is an efficient way to raise revenue. There is debate as to the economic incidence of payroll tax between employers, employees and consumers. The generally accepted view, as outlined in the *Australia's Future Tax System Review*, is that the incidence of payroll tax is likely to fall on labour, through either lower wages or higher prices.

The desire of state governments to maintain competitive tax systems has led over time to both a narrowing of the payroll tax base, primarily through exemption thresholds. As outlined in Section 5, Queensland's payroll tax effort is below that of the average of the other states.

The Commission does not make any recommendations in relation to the base or rate of payroll tax other than to suggest the Government closely monitor developments in other states with a view to maintaining both a competitive and robust revenue base.

12.4.2. Expenditure

12.4.2.1. Expenditure assignment in the federation

The limitation on State revenue sources and forecast subdued outlook for revenue growth places a priority on ensuring that government expenditure in Queensland is focused on areas of highest priority.

The Government must ensure that over the medium term, the composition and focus of government expenditure is on those services that are most appropriately delivered by state governments.

As part of the baseline review of department and agency budgets, the Government should identify any areas of expenditure currently undertaken by the state that are more appropriately undertaken by other levels of government. A number of examples fall into this category.

The Australian Government has principal responsibility for policy and financial support for residential aged care. This type of care is predominantly provided by both for profit and not for profit providers in the private sector. However, the Queensland Government still provides supported residential aged care services, separate to the provision of general health care. The continued provision of facilities and residential aged care services by government is at odds with national aged care policy objectives, which is focussed on support for private sector provision of residential aged care.

Transitioning the State's responsibility in this area to private providers would need to be undertaken over the medium term to minimise disruption to aged care residents and to ensure capacity exists in the private sector to accommodate existing government facilities.

The Queensland Government is also involved in the funding and provision of primary and community health care, which is also predominantly the responsibility of the Australian Government. The State should also review its role in these service areas and plan to exit from service areas that appropriately form part of the Commonwealth funded primary care system over the medium term with transition arrangements for those using the State provided services to Australian Government funded providers. The State would need to consider how services would be provided in rural and remote areas not currently serviced by the Australian Government.

Similarly, the Queensland Government provides a number of services to assist jobseekers enter the labour market even though this function has long understood to be a policy responsibility of the national government. The Government should look to exit these programs and where appropriate transition recipients of these services onto established Australian Government programs. Job seekers with specific employment needs could be assisted in the transition with direct access to Australian Government employment and training services.

12.4.2.2. Demand management tools

The traditional role of state governments has been the delivery of public services that for various reasons would either not be supplied by the private sector or would not be supplied by the private sector in sufficient quantities. This includes health, education, roads and public transport infrastructure and community services.

Typically, these core services are provided to the public within minimal effort to recover the cost of service delivery from the users of the service. This is because:

- the services are provided to the public because of the wider social, or external benefits they deliver the community – such as a better educated, more healthy and cohesive population; use of these services is therefore encouraged for a greater public benefit

- the general population has already paid for the delivery of these services through the taxes collected by the Government

- for the most part, there was minimal competition for these services within the private market.

However, the circumstances under which these services have traditionally been provided with little or no direct charge has changed:

- there is now a greater private sector involvement in the provision of public services, particularly in hospitals and schools

- alternative forms of service provision are available to traditional government provided services – such as greater use of preventative health measures and more widely available information and education on healthy lifestyles;

- the not for profit sector is now a major provider of services traditionally provided by government, such as disability services, public housing and employment assistance.

In some instances government contracts private operators to provide these services through government grants.

The emergence of these alternative services in turn reflects an increasing community demand for such services. Against the background of constrained and subdued revenue sources, the challenge for government is to ensure that future investment in core public services is directed at those who are most in need, so that those in the community who are able to access alternative services are encouraged to do so. The State would continue to have a role in those instances where no other provider exists (for example, in the more decentralised parts of the state).

To achieve this result for the most in need will require active management of demand for core public services. The focus of this demand management should be to provide incentives for:

- the general community to access government services only when it is necessary to do so

- those who can access privately provided services to do so.

Implementing demand management can take various forms including:

- pricing and charges, to ensure that services are only accessed when needed

- means testing of customers to ensure that those with a financial capacity to use alternative services are provided with an incentive to do so

- quantity restrictions – by provided an annual cap on the number of people who will be able to access a particular type of service each year.

Under each demand management model, special provisions would be required to ensure that the most vulnerable in the community continue to have priority access to services.

There have been significant increases in the demand for services provided by the Government over the last decade. A continuation of uncapped increases in demand for Government services would place increasing risks and cost pressures on the expenditure side of the budget, which would be increasingly difficult to fund.

Recommendation

The Government identify changes to the structure of revenues and expenses that will contribute to the debt reduction task under the Second Stage of the fiscal strategy. This includes exiting expenditure activities more appropriately supported by other levels of government. The Government should also examine medium term measures to manage demand for government services.

12.4.2.3. Balance sheet management

Achieving the Second Stage of the fiscal strategy would involve reducing debt by $25-30 billion by 2017-18, a halving of the debt ratio. This Report outlines why this cannot be done through revenue and expenditure measures alone. It will require careful utilisation of the balance sheet and utilising the proceeds of asset sales to reduce debt.

These issues will be examined further in the Commission's subsequent Reports.

Recommendation

The Government ensure careful utilisation of its balance sheet, including utilising the proceeds of asset sales, to achieve the objectives of the Second Stage of the fiscal strategy.

QUEENSLAND COMMISSION OF AUDIT

TERMS OF REFERENCE

The Independent Commission of Audit is asked to review and report on:

1. Financial position

a) the State's balance sheet, including net debt position and associated debt servicing charges

b) the forecast trend in the balance sheet position over the forward estimates period

c) the trends and long-term projections in growth of own-state revenue, including the various state taxes and charges as well as resources royalties

d) the trends and long-term projections of GST Revenue under current arrangements as well as potential future arrangements as a result of the Greiner-Brumby-Carter report, which will be released before the Commission of Audit is due to report

e) the trends and long-term projections of growth in expenditure across the various classes

f) whether there are any events, such as the 2018 Commonwealth Games funding obligation and the Carbon tax, not adequately provided for in the Mid-Year Fiscal and Economic Review or forward estimates

g) any contingent liabilities that should be brought to the Government's attention.

2. Improving the State's financial position

a) policy settings and strategies to address any structural factors affecting the State's finances, and to restore its AAA credit rating

b) strategies to improve the State's balance sheet management

c) strategies to improve the sustainability of the State's capital program beyond the forward estimates period to 2030

3. Service delivery

a) benchmarking public sector management and service delivery issues, including procurement, corporate services, and asset management, against other states

b) identify any potential improvements to productivity, service quality, and value for money in service delivery across the public sector

c) effectiveness of existing performance metrics and options for greater transparency and accountability through improved public reporting

d) the adequacy, affordability and deliverability of the capital program over the forward estimates period

e) strategies to encourage greater private sector involvement in the funding and/or direct provision of public infrastructure and services

f) the efficiency of current pricing arrangements for regulated infrastructure, including electricity, water, rail and ports.

4. Government commercial enterprises

a) the financial performance of Government owned corporations (GOCs) and commercial agencies

b) the level of indebtedness of GOCs and commercial agencies, how such indebtedness compares with private sector peers and whether it is a prudent level

c) measures to improve the operational performance and financial returns to the State from GOCs and commercial agencies

5. The economy

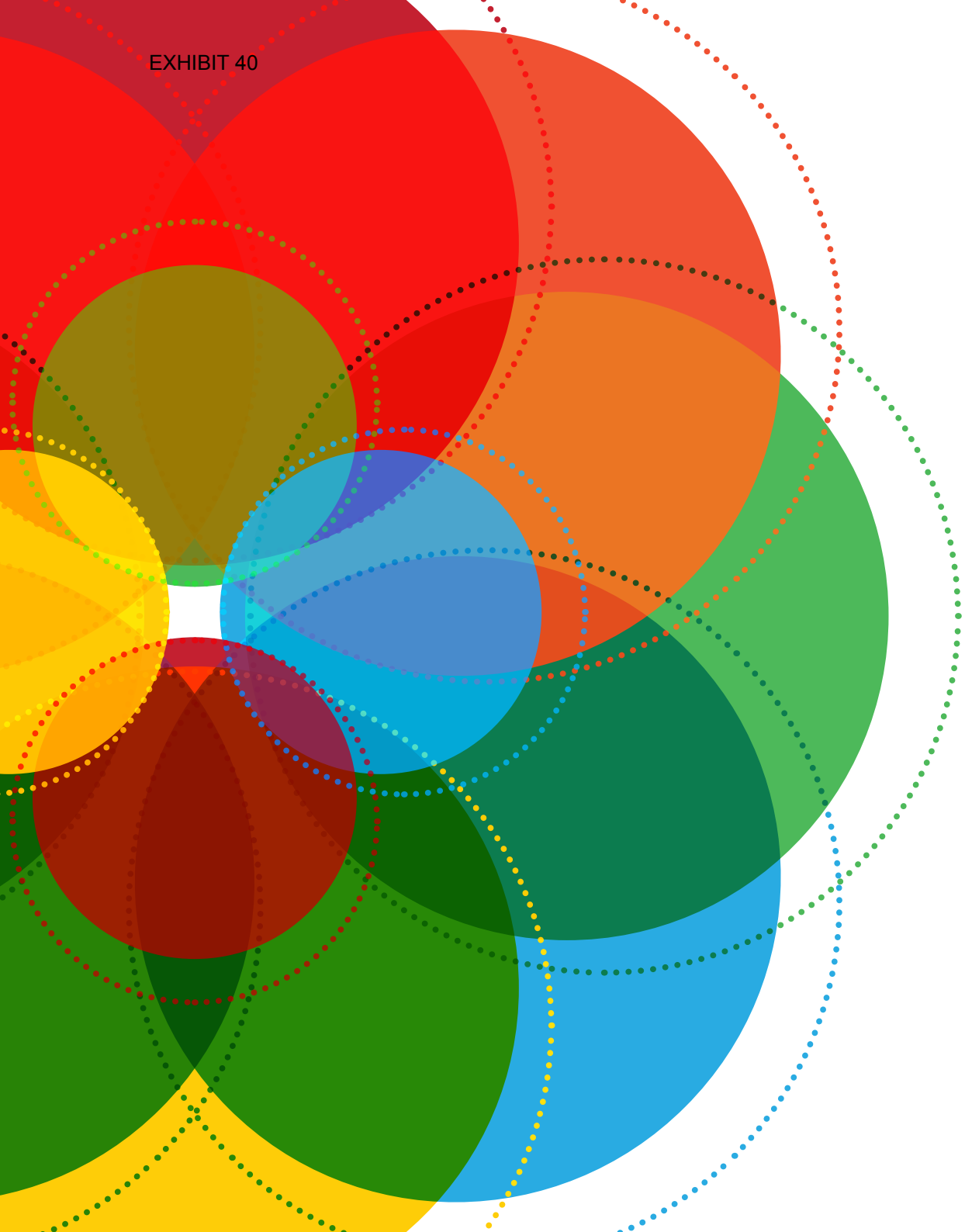
a) whether any government policies, taxes, regulatory arrangements, ownership structures or actions or inactions represent a constraint on Queensland's economic growth

b) recommendations to generate long-term systemic reform to grow and strengthen the Queensland economy.

Glossary

AASB	Australian Accounting Standards Board
ACMA	Australian Communication and Media Authority
AMLP	Abandoned Mine Lands Program
ATO	Australian Taxation Office
AWTP	Advanced Water Treatment Plant
BCA	Baseline Credit Assessment
BMAP	Budget Management Action Plan
CBRC	Cabinet Budget Review Committee
CGC	Commonwealth Grants Commission
CIF	Community Investment Fund
CMC	Crime and Misconduct Commission
CSO	Community Service Obligation
CSP	Corporate Solutions Program
CSS	Child Safety Services
DAE	Deloitte Access Economics
DCS	Department of Community Safety
DETE	Department of Education, Training and Employment
DEWS	Department of Energy and Water Supply
DMB	Digital Mobile Broadband
DPC	Department of the Premier and Cabinet
DPW	Department of Public Works
DR	Distributor-retailer authorities
EBA	Enterprise Bargaining Agreement
FE	Forward Estimates
FHOG	First Home Owner Grant
FTE	Fulltime Equivalent
FWA	Fair Work Australia
GA	Government Actuary
GCRT	Gold Coast Rapid Transit
GENCOs	Government Owned Generators
GFC	Global Financial Crisis
GFS	Government Finance Statistics
GSP	Gross State Product
GWN	Government Wireless Network
HHF	Health and Hospitals Funds
HoF	Helping out Families
HR	Human Resources
ieMR	Integrated Electronic Medical Record
IGA	Intergovernmental Agreement
IPO	Initial Public Offering

lppd	Litres per person per day
MYFER	Mid Year Fiscal and Economic Review
NDIS	National Disability Insurance Scheme
NDRRA	Natural Disaster Relief and Recovery Arrangements
NFPS	Non-financial Public Sector
NGO	Non-Government Organisation
NIIS	National Injury Insurance Scheme
NP	National Partnership
NPA	National Partnership Agreement
NTER	National Tax Equivalents Regime
OLGR	Office of Liquor Gaming and Racing
PC	Productivity Commission
PCEHR	Personally Controlled Electronic Health Record
PE stage	Preliminary evaluation stage
PNFC	Public Non-financial Corporation
PPP	Public Private Partnership
QGCIO	Queensland Government Chief Information Office
QGIF	Queensland Government Insurance Fund
QH	Queensland Health
QIRC	Queensland Industrial Relations Commission
QPS	Queensland Police Service
QTC	Queensland Treasury Corporation
QTH	Queensland Treasury Holdings Pty Ltd
QWC	Queensland Water Commission
RCH	Royal Children's Hospital
S&P	Standard and Poor's Ratings Services
SEQ	South East Queensland
SPER	State Penalties Enforcement Register
SPP	Specific Purpose Payment
TMR	Transport and Main Roads
TSC	Transport Service Contract
TSC (RI)	Transport Service Contract (Rail Infrastructure)
TSC-SEQIPP	Transport Service Contract – South East Queensland Infrastructure Planning and Programming
UEFO	Updated Economic and Fiscal Outlook
UPF	Uniform Presentation Framework
VSP	Voluntary Separation Program
WCQ	WorkCover Queensland
WCRW	Western Corridor Recycled Water
WGM	Water Grid Manager
WoG	Whole of Government



Improving mental health and wellbeing

Queensland Mental Health, Drug and Alcohol
Strategic Plan 2014–2019

Queensland Government

Improving mental health and wellbeing
The Queensland Mental Health, Drug and Alcohol
Strategic Plan 2014–2019

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The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on 1300 855 945 and we will arrange an interpreter to effectively communicate the report to you.

We value the views of our readers and invite your feedback on the Strategic Plan.
Please contact the Queensland Mental Health Commission on telephone 1300 855 945
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Contents

Foreword

Minister for Health

The Queensland Government is committed to a strong plan to improve the mental health and wellbeing of all people living in our State. We understand the emotional, physical, economic and social impact of mental health difficulties and issues related to substance use and are resolved to make a difference.

Through consultations to develop *The Queensland Plan: Queenslanders' 30 year vision* we know Queenslanders aspire to a brighter future where people are physically and mentally healthy.

We have already promised the people of Queensland a leading healthcare system, and the *Blueprint for better healthcare in Queensland* will guide this important reform.

However, we must not limit our approach to mental health, drug and alcohol reform by assigning sole responsibility to the health sector. The health system is only one part of the broader network of services and supports required to improve mental health and minimise adverse impacts of substance use in our communities.

A strong plan with a stronger focus on improving awareness, as well as prevention and early intervention, will see better long-term health outcomes and provide the best value for money for taxpayers.

The Queensland Mental Health Commission has been tasked with developing a whole-of-government strategic plan to help guide the reform that Queenslanders expect and deserve. This plan will support the achievement of many of the Queensland Plan's goals and targets across foundation areas including community and economy, as well as health and wellbeing.

Since its establishment in July 2013, the Commission has worked with the many individuals, families and communities affected by mental health difficulties and issues related to substance use, as well as government and non-government agencies and service providers, to identify the issues and opportunities that exist across our diverse State.

I thank the Mental Health and Drug Advisory Council, the Mental Health Commissioner and her team for their efforts in developing the plan. I encourage all Queenslanders to support its implementation to achieve a better future for us all.

Lawrence Springborg
Minister for Health

Foreword

Queensland Mental Health Commissioner

In developing the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019*, staff of the Commission and I were privileged to hear the stories of the many Queenslanders affected by mental health difficulties or issues related to substance use. We heard from people with a personal experience as well as their families, carers and supporters and members of the community. We also heard from many dedicated professionals who work to support those personally affected.

Each individual's experience was unique, their perspectives and opinions were often different, but they spoke with hope and came with ideas about how to make things better.

More and more, our society has come to understand the value and importance of mental health and wellbeing – not only for individuals, but for their families and friends, their colleagues or school mates, and the community in which we all live.

Government attention to and investment in mental health, drug and alcohol reform has continued to grow and yet too many people still require acute and expensive services. Often by the time these services are accessed, a person is experiencing significant hardship in many areas of their life – their relationships with family and friends, their ability to learn or find and maintain a job, even having somewhere to call home can be compromised by their experience of mental health difficulties or issues related to substance use.

The evidence is clear. The impact and cost of these issues can often be reduced by providing better services and support in our communities and, in most cases, close to home. Providing better services will require effort and commitment across government and at all levels.

To make a positive difference and achieve lasting change, we must balance our focus, investment and resources to include strategies that help people maintain their mental health and wellbeing, prevent problems from developing, and aid early identification and intervention when problems do arise, to minimise their duration and severity. We must focus on returning people to wellness at every opportunity.

This plan addresses those areas that emerged as clear priorities for Queenslanders. Evidence about what works best and the views of those consulted have been used to shape the directions and give a clear way forward.

We recognise there is much work to do. By focusing on a few key ideas that will set the foundation for a culture of innovation, and with determination for sustained change, we can make solid progress towards achieving our shared vision for Queensland.

I am grateful to the people of Queensland for sharing their stories and helping us to shape a plan to guide this important reform.

Dr Lesley van Schoubroeck
Mental Health Commissioner

We all have a role to play
and share the responsibility
for improving the mental health
and wellbeing of Queenslanders.

Executive summary

In any year, one in five Queenslanders will experience a mental illness or substance use disorder. Half of us will be affected at some stage during our life, and all of us will likely know a family member, friend or colleague living with mental health difficulties or issues related to substance use.

Our shared vision for Queensland is:

A healthy and inclusive community, where people living with mental health difficulties or issues related to substance use have a life with purpose and access to quality care and support focused on wellness and recovery in an understanding, empathic and compassionate society.

The ***Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019*** (the plan) sets a path towards achieving our vision. It is based on what we heard from Queenslanders, as well as the evidence about what is needed and what works.

Seven principles underpin the plan and will guide all actions. They embed a strong focus on **person centred** approaches to improving **quality of life** and respecting the **rights and dignity** of all Queenslanders. They call for a **responsive and effective** system that **respects diversity** and is **fair, accessible and equitable**. The principles acknowledge that we all have a role to play and must **share the responsibility** for improving the mental health and wellbeing of Queenslanders.

The plan seeks to achieve meaningful long-term outcomes. Performance measures and indicators will identify if this plan has made a positive difference towards **a population with good mental health and wellbeing** and had an impact on reducing stigma and discrimination. We will monitor whether there is **reduced avoidable harm**, and people with mental illness or substance misuse disorders **have improved physical and oral health and have longer life expectancy**. We also expect people to have **positive experiences of their support, care and treatment**.

Improvements in the mental health, drug and alcohol systems will be supported by four pillars of reform:

- **Better services** for those who need them, when and where they need them
- **Better awareness, prevention and early intervention** to reduce the incidence, severity and duration of problems
- **Better engagement and collaboration** to improve responsiveness to individual and community needs
- **Better transparency and accountability** to ensure the system is working as intended and in the most effective, efficient way possible.

Shared commitments to action will require whole-of-government leadership and a willingness to innovate. Government, business, industry, the community and individuals will all need to work together to improve the mental health and wellbeing of Queenslanders.

The Queensland Mental Health Commission will publish an annual progress report and will review the plan within five years.

Introduction

Mental health is more than the absence of mental disorders … [It] is a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community[1].

Good mental health and wellbeing is integral to overall good health and is the foundation of strong and resilient individuals, families and communities and of our economy. However, mental health difficulties and issues related to substance use are common and costly, affecting people from all walks of life, ages and backgrounds. Many do not seek or receive the treatment and support they need. This leads to poor outcomes for individuals and families and contributes to a growing social and economic burden for communities.

People living with mental health difficulties or issues related to substance use are also less likely than others to be engaged in their communities and are more likely to experience difficulty accessing and maintaining housing, education and employment. They are often the most marginalised in our community and are particularly vulnerable to becoming involved in the criminal justice, youth justice or child protection systems. These disadvantages are compounded for people with exceptionally complex problems who experience multiple problems and interact with health and social services systems on a long-term basis.

Access to an integrated service system providing the right type of support when it is needed and, in most cases, as close to home as is safe is essential. We must also support and recognise the importance of empowering individuals to make decisions about their lives and the importance of maintaining relationships in a person's recovery. Greater community awareness and a focus on prevention and early intervention offer great promise to reducing the incidence, severity and impacts of mental illness and substance use disorders.

This plan focuses on system wide actions within a culture of innovation, to achieve long-term and sustainable reform and improve the mental health and wellbeing of Queenslanders.

Shaping a shared plan

The plan is based on evidence about the prevalence of mental illness and substance use disorders and on what we heard from people across Queensland including individuals living with mental health difficulties or issues related to substance use, their families, carers and supporters. Other members of the community, government agencies, industry, businesses and the community sector shared their ideas and concerns. The plan brings together the best ideas to shape a new direction for mental health, drug and alcohol reform.

An estimated **one in five Queenslanders** will experience mental illness, including substance use disorders, in any one year[2].

Almost **one in two people** between the ages of 16 and 85 will experience mental illness at some point in their lives[3].

In 2011–12 around **900,000 Queenslanders** experienced a mental illness or substance use disorder:

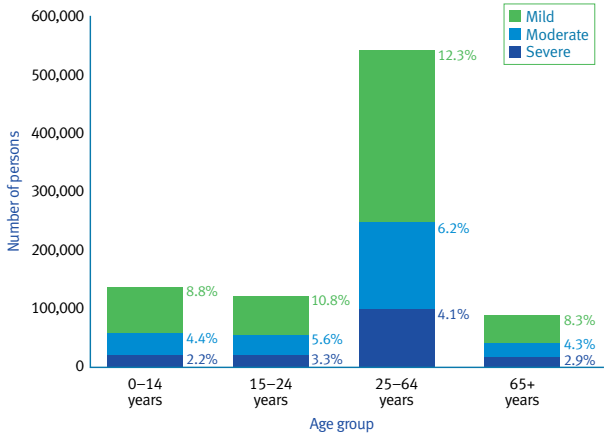
492,000 More than half experienced **mild disorders**

249,000 people experienced **moderate disorders**

156,000 people experienced a **severe disorder**

The severity of mental illness or substance use disorders is measured by considering the level of impact on a person's quality of life[4].

Figure 1. Estimated number of people with mental illness including substance use disorders in Queensland, 2011–2012 (with percentage of all persons in each age group who have a mild, moderate or severe disorder)



Mental illness and substance use disorders also contribute to the risk of suicide. Suicide rates have remained relatively stable over the past decade[5]. From 2008 to 2012, the Queensland age standardised suicide rate was 13.0 per 100,000 people compared with 10.8 per 100,000 people nationally[6].

Responding to need in Queensland

The onset, progression, duration and severity of mental illness and substance use disorders are influenced by a complex mix of individual, social, environmental, economic and cultural factors. Some groups of people and communities are more exposed than others to risk factors and are more likely to experience poor mental health and wellbeing.

While most people within these vulnerable groups have good mental health and wellbeing, customised responses are needed to meet their unique cultural needs and circumstances. Outlined below are some known issues that need to be addressed to improve the overall mental health and wellbeing of these vulnerable groups.

Mothers, infants and families

- The period from conception until two years post birth is the highest risk time for women to develop mental health difficulties. Fathers are also at risk during this period for depression and anxiety and this can affect the functioning and wellbeing of the family.
- Suicide is the leading cause in Australia of maternal deaths during the two years post birth, with little improvement seen over the past two decades[7].

Children and young people

- Half of all mental illness starts before the age of 14 years[8] and experimenting with alcohol or other drugs often begins during teenage years.
- Between a quarter and a half of all adult mental illness may be avoided with prevention and early intervention services during childhood and adolescence[9].
- Children living with parents who have chronic health or social problems often experience lower levels of wellbeing and are more vulnerable to mental health difficulties and disadvantage, and to involvement in the child protection or youth justice systems.

Older people

- A significant minority of older people experience one or more mental or behavioural disorders, high levels of psychological distress, or take medication for their mental wellbeing[10].
- Older people are less likely to receive or have access to mental health, drug or alcohol services and therefore often do not receive the treatment or support they need[11].

People living in rural and remote communities

- The wellbeing of people living in rural and remote communities can be challenged by social, financial and environmental factors such as limited employment or education opportunities, social and geographic isolation, and economic hardship and uncertainty, as well as the hardship and stress of extreme weather conditions.
- Lack of information and accessible, quality services in some cases can make people living in rural and remote areas less likely to seek or receive treatment or support.

Aboriginal and Torres Strait Islander peoples

- Mental illness is a leading cause of the burden of disease among Aboriginal and Torres Strait Islander peoples in Queensland[12].
- Suicide rates among Aboriginal and Torres Strait Islander peoples are significantly higher than for non-Indigenous people[13].
- Strategies to improve outcomes must be culturally capable and take a holistic view of life and health with a focus on the individual and also their family and community.

People from culturally and linguistically diverse (CALD) backgrounds

- People from CALD backgrounds – particularly those who do not speak English, the most recently arrived and refugees – may be more vulnerable to experiencing mental health difficulties and issues related to substance use.
- Mental health, drug and alcohol services that are accessible, culturally appropriate and effective in meeting the needs of CALD people and their families are required[14].

Lesbian, gay, bisexual, transgender and intersex (LGBTI) people

- LGBTI Queenslanders experience higher rates of mental illness and psychological distress, are more likely to drink at risk levels or use illicit drugs, and are at greater risk of suicide than their heterosexual counterparts[15, 16].
- The increased risks among LGBTI people are attributed to their exposure to or fear of discrimination and exclusion[17].

People with disability

- The incidence of mental illness or impairment in people with physical or intellectual disabilities is significantly higher than in the general population[18].
- Psychiatric disorders in people with a physical, hearing or intellectual disability are sometimes not recognised, misdiagnosed or inappropriately treated.

People experiencing both mental health difficulties and issues related to substance use

- The high prevalence and chronic nature of co-occurring mental health difficulties and issues related to substance use account for a large proportion of the overall burden of disease[19]. Dual diagnosis commonly leads to poor treatment outcomes and high rates of relapse due to the complexity and severity of problems [20, 21].
- People with a dual diagnosis often experience challenges navigating a complex health care system with many points of entry[22] and many options regarding directions to be taken.

People involved with the criminal justice system

- Compared with the general population, rates of mental illness, substance use disorders and being at risk of suicide are significantly higher for people in contact with the criminal justice system, including those incarcerated and those transitioning back into the community[23].
- Responding to calls regarding people with mental health difficulties or under the influence of alcohol or drugs is a significant burden on police resources[24].

People with exceptionally complex problems

- Individuals who experience multiple, complex and often inter-related problems are often long-term frequent users of a range of government services including disability services and the criminal justice and child protection systems.
- Intensive, coordinated and innovative responses are needed to address their problems.

All Queenslanders must be able to start well, develop well, live well, work well and age well.

Access to services

Access to a range of health and social services, at the right time and as close to home as is safe, is critical to recovery from mental health difficulties and substance use problems and often prevents issues from developing into significant or long-term problems.

Mental health, drug and alcohol services comprise both clinical and non-clinical services, including clinical assessment and treatment services, private psychiatrists and psychologists and services to support people to live well and participate in their community. Services are delivered by a range of providers operating within and across different sectors.

In Queensland, more than 85,000 people receive clinical services each year through the public mental health system. More than 300,000 Queenslanders receive treatment for mental health disorders in the private sector each year. Nationally, a recent report estimated that drug and alcohol services provide more than 1.6 million contacts, episodes of care or encounters annually[25].

In 2011–12, just under half of Queenslanders experiencing a mental illness or substance use disorder received some type of clinical treatment. Almost everyone living with a severe disorder received treatment (94 per cent), primarily delivered by specialised public health services (49 per cent) or Medicare subsidised services (39 per cent). However, access to non-clinical support services – essential for sustained recovery – is low, with only 14 per cent of people with severe disorders receiving non-health support[26].

Substantial proportions of people reporting moderate (more than 50 per cent) and mild disorders (77 per cent) do not access services. Sometimes this is because they do not believe treatment is required or will assist them[27]. Other common barriers to accessing services include lack of information about available services, fear of social stigma or discrimination, and cultural and language barriers.

Balancing our investment

We know that access to treatment services can be costly for individuals and governments. According to the *Report on Government Services 2014*, government investment in mental health, drug and alcohol services has continued to grow over time. The Australian Government spent $2.15 billion nationally on mental health treatment in 2011–12[28] and $360 million on alcohol and other drug treatment in 2012–13 [29]. The Queensland Government invests more than $1.1 billion each year in mental health services with around eight per cent directed to the non-government sector.

In addition to the direct cost of services, the economic impacts of mental health difficulties and substance use problems are substantial. They include lost productivity and greater use of government funded services in housing, education, child protection and justice.

While it is important to continue to invest in high quality acute and clinical services, we also need to reduce demand for these services. This requires an increased investment in and focus on early intervention and prevention strategies and building individual and community capacity.

Prevention and early intervention strategies will not provide a quick fix and will take time to achieve better outcomes. However, the right balance of investment and the right type of services can result in improved mental health and wellbeing, and are critical to long-term and sustainable reform.

What Queenslanders told us

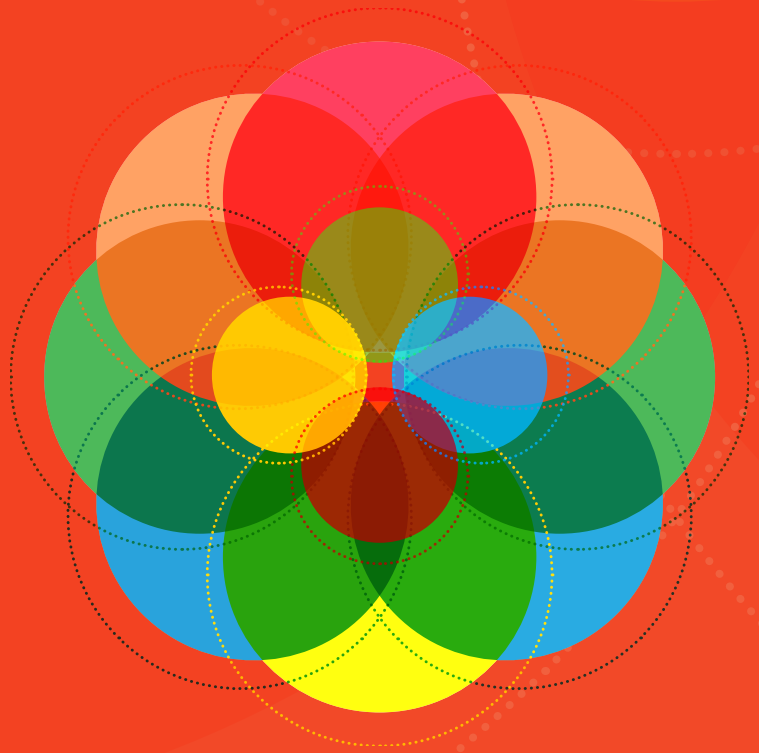
The plan has been shaped by the collective views of people throughout Queensland including individuals with mental health difficulties and issues related to substance use, their families and carers, and the broader community.

Community, government and industry stakeholders throughout Queensland participated in major regional forums in Cairns, Townsville, Rockhampton, Toowoomba and Brisbane. Consultations were also conducted to discuss issues and opportunities to better meet the unique needs and circumstances of individuals and groups who are particularly vulnerable to experiencing mental health difficulties or issues related to substance use.

Consultations continued with peak bodies, community members and government and non-government stakeholders to refine and develop the plan's vision and priorities.

The Queensland Mental Health and Drug Advisory Council has played a pivotal role in refining and shaping the plan, bringing a wealth of diversity, experience and knowledge.

People with lived experience, their families, carers and supporters must be valued partners in developing policies and services.



Our shared vision for Queensland

A healthy and inclusive community, where people experiencing mental health difficulties or issues related to substance use have a life with purpose and access to quality care and support focused on wellness and recovery, in an understanding, empathic and compassionate society.

Principles

Seven principles will guide our work to reform the mental health, drug and alcohol system and improve outcomes for Queenslanders.

1. Person centred

The unique experiences of individuals, families and communities are central to our work. People living with mental health difficulties or issues related to substance use must be engaged as valued partners in guiding reform and in service development, planning, delivery, monitoring, and evaluation. Their active and informed involvement in decisions that affect them will lead to better outcomes.

2. Shared responsibility

Individuals, families, government, industry and the community have a shared responsibility to improve mental health and wellbeing in Queensland. We all have a critical role to play. By working together we can increase our collective impact and achieve our shared vision.

3. Rights and dignity

The rights and dignity of individuals, families and communities are respected and upheld. All members of our community have the same rights and responsibilities, including the right to be and feel safe, the right to privacy, and the right to be treated fairly, with respect and dignity.

4. Quality of life

Individuals must be supported to make decisions about their own futures, develop meaningful relationships and lead purposeful lives through community participation, education and employment. Everyone must have access to good health care, quality treatment and support when needed.

5. Responsive and effective

Programs and services must be innovative and recovery oriented with a focus on maintaining or returning to wellness. They must be based on best practice and tailored to meet health and social needs through all stages of the life course from the perinatal period to infancy, childhood, adolescence, adulthood and old age. We must evaluate services, programs and strategies to build our collective knowledge of what works.

6. Diversity and respect

The views, needs, strengths and resilience of people from all social and cultural backgrounds are acknowledged, respected and valued. Aboriginal tradition and Islander custom will be acknowledged and respected, and will inform our actions.

7. Fair, accessible and equitable

Programs and services must be effective, accessible and affordable, and be provided as close to home as is safe. Priorities and resources must be allocated based on need.

Outcomes

The plan aims to improve the mental health and wellbeing of Queenslanders by working towards six long-term outcomes.

Informed by the *National Targets and Indicators for Mental Health Reform* developed by the Council of Australian Governments' Expert Reference Group in 2013 and the *National Drug Strategy 2010–15*, the six outcomes are:

1. A population with good mental health and wellbeing
2. Reduced stigma and discrimination
3. Reduced avoidable harm
4. People living with mental health difficulties or issues related to substance use have lives with purpose
5. People living with mental illness and substance use disorders have better physical and oral health and live longer
6. People living with mental illness and substance use disorders have positive experiences of their support, care and treatment.

Assessing whether these outcomes have been achieved will involve identifying clear and measurable indicators, and will lead to greater transparency and accountability. Shared commitment 8 will identify indicators and establish baseline data.

Pillars of reform

Improvements in the mental health, drug and alcohol service systems will be supported by four pillars of reform that will lead to a better quality of life and better outcomes for people living with mental health difficulties or issues related to substance use, their families and communities.

The four pillars of reform are:

1. Better services for those who need them, when and where they are required
2. Better promotion, prevention and early intervention initiatives to maintain wellbeing, prevent onset, and minimise the severity and duration of problems
3. Better engagement and collaboration to improve responsiveness to individual and community needs
4. Better transparency and accountability so the system works as intended and in the most effective and efficient way possible.

Better services

Better services, delivered by a capable and compassionate workforce, are critical to support people living with mental health difficulties or issues related to substance use to maintain or return to wellness. Better services will involve improving access to existing services and developing new services based on evidence of what works, best practice and least restrictive practices. For some groups, better services will require tailored, culturally capable services to meet their unique cultural needs and circumstances. High quality statewide specialist services will be needed to complement local services.

Better services will require a culture of innovation and solution-focused leadership that embraces quality improvement and system reform.

Better engagement and collaboration

Collaborative approaches have significant benefits and are essential to achieving genuine reform and improved mental health and wellbeing. Integrated and holistic responses are best achieved through strong, effective and outcomes-focused partnerships, and clear pathways and mechanisms to work together. This involves identifying and removing systemic barriers to collaboration between health and social services and between government and non-government service providers.

Better awareness, prevention and early intervention

Many mental health difficulties and issues related to substance use can be prevented and their duration and severity reduced. Raised community awareness, together with effective prevention and early intervention strategies, will improve individual and community outcomes by fostering more resilient families, schools, workplaces and communities where people can start well, develop well, work well, live well and age well.

Better transparency and accountability

Better transparency and accountability is essential to ensure the mental health and drug and alcohol service systems provide the right types and balance of quality, effective and appropriate services, across the government, private and community sectors, delivered where and when they are most needed. For individuals better transparency and accountability will mean clearer pathways and systems for complaints investigation and greater resolution and clarity about their rights and responsibilities while receiving treatment and accessing support services.

Shared commitments to action

The shared commitments to action address immediate priorities and will strengthen partnerships and capacity for collective action over the next three to five years. They build on work already occurring and will support the implementation of new and innovative solutions. Actions implemented to fulfil these commitments will respond to emerging issues and new evidence of what works.

Shared commitment 1
Engagement and leadership priorities for individuals, families and carers

Shared commitment 2
Awareness, prevention and early intervention

Shared commitment 3
Targeted responses in priority areas

Shared commitment 4
A responsive and sustainable community sector

Shared commitment 5
Integrated and effective government responses

Shared commitment 6
More integrated health service delivery

Shared commitment 7
Mental Health, Drug and Alcohol Services Plan

Shared commitment 8
Indicators to measure progress towards improving mental health and wellbeing

Shared commitment 1

Engagement and leadership priorities for individuals, families and carers

We will improve inclusion, meaningful participation and outcomes by drawing on the diversity of the experience and wisdom of people with a lived experience of mental health difficulties and substance use problems, their families and carers.

What do we want to achieve?

- Meaningful opportunities for individuals, families and carers to participate as equal partners in the co-design, planning, monitoring and evaluation of mental health, drug and alcohol services and in all levels of policy development
- Individuals, families and carers who are informed, equipped and empowered to voice their perspectives, particularly in relation to their rights

How will this be achieved?

- Information, training and support for individuals, families and carers with a focus on systemic reform
- Formal mechanisms and opportunities for genuine engagement and participation in the co-design of policies, strategies and programs
- Accountability mechanisms to support increased engagement and participation
- Committed leadership and continuing education of clinical and non-clinical service providers
- Development of and support for the peer workforce and peer support networks

Who is responsible?

The **Queensland Mental Health Commission** will lead this work drawing on the expertise of the Mental Health and Drug Advisory Council and in partnership with consumer, family and carer representatives. Government agencies, representative groups and peak bodies will also contribute to this work.

When will this happen?

Work commenced in July 2014.

Shared commitment 2

Awareness, prevention and early intervention

Effective and well targeted awareness, prevention and early intervention actions can reduce the incidence, severity and impact of mental illness and substance use disorders. They have the potential to produce substantial long-term benefits for individuals, the community and the economy. Shared commitment from multiple sectors will enable actions that provide support to families and in communities, schools, workplaces and the media.

What do we want to achieve?

- More people across Queensland and within key groups with good mental health and wellbeing
- Fewer people living with mental health difficulties or issues related to substance use being subjected to stigma and discrimination
- People receiving the right type of support, as early as possible, to start well, develop well, work well, live well and age well
- Reduced risks of people living with mental illness being subject to harm or harming themselves

How will this be achieved?

- Improved awareness and understanding of mental illness and substance use disorders to reduce stigma and discrimination
- Tailored awareness, prevention and early intervention initiatives for known priority groups including mothers, infants and their families, children and young people
- Initiatives provided in settings such as schools, workplaces and communities
- Greater focus on the wellbeing of children and young people living in families with exceptionally complex social and health problems, as well as other vulnerable individuals and communities
- Improved community and individual connectedness, including through volunteering
- Actions and alliances to develop mentally healthy workplaces, build workforce capability and capacity, and increase employment of people with a lived experience of mental health difficulties or substance use problems

Who is responsible?

This work will be led by the **Queensland Mental Health Commission**, with contributions from key stakeholders including other Queensland Government agencies, representative groups and peak bodies.

When will this happen?

Work will commence in February 2015.

Shared commitment 3

Targeted responses in priority areas

Initial priorities have been identified through our consultation with the community and based on evidence about current issues in Queensland. New actions will be delivered to respond to emerging issues or trends that require a targeted response.

Stage one priorities are:

- the wellbeing of people living in rural and remote communities
- the wellbeing of Aboriginal and Torres Strait Islander peoples
- suicide prevention
- actions to prevent and reduce the adverse impacts of alcohol and drugs on the health and wellbeing of Queenslanders.

Stage two priorities are:

- the wellbeing of people in contact with the criminal justice system
- individual advocacy and rights protection within the mental health, drug and alcohol system
- the wellbeing of people with disability and other vulnerable groups.

What do we want to achieve?

- Better outcomes and wellbeing for individuals and communities who may be more vulnerable to experiencing poor mental health and wellbeing
- Tailored and effective responses to meet the unique cultural, social and developmental needs of priority groups
- Improved access to integrated and innovative health and social services to meet the needs of individuals and communities in more holistic ways

How will this be achieved?

- Promoting and building on best practice and embedding a culture of innovation
- Identifying service access barriers and finding practical solutions to overcome them
- Embedding integration across the health and social services and across government and non-government sectors
- Streamlining systems and removing duplication

Who is responsible?

Actions to fulfil this commitment will be coordinated by the **Queensland Mental Health Commission**. Leadership for each priority area will be determined in consultation with key stakeholders including Queensland Government agencies, representative groups and peak bodies.

When will this happen?

Stage one actions will commence in 2014–15.

Stage two actions will commence in 2015–16.

Shared commitment 4

A responsive and sustainable community sector

The community sector plays a vital role as the primary providers of non-clinical services that support people living with mental health difficulties and issues related to substance use to live well and participate in their community. A responsive, sustainable and cost-effective community sector is an essential component of an effective mental health, drug and alcohol system.

What do we want to achieve?

- Access for people living with mental health difficulties or issues related to substance use – including those with exceptionally complex problems – to quality services in the community and as close to home as is safe
- Responsive, sustainable, evidence based, cost-effective services delivered by the community sector
- A community sector that can operate and thrive in a changing funding and service delivery environment

How will this be achieved?

- Collaboration between the government and community sectors to develop agreed service outcomes and identify areas of need and funding priorities
- Improving service coordination and integration
- Supporting community organisations to implement innovative solutions and manage risk through flexible and accountable funding arrangements
- Building and sharing evidence about what works
- Organisational and workforce planning and training to build capacity for appropriate actions
- Getting the balance and mix of community based services required to improve outcomes for people living with mental health difficulties or issues related to substance use
- Investigating options to include social outcomes in procurement policies and processes to increase opportunities for community organisations to support people living with mental health difficulties or issues related to substance use

Who is responsible?

Leadership will be shared among key stakeholders including peak bodies and Queensland Government agencies. The Queensland Mental Health Commission will coordinate activities implemented as part of this shared commitment to action.

When will this happen?

Work will commence in 2014–15.

Shared commitment 5

Integrated and effective government responses

We will strengthen the capacity of the Queensland Government as a service provider and employer to meet the complex and inter-related health and social needs of people living with, or at risk of, mental health difficulties or issues related to substance use. This shared commitment to action will also contribute to improved levels of wellbeing in our community.

What do we want to achieve?

- More people living with mental health difficulties or issues related to substance use, including those with exceptionally complex problems, are able to access quality services in the community and as close to home as is safe
- More accessible and responsive public services to meet the needs of all customers, including those with mental health difficulties or issues related to substance use
- Better engagement, capacity and accountability across government service areas to improve mental health and wellbeing

How will this be achieved?

- Supporting, fostering and promoting agency initiatives that improve outcomes, increase knowledge and evidence about what works and embed best practice principles
- Aligning services to better meet the needs of individuals in government agency operational planning, reporting, program management and service delivery
- Developing and implementing innovative and collaborative responses to meet the health and social needs of people with exceptionally complex problems
- Building government capacity and capability to provide accessible and effective services to improve mental health and wellbeing
- Contributing to other government plans and actions to improve the wellbeing of our communities and improve outcomes for people living with mental health difficulties or issues related to substance use

Who is responsible?

Chief executives of relevant government agencies are responsible within their portfolios. The **Queensland Mental Health Commission** will encourage and support initiatives with interagency relevance.

When will this happen?

Work will commence in 2014–15.

Shared commitment 6

More integrated health service delivery

Our actions will identify and reduce systemic barriers between general health and specialist mental health, drug and alcohol services to achieve a more seamless experience and better outcomes for people accessing these services. We will consider when and in what form separate structures and processes are desirable and when they impact negatively on the wellbeing and overall physical and oral health of individuals.

What do we want to achieve?

- Continuity of care and integrated pathways between general health and specialist mental health, drug and alcohol services
- Separate structures and processes only where they lead to better outcomes for the individual
- More seamless access to the full spectrum of services and supports required for holistic care, with no wrong door
- A primary health care workforce equipped with sufficient support, knowledge and information to ensure appropriate treatment, care or referral

How will this be achieved?

- Service delivery models, interagency processes and infrastructure that foster support and promote integration
- Strategies, models, systems and practices that facilitate access rather than exclude people on the basis of a mental illness or substance use disorder
- Formal mechanisms, such as shared assessment forms, and structures to support partnerships and integration between services
- Organisational and workforce capacity to provide integrated care
- Consideration of the role of state and national structures and processes that frame the way in which mental health, drug and alcohol services are designed and delivered

Who is responsible?

The **Department of Health** and the **Queensland Mental Health Commission** will jointly lead this action in partnership with **Hospital and Health Services** and relevant peak bodies.

When will this happen?

Work will commence in March 2015.

Shared commitment 7

Mental Health, Drug and Alcohol Services Plan

The Mental Health, Drug and Alcohol Services Plan will govern service planning and delivery of the state funded mental health, drug and alcohol system in accordance with the principles and directions of this plan, the Blueprint for better healthcare in Queensland, and relevant quality and safety standards.

What do we want to achieve?

- A service system that better prioritises and more effectively responds to individuals and communities with the highest incidence, prevalence and severity of mental illness or substance use disorders
- A greater proportion of services delivered in the community and as close to home as is safe
- More flexible service and funding models that foster innovation and meet the needs of individuals in more holistic ways
- Comprehensive high quality statewide and specialist services to achieve equity of access and outcomes in a decentralised system

How will this be achieved?

- Planning and investment that reflects population need and is supported by evidence based standards of care and thorough analysis of the current service system
- Tailored responses for vulnerable individuals and communities based on evidence of need
- Formal structures for meaningful input into service planning, delivery and evaluation for people accessing services, families, carers and support people
- Planning to identify and resourcing to address required and changing workforce configurations, professional development and capacity, recruitment and retention needs
- Structures and processes to monitor all services for alignment with agreed quality and safety standards and principles

Who is responsible?

The **Department of Health** will lead this action with contributions from key stakeholders including **Hospital and Health Services**, other government departments and non-government organisations.

When will this happen?

Work will commence in January 2015.

Shared commitment 8

Indicators to measure progress towards improving mental health and wellbeing

We need to know whether, and to what extent, our efforts are making a positive and long-term difference to improving the mental health and wellbeing of Queenslanders. Significant work has already been undertaken at the national level to identify potential indicators and data sets.

What do we want to achieve?

- Robust indicators to help measure, monitor and report on progress towards achieving the plan's vision and outcomes and, together with other information, identify areas for future action
- Meaningful reporting to Queenslanders on the progress of reforms to the mental health, drug and alcohol service system

How will this be achieved?

- Identifying and using existing data sets that can help measure progress
- Addressing information gaps by developing new data sets where feasible
- Aligning performance indicators to the goals and targets set by The Queensland Plan

Who is responsible?

Work to fulfil this commitment to action will be led by the **Queensland Mental Health Commission** with assistance from key Australian and Queensland Government agencies and relevant data custodians.

When will this happen?

Work will commence in 2014–15.

Reporting and reviewing the plan

The Commission will monitor the plan's implementation and progress towards achieving its vision and outcomes. An annual progress report will be published by the Commission outlining implementation to date, progress against the plan's outcomes and future actions.

The plan will be reviewed within five years to determine if it has contributed to sustainable reforms and better outcomes for people with mental health difficulties and substance use problems. The review will analyse indicators of progress towards achieving the plan's outcomes and consider research about what works and promising practice. The review findings will be translated to practical actions that can be taken in the future.

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EXHIBIT 40

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Fourth National Mental Health Plan

An agenda for collaborative government action in mental health 2009–2014

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EXHIBIT 40

Table of contents

Foreword

One in five Australians continue to experience a mental illness in a given year. Confirmation of this comes at a time when significant investment and effort has been made by all governments to improve outcomes for people with mental illness, their families and carers. There has been significant reform in where and how mental health services are delivered—especially in recent years through growth of services in the community and in primary care.

Australia's leadership in mental health service development has been recognised internationally. Reform into the future must maintain the effort and build on the successes of the past, but recognise that new challenges require innovation and new ways of working together across systems and sectors.

A new *National Mental Health Policy* (the Policy) was endorsed by health ministers in December 2008. The Policy provides an overarching vision and intent for the mental health system in Australia and embeds the whole of government approach to mental health reform that formed the centrepiece of the *COAG National Action Plan on Mental Health*.

The Policy gave a vision for mental health in Australia:

> … *a mental health system that enables recovery, that prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community.*

This *Fourth National Mental Health Plan* (the Fourth Plan) has been developed to further guide reform and identifies key actions that can make meaningful progress towards fulfilling the vision of the Policy. The whole of government approach articulated within the Fourth Plan acknowledges that many of the determinants of good mental health, and of mental illness, are influenced by factors beyond the health system.

On behalf of the Australian Health Ministers' Conference I would like to extend our appreciation to the Ministerial Advisory Councils outside of Health who have contributed their time and expertise to developing a Health Plan that is truly built within the whole of government partnership approach. Further, I encourage these councils to take up this Fourth Plan and use it as a basis for further work in their areas of responsibility. With the commitment of other sectors to progress the actions, indicators and outcomes identified in the Fourth Plan, we can make a real difference for people with a mental illness, their families and carers. Health ministers are committed to working with our cross sectoral colleagues towards this outcome.

The Fourth Plan comes at a time where there is significant focus on the roles and responsibilities of governments within the health system. We acknowledge this and accordingly have adopted a flexible approach to enable the Fourth Plan to respond to a rapidly changing environment. This will be achieved by monitoring and responding to developments in the broader health system and whole of government reforms over the next five years.

Advancing many of the actions related to service reform will require consideration of funding and governance arrangements, operational issues, and cross portfolio and cross government structures. Some of the actions will require commitments of time and effort rather than financial investment to navigate the shared issues within and across sectors.

Robust accountability for both mental health reform and service delivery is central to the Fourth Plan, and progress in implementation will be reported annually. The Fourth Plan explicitly outlines indicators against which to measure progress. For some of these indicators, data are already available; for others, collaboration with other sectors and further developmental work may be required to achieve a suite of cross sectoral indicators that will robustly measure how progress in implementation of the Fourth Plan has changed the lived experience of people with a mental illness.

Specific targets have not yet been set for any indicators, but this will be given priority during the first year of the Fourth Plan. Collaboration between governments will be needed to fill data gaps and develop appropriate targets for data collection and reporting.

Health ministers are pleased to lead the implementation of the Fourth Plan and to work in conjunction with the Ministerial Advisory Councils outside of Health to progress the actions, indicators and outcomes identified in the Fourth Plan. The actions in the Fourth Plan will be progressed by governments both independently and nationally under the Australian Health Ministers' Advisory Council, but with the commitment of other sectors we can make a real difference for people with a mental illness, their families and carers.

The Fourth Plan has been built from an extensive national process of consultation and the time, effort and advice of the many people who have contributed to this Fourth Plan is acknowledged and appreciated. I encourage all of you to embrace and take forward this Fourth Plan and its actions towards a better mental health system for all Australians.

Ms Katy Gallagher MLA
Chair
Australian Health Ministers' Conference

Summary of priority areas, outcomes and actions

Priority area 1. Social inclusion and recovery	
Outcome	*Actions*
The community has a better understanding of the importance and role of mental health and wellbeing, and recognises the impact of mental illness. People with mental health problems and mental illness have improved outcomes in relation to housing, employment, income and overall health and are valued and supported by their communities. Service delivery is organised to provide more coordinated care across health and social domains.	Improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy. Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs. Improve coordination between primary care and specialist mental health services in the community to enhance consumer choice and facilitate 'wrap around' service provision. Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models. Develop integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community. Develop integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage. Lead the development of coordinated actions to implement a renewed Aboriginal and Torres Straits Islander *Social and Emotional Well Being Framework*.

EXHIBIT 40

Priority area 2. Prevention and early intervention	
Outcome	*Actions*
People have a better understanding and recognition of mental health problems and mental illness. They are supported to develop resilience and coping skills. People are better prepared to seek help for themselves and to support others to prevent or intervene early in the onset or recurrence of mental illness. There is greater recognition and response to co-occurring alcohol and other drug problems, physical health issues and suicidal behaviour. Generalist services have support and access to advice and specialist services when needed.	Work with schools, workplaces and communities to deliver programs to improve mental health literacy and enhance resilience. Implement targeted prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations. Expand community based youth mental health services which are accessible and combine primary health care, mental health and alcohol and other drug services. Implement evidence based and cost effective models of intervention for early psychosis in young people to provide broader national coverage. Provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors. Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them. Expand the level and range of support for families and carers of people with mental illness and mental health problems, including children of parents with a mental illness. Develop tailored mental health care responses for highly vulnerable children and young people who have experienced physical, sexual or emotional abuse, or other trauma.

Priority area 3. Service access, coordination and continuity of care	
Outcome	*Actions*
There is improved access to appropriate care, continuity of care and reduced rates of relapse and re-presentation to mental health services. There is an adequate level and mix of services through population based planning and service development across sectors. Governments and service providers work together to establish organisational arrangements that promote the most effective and efficient use of services, minimise duplication and streamline access.	Develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models. Establish regional partnerships of funders, service providers, consumers and carers and other relevant stakeholders to develop local solutions to better meet the mental health needs of communities. Improve communication and the flow of information between primary care and specialist providers, and between clinical and community support services, through the development of new systems and processes that promote continuity of care and the development of cooperative service models. Work with emergency and community services to develop protocols to guide and support transitions between service sectors and jurisdictions. Improve linkages and coordination between mental health, alcohol and other drug and primary care services to facilitate earlier identification of, and improved referral and treatment for, mental and physical health problems. Develop and implement systems to ensure information about the pathways into and through care is highly visible, readily accessible and culturally relevant. Better target services and address service gaps through cooperative and innovative service models for the delivery of primary mental health care.

EXHIBIT 40

Priority area 4. Quality improvement and innovation	
Outcome	*Actions*
The community has access to information on service delivery and outcomes on a regional basis. This includes reporting against agreed standards of care including consumer and carer experiences and perceptions.	Review the *Mental Health Statement of Rights and Responsibilities*.
Mental health legislation meets agreed principles and, in conjunction with any related legislation, is able to support appropriate transfer of civil and forensic patients between jurisdictions.	Review and where necessary amend mental health and related legislation to support cross border agreements and transfers of people under civil and forensic orders, and scope requirements for the development of nationally consistent mental health legislation.
There are explicit avenues of support for emerging and current leaders to implement evidence based and innovative models of care, to foster research and dissemination of findings, and to further workforce development and reform.	Develop and commence implementation of a National Mental Health Workforce Strategy that defines standardised workforce competencies and roles in clinical, community and peer support areas.
	Increase consumer and carer employment in clinical and community support settings.
	Ensure accreditation and reporting systems in health and community sectors incorporate the *National Standards for Mental Health Services*.
	Further develop and progress implementation of the *National Mental Health Performance and Benchmarking Framework*.
	Develop a national mental health research strategy to drive collaboration and inform the research agenda.
	Expand and better utilise innovative approaches to service delivery including telephone and e-mental health services.

Priority area 5. Accountability—measuring and reporting progress	
Outcome	**Actions**
The public is able to make informed judgements about the extent of mental health reform in Australia, including the progress of the Fourth Plan, and has confidence in the information available to make these judgements. Consumers and carers have access to information about the performance of services responsible for their care across the range of health quality domains and are able to compare these to national benchmarks.	Establish comprehensive, timely and regular national reporting on the progress of mental health reform which responds to the full range of stakeholder needs. Build an accountable service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders. Further develop mental health information, including national mental health data collections, that provide the foundation for system accountability and reporting. Conduct a rigorous evaluation of the *Fourth National Mental Health Plan*.

The Fourth National Mental Health Plan

Good mental health is a crucial aspect of good general health, and underpins a productive and inclusive society. For this reason, it is a priority area for all levels of government. This *Fourth National Mental Health Plan* (the Fourth Plan) sets an agenda for collaborative government action in mental health for the next five years. It offers a framework to develop a system of care that is able to intervene early and provide integrated services across health and social domains. It provides guidance to governments in considering future funding priorities for mental health.

A population health framework

The Fourth Plan adopts a population health framework. This framework recognises that mental health and illness result from the complex interplay of biological, social, psychological, environmental and economic factors at all levels. The determinants of mental health status include factors such as income, education, employment and access to community resources. The population health framework acknowledges the importance of mental health issues across the lifespan from infancy to old age, and recognises that some people may be particularly vulnerable because of their demographic characteristics (e.g. age, cultural background) or their experiences (e.g. exposure to trauma or abuse). Services must be flexible to meet the specific needs of different groups with different needs. This means that a holistic response to mental health problems and mental illness is required—one that recognises the importance of community support services and accommodation, as well as expert and appropriate clinical services. Interventions must be evidence based, comprehensive and complementary, and cover the spectrum from prevention to relapse prevention and recovery. They must also recognise the importance of self determination, self care and self help. Service development should strive to ensure equitable access and to achieve the best possible outcome. The Fourth Plan recognises effective linkages must be formed between different sectors for this holistic response to work.

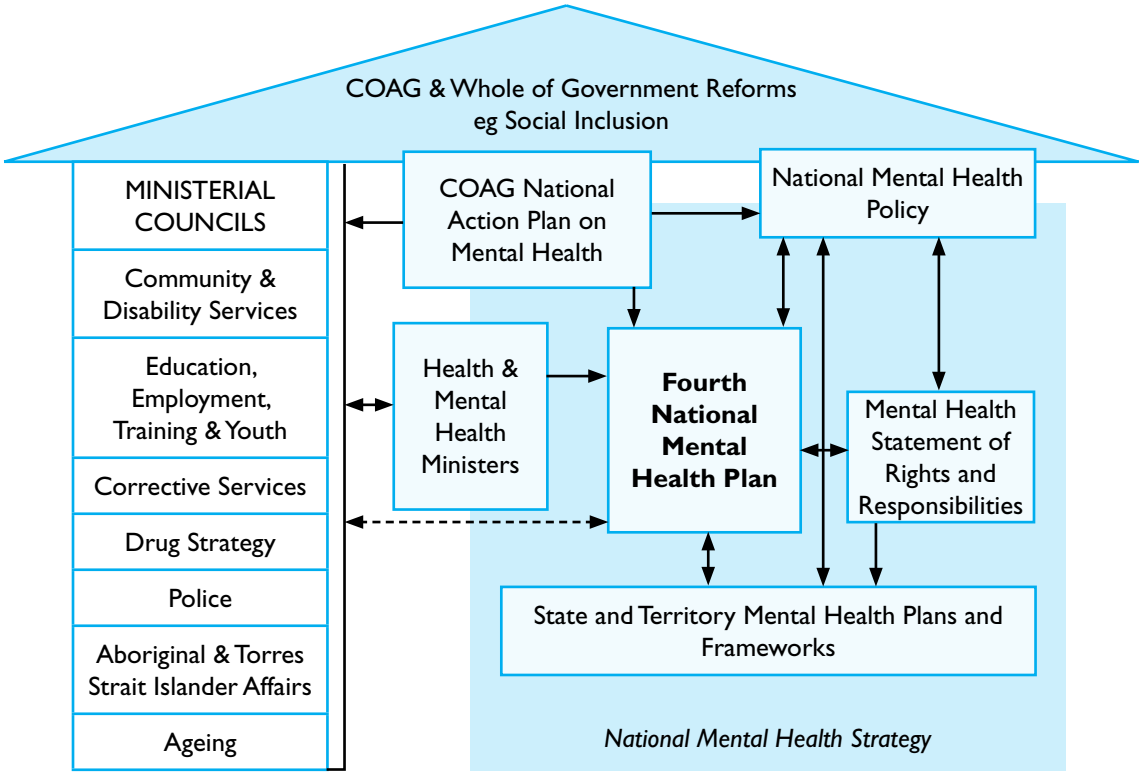
A whole of government approach

The Fourth Plan operationalises the population health framework through a whole of government approach to achieving change. The whole of government approach involves a national effort which operates across Commonwealth and state/territory levels of responsibility, and extends beyond the mental health sector, in recognition of the fact that the determinants of good mental health, and of mental illness, are influenced by factors outside the health system.

The Fourth Plan emphasises the way in which reforms in the mental health sector can inter-relate with policy directions of other government portfolios, with a view to ensuring that people with mental health problems and mental illness can benefit from them in the greatest way possible.

Ministerial Advisory Councils from beyond the health sector were involved in the development of the Fourth Plan. This enabled articulation of the current roles and responsibilities of other portfolios as they relate to improving mental health outcomes (see Appendix 1), and constitutes recognition of the responsibility that the health sector has in engaging with other sectors to achieve demonstrable gains in the mental health and wellbeing of the community. The Fourth Plan recognises that a number of other sectors have begun to make headway in this regard, and builds on current developments.

The relationships between relevant portfolio areas must continue to be developed. This Fourth Plan provides a basis for governments to emphasise mental health in a more



Fourth National Mental Health Plan and its relationship to the *National Mental Health Strategy* and a whole of government approach

Figure 1: A whole of government approach to mental health

integrated way, as represented in Figure 1. This figure shows how the Fourth Plan works within the existing *National Mental Health Strategy* and the new whole of government approach to mental health reform. At a basic level, it shows the relationship between areas of government and in doing so formally recognises that many sectors can contribute to better outcomes for people living with mental illness.

Scope and directions

The Fourth Plan targets the full spectrum of people living with mental health problems and mental illness, as well as their carers and families.

The Fourth Plan is underpinned by eight key principles (see Box 1) and focuses on the following five priority areas for national action, identified through a series of national consultations:

- Social inclusion and recovery;
- Prevention and early intervention;
- Service access, coordination and continuity of care;
- Quality improvement and innovation; and
- Accountability—measuring and reporting progress.

For each priority area, key outcomes have been identified as well as actions to achieve these outcomes. The actions have been agreed to by all governments and encompass

Commonwealth and state/territory areas of responsibility. The actions require collaborative national effort across different levels of government. They build on national reforms which are already in place, and complement activities being undertaken or planned in different jurisdictions under existing state and territory mental health plans. The actions primarily relate to service planning and delivery in the health arena, but they also rely on investment by other areas of government and community.

Health ministers will lead implementation of the Fourth Plan. The actions will be progressed by governments both independently and nationally through the Australian Health Ministers' Advisory Council. Some of the actions will require commitments of time and effort rather than financial investment to navigate the shared issues within and across sectors; others will require new or re-focused funding.

Not all actions may be able to be fully implemented within a five year framework, but many will, particularly with the commitment of government and the community. Advancing many of the actions related to service reform will require consideration of funding and governance arrangements, operational issues, and cross portfolio and cross government structures.

Improving accountability for both mental health reform and service delivery are central to the Fourth Plan. The Fourth Plan explicitly outlines indicators against which to measure progress. For some of these indicators, data are already available; for others, further development work is required and will occur during the first 12 months of the Fourth Plan. Specific targets have not yet been set for any indicators, but this will also be given priority during the first year of the Fourth Plan. Collaboration between governments will be needed to fill data gaps and develop appropriate targets.

Box 1: Principles underlying the *Fourth National Mental Health Plan*

Respect for the rights and needs of consumers, carers and families

Consumers, their carers and families should be actively engaged at all levels of policy and service development. They should be fully informed of service options, anticipated risks and benefits. Consumers and carers should be able to access information in a language they understand or have access to interpreters. Mental health legislation should be regularly reviewed to ensure compliance with relevant national and international obligations and charters.

Families and carers should be informed to the greatest extent consistent with the requirements of privacy and confidentiality about the treatment and care provided to the consumer, the services available and how to access those services. They need to know how to get relevant information and necessary support. The different impacts and burdens on paid and unpaid carers need to be acknowledged.

Services delivered with a commitment to a recovery approach

Mental health service providers should work within a framework that supports recovery (refer to definitions of recovery on page 26)—both as a process and as an outcome to promote hope, wellbeing and autonomy. They should recognise a person's strengths including coping skills and resilience, and capacity for self determination. This may require a significant cultural and philosophical shift in mental health service delivery.

Social inclusion

Recognition of the importance of social, cultural and economic factors to mental health and wellbeing means that both health and social issues should be included in the development of mental health policy and service development. The principle includes support to live and participate in the community, and effort to remove barriers which lead to social exclusion such as stigma, negative public attitudes and discrimination in health and community settings. The National Social Inclusion Principles should underpin reform in mental health.

Recognition of social, cultural and geographic diversity and experience

Our community is rich in diversity. It embraces cultural and religious differences. This brings many strengths and opportunities, but we also need to recognise the challenges faced at times by some within our community. There should be demonstrated cultural competency in the planning and delivery of responsive mental health services.

There are particular issues faced by women in mental health services who may have previously experienced sexual abuse or other trauma as a child or adult. The mental health workforce needs to be aware of such issues and services provided to ensure a safe and respectful environment.

Indigenous communities and individuals require all providers to demonstrate cultural competency in the planning and delivery of culturally safe, responsive and respectful mental health services. It should be recognised that remote Indigenous communities face very different challenges from those in urban communities and that both face challenges that differ to other community groups.

Rural and remote communities face particular challenges. Workforce development and support, and equitable access to services, are difficult to achieve in some parts of Australia and require recognition that communities may have different priorities that rely on local knowledge and need a whole of community response. They need innovative service development that enables use of new technology and flexible models to support the provision of access to specialist assessment and advice.

Recognition that the focus of care may be different across the life span

Mental health services, whether in the primary care or specialist sector, cannot be provided as a 'one size fits all' across the age range. The family will play a different role where an infant or child is the focus of care. Mental health care for older people may involve greater support to their family or to staff of residential facilities.

Services delivered to support continuity and coordination of care

While recognising that different service types and locations are important, services across the spectrum of age and need should be developed and delivered in a way that reduces the risk of people falling through gaps, reduces unnecessary duplication and complexity and promotes information sharing. This depends on both collaboration between services at all levels, and integrated models of service delivery.

Service equity across areas, communities and age groups

Mental health should be provided at a standard at least equal to that provided in other areas of health. Services should be informed by the available evidence and look to innovative models as examples of service improvement.

While it is not appropriate or possible that uniform service provision exists in every area or across all age groups, we should strive for equity of access and equity of quality. Services should strive to be accessible and responsive. The level of service provision and the outcomes of care should be transparent to consumers and carers.

Consideration of the spectrum of mental health, mental health problems and mental illness

Mental health promotion, prevention and interventions need to include consideration of the spectrum from health and wellbeing to mental health problems to mental illness. The range of service options needs to include those illnesses that are most often managed within the primary care sector, as well as those that may require greater specialist involvement. Services should be provided on the basis of need, not diagnosis or whether an illness is common or uncommon. Service options need to be responsive to the needs of different age groups, including young children and older people, and to the differing needs of those who suffer particular illnesses such as perinatal mental health problems and eating disorders.

Setting the context

The magnitude of the problem

Mental illness is widespread in Australia, as it is in other developed countries, and has substantial impact at the personal, social and economic levels. Results from the *2007 National Survey of Mental Health and Wellbeing*, conducted by the Australian Bureau of Statistics (ABS), indicate that one in five people aged 16 to 85 years experience one of the common forms of mental illness (anxiety, affective or mood disorders, and substance use disorders) in any one year. Prevalence rates vary across the lifespan and are highest in the early adult years, the period during which people are usually establishing families and independent working lives (Figure 2). Earlier surveys of children and adolescents aged 4–17, conducted in 1998, found 14% to have a mental illness.

Anxiety related and affective disorders are the most common, affecting approximately 14% and 6%, respectively, of adults each year, with about a quarter having more than one disorder. Collectively referred to as 'high prevalence' illnesses, these disorders include diverse conditions (e.g. post traumatic stress disorder, obsessive compulsive disorder, depression, bipolar disorder) that have different treatment requirements and outcomes.

Mental illness includes 'low prevalence' conditions such as schizophrenia and other psychoses that affect another 1 to 2% of the adult population that were not included in the ABS 2007 survey of adults. Although relatively uncommon, people affected by these illnesses often need many services, over a long period, and account for about 80% of Australia's spending on mental health care.

Mental illness impacts on people's lives at different levels of severity. Depending on definitions, an estimated 3% of Australian adults have severe disorders, judged according to the type of illness (diagnosis), intensity of symptoms, duration of illness (chronicity),

Figure 2: Prevalence of selected mental illnesses by age group

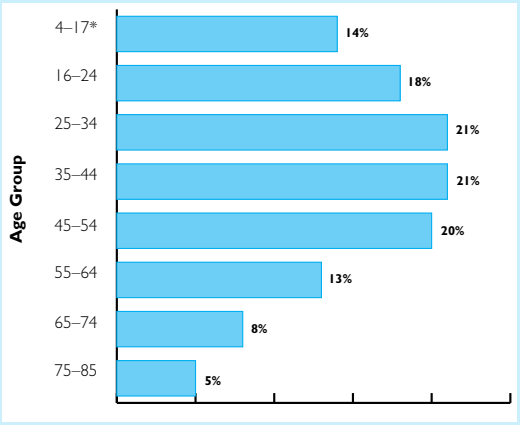
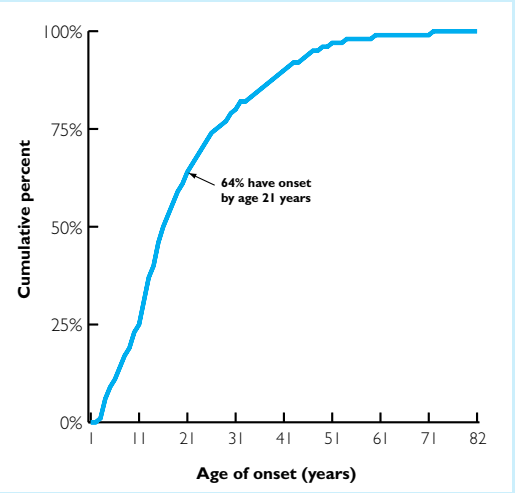


Figure 3: Age of onset for the most common mental illnesses (anxiety and affective disorders)



Notes:
Figure 2: Ages 16–85 based on supplementary analysis of data collected in the Australian Bureau of Statistics (ABS) *2007 National Survey of Mental Health and Wellbeing*. Prevalence estimates exclude counts of persons with drug and alcohol disorders for whom there is no other co-existing mental illness (3% of adults). Prevalence data for ages 4–17 are based on the 1998 child & adolescent component of the first National Survey of Mental Health and Wellbeing.

Figure 3: Based on supplementary analysis of data collected in the ABS *2007 National Survey of Mental Health and Wellbeing*.

Sources:

Australian Bureau of Statistics (2008). National Survey of Mental Health and Wellbeing 2007: Summary of results. ABS Cat. No 4326.0. Australian Bureau of Statistics: Canberra.

*Sawyer, MB et al. (2000). The mental health of young people in Australia. Commonwealth Department of Health and Aged Care: Canberra.

and the degree of disability caused. This group represents approximately half a million Australians. About 50% have a psychotic illness, primarily schizophrenia or bipolar affective disorder. The remainder mainly comprise individuals with severe depression or severe anxiety disorders.

For most people, the mental illness they experience in adult life has its onset in childhood or adolescence. For example, of those who will experience an anxiety or affective disorder, two thirds will have had their first episode by the time they are 21 years of age (Figure 3).

Because many illnesses affect the individual's functioning in social, family, educational and vocational roles, the early age of onset can have long term implications. Mental illnesses are the largest single cause of disability in Australia, accounting for 24% of the burden of non-fatal disease (measured by total years of life lived with disability, Figure 4). This has a major impact on youth and people in their prime adult working years.

People who live with a mental illness are also more at risk of experiencing a range of adverse social, economic and health outcomes. Analysis by the Productivity Commission found that of six major health conditions (cancer, cardiovascular, major injury, mental illness, diabetes, arthritis), mental illness is associated with the lowest likelihood of being in the labour force. For those affected by severe illnesses, particularly those with psychotic disorders, average life expectancy is shorter and is second only to Indigenous Australians, due mainly to high levels of untreated comorbid physical illness.

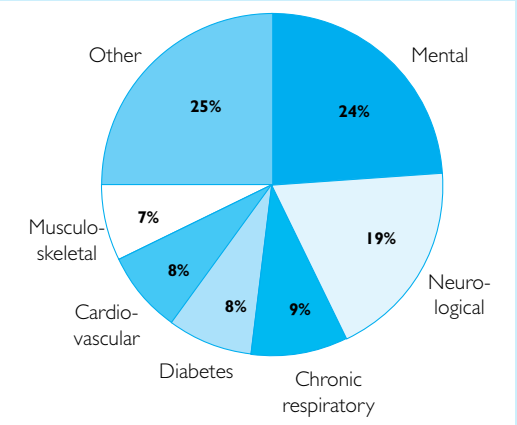
People with mental illness are also over represented in the homeless and prison populations. Australian data suggests that up to 75% of homeless adults have a mental illness and, of these, about a third (approximately 29,000 people) are affected by severe disorders. Additionally, Australian studies have found that around 40% of prisoners have a mental illness and that 10–20% are affected by severe disorders.

The economic costs of mental illness in the community are high. Outlays by governments and health insurers to provide mental health services in 2006–07 totalled $4.7 billion, representing 7.3% of all government health spending. Mental health as a share of overall government spending on health has remained stable over the 15 year course of the *National Mental Health Strategy*.

These figures reflect only the cost of operating the specialist mental health service system and do not indicate the full economic burden of mental illness and costs to government. Because of the disability often associated with mental illness, many people depend on governments for assistance that extends beyond specialist mental health treatment. They require an array of community services including housing, community and domiciliary care, income support, and employment and training opportunities. The *National Mental Health Report 2007* most recently analysed these costs and estimated that outlays by government on mainstream support for people with mental illness substantially exceed the costs of specialist mental health care (Figure 5).

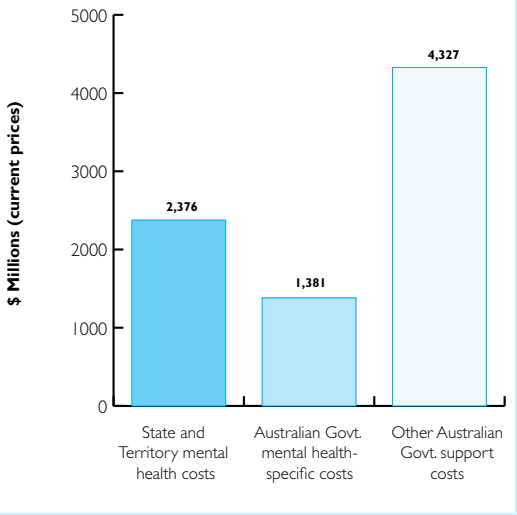
In addition to outlays by government, mental illness impacts on the broader economy by reducing workforce participation and impairing the productivity of those who are in employment. Estimates of the annual costs of the productivity losses attributable to mental illness range from $10 to $15 billion.

Figure 4: Burden of mental illnesses relative to other disorders, in terms of years lost as a result of disability



Source: Begg S et al. (2007). The burden of disease and injury in Australia 2003. PHE 82. Australian Institute of Health and Welfare: Canberra.

Figure 5: Comparing the direct and 'indirect' cost to governments of mental illness, 2004–05



Source: Department of Health and Ageing (2007). *National Mental Health Report 2007*. Commonwealth of Australia: Canberra.

The National Mental Health Strategy

The *National Mental Health Strategy* has guided mental health reform in Australia since 1992, the year in which Australian health ministers agreed to the original National Mental Health Policy and the first five-year National Mental Health Plan. Two further National Mental Health Plans followed in 1997 and 2003, and complementary action was guided by the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006–2011. The original National Mental Health Policy was recently revised (see below for more detail). The Fourth Plan is set in the context of the updated Policy, and builds on the work of previous plans. Like its predecessors, it is underpinned by the *Mental Health Statement of Rights and Responsibilities*.

The *National Mental Health Strategy* has steered a changing reform agenda over time, and understanding this agenda helps to set the context for the Fourth Plan. The *First National Mental Health Plan* (1993–98) represented the first attempt to coordinate mental health care reform in Australia, through national activities. It focused on state/territory based, public sector, specialist clinical mental health services and advocated for major structural reform, with particular emphasis on the growth of community based services, decreased reliance on stand alone psychiatric hospitals, and 'mainstreaming' of acute beds into general hospitals.

The *Second National Mental Health Plan* (1998–2003) consolidated ongoing reform activities and expanded into additional areas of focus. It built on the First Plan by adding a focus on the promotion of mental health and the destigmatisation of mental illness, with the Commonwealth Government and selected state and territory governments providing funding for major initiatives like *beyondblue*. It attended to the question of how

the public mental health sector could best dovetail with other government and non-government areas (e.g., private psychiatrists, general practitioners, general health services, and community support services) to maximise treatment outcomes and opportunities for recovery. Whereas the First Plan focused largely on severe and disabling low prevalence illnesses that are principally the responsibility of the states and territories, the Second Plan expanded the emphasis to include the more common illnesses such as depression and anxiety disorders that are treated in primary health care settings.

The *Third National Mental Health Plan 2003–2008* set out to consolidate the achievements of the First and Second Plans, by taking an explicit population health approach and reaffirming an emphasis on the full spectrum of services that are required to assure the mental health of Australians. It focused on mental health promotion and mental illness prevention, improving service responsiveness, strengthening service quality, and fostering innovation.

Both the Second and Third Plans recognised the importance of cross sectoral partnerships in supporting mental health and wellbeing, and in responding to mental illness through an integrated and inclusive service system. The *COAG National Action Plan on Mental Health 2006–2011* was developed between governments to provide further impetus to mental health reform and sharpen the focus on areas that were perceived by stakeholders to have not progressed sufficiently under the various National Mental Health Plans. The *COAG National Action Plan* emphasised the importance of governments working together, and the need for more integrated and coordinated care. It also committed governments to a significant injection of new funds into mental health, including the expansion of the Medicare Benefits Schedule to improve access to mental health care delivered by psychologists and other allied health professionals, general practitioners and psychiatrists. The *COAG National Action Plan* led to increased investment by states and territories in community based mental health services, enabling them to better respond to consumers with severe and persistent mental illnesses, and their carers and families. It also increased investment in services delivered outside the health sector that are needed by people who live with mental illness, including employment, education and community services.

Alongside these national activities, states and territories have developed their own specific mental health plans or strategies which help set the context for the Fourth Plan. Consistent with the *COAG National Action Plan*, state and territory plans and strategies have reflected the shift towards a whole of government, cross sectoral approach to mental health. At a state/territory level, stronger partnerships have been forged between mental health and other areas within health such as emergency departments, and with programs operating outside the health system, such as community services and correctional services. Models of accommodation and support have been developed in each jurisdiction, as have specific mental health social and emotional wellbeing frameworks to work with people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander communities.

Progress of mental health system reform in Australia

The last decade and a half of mental health system reform under the *National Mental Health Strategy* has led to significant change. Public sector specialist mental health services are now staffed by a significantly larger mental health workforce. Nationally, the number of state and territory employed professionals who work directly with consumers in specialist

Figure 6: Growth in the state and territory clinical workforce 1993 to 2007

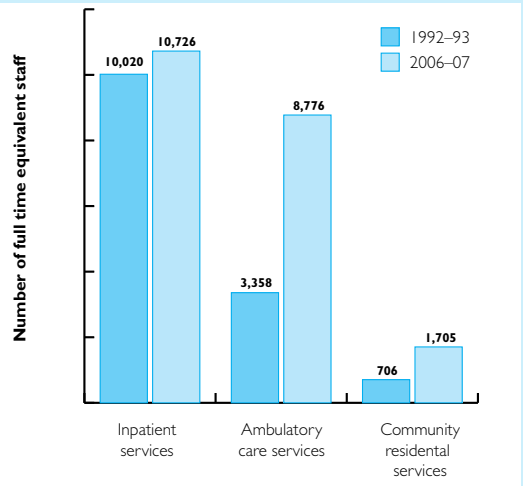
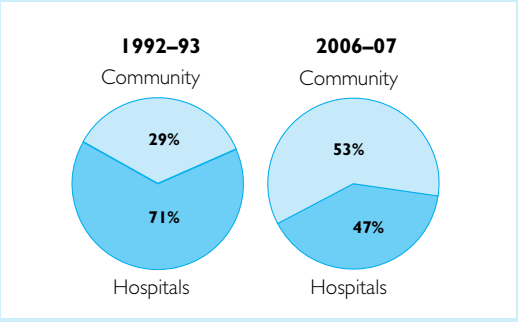


Figure 7: Community based services as percentage of total state and territory spending on mental health services, 1992–93 and 2006–07



Sources:

Figure 6 and Figure 7: Australian Government Department of Health and Ageing.

mental health settings grew by 51% between 1993 and 2007 (Figure 6). This workforce is complemented by employed consumer consultants and peer workers who did not previously exist as a professional group but are now growing in number.

Care is now delivered primarily in community settings, compared with the previous heavy reliance on inpatient services that characterised Australia's mental health system. At the commencement of the Strategy, 29% of state and territory mental health spending was dedicated to caring for people in the community; by 2007, the community share of total mental health expenditure had increased to 53% (Figure 7). There has also been an increased emphasis on the safety, quality and outcomes of care, as evidenced by activities like the routine measurement of clinician rated and consumer rated outcomes in all services.

Access to mental health care in primary care settings has been substantially increased as a result of changes to the Medicare Benefits Schedule at the end of 2006, with more than 1.3 million mental health treatment plans developed by general practitioners, and 4.95 million services provided by psychologists and other allied health professionals through Medicare subsidised services.

The *2007 National Survey of Mental Health and Wellbeing* provided evidence of the impact of these changes, with the finding that the percentage of those with a mental illness who saw a mental health professional in 2007 was almost double those who did so in 1997 (Figure 8).

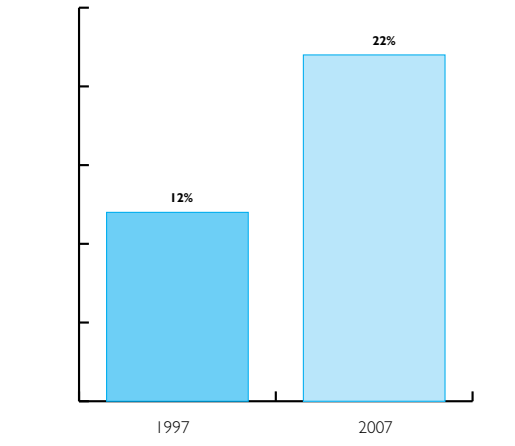
Community mental health literacy has also improved during the life of the *National Mental Health Strategy*, indicating that the substantial investment in mental health promotion initiatives—particularly those driven by *beyondblue*—are bearing fruit. Research undertaken by the University of Melbourne has demonstrated an increase in awareness of depression and the issues associated with

it (e.g. discrimination) between 1995 and 2004, which was most pronounced in states and territories that contributed funding to *beyondblue*.

The broader, cross sectoral activities are gaining traction too. Across most states and territories, work in the housing sector has begun to recognise the needs of those with mental illness when planning social housing initiatives. Similarly, developments in the justice sector have seen diversionary programs developed for people with mental illness or substance dependency. In other areas, state and territory cross portfolio COAG Mental Health Groups are beginning to take forward whole of government initiatives and foster stronger partnerships.

These achievements have led to Australia being regarded as a world leader in mental health system reform, but the Fourth Plan acknowledges that there is still much to be done. While the directions of each of the previous plans have been broadly supported, the pace of reform has varied, often considerably, across jurisdictions. The prevalence and impact of mental health problems remain significant issues, and, according to the *2007 National Survey of Mental Health and Wellbeing*, only one-third of those with a mental illness receive mental health services each year. Major disparities continue between different states and territories in the mix and level of services. Demand for mental health care—particularly for acute and emergency care—continues to outstrip supply. Challenges in recruiting, retaining and supporting a workforce with appropriate competencies also continue to compromise the quantity and quality of care available. Consumers and carers still report that they experience difficulties in accessing the right care at the right time, and that they experience discrimination from within the mental health system, from other sectors with which they come into regular contact, and from the general community.

Figure 8: Percentage of people with a current mental illness who consulted a mental health professional, 1997 and 2007



Sources:

Figure 8: Based on supplementary analysis of data collected in the Australian Bureau of Statistics 1997 and 2007 National Surveys of Mental Health and Wellbeing.

The Fourth Plan extends the reform efforts of the *National Mental Health Strategy* to improve the mental health of all Australians. Its whole of government emphasis distinguishes it from the three previous National Mental Health Plans, and it gives particular consideration to a collaborative approach that will foster complementary programs that deliver responsive services.

The new National Mental Health Policy

As noted, the original National Mental Health Policy marked the beginning of the *National Mental Health Strategy* in 1992. A revised *National Mental Health Policy 2008* was endorsed by the Australian Health Ministers' Conference (AHMC) in December 2008 and released in March 2009. The Policy was updated to align with the whole of government approach articulated within the *COAG National Action Plan* and with developing policy and practice in other areas.

The Policy provides an overarching vision for a mental health system that enables recovery, prevents and detects mental illness early, and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in the community. This vision should be seen in the context of the social inclusion agenda which focuses on engagement of the whole community, especially in areas of social and economic disadvantage. The Policy does not set out to provide explicit guidance for service delivery, nor does it set funding expectations, targets or deliverables.

The aims of the *National Mental Health Policy 2008* are to:

- promote the mental health and wellbeing of the Australian community and, where possible, prevent the development of mental health problems and mental illness;
- reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community;
- promote recovery from mental health problems and mental illness; and
- assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.

The Fourth Plan furthers the aims of the Policy through actions which will:

- maintain and build on existing effort;
- integrate recovery approaches within the mental health sector;
- address service system weaknesses and gaps identified through consultation processes; and
- better measure how we do this and the outcomes achieved.

Consistent with the *National Mental Health Policy 2008*, the Fourth Plan acknowledges our indigenous heritage and the unique contribution of Indigenous people's culture and heritage to our society.

Furthermore, it recognises Indigenous people's distinctive rights to status and culture, self determination and the land. It acknowledges that this recognition and identity is fundamental to the wellbeing of Indigenous Australians It recognises that mutual resolve, respect and responsibility are required to close the gap on indigenous disadvantage and to improve mental health and wellbeing.

Priority area 1: Social inclusion and recovery

EXHIBIT 40

Outcome

The community has a better understanding of the importance and role of mental health and wellbeing, and recognises the impact of mental illness. People with mental health problems and mental illness have improved outcomes in relation to housing, employment, income and overall health and are valued and supported by their communities. Service delivery is organised to deliver more coordinated care across health and social domains.

Summary of actions

- Improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy.
- Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs.
- Improve coordination between primary care and specialist mental health services in the community to enhance consumer choice and facilitate 'wrap around' service provision.
- Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models.
- Develop integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community.
- Develop integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage.
- Lead the development of coordinated actions to implement a renewed Aboriginal and Torres Strait Islander *Social and Emotional Well Being Framework*.

Cross-portfolio implications

To support a collaborative whole of government approach, these actions will require work across areas outside health such as employment, education, justice (including police, courts and correctional services), Indigenous, aged services, community services and housing and the arts.

Indicators for monitoring change

- Participation rates by people with mental illness of working age in employment
- Participation rates by young people aged 16–30 with mental illness in education and employment
- Rates of stigmatising attitudes within the community *
- Percentage of mental health consumers living in stable housing *
- Rates of community participation by people with mental illness *

** These indicators require further development*

Mental health and wellbeing are important for the whole community, including the broad spectrum of people who experience mental illness. Consumers and their families have highlighted that stigma and discriminatory attitudes to mental illness are still prevalent. They have told us that stable housing and meaningful occupation—key elements of social inclusion—are important aspects of their recovery and self determination.

People should feel a valued part of their community, and be able to exert choice in where and how they live. Some groups are at risk of entrenched social exclusion, including those with chronic and persistent mental illness. Developing pathways that support community participation and that allow movement towards greater independence minimises the risk of social exclusion.

Policy and service development needs to recognise the importance of a holistic and socially inclusive approach to health in promoting mental health and wellbeing, that includes social as well as health domains and supports people to establish community engagement and connectivity. This applies to all members of the community including those from culturally and linguistically diverse backgrounds and new arrivals. A socially inclusive approach is especially important during times of economic downturn. The role of the family in promoting wellbeing and recovery needs to be recognised, as does the importance of community acceptance.

There have been significant developments in these areas, including establishment of a national Social Inclusion Board, the development of the *Homelessness White Paper* and the *COAG National Partnership Agreement on Homelessness*.

Maintaining connections and support can be especially crucial during adverse events or periods of transition such as loss of employment, exposure to domestic violence, exiting from prison, and family breakdown and disruption. Management of mental illness also needs to be linked to good physical health, with engagement between primary and specialised treatment and care. Likewise, physical illness is often associated with mental distress and illness.

There are many good examples where mental health promotion has supported greater social inclusion. The *Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders* developed in 2008 brings together a number of key findings in the area of promotion and prevention. Elements of this include the importance of population based approaches to redress inequities and discriminatory practices, and joining up policies and practices across sectors. Information regarding mental health, mental health promotion and mental health interventions should be widely available, culturally appropriate and accessible, including to young people.

Despite very effective initiatives directed to promoting mental health and wellbeing (e.g. *VicHealth*), and improving awareness and understanding of mental illness (e.g. *beyondblue*), those with mental illness are still at risk of being discriminated against in areas such as employment and housing, and there are still stigmatising attitudes evident in the media and community. Discriminatory behaviour and stigmatising attitudes also occur within the health sector. The mental health workforce in clinical and community living support services needs to respect and adopt a recovery philosophy in how they provide services. The role of 'step up/step down' services and community support is particularly important in preventing relapse and supporting community based recovery.

Recovery in the context of mental illness is often dependent on good clinical care, but means much more than a lessening or absence of symptoms of illness. Recovery is not synonymous with cure. For many people

who experience mental illness, the problems will recur, or will be persistent. Adopting a recovery approach is relevant across diagnoses and levels of severity. It represents a personal journey toward a new and valued sense of identity, role and purpose together with an understanding and accepting of mental illness with its attendant risks. A recovery philosophy emphasises the importance of hope, empowerment, choice, responsibility and citizenship. It includes working to minimise any residual difficulty while maximising individual potential. This is relevant to all ages, including the elderly, and to all those involved—the individual consumer, their family and carers, and service providers.

Within current service delivery, a recovery focus has mainly been championed by the non-government community support sector and consumer advocacy bodies. This Fourth Plan intends that the attitudes and expectations that underpin a recovery focus are also taken up by clinical staff within the public and private sectors—both bed based and community based. This will strengthen the partnership and sharing of responsibility between the consumer, their families and carers, and service providers.

National actions

Improve community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy.

Addressing community attitudes and behaviours requires sustained and multi-pronged activity. There are examples nationally and internationally of effective education and awareness campaigns—for example the *Like Minds, Like Mine* campaign in New Zealand and the *See Me* campaign in Scotland, as well as the *SANE StigmaWatch* program and *beyondblue* in Australia. Such campaigns directed at the whole community need to be supported by more local activity, including in the workplace, and need to work in partnership with the

Definitions of recovery

The definition provided in the *National Mental Health Policy 2008* is:

> *A personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually-identified essential services and resources.*

The definition developed by Patricia Deegan, a consumer who contributed greatly in this area, is:

> *Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter, slide back, regroup and start again… The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work and love in a community in which one makes a significant contribution.*

The definition provided by the New Zealand Mental Health Advocacy Coalition in *Destination Recovery* is:

> *… a philosophy and approach to services focusing on hope, self determination, active citizenship and a holistic range of services.*

media. They need to include those illnesses that are more complex and difficult to understand such as psychosis. They should also work in conjunction with actions addressed to particular groups such as those from culturally and linguistically diverse backgrounds, rural and remote communities and particular age groups.

Legislation and the introduction of rights based charters are also ways to support destigmatisation. Feedback from consumers, families and carers has highlighted that stigmatising behaviour and attitudes are sometimes encountered in mental health services, and that consumers themselves may have stigmatising attitudes. These need to be the focus of targeted programs to address this, including the incorporation of a recovery approach in staff training and development. People affected by mental illness should be supported to take action on discrimination encountered in health, education, employment and community services.

Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs.

Education and employment success has a significant impact on a person's self confidence and wellbeing. It promotes development of friendship, community engagement and improved quality of life. Unfortunately mental illness and mental health problems are associated with increased risk of unemployment, and associated negative consequences.

There is now a good research base (for example, the work of the Queensland Centre for Mental Health Research) that, for people with mental illness, remaining or returning to employment can be improved through the introduction of vocational support closely linked to treatment service delivery and support in other areas of life. Some models involve clinical services; others have greater emphasis on non-government support agencies. Some involve post placement support as well as employment readiness support.

Mental health services can provide advocacy and take a leadership role in supporting closer engagement with employment and education sectors. For example, they can promote and facilitate the placement of vocational support officers within clinical and community support services. They can also assist a person to maximise their capacity to engage with the community through fully utilising the skills of a multidisciplinary team including teaching psychological techniques, and enhancing social skills training.

Related to this action, a *National Mental Health and Disability Employment Strategy* has been developed by the Australian Government to address barriers to employment faced by people living with disability, including mental illness.

Improve coordination between primary care and specialist mental health services in the community to enhance consumer choice and facilitate 'wrap around' service provision.

Over the past few years, the range and focus of community based services has increased. Community mental health services now include a range of clinical services provided through primary care and specialist mental health services, such as acute assessment, continuing care, and intensive outreach; and living support services, such as accommodation and support, home based outreach, day program, carer respite and vocational support services delivered through non-government organisations. Some of these are targeted towards aged people in the community, others to adults or families. The importance of good physical health care has also been recognised as has the role of the general practitioner. The private sector also needs to be recognised in the development of greater coordination.

However, community mental health services in a given area are often provided through different locations and different organisations with limited integration between service elements. Development of partnerships and linkages between service types—both through co-location and service agreements—can promote coordination and continuity of care, and enhance consumer choice, as well as ensuring that physical and mental health care are considered jointly rather than separately.

Integrated care centres or greater utilisation of community health centres may be options for the development of services to deliver coordinated care and improve access. The development of partnerships or 'platforms' which deliver a more holistic service response may require new governance models to oversee and drive change in service delivery. There will also need to be consideration of funding models and how these can be adapted to promote more flexible and person centred responses. Determination of effectiveness could be supported by the adoption of a national tool to measure performance against recovery based competencies.

Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models.

Elements of this approach include targeted workforce development, establishment of an effective peer support workforce, and expansion of opportunities for meaningful involvement of consumers and carers.

From the perspective of people with emotional, physical, sensory or intellectual differences, they overwhelmingly report their experience as being one of social exclusion. The link between disability and social exclusion is well documented. Meaningful and diverse means of addressing structural barriers that exist for people excluded because of emotional and psychosocial experiences need to be developed to begin to expand opportunities for enhanced participation of consumers and carers.

Consumer and carer leaders need to actively promote, lobby and encourage an approach that introduces and acknowledges best practice in policy and activity. This approach should promote the individual's value and strengths, encourage participation and relevant and equitable service provision. Best practice models that promote the development of a certified peer specialist workforce accountable to peers and to funders are elements of a recovery oriented framework of service provision.

Develop integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community.

Provision of a sufficient number and range of accommodation options with varying levels of support was an important recommendation from recent inquiries. Options may range from single person independent housing through to shared and intensively supported accommodation. Support may include clinical assessment and treatment, or living skills and vocational support. This depends on collaboration between agencies and engagement of local communities. In particular it requires close cooperation between the providers of public housing and tenancy management, and mental health support services to tailor support to that required by the consumer.

People need different types of support and assistance at different stages of illness and recovery, and at different ages. There is good evidence that, when clinical treatment and community support co-exist, they complement each other and promote better outcomes for consumers, their families and carers. Such outcomes include tenancy stability and greater capacity to seek employment and

other community participation. While there has been considerable attention to this area at a national level and through state/territory and Commonwealth partnerships, nationally consistent models to match support to a person's needs require further development.

Develop integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage.

In addition to young people, some adults most at risk of developing a mental illness, for a range of reasons, cannot access services in clinics or other community settings. Ways need to be found to facilitate their access and engagement. Intervening to address mental illness may need assertive and flexible models of care—able to engage the person at a time and location that best meets their needs, and in a way that supports continuity through key transition periods.

The development of service models embedded in relevant services or locations—e.g. homelessness services and social housing initiatives, correctional facilities, residential child welfare services and workplaces, or which respond to particular events such as in the aftermath of natural disasters—will support better recognition, engagement and effective interventions. Where mental health services are provided in particular service settings, such as a correctional services facility or residential setting, it is important that there is close liaison between the mental health service providers and other workers to ensure clear communication and common understanding—for example, in relation to prisoners at risk of self harm, and the management of those with severe personality disorders.

Lead the development of coordinated actions to implement a renewed Aboriginal and Torres Straits Islander Social and Emotional Well Being Framework.

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004–2009* (the Framework) was developed to respond to the high rates of social and emotional wellbeing problems and mental illness experienced by Aboriginal and Torres Straits Islander (ATSI) people and communities.

The Framework was designed to complement the *National Mental Health Plan* and the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (2003–2013). It was endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in 2004. The Framework emphasised a number of important areas for shared action and initiatives. These remain relevant but need to be re-visited and implemented in the new environment of joint government effort. This work will need to take into account other recent developments through COAG and other sectors relevant to a social and emotional wellbeing approach.

Most importantly, Australia is undertaking a comprehensive approach to 'Closing the Gap' of Indigenous disadvantage in health. It is imperative that these efforts prioritise mental health, social wellbeing and emotional wellbeing, as this is critical to all efforts that aim to give Indigenous Australians the same health status as other Australians.

EXHIBIT 40

Priority area 2: Prevention and early intervention

EXHIBIT 40

Outcome

People have a better understanding and recognition of mental health problems and mental illness. They are supported to develop resilience and coping skills. People are better prepared to seek help for themselves, and to support others to prevent or intervene early in the onset or recurrence of mental illness. There is greater recognition and response to co-occurring alcohol and other drug problems, physical health issues and suicidal behaviour. Generalist services have support and access to advice and specialist services when needed.

Summary of actions

- Work with schools, workplaces and communities to deliver programs to improve mental health literacy and enhance resilience.
- Implement targeted prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations.
- Expand community based youth mental health services which are accessible and combine primary health care, mental health and alcohol and other drug services.
- Implement evidence based and cost effective models of intervention for early psychosis in young people to provide broader national coverage.
- Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them.
- Provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors.
- Expand the level and range of support for families and carers of people with mental illness and mental health problems, including children of parents with a mental illness.
- Develop tailored mental health care responses for highly vulnerable children and young people who have experienced physical, sexual or emotional abuse, or other trauma.

Cross-portfolio implications

To support a collaborative whole of government approach, these actions will require the health sector to work collaboratively with departments and agencies representing areas such as community services, child and family services, aged care, alcohol and other drugs, housing, justice and Aboriginal and Torres Strait Islander partnerships.

Indicators for monitoring change

- Proportion of primary and secondary schools with mental health literacy component included in curriculum
- Rates of contact with primary mental health care by children and young people
- Rates of use of licit and illicit drugs that contribute to mental illness in young people
- Rates of suicide in the community
- Proportion of front-line workers within given sectors who have been exposed to relevant education and training *
- Rates of understanding of mental health problems and mental illness in the community *
- Prevalence of mental illness *

** These indicators require further development*

The importance of promotion, prevention and early intervention (PPEI) in mental health has been recognised in previous plans. *Promotion, Prevention and Early Intervention for Mental Health: A Monograph* and the subsequent National Action Plan on Promotion, Prevention and Early Intervention in Mental Health remain key documents informing action in this area. In recent years there has been development of a stronger evidence base to support models of intervention in children and young people—especially in areas such as early intervention in psychosis, and school and family based interventions for challenging behaviours. But we also need to recognise the importance of relapse prevention and early intervention for people who experience recurrent episodes of illness, to minimise the distress and disruption experienced by the consumer and their families and carers. Prevention and early intervention activities are therefore best considered from three perspectives: early in life, early in illness and early in episode. The primary care sector has a particularly important role to play in prevention, both in promoting behaviours that support good mental health, and in the management of chronic or recurring illness to lessen the negative impact of illness.

Primary prevention endeavours to avoid the development of an illness, generally through population based health activities, mental health promotion and reduction of known risk factors such as exposure to child abuse, sexual assault and domestic violence. Secondary prevention aims to prevent progression through recognition of emerging symptoms and early intervention. Tertiary prevention targets the negative impact of an illness through continuing treatment and rehabilitation. Prevention activities can also be considered across universal, selected and targeted areas. Responsibility for prevention is shared by individuals, families and the community.

Mental health needs to be seen as important for the whole population, with better awareness of factors that support resilience and coping strategies including self care, community connectedness and engagement. Not all mental illnesses can be prevented. However, the impact and subsequent disability can be lessened by early and effective intervention. While prevention and early intervention are relevant at all ages, it is recognised that there is increased risk of mental illness at some life stages, in certain groups within the Australian community, and in association with critical life events. For example, intervention directed to parents and infants in the perinatal period to encourage positive attachment, and in early childhood to support appropriate social interaction and engagement, has been shown to enhance resilience.

Recognising children who are showing disturbed behaviour and intervening in school and family environments can lessen the risk of subsequent conduct disorder and propensity to substance dependence. Some groups experience multiple areas of disadvantage and vulnerability. For example, children in care may have experienced parental rejection, inconsistent care or domestic violence. Young people in youth justice are often disengaged from their families or other social supports, and have engaged in risk taking behaviour including substance use. There should be a particular priority given to addressing the multiple needs of such groups, including their mental health needs.

Mental health problems are also more likely to occur in association with disability, including intellectual disability, and with physical ill health. Serious mental illnesses such as schizophrenia and anorexia nervosa may first become apparent during adolescence and early adulthood—a time critical for the establishment of relationships, family and vocation. Intervening early in the onset of a dementing illness, or depression with onset in old age, will assist in sustaining independent living or maintenance in familiar surroundings.

If a person has experienced a mental illness, better knowledge about the illness will assist them and their family and carers to be aware of warning signs of relapse and the steps to take to intervene early. This can circumvent the development of an episode of illness and the associated personal and social disturbance. Additional effort through re-orienting the service system can bring substantial improvement to individual and community outcomes.

National actions

Work with schools, workplaces and communities to deliver programs to improve mental health literacy and enhance resilience.

Mental health promotion includes a range of strategies and activities which aim to have a positive impact on mental health through improved living conditions, supportive, inclusive communities and healthy environments. It may be targeted to addressing negative behaviours such as bullying, or to supporting and respecting the rights of others. Promotion activities can be run at a local level, in particular services such as child care centres or schools, or delivered through mass media campaigns (e.g., *VicHealth*). The media are also important partners in delivering information to improve the mental health literacy of the general community.

Better understanding and recognition of mental health problems and illness will help to lessen discrimination and stigmatisation, increase help seeking and promote supportive and inclusive communities. This needs to include the spectrum of mental health problems and mental illnesses, including those that are less common such as schizophrenia and other psychoses, and the more common anxiety and mood disorders. The *National Survey of Mental Health and Wellbeing 2007* found that, amongst those people who met the criteria for a mental illness who may have benefited from accessing services, the most frequent reason they did not do so was that they did not believe they had a need for this help.

Schools are important not only for improving mental health literacy but also for supporting resilience and developing coping skills. Examples of programs that address such issues in schools are *KidsMatter* and *MindMatters*. School based programs should be consistent in their approach. National initiatives such as *beyondblue* have had a significant impact in improving the understanding and awareness of depression and related disorders, and how to access treatment and care. Workplaces are also important settings for building resilience and fostering coping strategies.

Implement targeted prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations.

It is recognised that different developmental stages will need different service responses. For example, the early years of life are crucial in establishing attachment and resilience to later life stressors. Supporting parents who have a mental illness and their children will lessen the risk of later development of mental health problems. The *National Perinatal Depression Initiative* recognises that depression is common in the perinatal period and that maternal wellbeing is critical for early attachment. Good parenting, support to children in schools and families in contact with child protection services through better linkages and engagement across community and specialist mental health services will lessen the risk of future mental health problems. There need to be formal links between generalist and specialist services to provide support and advice, and to facilitate referral for treatment and care when needed.

Expand community based youth mental health services which are accessible and combine primary health care, mental health and alcohol and other drug services.

It is known that adolescence and early adulthood are times of transition and challenge. They are also the time when there is the greatest risk of emergence of mental health problems and mental illness, and yet young people are often reluctant to seek assistance. How and where we provide services to young people needs to be reconsidered. This may involve greater use of Internet based technology, and joining up mental health, primary care and alcohol and other drug services.

There should be the development of nationally consistent principles to guide the establishment of youth focused services that are relevant and accessible and support better engagement. There should be close links between youth focused components of care delivery, and capacity to assist those presenting with a range of problems. Where services to respond to the early onset of psychotic illness have already been established, these need to be linked in with other youth mental health supports.

Implement evidence based and cost effective models of intervention for early psychosis in young people to provide broader national coverage.

Early intervention is critical in minimising the impact of mental health problems over the life of a person. Effective and accessible clinical and non-clinical intervention for young people with early psychoses will improve their capacity to manage their illness over their life (and reduce their risk of social exclusion and homelessness) and reduce the cost to the community and the health system.

About 50,000 Australians experience severe and persistent mental illness including psychosis, and of these it is estimated that up to 10,000 young people would benefit from early psychosis interventions. For young adults, mental illness accounts for almost half of their total ill health, and young people in their teens and twenties lose over three times as many disability adjusted life years per person to mental illness compared to the rest of the population.

Provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors.

Many groups who work in the community will come into contact with people at all stages of mental illness and recovery, including individuals who may be suicidal. Supporting these groups to better understand and recognise mental illness and to know how to react to individuals during an acute episode of illness or suicidal behaviour will improve earlier intervention and bring better outcomes for individuals and their families. Workers that are particularly important include police, ambulance, child protection workers, correctional services staff, employment support officers, pharmacists, residential aged care workers and teachers.

Mental Health First Aid is an example of a program that provides greater awareness and understanding of mental health issues. Other similar programs have been developed by organisations such as *beyondblue* and Lifeline. For example, Lifeline has developed a two-day, practical interactive workshop in suicide first aid called *Applied Suicide Interactive Skills Training (ASIST)* that helps people recognise when someone may be at risk of suicide, explores how to connect with them in ways that understand and clarify that risk, increase their immediate safety and link them with further help. Again, while education regarding mental health problems should incorporate those issues and problems which are common, front line workers also need to be able to recognise and respond appropriately to those who present with more complex problems, including personality disorders and psychoses,

as well as having an appreciation of issues facing particular groups such as refugees. Those who are responsible for developing and providing training to front line workers need to be competent in the area of mental health and suicide prevention, or ensure that appropriate training staff are available to provide such input.

Education and training should also include consideration of the impact of substances such as alcohol, prescribed medication and illicit substances. It should also include education about the relationship between mental illness, substance abuse and increased risk of suicidal behaviour, and training should emphasise the role that various workers should play in recognising and responding to people at higher risk of suicide.

Coordinate state, territory and Commonwealth suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them.

While there has been considerable attention to suicide prevention activities, there has not always been good coordination between actions at a jurisdictional level. Suicide prevention strategies need to consider what services are already in place and how best to complement rather than duplicate programs, and how to make sure that successful programs are generalised across the service system rather than delivered as a time limited project. Consistent and sustained education and support should be in place to ensure that relevant professionals are aware of the signs and periods of increased risk, and how to put in place strategies to reduce this risk. Where there are particular populations at risk (for example, prisoners), there needs to be consistent terminology and clear communication across different areas of service provision and professions.

Specific support mechanisms should be developed to help people at high risk of suicide including the development of a nationally consistent set of suicide risk assessment tools for use in primary and community care appointments for all persons who have significant risk factors such as mental health problems including depression or substance abuse disorders. In addition, policies and practices should be developed and implemented that promote improved continuity of care for individuals who are at higher risk of suicide following discharge from inpatient psychiatric hospitalisation or from emergency departments following a suicide attempt. There should also be greater availability of a range of after hours services in the community for people who are at risk of suicide.

Expand the level and range of support for families and carers of people with mental illness and mental health problems, including children of parents with a mental illness.

Some mental illnesses carry a high risk of relapse. Often families and carers are in the best position to recognise and support a person early in relapse to get back into treatment and back on the road to recovery. But this can place a considerable burden on family members and sometimes the most effective way to support a person at risk of relapse will be to support the family system around them. Recognition of the needs of young carers, and of families with younger children, is important when considering the types of respite and support required. Families and carers in rural, regional and remote areas may feel particularly isolated in such situations. Provision of respite and access to support should ensure equitable access by all communities.

Children of parents with a mental illness are at greater risk of themselves experiencing mental health problems. Early intervention can reduce this risk. The *National Framework for Protecting Australia's Children 2009–2020* recognises the

need to address major parental risk factors that are associated with child abuse and neglect, including mental illness. Targeted programs have begun to address this issue. The next step is to embed capacity to identify and respond to these issues across the service system, including family welfare and child protection agencies, general practitioners and other health professionals working with families and young children, and specialist mental health services.

Develop tailored mental health care responses for highly vulnerable children and young people who have experienced physical, sexual or emotional abuse, or other trauma.

Addressing mental health issues of highly vulnerable children and young people is a critical aspect of an integrated response to improve their life chances. Children and young people who have experienced family violence, sexual abuse and other trauma are more likely to develop mental health problems than those who have not. Highly vulnerable children and young people can be identified in a range of settings, including homeless services, drug and alcohol services, child protection, out of home care and youth justice. Children and young people are often reluctant to engage in treatment and mental health services have not always provided an adequate response.

The *National Framework for Protecting Australia's Children 2009–2020* emphasises the importance of enhancing access to appropriate support services for recovery, where abuse and neglect has occurred, and improves support for young people leaving care. A new level of collaborative service provision is now required. Tailored service models for these groups could include flexible, community outreach teams linked to clear referral pathways; dedicated positions in specialist mental health services linked to statutory services; inclusion of family therapy in treatment plans; intensive therapeutic services for children and young people in care; and models for greater involvement from general practitioners and other health professionals working with families with young children.

EXHIBIT 40

Priority area 3: Service access, coordination and continuity of care

EXHIBIT 40

Outcome

There is improved access to appropriate care, continuity of care and reduced rates of relapse and re-presentation to mental health services. There is an adequate level and mix of services through population-based planning and service development across sectors. Governments and service providers work together to establish organisational arrangements that promote the most effective and efficient use of services, minimise duplication and streamline access.

Summary of actions

- Develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models.
- Establish regional partnerships of funders, service providers, consumers and carers and other relevant stakeholders to develop local solutions to better meet the mental health needs of communities.
- Improve communication and the flow of information between primary care and specialist providers, and between clinical and community support services, through the development of new systems and processes that promote continuity of care and the development of cooperative service models.
- Work with emergency and community services to develop protocols to guide and support transitions between service sectors and jurisdictions.
- Improve linkages and coordination between mental health, alcohol and other drug, and primary care services to facilitate earlier identification of and improved referral and treatment for mental and physical health problems.
- Develop and implement systems to ensure information about the pathways into and through care is highly visible, readily accessible and culturally relevant.
- Better target services and address service gaps through cooperative and innovative service models for the delivery of primary mental health care.

Cross-portfolio implications

To support a collaborative whole of government approach, these actions will require work across state, territory and Commonwealth governments, including work with acute health, community mental health, community support, income support, housing, Indigenous, primary care, alcohol and other drug services and justice programs.

Indicators for monitoring change

- Percentage of population receiving mental health care
- Readmission to hospital within 28 days of discharge
- Rates of pre-admission community care
- Rates of post-discharge community care
- Proportion of specialist mental health sector consumers with nominated general practitioner *
- Average waiting times for consumers with mental health problems presenting to emergency departments *
- Prevalence of mental illness among homeless populations *
- Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities *

* These indicators require further development

The past few years have seen major changes in how mental health services are provided in primary care, especially through the development of initiatives such as the *Better Outcomes in Mental Health Care* program and the *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (Better Access) initiative. These initiatives recognised that people commonly present to their general practitioner with mental health problems, and provided increased access to psychological treatments funded through the Medicare Benefits Schedule.

A number of state/territory based initiatives also provide enhanced support to primary care. These developments recognised the high prevalence of mental health problems, and also the need to improve physical health care for those who experience mental illness. There has also been expansion of living support services provided by non-government organisations in the community which complement the treatment and care provided by clinical mental health services.

These initiatives have greatly increased the range of services provided, including models that cross sectors such as 'step up/step down' facilities located within community settings but with strong input by clinical staff. There have been improvements in design and amenity—for example, through the development of dedicated areas within emergency departments, or consideration of gender specific issues in bed based hospital and community units. The need for services which respond to particular groups or issues such as mother/baby units, secure forensic units or services for people with personality disorders also need consideration.

However, despite increased funding to primary and specialist services, treatment rates for people with mental illness remain low compared with the prevalence of illness. For access to the right service to be improved, there needs to be an agreed range of service options, across both health and community support sectors. This should be informed by population based planning frameworks that specify the required mix and level of services required, along with resourcing targets to guide future planning and service development that are based on best practice evidence.

A nationally agreed planning framework would also include delineation of roles and responsibilities across the community, primary and specialist sectors, including the private sector, and consideration of the workforce requirements to deliver the range of services. Some service planning work along these lines has been commenced at a state/territory level—in New South Wales and Queensland in particular—and provides a foundation for building a comprehensive national service planning framework for mental health services.

In order to use the service system most effectively and appropriately, there is a critical need for links between and within sectors. Within the specialised mental health system, access pathways should be clear, and consumers, their families and carers engaged so that they can make an informed choice regarding the most appropriate service. This may be particularly important in those illnesses where recurrence or relapse is likely, so that consumers and their carers can access care as early as possible. Service providers need to inform consumers about how to re-access their service when doing discharge planning. There needs to be better coordination between the range of service sectors providing treatment and care, to promote continuity and lessen the risk of dropping out of services at periods of transition. These include both across the life span, and also in particular groups such as those in the justice system, children in protective services, and those with chronic physical illness or disability.

This connectivity and collaboration needs to be embedded across sectors including the

public and private, primary and specialist, clinical and community living support sectors, and coordinated at a local or regional level, recognising that the service mix will vary, given the diversity of Australian communities across metropolitan, rural and remote areas.

Services will work in more collaborative ways if there is greater understanding and respect across and within sectors, and if funding supports flexible and responsive models rather than discrete and often rigid silos. There are particular areas of tension in this area, such as transport of people experiencing acute mental illness, access to inpatient units when demand is great, and management of people who may be acutely ill or intoxicated or both in an emergency department setting. How such tensions are resolved will depend on the development of local solutions backed by good collaboration between sectors and recognition of roles, responsibilities and limitations. Consumers and carers should routinely be involved in such deliberations.

National actions

Develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models.

A national service planning framework will include acute, long stay, 'step up/step down' and supported accommodation services, as well as ambulatory and community based services. It will take account of the contribution of public, non-government sectors and private mental health service providers, and clearly differentiate between the needs of children and young people, adults and older people. Indicative planning targets must be based on clear role definitions and delineations to determine the appropriate mix of services, and address scarcity or mal-distribution in some geographical locations. The framework needs to be supported by flexible funding models that allow innovation and service substitution to meet specified targets in different delivery contexts.

Jurisdictions across Australia have moved from a bed based to a largely community based mental health system. While access to inpatient care is vital during the acute phase of some illnesses, innovative models of support in the community have been developed and have demonstrated that they can reduce the need for inpatient beds. However, to improve access and promote equitable access and consumer choice, we need to have a better understanding of the necessary components and best mix of services, recognising that there will be variation between areas, and for different age groups.

For example, aged people may need the support of mental health services in their homes and in generic hostel and nursing home accommodation, as well as access to specialist services when they experience more severe problems. There needs to be clarity regarding responsibility for service provision between health, mental health and aged care. The relationship and governance arrangements between components should enable access on the basis of an individual's need rather than the structure of the service. Service planning should include those involved in the planning and delivery of supported accommodation and community health. Service frameworks should include consideration of socio-demographic factors such as culturally and linguistically diverse groups in a given community.

Most importantly, development of a national service planning framework for mental health services needs to be based on sound epidemiological data that quantifies the prevalence and distribution of the various mental illnesses, as well as evidence based guidelines that identify the treatment required for the range of conditions. Construction of the service framework needs to translate this knowledge about illness prevalence and

required treatments into resources, measured in terms of the workforce and service components required to establish an adequate service system. Australia is fortunate to have a body of internationally recognised mental health researchers and expert clinicians who have established the groundwork in these areas.

Establish regional partnerships of funders, service providers, consumers and carers and other relevant stakeholders to develop local solutions to better meet the mental health needs of communities.

Most people access services in their local community. The service systems should be able to respond to the needs of people of all ages in their community. Services should operate through a local or regional organisation or partnership arrangement to lessen duplication and promote shared information and continuity. Regional partnerships should recognise the importance of the interface between primary and specialist services.

Further development of locally responsive area-based services and specialist services with regional responsibility will increase access to care, including to areas traditionally under serviced such as rural and remote communities. Where population size or geographical location means that a specialist service cannot viably be provided locally, alternatives through the development of improved technology, and support of generic services should be systematically put in place to reduce the risk of 'falling though the gaps'.

Supporting local solutions for local communities will enable 'wrap around' services to better respond flexibly to individuals with complex needs, while understanding the constraints imposed by geographical location, and workforce availability. The service mix should include community supports such as drop in centres and peer support. Consumers and carers should be actively involved to better contribute to service development.

Improve communication and the flow of information between primary care and specialist providers, and between clinical and community support services, through the development of new systems and processes that promote continuity of care and the development of cooperative service models.

A key impediment to seamless, joined up services and cooperation between service providers is the different systems of communication and documentation that currently exist. The need for confidentiality and respect for privacy does not preclude sharing information across providers with the consent of the person, and will lessen duplication and fragmentation of services. In particular, systems should enable better communication between areas funded through different levels of government such as primary care and mental health services. They should support the integration between specialist mental health (private and state/territory funded) and primary care. Technological advances should support the provision of safe and efficient treatment and support. There should be consistency and compatibility in the information technology used across jurisdictions wherever possible. Improvement in the interface and accessibility of private and public service is needed. Systems need to support better continuity of care for those presenting with mild through to severe mental health problems and illness.

Work with emergency and community services to develop protocols to guide and support transitions between service sectors and jurisdictions.

People and families who experience mental illness may also have involvement with other services such as emergency services (ambulance, police and fire fighters), child protection services, and may move between jurisdictions. To further support coordination of care, there needs to be shared responsibility

and clear understanding of roles and responsibilities across sectors to ensure good communication and responsiveness.

This can be especially important in complex and busy environments such as hospital emergency departments, or where there are differences in legislative framework and core business such as between corrections and health sectors, or where resource limitations mean that, for example, police are used to transport those experiencing a mental health crisis. Transitions are often associated with increased risk of dropping out of care, or being lost to follow up. Agreements between service areas and improved means of communication provide some strategies to minimise this risk.

Improve linkages and coordination between mental health, alcohol and other drug, and primary care services to facilitate earlier identification of, and improved referral and treatment for, mental and physical health problems.

Many people who seek help for mental health problems or for problems associated with use of alcohol or other drugs will do so through their general practitioner. Often these problems will occur together and may be complicated by poor physical health. The impact of misuse of prescribed drugs as well as use of illicit substances needs to be recognised. The impact of combined mental health problems and substance use may require referral from primary care to more specialist assessment, treatment or support. However, the provision of services varies and is often poorly coordinated across and within drug and alcohol services, mental health services, and primary care.

The different service sectors do not always work well together, or have an understanding of roles, responsibilities or limitations. Developing better reciprocal understanding and awareness will support better joint service development and delivery that addresses the physical and mental health needs. This will also support a 'no wrong door' approach, and lessen the frustration experienced by consumers, their carers and families.

Develop and implement systems to ensure information about the pathways into and through care is highly visible, readily accessible and culturally relevant.

For many people, knowing who to contact and how in the event of a mental health crisis or problem is confusing. The system can be complex to navigate and the response uncertain. Developing clearer pathways will support early intervention, and diversion to the most appropriate service. We need to incorporate new technological advances that will promote access and information about services. This may involve mapping available support services and considering better information referral systems or portals between nationally available services such as crisis telephone services, specialist helplines and online services, and those available in the person's local area.

The mental health system is only one component of mental health care. In some places—particularly in rural and remote communities—primary care will play the central role in service coordination. For many people, mental health care will only involve the primary care sector, but, for those with more complex needs, there should be an integrated response which is better able to address the needs of individuals and their carers or families. Transition between service areas or components should be experienced as responsive rather than rejecting by consumers, their families and carers. Discharge planning should involve transfer of sufficient information to the continuing care provider and appropriate engagement of family and carers.

Better target services and address service gaps through cooperative and innovative service models for the delivery of primary mental health care.

Many people, who for reasons of geographical location or other barriers such as service delivery options or workforce constraints, are not able to easily access private mental health care services, such as Medicare based mental health support. Commonwealth and state and territory government primary mental health care programs, which utilise the non-government sector, are well placed to develop and support innovative service delivery models that assist to target service gaps, making primary mental health care more accessible. An example is the Commonwealth Government's *Access to Allied Psychological Services* Program.

Work has previously been undertaken to develop cooperative approaches to primary mental health care service delivery at the state/territory level, such as *Partners in Mind*, a Queensland Framework for Primary Mental Health Care.

Innovative models may offer more flexibility at the local level, enabling non-government primary mental health care service providers to manage local workforce recruitment and retention issues, and provide targeted services that address service gaps. Consultation with local communities and service providers is required to accurately identify and prioritise unmet need and facilitate coordination between primary, specialist and non-government services to improve access and continuity of care for consumers.

EXHIBIT 40

Priority area 4: Quality improvement and innovation

EXHIBIT 40

Outcome

The community has access to information on service delivery and outcomes on a regional basis. This will include reporting against agreed standards of care including consumer and carer experiences and perceptions. Mental health legislation meets agreed principles and, in conjunction with any related legislation, is able to support appropriate transfer of civil and forensic patients between jurisdictions. There are explicit avenues of support for emerging and current leaders to implement evidence-based and innovative models of care, to foster research and dissemination of findings, and to further workforce development and reform.

Summary of actions

- Review the *Mental Health Statement of Rights and Responsibilities*.
- Review and where necessary amend mental health and related legislation to support cross-border agreements and transfers of people under civil and forensic orders, and scope requirements for the development of nationally consistent mental health legislation.
- Develop and commence implementation of a *National Mental Health Workforce Strategy* that defines standardised workforce competencies and roles in clinical, community and peer support areas.
- Increase consumer and carer employment in clinical and community support settings.
- Ensure accreditation and reporting systems in health and community sectors incorporate the *National Standards for Mental Health Services*.
- Further develop and progress implementation of the *National Mental Health Performance and Benchmarking Frameworks*.
- Develop a national mental health research strategy to drive collaboration and inform the research agenda.
- Expand and better utilise innovative approaches to service delivery including telephone and e-mental health services.

Cross-portfolio implications

To support a collaborative whole of government approach, actions in this area will require the health sector to work collaboratively with justice, community services, workforce accreditation and registration agencies, and research funding bodies.

Indicators for monitoring change

- Proportion of total mental health workforce accounted for by consumer and carer workers
- Proportion of services reaching threshold standards of accreditation under the *National Mental Health Standards*
- Mental health outcomes for people who receive treatment from state and territory services and the private hospital system
- Proportion of consumers and carers with positive experiences of service delivery *

** These indicators require further development*

Mental health service quality should be at least equal to that of other health services. In addition, because those who experience mental illness may be treated under the provisions of mental health legislation, services should meet all legal requirements and the expectations of rights charters or agreements.

Service amenity and legislative provisions should ideally be consistent across the nation and accord with national standards and agreements. In practice, uniform legislation is difficult to achieve because of the many inter-related state/territory based pieces of legislation. But we can work towards consistent legislative frameworks, and we can minimise the disruption to treatment and care caused by incompatibility between state/territory based mental health legislative frameworks. The rights of consumers and the needs of carers must be recognised and monitored through efforts to improve the carer and consumer experience of engagement with mental health services, including those from culturally and linguistically diverse backgrounds. Service development should include mechanisms to support advocacy and enable self determination to the greatest extent possible.

The *National Mental Health Performance Framework* has proven useful for developing Key Performance Indicators (KPI) for each domain. The KPIs that have been endorsed for Australian Public Mental Health Services will be considered for further development and adaptation to other service settings.

Workforce development is a crucial aspect of quality and a critical enabler for mental health reform. Like many other areas, workforce development crosses areas of Commonwealth and state/territory responsibility through undergraduate and postgraduate training places, and continuing education and professional development. The mental health workforce includes those who work in primary care, the public and private sectors, and the non-government community support sector. It includes a broad range of professions including counsellors, social workers, psychologists, occupational therapists, nurses and doctors. Workforce issues cross areas of direct service provision, teaching, research and administration. Understanding workforce issues also requires consideration of workplace culture and practices, which then influence recruitment and retention.

Although mental health was proactive in developing a multi-disciplinary workforce, like other areas of health, it still faces problems of limited supply, an insufficient and poorly distributed workforce, and, particularly in some professions and areas, an ageing workforce. Particular challenges face the workforce in rural and remote areas. We need to not only attract more staff, but also to consider how to use the skills and talents of the current workforce to best advantage. That may mean re-consideration of the role of psychiatrists in private practice, greater use of nurse practitioners or mental health nurses in primary care settings.

The use of innovative technology as a means of increasing access to treatment for people in remote areas can overcome some of the workforce challenges in these areas, along with enabling access for people who wish to remain anonymous. There has been insufficient development of the workforce in non-government organisations and a lack of clarity about roles, responsibilities, competencies and need for support across the different sectors. Staff in the mental health sector need to have a greater understanding of how to promote social and emotional wellbeing and bring a stronger recovery orientation to their work.

Supporting and developing leaders in mental health service delivery is crucial to the development of sustainable innovative services. Leaders and champions are important in all professions and all sectors, including government, to support the implementation of new and proven service models and practices.

This needs to be underpinned by an active research agenda, including both quantitative and qualitative research led by or involving consumers.

Research and evaluation should cover relevant areas such as effectiveness of treatment, community support services, service coordination models, prognosis and course of illness; and should cover the life span and service system so that we can develop or expand services based on a solid body of information regarding their effectiveness. Clinician led research, and engagement of the academic sector with clinical service development has been shown to support the evaluation and acceptance of evidence based methods into mainstream practice. Several models of better promulgating research exist—including Cochrane collaborations and the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom.

National actions

Review the Mental Health Statement of Rights and Responsibilities.

The *Mental Health Statement of Rights and Responsibilities* was developed in 1991 at the beginning of the *National Mental Health Strategy*. Although it remains a valid document, in the context of expanded service provision in primary care and the whole of government responsibility for mental health, it is timely for the document to be reviewed.

Review and where necessary amend mental health and related legislation to support cross border agreements and transfers of people under civil and forensic orders, and scope requirements for the development of nationally consistent mental health legislation.

Mental health legislation exists in each jurisdiction. There are some significant differences, especially in relation to model of external review, and interaction with related legislation. However, Australia is a signatory to national and international instruments regarding human rights, and some jurisdictions have developed their own Human Rights Charter. All mental health legislation should meet principles in accordance with these agreements. In addition, people who are receiving treatment under mental health legislation—both civil and forensic—should be able to be transferred between jurisdictions when it is in their best interests and accords with their wishes. Mental health legislation in all jurisdictions needs to be reviewed and where necessary amended to meet these expectations. This may require consideration of the interface between mental health legislation and related legislation such as guardianship and administration, and aged care, to identify barriers these create for the care of individuals that may be affected by more than one Act in order to scope opportunities to overcome such barriers.

Develop and commence implementation of a National Mental Health Workforce Strategy that defines standardised workforce competencies and roles in clinical, community and peer support areas.

Recruiting, retaining and ensuring future supply of a suitably qualified staff across the diverse range needed in mental health service delivery is a challenge for all governments. Mental health requirements should be considered when determining the number of undergraduate places in courses such as medicine, nursing, psychology and allied health. The mental health content of relevant undergraduate and postgraduate courses should be of sufficient quantity and quality to enable competency at the level required.

Mental health should be developed as a workplace of choice, with an open and inclusive workplace culture. There needs to be consideration of supply, including how

to market mental health as an exciting and rewarding area in which to work. There should be better integration of the workforce across public and private sectors, and between primary care and specialist services to make best use of skills and interests. Having clear guidelines to determine roles, competencies, skill mix and professions required for a capable workforce will improve consistency of care and increase the effective and efficient use of the available workforce. These developments should be consistent with the *National Practice Standards for the Mental Health Workforce*.

There should be sufficient flexibility to take into account the very different pressures that may exist across rural and remote communities to enable local solutions to workforce constraints. This should include assisting people of Aboriginal and Torres Strait Islander background to become mental health workers. The mental health workforce should be inclusive of those in other sectors who also provide support and care to people with a mental illness. For example, the Industry Skills Council's *Mental Health Articulation Project* is considering the competencies required by community support workers in the mental health area.

Increase consumer and carer employment in clinical and community support settings.

Although consumers and carers are employed in some service sectors, their expertise and utility is under recognised. Utilising the skills and knowledge of those with 'lived experience' has been shown to improve engagement and outcomes for people with mental illness in a range of settings. Consumers and carers should also be utilised in staff training programs and in staff selection processes. There are a variety of models of employment of consumers and carers in community and bed based settings, but this has not been systematically developed or implemented in Australia compared with other parts of the world. We do not have minimum standards to guide the number or available hours of consumer and carer support workers across the community and bed based sectors. We need to develop models that provide sufficient support and determine the role and responsibilities of peer employees.

Suitable training, supervision and roles need further exploration. Development of a strategy needs to incorporate findings and proposals from other projects and national activity including developments related to accreditation and registration.

Ensure accreditation and reporting systems in health and community sectors incorporate the National Standards for Mental Health Services.

There have been considerable advances in the introduction of standards and monitoring through accreditation programs, especially in the clinical sector. These have not been implemented to the same extent in the community support sector. Different accountability regimes apply to some sectors such as general practice and hospital based services, and these need to be made consistent where possible. Accreditation provides an opportunity for influencing cultural change, supporting leadership, and improving the attractiveness of mental health as a career of choice. There should be consideration of rewards or incentives linked to practices which lead to improved outcome and are experienced as positive by consumers and carers. Consumer, carer and staff perceptions and experience should be sought and taken into consideration when considering the quality of service provision and how to improve this.

Further develop and progress implementation of the National Mental Health Performance and Benchmarking Framework

Developing a clear performance and benchmarking framework across the service system enables comparison between services

and within services over time, and is a key tool for promoting quality improvement in health care. The *National Mental Health Performance Benchmarking Framework* and associated indicators developed over recent years cover public sector clinical services but we do not yet have agreed frameworks against which to report on performance and quality that includes all mental health sectors—private, public and non-government organisations. These will be developed under the Fourth Plan, along with increased effort to build a culture of continuous quality improvement in all sectors involved in mental health care.

Develop a national mental health research strategy to drive collaboration and inform the research agenda.

Research and evaluation are critical to maintain momentum of reform and to question models of treatment and service delivery and whether we could do better or invest more wisely. Research and teaching activity is also important in maintaining the interest and enthusiasm of our workforce through development of academic positions and promotion of mental health leaders.

Considerable mental health research activity is undertaken across Australia and internationally. But it is often poorly coordinated and there is limited translation of the resultant evidence base into practice. The research is not always directed to areas in a targeted or coordinated manner, so that some areas and some populations are relatively under-researched.

Compared to the clinical sector, research and evaluation in the community non-government sector has received less funding and is less developed. Strong leadership is needed to support better collaboration and to drive a better coordinated future research agenda. Better access to this information, such as through a clearing house mechanism similar to that developed through the National Drug and Alcohol Research Centre, will improve the promotion of new and effective programs and models of service delivery. A requirement to demonstrate implementation of accepted treatment or support models will further support effective and efficient service models. Future investment should be prioritised to those areas where there is evidence of need or a solid basis for the effectiveness of particular models or approaches.

Expand and better utilise innovative approaches to service delivery including telephone and e-mental health services.

Telephone and internet based services and treatment programs provide a valuable opportunity to enhance mental health service delivery due to their inherent accessibility and capacity to address current service deficits, as either a supplement to or substitute for existing face to face services for mild to moderate mental disorders. There is strong domestic and international evidence to support the use of internet based clinical treatments as a cost effective and beneficial alternative or adjunct to traditional treatment options.

The emerging field of e-mental health solutions has a potentially important role in extending mental health service delivery. E-mental health treatments extend access and aim to address the service deficit through the provision of innovative treatment and support options for people with mental illness, their families and carers. These initiatives aim to capture populations currently not accessing traditional services, particularly rural and remote communities, those isolated due to other causes, and those for whom anonymity is a priority or who prefer a non-clinical setting.

Priority area 5: Accountability—measuring and reporting progress

Outcome

The public is able to make informed judgements about the extent of mental health reform in Australia, including the progress of the Fourth Plan, and has confidence in the information available to make these judgements. Consumers and carers have access to information about the performance of services responsible for their care across the range of health quality domains and are able to compare these to national benchmarks.

Summary of actions

- Establish comprehensive, timely and regular national reporting on the progress of mental health reform which responds to the full range of stakeholder needs.
- Build an accountable service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders.
- Further develop mental health information, including national mental health data collections, that provide the foundation for system accountability and reporting.
- Conduct a rigorous evaluation of the *Fourth National Mental Health Plan*.

Cross-portfolio implications

Responsibility for establishing an accountable mental health service system lies primarily with the health sector. Health will need to collaborate with other sectors including community services, housing, and correctional services to assist them with developing indicators to monitor the extent to which they are having an impact on the community's mental health. Health will also need to work with other sectors in the overarching evaluation of the Fourth Plan.

Indicators for monitoring change

- Proportion of mental health service organisations publicly reporting performance data *

** This indicator requires further development*

Building a more accountable and transparent mental health system is an essential step to establishing public confidence. Confidence is needed at two levels. At the broad policy level, the public needs to have confidence in the mental health reforms agreed by governments, and that governments are doing as promised. At the service delivery level, consumers and others who depend on mental health services need to be confident that those services are providing quality care in a manner consistent with modern standards. Both of these aspects of accountability have been a source of community concern, and will be central to actions taken under the Fourth Plan.

Processes designed to improve accountability depend on the right information being available. In the mental health sector, there is a complex mix of stakeholders, each with different information needs, but who share a common interest in knowing how the mental health system is performing. Consumers are the central group. They need the health organisations responsible for their care to make information available that allows them to understand treatment options, make informed decisions and participate actively in their care. This should include information about how the organisation performs in comparison to its peers on a range of health quality indicators, presented in a way that will assist the person to understand what they can expect as a consumer of the organisation. While there are few examples of such practice being adopted in Australian mental health services, there are multiple innovations in this direction developing overseas and in areas outside mental health within Australia.

Beyond consumers, other stakeholders have legitimate needs for information about mental health system performance. Carers need information to be able to understand the treatment being offered to their relative or friend, and the outcomes that can be expected for the person while they receive treatment provided by the organisation. Mental health service providers also need information about how the treatments they provide compare with similar organisations so that they can establish evidence based treatment systems. Service managers need information about the performance of services for which they are responsible (and other similar services), in order to make operational decisions that will affect the efficiency and effectiveness of the service. Mental health policy makers and planners need a wide range of information about how the mental health system is performing to enable them to determine priorities for resource allocation, plan and pay for services, and monitor the achievement of outcomes.

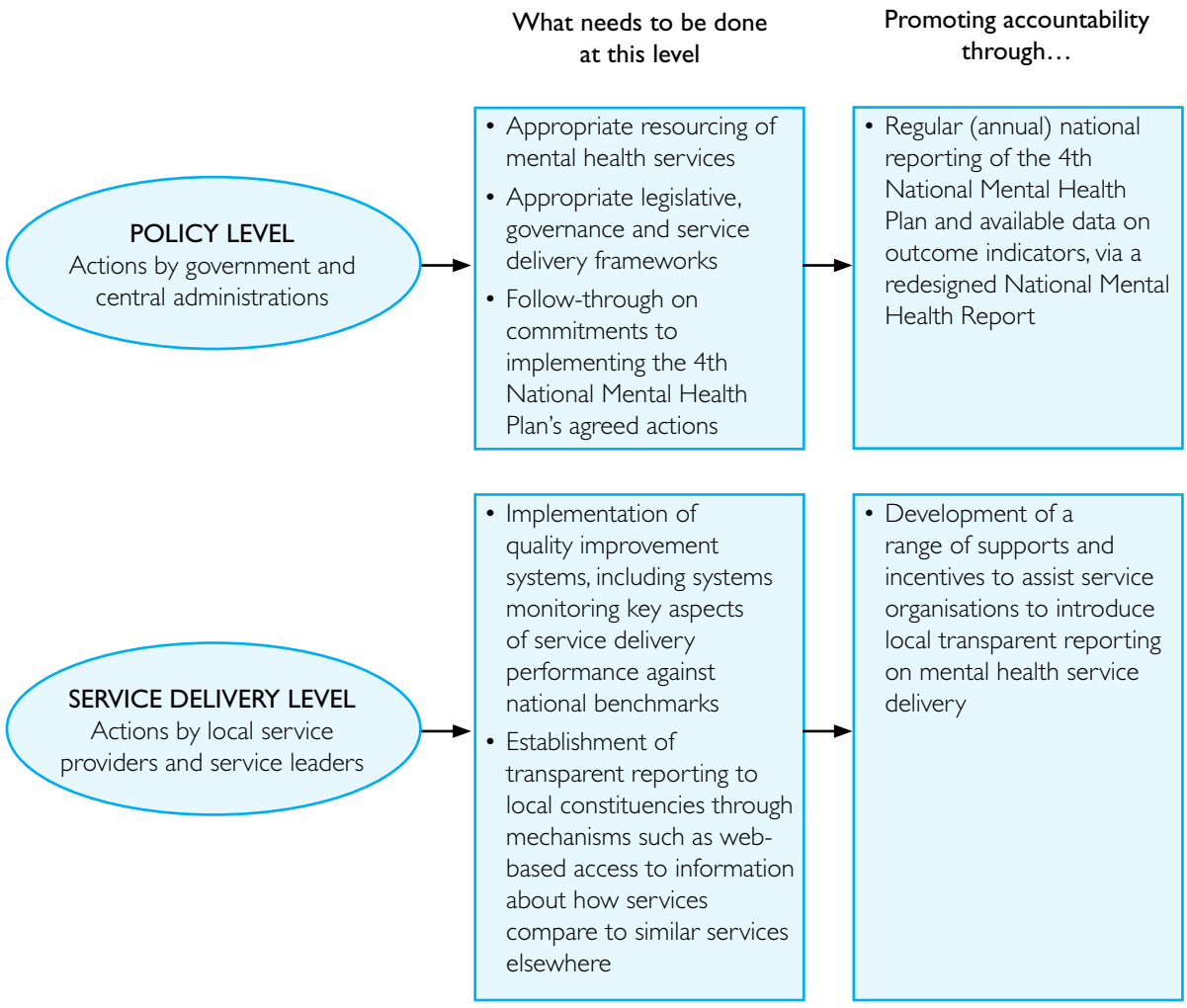
Australia's mental health sector has been a world leader in reporting on indicators of mental health reform, and has a longer and stronger history of doing so than many other sectors. The process began with the original *National Mental Health Plan* in 1992, when health ministers imposed on themselves the discipline of public reporting on reform progress through the National Mental Health Report. Having no international counterpart, ten reports were released over the period 1994 to 2008, charting the progress of all governments in reforming their mental health service delivery. Complementing this work, first and second editions of a national mental health information development plan were prepared to guide the developmental work needed to build an 'informed mental health system'.

These plans drove a number of major achievements, including: the implementation of routine outcome measurement for all consumers receiving care through state and territory mental health services; the development of national performance indicators for public mental health services and the introduction of service level benchmarking; the establishment of national minimum data sets to cover all aspects of public sector mental health service delivery; and the conduct of various population based mental health

surveys designed to monitor the prevalence of mental illness in the community.

Despite these achievements, a range of concerns have been raised about existing mechanisms for promoting accountability. The area of reporting on mental health reform has been particularly targeted, with calls for information to be more readily available, timelier and of greater relevance to the current national reform agenda. Additionally, significant gaps remain in the information collections that underpin national reporting, restricting what we are able to routinely monitor about mental health system performance. Foremost among these are nationally consistent measures of consumers' experiences of services, recovery based outcome measures and collections that cover the growing specialised mental health non government sector. At the service delivery level, very little information is readily available to consumers and other stakeholders on the performance of their local mental health services.

Figure 9: Multi-level approach to building an accountable and transparent mental health system



The Fourth Plan acknowledges these concerns and responds by committing governments to a series of actions designed to build an accountable and transparent mental health system. These actions will work across both the policy level and the service delivery level, recognising that each level of the mental health system has a unique contribution to make in establishing public confidence.

- At the policy level, accountability is about ensuring that governments are doing what they promised to do, and monitoring whether actions taken are effective. Accountability arrangements at this level primarily involve public reporting on performance.
- At the service delivery level, processes to strengthen accountability need to be progressed within a quality improvement framework. Services that actively pursue quality inherently seek to be transparent and accountable to those they serve. Steps to build stronger accountability at this level involve providing tools and incentives to support service managers and clinical leaders to establish a culture of continuous quality improvement. Accountability arrangements at this level include such efforts as benchmarking exercises and transparent reporting of a variety of indicators across the domains of health quality.

Figure 9 summarises the approach.

National actions

Establish comprehensive, timely and regular national reporting on the progress of mental health reform which responds to the full range of stakeholder needs.

The Fourth Plan provides an opportunity to develop a comprehensive, tailored system of reporting on performance, both within and beyond the health sector. There are currently several vehicles for regular reporting on mental health in Australia that provide a good foundation but these need to be overhauled to remove duplication and improve their timeliness and relevance (see Table 1). Amongst these, a restructured and modernised *National Mental Health Report* will be the primary vehicle for reporting on mental health reform, including the progress of the Fourth Plan. Health ministers will jointly authorise this report, and commit their respective administrations to the collection and reporting of all required data in a timely way. The report will be developed in a way that builds the momentum for change through its role in encouraging peer pressure and enabling of public scrutiny.

The *National Mental Health Report* will draw on and interpret a range of data sources, including the *Mental Health Services in Australia* report, prepared annually by the Australian Institute of Health and Welfare. In addition to presenting analysis of reform trends, the redesigned *National Mental Health Report* will include independent commentaries from invited national stakeholder and other bodies, to contribute to the ongoing analysis of mental health reform in Australia. As such, the report will not only present the 'good news', but also point to where further action is needed to achieve the vision of the *National Mental Health Policy 2008* for services to people with mental illness in Australia.

Table 1: Regular national level reports contributing to comprehensive information about mental health services in Australia

Title	*Purpose*	*Prepared/ Released by*	*How the report will be developed 2009–14*	*Frequency*
National Mental Health Report	Principal report for monitoring progress of mental health reform in Australia. Presents analysis of reform against specified indicators.	Australian Government, for AHMC	Focus to be on reporting progress and outcomes of Fourth Plan. Key contextual indicators used in previous National Mental Health Reports to be continued, to allow monitoring of long term trends in mental health resourcing and service mix. Special commentaries to be added to allow stakeholder opinion and analysis to inform national debate.	Annual
Mental Health Services in Australia	Presents the source descriptive data on the activity of mental health services, primarily based on annual National Minimum Data Sets. Also includes descriptive information on activities of services operating beyond the health sector which are of relevance to mental health.	Australian Institute of Health and Welfare, funded by Australian Government	Publication to be developed as the comprehensive report for all source data that describe mental health services in Australia. Increasing range of source data and customised analyses to be developed for on-line access	Annual
COAG Action Plan on Mental Health Annual Progress Report	Serves as the key accountability instrument for the Action Plan—summarises progress in the Action Plan's implementation and available data on outcomes.	Prepared under auspice of AHMC for COAG	Report scheduled to conclude at end of Action Plan in 2011. Progress indicators are incorporated in indicators developed for Fourth Plan and will be published in National Mental Health Report.	Annual to 2011

Indicators to be used to monitor the success of the Fourth Plan are listed in Table 2. The *National Mental Health Report* will publish updates on these indicators as they become available, along with reporting on the progress of the actions committed by governments in each of the five Priority Action Areas. Complementing this information, future National Mental Health Reports will continue to analyse and report on other key measures currently used for national monitoring (for example, per capita expenditure, workforce levels, hospital–community mix). These are important measures to add to understanding of the long term trends in mental health reform in Australia as well as providing essential context for the new indicators to be reported.

The indicators summarised in Table 2 represent core measures for assessing the achievements of the Fourth Plan, and details on data sources for these indicators are provided in Appendix 2. For some of these indicators, relevant data are already available and are used for current monitoring of the performance of the mental health system. For other indicators, relevant data collections are not in place, or, where they are, further work is needed to enable them to be used to inform the indicator. Collaboration between governments will be needed to fill these data gaps.

Targets have not been set for the indicators outlined in Table 2 but will be progressed during the first twelve months of the Fourth Plan. The setting of targets should not be done arbitrarily but needs to take into account objective evidence derived from local and international research, as well as best practice guidelines and opinions of both experts and stakeholders. As with the collaborative work needed to fill the data gaps, the contributions of all governments will be needed to develop performance targets for each of the indicators that are credible and expressed in a way that is meaningful to all parties.

Table 2: Indicators of outcomes of the Fourth National Mental Health Plan

Priority area 1: Social inclusion and recovery

Outcome:

The community will understand the importance and role of mental health and wellbeing, and recognise the impact of mental illness. People with mental health problems and mental illness will be embraced and supported by their communities to realise their potential, and live full and productive lives. Service delivery will be organised to deliver more coordinated care across health and social domains.

Indicators for which data are currently available:

- Participation rates by people with mental illness of working age in employment
- Participation rates by young people aged 16–30 with mental illness in education and employment

Indicators requiring further development:

- Rates of stigmatising attitudes within the community
- Percentage of mental health consumers living in stable housing
- Rates of community participation by people with mental illness

Priority area 2: Prevention and early intervention

Outcome:

People will have a better understanding and recognition of mental health problems and mental illness. They will be supported to develop resilience and coping skills. They will be better prepared to seek help for themselves and others to prevent or intervene early in the onset of recurrence of mental illness. There will be greater recognition and response to co-occurring alcohol and other drug problems and physical health issues. Generalist services will have support and access to advice and specialist services when needed.

Indicators for which data are currently available:

- Proportion of primary and secondary schools with mental health literacy component included in curriculum
- Rates of contact with primary mental health care by children and young people
- Rates of use of licit and illicit drugs that contribute to mental illness in young people
- Rates of suicide in the community

Indicators requiring further development:

- Proportion of front line workers within given sectors who have been exposed to relevant education and training
- Rates of understanding of mental health problems and mental illness in the community
- Prevalence of mental illness

Priority area 3: Service access, coordination and continuity of care

Outcome:

There will be improved access to appropriate care, continuity of care and reduced rates of relapse and re-presentation to mental health services. There will be an adequate level and mix of services through population based planning and service development across sectors. Governments and service providers will work together to establish organisational arrangements that promote the most effective and efficient use of services, minimise duplication and streamline access.

Indicators for which data are currently available:

- Percentage of population receiving mental health care
- Readmission to hospital within 28 days of discharge
- Rates of pre-admission community care
- Rates of post-discharge community care

Indicators requiring further development:

- Proportion of specialist mental health sector consumers with nominated general practitioner
- Average waiting times for consumers with mental health problems presenting to emergency departments
- Prevalence of mental illness among homeless populations
- Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities

Priority area 4: Quality improvement and innovation

Outcome:

The community will have access to information on service delivery and outcomes on a regional basis. This will include reporting against agreed standards of care including consumer and carer experiences and perceptions. Mental health legislation will meet agreed principles and, in conjunction with any related legislation, be able to support appropriate transfer of civil and forensic patients between jurisdictions. There will be explicit avenues of support for emerging and current leaders to implement evidence based and innovative models of care, to foster research and dissemination of findings, and to further workforce development and reform.

Indicators for which data are currently available:

- Proportion of total mental health workforce accounted for by consumer and carer workers
- Proportion of services reaching threshold standards of accreditation under the *National Mental Health Standards*
- Mental health outcomes for people who receive treatment from state and territory services and the private hospital system

Indicators requiring further development:

- Proportion of consumers and carers with positive experiences of service delivery

Priority area 5: Accountability—measuring and reporting progress

Outcome:

The public will able to make informed judgements about the extent of mental health reform in Australia, including the progress of this Fourth Plan, and have confidence in the information available to make these judgements. Consumers and carers will have access to information about the performance of services responsible for their care across the range of health quality domains and be able to compare these to national benchmarks.

Indicators for which data are currently available:

- N/A

Indicators requiring further development:

- Proportion of services publicly reporting performance data

Build an accountable service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders.

Accountability at the service delivery level will be strengthened by the introduction of systems of public reporting by service organisations on key performance measures. This will be progressed as part of broader initiatives to establish a culture of continuous quality improvement within service delivery systems that revolve around benchmarking and consumer and carer involvement. The aim will be to stimulate the development of informed mental health service delivery organisations that value positive results, strive for quality and are transparent to those they serve.

Introduction of these new arrangements will be achieved through incentives and supports to organisations seeking to participate in the new developments. This will include providing access to national benchmarking data, forums for interaction between peer organisations to share performance data and learn from

each other and other leadership development opportunities. Internet based systems of reporting and benchmarking will be developed to better inform consumers, carers and the general community about local service performance.

Further develop mental health information, including national mental health data collections, that provide the foundation for system accountability and reporting.

The solid information foundation developed over the past decade requires continuing collaborative effort between governments to keep data sources up to date, as well as fill gaps in current national collections. Key gaps in regularly available national data to be corrected over the course of the Fourth Plan are measures of consumers' experiences of services, recovery based outcome measures and collections that cover the growing specialised mental health non government sector. To guide the information development work, an updated National Mental Health Information Development Priorities document will be prepared in the first year of the Fourth Plan.

Conduct a rigorous evaluation of the Fourth National Mental Health Plan

The Fourth Plan has a strong commitment to evaluation. The monitoring and reporting activities described above, including the assessment of the achievements of the Fourth Plan against explicit indicators, will form the core of the evaluation. The evaluation will go beyond this. It will draw on a range of additional sources, in recognition of the fact that the indicators can only present a partial picture of progress. For example, the indicators are quantitative in nature, and the evaluation will ensure that qualitative information is captured too. In particular, the perceptions of consumers, families and carers, and the broader community will be sought through stakeholder consultations that employ qualitative data collection and analysis techniques. The emphasis here will be on the extent to which the mental health system and related sectors work together to promote recovery. Similar methods will be used to gauge workers' views of the system, competencies and morale.

The evaluation of the Fourth Plan will involve the development of a clear framework at its outset that operationalises the aims of the Fourth Plan in a manner that enables them to be assessed. It will then use this information to determine any additional evaluative information that needs to be collected to examine the extent to which the aims of the Fourth Plan are achieved.

The evaluation will recognise the role of other sectors in mental health. Assessing the activities occurring in other sectors that may have an influence on the mental health of the community will be challenging, but the evaluation will incorporate an emphasis on these wherever possible.

Appendix 1: A partnership approach

The *National Mental Health Policy 2008* articulated the current mental health and broader policy environment. The Fourth Plan seeks to progress the relationships between these sectors and advisory structures towards a strategic, coordinated and collaborative approach to mental health across the service systems.

A partnership approach

An important first step towards the goal of greater whole of government responsibility articulated in the Policy has been the inclusion of Ministerial Advisory Councils on the Reference Group responsible for the development of this Fourth Plan. This has enabled the Fourth Plan for the first time to articulate the current roles and responsibilities of these non-health portfolios in contributing to improved outcomes for people with mental illness.

The relationships between relevant portfolio areas must continue to be developed. It is envisaged that the Fourth Plan will provide a basis for governments to include mental health responsibilities into policy and practice in a more integrated way, as represented in Figure 1, to create better links between the work of national advisory committees.

It is recognised that the needs of people with mental illness, their families and carers, is not the core area of responsibility by these sectors. However, better integration and reciprocal service enhancements will benefit both the recipients of services, and result in more appropriate and effective use of services in all areas. The circumstances in which other sectors come into contact with individuals, either directly or through the transition of people through service systems, provide valuable starting points for further collaboration and integration. There are already good examples of work across portfolios at a jurisdictional level, such as between police and mental health, or child protection services and mental health, but there is considerable opportunity to strengthen and expand these.

The Fourth Plan is guided by a recognition that good mental health, like good physical health, is determined by many factors—within the individual, and also within families and communities. How and where we live, our work, our access to education, and our relationships all influence mental health and wellbeing. Equally, when health services are needed, and how and where these are provided, influences our experience and the speed and extent of return to health and wellbeing. To improve this will need action and commitment from all areas of government, and the community. Health ministers and mental health ministers at the state, territory and Commonwealth level need to work with their ministerial colleagues in relevant portfolios to advocate for complementary policy and service development, including prioritising these in budget decisions.

Mental health reform operates in a dynamic environment. Early intervention strategies are important early in life, early in illness and early in episode, but each might involve different approaches and different components of the service system. Mental health awareness and promotion is just as important in treating environments as it is in schools and the workplace. Some reform areas are mutually dependent—for example, housing, support and employment are important for ensuring wellbeing for people who suffer mental illness—but are often difficult to maintain when a person experiences symptoms of their illness. Likewise a person's illness may become difficult to treat when they do not have secure housing, meaningful employment and personal support. Some issues will achieve the best outcome through nationally consistent approaches, while others will require actions tailored to address local imperatives.

There are also areas where further consideration of how services could or should respond is warranted. Some of the areas are primarily under the direction of the Commonwealth Government such as employment services, while others such as correctional services are primarily determined by policy at a state or territory level. In each, there are areas that will impact on mental health and mental health services. In some of these areas the state based COAG Mental Health Groups, developed through the *COAG National Action Plan on Mental Health 2006–2011*, have made some progress towards a whole of government approach and to foster stronger partnerships across service sectors. Providing staff in areas outside health with better skills to recognise mental health problems, and ensuring that they have knowledge about the mental health system and are able to access support through advice and referral, will mean that all systems better respond to a person's needs.

Partnerships within the health system

Like many physical illnesses, mental illnesses are frequently chronic and relapsing and require a multidisciplinary approach. Regrettably, there is still a gap in health outcomes of those with mental illness compared to the general population, largely because of the co-occurrence of physical ill health. We need to do more to lower the risk factors and improve the management of physical illness in those who suffer mental health problems. This includes health promotion, as well as prevention and intervention measures. A useful document which outlines areas for attention is the *Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders*, which was developed by experts during a conference in 2008. The Charter recognises the social and structural determinants of mental health and provides a framework for health promotion and prevention.

Mental health and physical health are interdependent. Partnerships across and within primary care and acute health systems are important in developing a more holistic approach to health. Within government, greater recognition of areas such as preventative health (National Preventative Health Taskforce), and management of chronic disease have emphasised the importance of attention to social and medical domains.

Primary care

Primary care plays a central role in the treatment and care of those experiencing mental health problems and mental illness. General practitioners (GPs) are often the first point of entry to the care system. GPs are the route of access to psychologists and other appropriately trained professionals providing services through the *Better Outcomes in Mental Health Care* and *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* initiatives and the Mental Health Nurse Incentive Program. Their training, attitudes and knowledge of the service system positively influence peoples' experiences of care and treatment outcomes. GPs are also ideally placed to identify comorbidities, including physical health and substance use problems. Increased awareness of the likelihood of mental health problems leads to earlier intervention and better support for carers. In many areas primary care has to be self reliant as access to more specialist services is limited by distance or availability. Other practitioners who work in primary care such as maternal and child health nurses, and practice nurses, are also important in recognising and supporting those with mental health problems and mental illness. Developments such as Primary Care Partnerships or Networks are exploring better ways to link primary care with other

relevant services to support coordinated and integrated care. In the context of the work by the National Health and Hospitals Reform Commission, there is currently an opportunity for further development of mental health in primary care, and its integration with the specialist sector.

Emergency departments

Another critical area is the hospital emergency department. In the context of concerns about the appropriateness of the emergency department environment for people who are often distressed and agitated, a number of service responses have been introduced. In recent years there has been the development of new models of care such as Psychiatric Emergency Care Centres, Short Stay Units, and dedicated mental health and drug practitioners within the emergency department. These provide a more immediate and specialised response to people presenting in crisis. Emergency departments may be the first point of contact with the mental health system, and need to be able to initiate treatment, especially if access to bed based or community services is difficult.

Consultation-liaison services

Consultation-liaison services exist in many acute health services and there are also models of such support in primary care. These services recognise that mental illness may complicate the presentation and treatment of physical illness and vice versa. Mental illness is recognised as a common and significant complication in areas such as oncology, following cerebro-vascular accidents and after myocardial infarction. General hospital services need to be able to access expert advice and intervention, including support to nursing and medical staff to better manage people with physical illness complicated by psychological and behavioural problems.

Partnerships with other government areas of responsibility

A number of areas outside Health provide services to similar populations within our community. Policy, service planning and delivery in these areas need to be mindful of developments in the mental health area and vice versa. Examples of cross portfolio committees include the state based COAG mental health committees, and inter-departmental liaison committees. A national focus on areas such as social inclusion, or implementation of the National *Mental Health and Disability Employment Strategy*, provides opportunity to further engage across government and community areas.

The following sections illustrate non-health portfolio areas in which a collaborative approach to policy and service development will benefit service recipients across sectors.

Aboriginal and Torres Strait Islander Partnerships

Overview

Cultural respect and awareness of the importance of a holistic approach across the continuum of mental health and wellbeing to mental illness are critical in the delivery of services to Aboriginal and Torres Strait Islander (ATSI) people. While some services are provided through Aboriginal Community Controlled Health Services, mainstream services need to be culturally proficient so that ATSI people feel confident to seek assistance when required.

Interface and future directions

Services need to be aware of issues of cultural safety and respect in how services are provided, and the impact of life events

such as incarceration. They need to be aware of the importance of family, family dynamics and how cultural beliefs may impact on the presentation and management of mental illness. The impact of trans-generational trauma needs to be taken into account when planning and delivering services. In rural and remote communities, health and community workers need to be aware of mental health issues, and of the risks that comorbid substance abuse or physical ill health brings to mental wellbeing. ATSI specific services will need to support and inform workers in mainstream services how to provide the most appropriate interventions to Indigenous people.

Particular challenges that face service improvement in ATSI health include the diverse nature of the needs of ATSI people, and the ongoing development of the ATSI health workforce. The needs of urban ATSI people may be very different from those in remote communities, but the aim of promoting mental health and wellbeing is just as relevant. The Indigenous workforce needs to have confidence that they have access to advice and backup when required.

Ageing

Overview

The proportion of older people in Australia is increasing, as is life expectancy. While many remain in their own homes, others require the additional support of hostel or nursing home placement. Older people have an increased risk of mental health problems—through pre-existing illness, the recent onset of illness such as depression, and age specific illness such as dementia. They are also more likely to experience chronic physical health problems. They may be reliant on family or friends for support and have difficulty accessing some services because of limited mobility. They access specialist psychiatric services less than younger people. The delivery of services to ageing people in the community, and in aged care facilities, is complicated by the frequent co-existence of mental health and physical problems, sometimes with associated challenging behaviours.

Interface and future directions

Services for aged people are often delivered in partnership across health and community sectors. Care coordination is particularly important is such situations where general practice, multiple support agencies and clinical specialists are involved. While it is not expected that aged care staff will have the level of clinical skill that may be required for detailed assessment and treatment, workers from aged care and community sectors need to be aware of the risk of mental health problems, and should be able to screen, and where appropriate support, referral to more specialised services for mental health treatment and care.

Likewise, specialist mental health services for older people should develop improved capacity to support generic services, provide additional training and consultation to support the person remaining at home or in a mainstream facility. This may involve 'in-reach' of clinical services to the person's home or residential facility. Where admission to an inpatient service is indicated, discharge planning needs to incorporate advice and support to those involved in ongoing care, including family members.

Alcohol and other drug services

Overview

There is a complex and multifactorial association between mental health problems, mental illness and excessive use of alcohol and illicit substances. Use of some substances such as cannabis and psycho stimulants is causally associated with mental health problems and

mental illness. Those at increased risk for developing a mental illness, such as people who have experienced major disruptions during childhood, or exposure to trauma, are also at increased risk of developing substance dependence. This is especially so for those with high prevalence problems such as depressive illness, and anxiety disorders including post traumatic stress disorder. Children of parents with a substance abuse problem have an increased risk of developing mental health problems.

Interface and future directions

Until fairly recently, there was little engagement between mental health services and alcohol and other drug (AOD) services. There is now considerable effort in a number of jurisdictions to better coordinate service delivery and to improve mutual understanding and respect between the sectors. Screening for mental health problems and staff training in their recognition and management leads to earlier identification and support to access appropriate services. Establishing linkages with mental health services, transfer of information and the development of joint care plans for people with multiple and complex needs will lessen duplication and discontinuity of care and support early intervention and sustained recovery.

At a state/territory and Commonwealth level there has been investment to support workforce development, but further work is required to determine best practice in delivery of services to people with comorbid mental health problems and substance abuse. The interface between mental illness and mental health problems, and presentation to AOD services, warrant an investigation of new service delivery and care models. These may involve co-location, or one arm of service taking a lead in particular areas. For example, services focusing on psychotic disorders could provide interventions for cannabis and amphetamine users, while services for AOD could have arrangements for anxiety and affective disorders available. *Headspace* is one example of combined service delivery to young people. Future directions should support an improved response to mental health problems and to AOD dependency through comprehensive assessment, referral and treatment models.

The courts, police and other law enforcement officials are frequently faced with decisions regarding behavioural disturbance and its attributions. It can be difficult to distinguish at times the effects of intoxication from those of acute mental illness, and therefore to determine the most appropriate intervention and treatment. Collaboration between the courts, police, mental health services, AOD services and emergency department staff can make a significant difference to the immediate and longer term outcomes for the person involved.

Children in Care and Youth Justice

Overview

Children and their families who have contact with child protection services may present in the context of a particular crisis or be exposed to more enduring disadvantage and distress. Young people who come to the attention of the youth justice system often have multiple problems and challenges. These include increased risk of mental health problems, often experience of abuse or trauma, and exposure to illicit substances.

Interface and future directions

Contact with these services presents an opportunity for intervention. Such intervention may directly address mental health issues, or indirectly improve mental health outcomes via services such as speech therapy or assistance at school. Intervention should work

in ways that increase the young person's self confidence and resilience. Providing additional clinical and non-clinical support to parent(s) (e.g. via support for AOD issues) may be the most appropriate way to support children in the family and minimise risk. It is important that the staff working in these areas are aware of areas of vulnerability, and can adequately assess and be supported to assist the young person and his or her family.

There is sometimes a tension between the aims of child protection and youth justice services in relation to safety and risk minimisation, and those of mental health services in delivering treatment and care in the least restrictive environment. Greater effort is needed to improve understanding of the roles, responsibilities and limitations of each sector, and to develop models of service collaboration which include relevant information sharing and cross sector support.

Community services

Overview

Community services and mental health services often provide services to shared clients. Community services cover a diverse cross section of support services, generally provided by not-for-profit organisations which operate with a combination of charitable and government funding. Services include:

- family support;
- alcohol and other drug services;
- aged care;
- out of home care;
- carer respite;
- personal support;
- vocational and employment services;
- homelessness services;
- sexual assault services;
- disability services;
- women's services;
- recreational services;
- arts based services; and
- multicultural services, including assistance to victims of torture and trauma.

Services provided in these areas include counselling, accommodation, employment assistance, education and social activities.

Interface and future directions

Often workers in these services are at the front line, and will be involved in identifying people experiencing mental health issues, providing support to them, and promoting good mental health generally. While mental health clinical services focus on assessment and treatment, specialist and generic community services offer greater focus on opportunities that build resilience, community involvement and support that helps prevent escalation and relapse of mental illness. A partnership between the community sector and specialist mental health programs is critical to improving the mental health and wellbeing of a large number of Australians across a diverse range of cultures, locations and ages. Because of this, workers in all areas of community services need to be aware of mental health problems, including early identification and mental health first aid, the concerns faced by those with mental illness, and the needs of their carers.

Community services staff need to be aware of mental health issues to respond appropriately to people with mental illness, their families and carers. They also need an extensive knowledge of other support services that complement mental health services to facilitate local referrals between services to ensure timely and equitable access to appropriate care.

People with mental health as well as other health problems need to have their mental health needs addressed as well as their other

health needs. For example, people with intellectual disability are at increased risk of experiencing a mental illness, yet this is often overlooked and access to appropriate treatment for both disabilities is limited.

Carer respite services also need training to recognise mental illness and knowledge of other support services to offer support and early intervention to people with mental illness and their carers.

Correctional services and Justice

Overview

People who come into contact with the criminal justice system—through courts, prisons and community corrections—are more likely to have mental health problems or mental illness than the general community. They are also more likely to have alcohol and/or substance use problems. Incarceration can result in loss of contact with family, loss of accommodation and employment, and exacerbation or onset of mental illness. Indigenous people can be particularly at risk of mental health problems within a custodial environment.

Interface and future directions

Screening people for mental health problems at courts, and where possible diverting them to services in the community, supports an early intervention and prevention approach. Treatment and care within the custodial environment, and support to link with community services at the point of release, will reduce the risk of relapse of illness and is also likely to reduce the risk of recidivism. A significant proportion of those found guilty of an offence will also be managed in the community at some point—under parole or on community based orders.

Improving linkages between community correctional staff and the primary and specialist mental health service sector through better information exchange and staff training will lessen the risk of people falling between services. A particular challenge for correctional case managers is working within service criteria that fail to give sufficient weight to the complex needs of offenders. While there is a shared interest in community safety objectives, particularly where that is informed by assessment of the risk to self or others, there is less alignment between other health and corrections objectives. Offenders with apparently stable or sub-acute conditions may still require mental health support. Repeated involvement with the criminal justice system can exacerbate symptoms of mental illness. These issues are also relevant to the youth justice system. Cultural awareness and respect are particularly important in supporting ATSI people in the justice system.

It is recognised that the development of a consistent approach to the management of people with mental health problems in custody is complicated by the fact that models for the delivery of assessment and treatment services vary across jurisdictions. In some states and territories, mental health service provision is the responsibility of Health, while in others it is overseen by the Justice portfolio, or is a hybrid of both. Different legislative frameworks also apply. While there is general clarity with regard to the most appropriate management of offenders who have a mental illness, there is sometimes a tension regarding the management of offenders with behavioural disturbance in the context of a personality disorder. The manifestations of the most severe of these disorders continue to pose a major challenge in the correctional domain with a need for the development of specialist expertise and interventions. The National Statement of Principles for Forensic Mental Health covered a number of these areas, but has not been fully embraced across the service system. Court diversion programs and the development of mental health liaison staff

within prisons are examples of collaborative joined up interventions.

Culturally and linguistically diverse groups

Overview

The Australian community includes people from many different ethnic and cultural backgrounds. A number of issues relevant to mental health confront people who have come to Australia from other countries and cultures. They may have experienced trauma or torture in their country of origin or during the journey to Australia. They may be isolated, lacking community support and facing additional barriers because of language and cultural differences.

Interface and future directions

Mental health services need to make use of professional interpreting services and to be aware of particular sensitivities associated with different religions and cultures. They need to be aware of the impact of exposure to traumatic events and of loss on the presentation of mental health problems and their treatment. This includes issues related to gender sensitivity. They need to support and nurture a bilingual workforce. Likewise, agencies who come into contact with new arrivals or who provide community and support services to people from other countries need to include consideration of their mental health needs, and establish pathways for referral or advice.

Future developments could include greater access to information in other languages, and support for multicultural community groups that recognise issues of particular concern or prevalence in a given community. The amenity of bed based and community services should include consideration of the needs of different religious groups, including issues related to gender.

Emergency services—police, ambulance and fire authorities

Overview

Police, ambulance officers and fire fighters provide front line services. They are exposed to difficult and potentially dangerous situations, which sometimes involve those experiencing mental illness. With the shift to community based care and shortened inpatient episodes of care in less restrictive settings, there has also been increased expectation on police and others in the community to respond to people who experience mental illness.

Interface and future directions

Some mental illnesses are associated with a risk of functional disability and at times difficult behaviour. Comorbidity is common in such situations, particularly intoxication with alcohol and/or illicit substances. At such times there needs to be a close working relationship between mental health services and emergency services. Emergency service personnel have reported feeling that they were the 'meat in the sandwich', and that their concerns were given insufficient attention by those in the mental health sector.

Over the past decade, emergency services have responded to give staff greater training and support and to encourage local engagement. Transport of people experiencing mental illness has been an area of particular concern. Although ambulances are the preferred means of transport of mentally ill people, police will also be involved in transport in situations where there has been alleged offending behaviour, or when the risk of harm to the person or to others is very acute.

Emergency services should ensure their staff have adequate training in the recognition and early management of people in mental health crisis, and knowledge of the service system and how to access it. Respectful communication,

patience and reassurance can defuse a situation and avert a tragic outcome. But police and ambulance staff also need to be able to access specialist services rapidly, and to have sufficient information transfer to allow them to do their job.

Employment

Overview

There has been increasing recognition of the importance of employment or occupation in supporting good mental health, and of the impact of mental illness on absenteeism and subsequent loss of productivity. Mental health problems and mental illness often become evident in the work situation, particularly more common illnesses such as depression and anxiety disorders.

Interface and future directions

Workplace policies and practices designed to support people to remain employed or to return to employment have been implemented in some areas, but are not yet common. Likewise, support to find suitable employment and support through the early stages of vocational placement can be very effective in assisting a person who has experienced a mental illness to rejoin the workforce. The development of policies at government level to promote more inclusive practice in support to find and keep employment is an important aspect of the recovery focus included in the Fourth Plan. While some models are in place, they are still relatively new and untested. Some rely on partnerships between clinical service providers, community support agencies and employment support agencies. Centrelink and employment support agencies are responsible for facilitating and supporting models which improve the placement and retention of those who are at risk of mental health problems. Staff in these agencies need to have access to information about what type of employment and support needs may be required. Clinical and community mental health services should work in ways that assist people with mental illness to seek or retain employment.

Housing

Overview

Safe, secure and affordable housing is critical for all, but particularly those with mental health problems. As such, it is important that appropriate services and support is available to all people, regardless of their housing tenure. There has been considerable attention to this area in recent years. The *Homelessness White Paper* considers a range of areas relevant to mental health, including a statement that people should not be discharged from health services into homelessness. But this may not always be feasible. A given person may not accept the accommodation offered. There is also pressure on services to admit very unwell people, and accommodation options are sometimes limited. Recognition of the importance of stable accommodation to the recovery process has led to greater integration across services, but further improvement in the coordination and collaboration between housing services and mental health services is still needed.

Interface and future directions

Homelessness may be both a cause and an effect of mental illness and mental health problems. Engagement with services is difficult for those who are homeless, but can be improved by services being available at homeless shelters or drop in centres. This engagement can then support movement into more secure and appropriate accommodation. Admission to an inpatient unit can precipitate homelessness, and discharge planning should include consideration of accommodation and support on discharge. Some people with mental illness may need long term supported

accommodation. Others may require only transitional support.

There are a number of models for the provision of housing and support. These have demonstrated better outcomes, including sustained recovery from mental illness and return to employment. Planning for social housing developments should include consideration of the needs of people with mental illness and mental health problems, such as the proximity of clinical and support services, location and size of accommodation. Allocations made by social housing providers should also consider the needs of people with mental illnesses when offering properties, based on advice provided by mental health service providers where the person is linked with mental health services. Clinical and non-clinical mental health services should work with housing agencies to ensure tenancies are sustainable through the provision of suitable models of treatment and support.

Schools and education

Overview

Kindergarten, primary and secondary education are accessed by nearly all young people. They thus provide a universal platform where mental health promotion, prevention and early intervention activities should be fostered. Identification, early intervention and, where appropriate, referral to more specialised services can make a significant difference in a child's welfare and outcome. A number of mental health problems such as anxiety and mood disorders, eating disorders and challenging behaviour may first come to notice in the school environment.

Interface and future directions

Programs which address areas such as mental health and emotional wellbeing, bullying, challenging behaviours, healthy eating, and drug and alcohol education, are in place in some areas but could be expanded. We also need greater consistency in the range of programs provided, informed by evidence of what works best. School teaching staff and counsellors should have access to relevant training, and advice and support from the mental health specialist sector in relation to individuals or school programs.

Engagement between schools, community based mental health services, and child protection services should be supported by shared service agreements developed at a local or regional level. Transition from early childhood services to school and from primary to secondary school may represent a time of increased stress. It is during these times that staff need to be most alert to those who are at risk of dropping out of school.

EXHIBIT 40

Appendix 2: Technical notes on indicators to monitor the Fourth National Mental Health Plan

Priority area	*Outcome*	*Indicators*	*Technical notes regarding indicators*
1. Social inclusion and recovery	The community has a better understanding of the importance and role of mental health and wellbeing, and recognises the impact of mental illness. People with mental health problems and mental illness are valued and supported by their communities to realise their potential, and live full and productive lives. Service delivery is organised to deliver more coordinated care across health and social domains.	Participation rates by people with mental illness of working age in employment[1] Participation rates by young people aged 16–30 with mental illness in education and employment1 Rates of stigmatising attitudes within the community[2] Percentage of mental health consumers living in stable housing[3] Rates of community participation by people with mental illness[4]	1. Several data sources exist that could provide baseline data against which these indicators could be monitored, including the National Survey of Mental Health and Wellbeing, the Survey of Disability, Ageing and Carers, and the Household, Income and Labour Dynamics in Australia Survey. Consideration will need to be given to issues around the re-administration of these surveys. 2. No existing data sources are available to monitor this indicator, and a large scale population based survey would be required. It might be possible to adapt Jorm's mental health literacy survey (1997) for this purpose. 3. Existing data sources do not yet enable this indicator to be monitored. Amendments will be needed to the various National Minimum Data Sets covering state and territory services to routinely capture the relevant information. 4. Various instruments exist which could be adapted to inform this indicator. For example, New South Wales mental health services are developing an instrument known as the 'Activity Participation Questionnaire' which assesses involvement in a range of social and vocational activities. Such instruments could be routinely administered in mental health services, or could form part of a community based survey which also assessed mental health problems.

Priority area	*Outcome*	*Indicators*	*Technical notes regarding indicators*
2. Prevention and early intervention	People have a better understanding and recognition of mental health problems and mental illness. They are supported to develop resilience and coping skills. People are better prepared to seek help for themselves and to support others to prevent or intervene early in the onset or recurrence of mental illness. There is greater recognition and response to co-occurring alcohol and other drug problems and physical health issues. Generalist services have support and access to advice and specialist services when needed.	Proportion of primary and secondary schools with mental health literacy component included in curriculum[1] Rates of contact with primary mental health care by children and young people[2] Rates of use of licit and illicit drugs that contribute to mental illness in young people[3] Rates of suicide in the community[4] Rates of understanding of mental health problems and mental illness in the community[5] Prevalence of mental illness[6] Proportion of front line workers within given sectors who have been exposed to relevant education and training[7]	1. Routinely collected data through the national *MindMatters* and *KidsMatter* initiatives can be used to inform this indicator. 2. Numbers of GP Mental Health Care Plans provided for children and young people, identified from Medicare data, could be used to inform this indicator. 3. Data relevant to this indicator are collected at regular intervals via the National Drug Strategy Household Survey 4. Routinely collected data on suicide published by the Australian Bureau of Statistics are used to inform this indicator. 5. Jorm's mental health literacy survey could provide baseline data against which this indicator could be monitored. Consideration will need to be given to issues around the re-administration of this survey. 6. Baseline data relevant to this indicator are available for the Australian population aged 16–85 from the *2007 National Survey of Mental Health and Wellbeing*. The survey could be re-administered to provide a subsequent cross sectional picture of prevalence. It should be noted, however, that to collect meaningful comparative data in this way is an expensive undertaking as the survey is considerably more complex than other health related surveys conducted in Australia. 7 No existing data sources are available to monitor this indicator. New ways of quantifying exposure to education and training in different service sectors will need to be explored.

Priority area	*Outcome*	*Indicators*	*Technical notes regarding indicators*
3. Service access, coordination and continuity of care	There is improved access to appropriate care, continuity of care and reduced rates of relapse and re-presentation to mental health services. There is an adequate level and mix of services through population based planning and service development across sectors. Governments and service providers work together to establish organisational arrangements that promote the most effective and efficient use of services, minimise duplication and streamline access.	Percentage of population receiving mental health care[1] Readmission to hospital within 28 days of discharge[2] Rates of pre-admission community care[2] Rates of post-discharge community care[2] Proportion of specialist mental health sector consumers with nominated general practitioner[3] Average waiting times for consumers with mental health problems presenting to emergency departments[4] Prevalence of mental illness among homeless populations[5] Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities[6]	1. Numerator and denominator data for this indicator can be calculated at national and local levels from service contact data and census data. The indicator is currently reported in annual progress reports on the COAG National Action Plan on Mental Health. Data from the National Survey of Mental Health and Wellbeing could be used to further inform the question of who in the population is receiving mental health care. 2. Routinely collected data from the Admitted Patient Mental Health Care and the Community Mental Health Care National Minimum Data Sets can be used to inform these indicators. 3. Existing data sources do not yet enable this indicator to be monitored. Consideration will need to be given to novel ways of capturing relevant information (e.g. incorporating new fields into routinely collected data sets, auditing files from a representative sample of services) 4. Existing data sources do not yet enable this indicator to be monitored. Average waiting times could be calculated in many emergency departments, but it is not possible to accurately differentiate waiting times for people with and without mental health problems. Consideration will need to be given to new ways of capturing this information.

EXHIBIT 40

Priority area	*Outcome*	*Indicators*	*Technical notes regarding indicators*
			5. The Supported Accommodation Assistance Program (SAAP) provides crisis accommodation and related support services to people who are homeless or at imminent risk of becoming homeless. The SAAP program has been incorporated into the National Affordable Housing Agreement. Data sources linked to this include data on whether clients have mental health problems, including through a special purpose survey to explore the same issue. These data sources could inform this indicator 6. The Prisoners Health Information Group (a group established in 2004 by the Australian Health Ministers' Advisory Council) has undertaken a range of activities designed to enable regular monitoring of the health status of Australia's prison population. Stemming from this work, a one week census of new entrants to Australian prisons took place in July 2009, as a precursor to more regular national data collection.

Priority area	*Outcome*	*Indicators*	*Technical notes regarding indicators*
4. Quality improvement and innovation	The community has access to information on service delivery and outcomes on a regional basis. This includes reporting against agreed standards of care including consumers' and carers' experiences and perceptions. Mental health legislation meets agreed principles and is able to support appropriate transfer of civil and forensic patients between jurisdictions. There are explicit avenues of support for emerging and current leaders to implement evidence based and innovative models of care, to foster research and dissemination of findings, and to further workforce development and reform.	Proportion of total mental health workforce accounted for by consumer and carer workers[1] Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards[2] Mental health outcomes for people who receive treatment from state and territory services and the private hospital system[3] Proportion of consumers and carers with positive experiences of service delivery[4]	1. Data relating to this indicator are available in part through the Mental Health Establishments National Minimum Data Set, which provides information on the size of the total workforce and the numbers comprising particular workforce groups. NGO coverage is not included and will require new data collection. 2. Data relating to this indicator will be available as a by-product of routine reporting against the National Standards for Mental Health Services, again through the Mental Health Establishments National Minimum Data Set. 3. Data relating to this indicator are reported routinely through the National Outcomes and Casemix Collection. 4. Initiatives being taken by several jurisdictions to regularly monitor consumer perceptions of care will be reviewed, with a view to identifying a standard measure. Similarly, work on available measures of carer wellbeing, burden and perceptions of care will be consolidated to identify or develop an appropriate measure or set of measures to be used across services.

Priority area	*Outcome*	*Indicators*	*Technical notes regarding indicators*
5. Accountability—measuring and reporting progress	The public is able to make informed judgements about the extent of mental health reform in Australia, including the progress of the Fourth Plan, and has confidence in the information available to make these judgements. Consumers and carers have access to information about the performance of services responsible for their care across the range of health quality domains and are able to compare these to national benchmarks.	Proportion of services publicly reporting performance data[1]	1. As public reporting of performance information is not yet the norm, no existing datasets are available to collect data related to this indicator. Consideration will need to be given to systematic means of monitoring progress against this indicator.

EXHIBIT 40

Glossary of key terms

Acute mental health services: Acute mental health services provide specialist psychiatric care for people who present with acute episodes of mental illness. These episodes are characterised by recent onset of severe clinical symptoms of mental illness that have potential for prolonged dysfunction or risk to self and/or others. The treatment effort is focused upon symptom reduction with a reasonable expectation of substantial improvement. In general, acute services provide relatively short term treatment.

Advocacy: Representing the concerns and interests of consumers and carers, speaking on their behalf, and providing training and support to enable them to represent themselves.

Carer: A person who has a caring role for a person with a mental health problem or mental illness. They could be family, friends or staff and be paid or unpaid. The role of the carer is not necessarily static or permanent, and may vary over time according to the needs of the consumer and carer.

Carer consultants: People who have experience of caring for a person with a mental illness. They are employed by mental health services, and have knowledge of the mental health system and the issues that are faced by families and other carers. They work with mental health staff in developing service responsiveness to the needs of carers and families.

Consumer: A person who uses or has used a mental health service.

Consumer consultants: Consumers who are employed to advise on and facilitate service responsiveness to people with a mental health problem or mental illness and the inclusion of their perspectives in all aspects of planning, delivery and evaluation of mental health and other relevant services.

E-mental health: Mental health services or information delivered or enhanced through the Internet and related technologies. E-mental health can include mental health promotion, prevention, early intervention, treatment, relapse maintenance and emergency services. E-mental health solutions can also facilitate professional training for the mental health workforce.

Forensic mental health services: Refers to mental health services that principally provide assessment, treatment and care of people with a mental illness who are in the criminal justice system, or who have been found not guilty of an offence because of mental impairment. Forensic mental health services are provided in a range of settings, including prisons, hospitals and the community.

Mental health problem: Diminished cognitive, emotional or social abilities but not to the extent that the criteria for a mental illness are met.

Mental health services: Refers to services in which the primary function is specifically to provide clinical treatment, rehabilitation or community support targeted towards people affected by mental illness or psychiatric disability, and/or their families and carers. Mental health services are provided by organisations operating in both the government and non government sectors, where such organisations may exclusively focus their efforts on mental health service provision or provide such activities as part of a broader range of health or human services.

Mental illness: A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

Non-government mental health sector: Private, not-for-profit, community managed organisations that provide community support services for people affected by mental illness and their families and carers. Non-government organisations may promote self help and provide support and advocacy services for people who have a mental health problem or a mental illness, and their carers, or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, day programs, pre-vocational training, residential services and respite care.

Peer support: Social and emotional support, frequently coupled with practical support, provided by people who have experienced mental health problems to others sharing a similar mental heath condition. Peer support aims to bring about a desired social or personal change and may be provided on a financial or unpaid basis.

Performance indicator: Refers to a quantitative measure that is used to judge the extent to which a given objective has been achieved. Indicators are usually tied to specific goals and serve simply as 'yardsticks' by which to measure the degree of success in goal achievement. Performance indicators are usually expressed as a rate, ratio or percentage.

Prevalence: The proportion of individuals in a particular population who have an illness during a specific period of time.

Primary care services: Community based services which often constitute the first point of contact for people experiencing a mental health problem or a mental illness and their families. The primary care sector includes general practitioners, emergency departments and community health centres.

Private sector specialist mental health services: The range of mental health care and services provided by psychiatrists, mental health nurses and allied mental health professionals in private practice. Private mental health services also include inpatient and day only services provided by privately managed hospitals, for which private health insurers pay benefits, and some services provided in general hospital settings.

Psychiatric disability: Refers to the impact of a mental illness on a person's functioning in different aspects of a person's life such as the ability to live independently, maintain friendships, maintain employment and to participate meaningfully in the community.

Recovery: See the various definitions that have been described on page 26.

Social inclusion: Contemporary concepts of disadvantage often refer to social exclusion. Social inclusion refers to policies which result in the reversal of circumstances or habits which lead to social exclusion. Indicators of social inclusion are that all Australians are able to secure a job; access services; connect with family, friends, work, personal interests and local community; deal with personal crisis; and have their voices heard.

Social and emotional wellbeing: An holistic Aboriginal definition of health that includes: mental health; emotional, psychological and spiritual wellbeing; and issues impacting specifically on wellbeing in Aboriginal and Torres Strait Islander communities such as grief, suicide and self harm, loss and trauma.

Step up/step down: These are clinically supported services which are delivered through staffed residential facilities and offer short term care to manage the interface between inpatient and community settings. They provide an alternative to hospital admission (pre-acute) and provide bridging support following discharge from hospital (post-acute).

Supported accommodation: Safe, secure and affordable community based housing combined with non-clinical and clinical supports and services which enable people with mental health problems and mental illness to live independently in the community.

Targets: A target (or benchmark) refers to the desired standard of performance to be achieved on a given performance indicator. Whereas performance indicators are the measurement tools used to gauge the extent to which a goal is met, targets represent the 'marks' on those indicators that define the desired levels of performance. Targets may be set on the basis of objective evidence, expert consensus, values or simple averages.

Wrap around services: The term refers to individualised and integrated services provided through a single coordinated process to comprehensively meet the needs of a person with a mental illness.

EXHIBIT 40

Department of Health

Mental Health Alcohol and Other Drugs Branch

Statewide Mental Health Alcohol and Other Drugs Clinical Network Terms of Reference

2012-13

1. PREAMBLE

The Statewide Mental Health Alcohol and Other Drugs Clinical Network (the MHAOD Clinical Network) is established in accordance with the Queensland Health Clinical Networks Policy (v2.0). The clinical network is defined as a formally recognised group, principally comprising clinicians, established to address problems in systemic safety and quality, equity and or efficiency of health care. The clinical network provides an opportunity for clinicians and network members to engage in planning, priority setting, information sharing and system improvement.

2. PURPOSE

The purpose of the MHAOD Clinical Network is to:

- provide statewide governance for safety and quality in public system Mental Health Alcohol and Other Drugs (MHAOD) services.
- enable the knowledge and experience of clinicians to be used to improve the safety and quality of MHAOD services based on the available evidence and the needs of consumers, carers and community.
- evaluate the consistency of MHAOD services governance structures, safety and quality plans and procedures with:
  - Legislation relevant to mental health, alcohol and other drugs assessment and treatment.
  - National and State policies (e.g. Dual Diagnosis policies), plans, standards and priorities related to mental health, alcohol and other drugs.

The objective of the MHAOD Clinical Network is to address opportunities for improvement in consumer outcomes for public sector MHAOD services across Queensland through effective leadership, strategic coordination, planning, problem resolution, communication, collaboration and support.

3. FUNCTIONS

1. Planning for Safety and Quality

1.1 Develop, review and promote a range of evidence-based pathways, guidelines and models of care.

1.2 Provide opportunities for clinicians and network members to engage in planning and priority setting to guide the safe delivery of MHAOD services including:

- Clinical standards and guidelines
- Performance measures and risk management
- Clinician support, research and education
- Service innovation
- Consumer, carer and family support and involvement
- Stakeholder partnerships.

1.3 Participate, contribute to and provide expert advice in statewide planning initiatives.

1.4 Provide a platform for influencing legislation, Hospital and Health Service Agreements and Health Service Directives to promote safety in MHAOD services.

2. Action for Quality and Safety

2.1 Provide expert and evidence-based content advice about safety policy and practice.

2.2 Coordinate projects and initiatives to improve MHAOD quality and safety within public sector MHAOD facilities.

2.3 Develop and lead the implementation of the Clinical Governance Framework.

2.4 Provide advice and recommendations on statewide Health Service Directives, policies, protocols, guidelines and implementation standards relating to safety and quality issues.

2.5 Support research, identification and dissemination of evidence-based practice.

2.6 Review and provide advice on performance against clinical indicators and act on findings.

2.7 Review and provide advice on information system improvements, including setting targets and developing strategies for improvements in data collection.

2.8 Promote a safety culture for continuous improvement and delivery of high quality care.

3. Balanced Monitoring for Quality and Safety

3.1 Establish key milestones and performance indicators.

3.2 Provide advice on reporting requirements.

3.3 Monitor quality and safety activities e.g. accreditation, clinical audit, clinical indicators, reporting, benchmarking and peer review.

3.4 Define targets and strategies to achieve continuous improvements.

3.5 Develop and promote clinical research activities and teaching opportunities.

4. Appraisal, Learning and Action

4.1 Review and where appropriate, support compliance with clinical practice standards promulgated by the Health Quality and Complaints Commission.

4.2 Provide guidance and support to working groups created under the MHAOD Clinical Network.

4.3 Provide a medium for communication and information sharing with MHAOD stakeholders on systemic quality and safety issues.

4.4 Monitor and review the implementation and deliverables of National and State MHAOD quality and safety priorities.

4.5 Support Hospital and Health Services to develop sustainable safety and quality strategies.

4.6 Promote education and research in MHAOD services.

4.7 Analyse, assess and act upon collected data to inform priorities/strategies to address safety and quality improvement activities.

4.8 Promote and raise MHAOD issues, initiatives, policies and plans with other Statewide Clinical Networks where relevant.

4.9 Promote the value of MHAOD services in relevant forums wherever possible.

4. AUTHORITY AND REPORTING RELATIONSHIPS

Accountability

The MHAOD Clinical Network is accountable to the Deputy Director-General (DDG), Health Service and Clinical Innovation Division (HSCID) through the Chair.

The MHAOD Clinical Network has no formal authority. It reports to the DDG, HSCID and operates in accordance with the approved Terms of Reference. The MHAOD Clinical Network may provide advice within their remit to the Hospital and Health Boards and Hospital and Health Services upon request.

Reporting relationships to the Clinical Senate and the Queensland Mental Health Commission are outlined in Figure 1 and escalation to the Clinical Senate is via the Executive Director, MHAODB. Specialist advisory groups, reference groups, clinical committees and working groups report to the MHAOD Clinical Network on safety and quality issues for MHAODB services through the Chair (Figure 1).

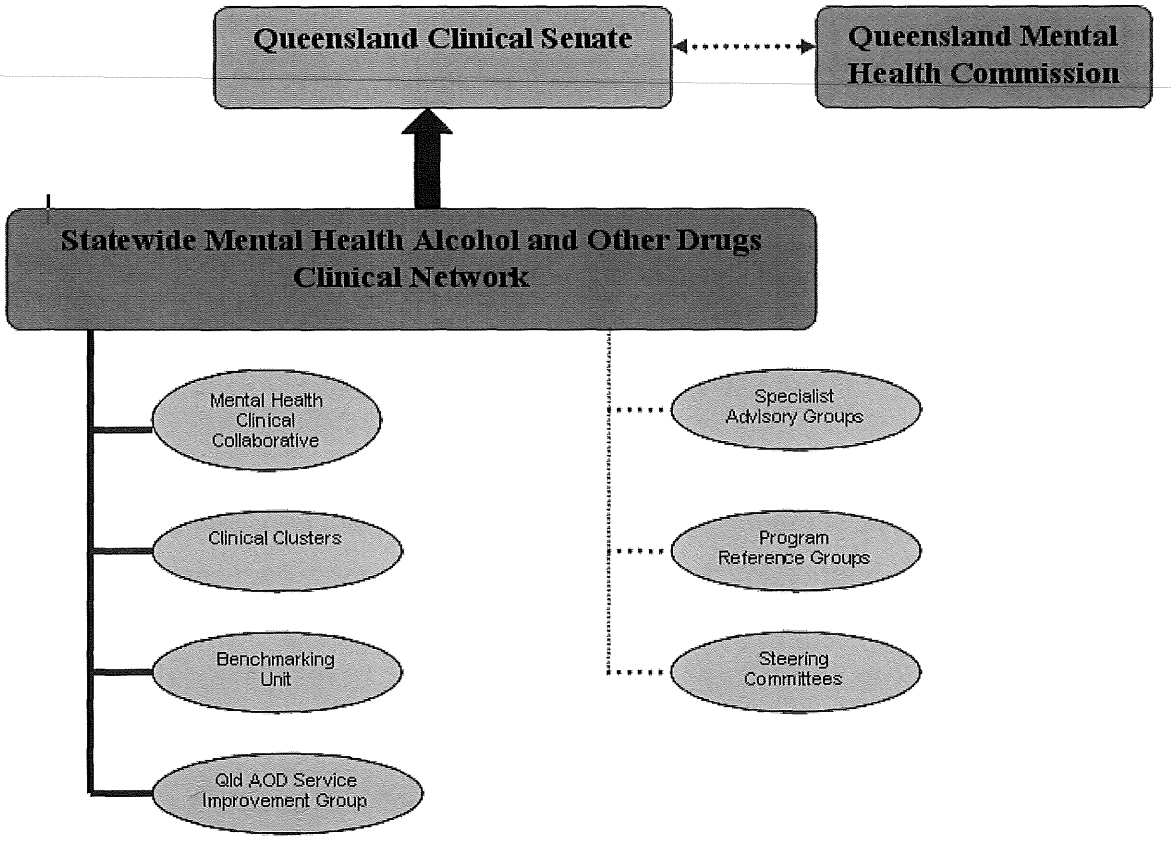


Figure 1 Reporting Relationships for the MHAOD Clinical Network

The MHAOD Clinical Network will provide strategic oversight of the Mental Health Clinical Collaborative, Benchmarking Unit, Clinical Clusters and Alcohol and Other Drugs (AOD) Service Improvement Group. These groups have a direct reporting relationship with the MHAOD Clinical Network and report through to the MHAOD Clinical Network on a regular basis to update on progress of initiatives, seek advice from and provide input into the work of the MHAOD Clinical Network.

The MHAOD Clinical Network will facilitate effective two way communication between Program Reference Groups / Specialist Advisory Groups / Steering Committees and vice versa as required.

Decision Making

MHAOD Clinical Network recommendations are made by consensus where possible. In the event that a consensus is not reached, a majority decision will be sought. Should this not occur, the Chair will have the casting vote.

A quorum for meetings will be 50% of voting members plus one for majority. Each member is entitled to one vote only.

Where relevant, decisions will be escalated by the Chair for endorsement to the appropriate authority.

5. GUIDING PRINCIPLES

The work of the MHAOD Clinical Network is underpinned by commitment to the best interests of users of public sector health services and ensuring quality and safety for the delivery of public sector mental health alcohol and other services.

Confidentiality

Proceedings and records of the MHAOD Clinical Network will not generally be considered confidential. However, information may from time to time be given by members or participants 'in confidence'. Members and proxies acknowledge their responsibility to maintain confidentiality of all information that is not in the public domain or deemed 'in confidence'.

6. MEMBERSHIP

Representation	Members Name
General Members	
Chair	Dr Darren Neillie
Executive Director, MHAOD Branch	Dr Bill Kingswell
Chief Psychiatrist	Assoc Prof Jagmohan Gilhotra
Central Clinical Cluster Clinical Representative	George Plint
Northern Clinical Cluster Clinical Representative	Dr Jason Lee
Southern Clinical Cluster Clinical Representative	Assoc Prof Gail Robinson
Mental Health Clinical Collaborative	Assoc Prof Brett Emmerson
Mental Health Benchmarking Unit	Olivia Falvey
Mental Health Nursing	Deanne Hellsten
Mental Health Allied Health	Lucille Griffiths
Psychiatrist	Dr Matira Tailkato
Alcohol and Other Drugs (AOD) Treatment Nursing	Rob Rolls
AOD Allied Health	Anthony Bligh
AOD Treatment Physician	Dr Jeremy Hayllar
The Qld AOD Treatment Services Improvement Group	Linda Hipper
Aboriginal and Torres Strait Islander Mental Health Worker	Lynette Anderson
Aboriginal and Torres Strait Islander clinician	Kimina Andersen
Child and Youth Mental Health clinician	Dr Stephen Stathis
Older Persons Mental Health clinician	Dr David Lie
Forensic Mental Health clinician	Bob Green
Consumers (2)	
Carers (2)	
Voting ex-officio members	
Director, Information and Performance Unit, MHAODB Director, Legislation Unit, MHAODB A/Director, Clinical Governance, MHAODB Director, Planning and Partnerships Unit, MHAODB	Ruth Catchpoole (proxy Kristen Breed) Janet Ceron Janet Martin Dr Leanne Geppert (Proxy Marie Kelly)
Non-voting ex-officio members	
Secretariat	Penny Dale, Principal Project Officer, Clinical Governance

Selection and appointment of membership

The Chair will be appointed by the Executive Director (ED), MHAODB.

Appointment to the MHAOD Clinical Network will be determined by the Chair.

Composition of the membership may be expanded by the Chair. The Chair may invite other persons with particular expertise of benefit to the group as either invited guests and/or observers. While these parties may be actively engaged in the discussions, they will not participate in member voting processes. Observers are bound by the relevant confidentially provisions contained within this Terms of Reference.

Term of membership

Membership is to be reviewed bi-annually by the Chair.

- General members (excluding consumer and carer representatives): appointed for two years, renewable to a maximum of three years.
- Consumer and carer members: appointed for a maximum two year term, as per the Guidelines for the Involvement and Remuneration of Consumer and Carer Representatives in Mental Health.

Responsibilities of members

It is expected that all members will:

- represent the perspectives of the specific group they represent - the reporting of issues through its membership is a primary mechanism to enable the 'up' and 'down' communication of issues from the workplace to the MHAOD Clinical Network and back;
- feedback relevant information to the specific groups they represent;
- have an equal say on any issues raised;
- attend meetings and prepare for meetings accordingly or nominate a proxy; and
- ensure a proxy is available and has been briefed in the event of non attendance
- attend a minimum of three meetings per calendar year
- champion MHAOD Clinical Network recommendations - communicate information to their work places and to the broader clinical community
- declare a conflict of interest if there is an issue under review that may have a direct influence on their ability to make an objective decision
- advise the Secretariat of changes to their contact details, including email addresses.

Proxies to meetings

Members of the MHAOD Clinical Network shall nominate and brief a proxy to attend a meeting if unable to attend.

The nominated proxy shall have voting rights at the attended meeting. The nominated proxy shall provide relevant comments/feedback to the MHAOD Clinical Network member they are representing.

Before nominating a proxy, the member must discuss the nomination of a proxy with the Chair and Secretariat.

Where practicable the Chair and Secretariat must be informed of the substitution at least five working days prior to the meeting.

Working groups

The Committee will convene specific working groups to develop, implement and drive strategies to increase safety and quality in priority areas. Participation in the working groups will be sought from experts drawn from the professions within the Queensland Department of Health, Hospital and Health Services and elsewhere, as required.

7. Meetings

Frequency of Meetings

Meetings will be held bi-monthly.

Meetings will be face to face for a duration of 2 hours or longer if required.

Teleconferencing/videoconferencing facilities will be used when appropriate/available.

Roles and Responsibilities of the Chair

The Chair will be responsible for:

- overseeing the development/updating of the Annual Work Plan and terms of reference in collaboration with MHAOD Clinical Network members;
- presenting MHAOD Clinical Network recommendations to the Queensland Clinical Senate;
- ensuring the Committee focuses on matters relevant to its function and considers each matter with appropriate care and propriety;
- fulfilling duties of representative or spokesperson for the MHAOD Clinical Network; and
- strengthening the composition and performance of the MHAOD Clinical Network.

Roles and Responsibilities of Secretariat

The Secretariat will be responsible for:

- compiling/disseminating an agenda and minutes;
- coordinating/preparing background information;
- compiling correspondence, reports, data etc. as required by the MHAOD Clinical Network;
- ensuring consumer and carer members receive appropriate support/assistance to enable full and effective participation;
- maintaining administrative aspects of the MHAOD Clinical Network Work Plan and terms of reference;
- coordinating/facilitating meeting requirements (venue, travel, parking, reimbursements, reminders re brief/report due dates etc);
- filing hardcopies of meeting papers in accordance with Department of Health requirements.

Agendas, Minutes, Reports and Correspondence

Documentation sent from the MHAOD Clinical Network Secretariat:

- Agenda, previous minutes and relevant attachments – Disseminated via email to Clinical Network members one week prior to meetings;
- Unconfirmed minutes – Disseminated to MHAOD Clinical Network members two weeks following meetings; and
- Confirmed minutes – Minutes will be confirmed at the MHAOD Clinical Network meeting.

Out of Session Business

Business may be progressed out of session by the Chair. Papers will be circulated to members for feedback by a specified date. In these circumstances, the Chair will determine the final position based upon members feedback. The Secretariat will update members accordingly.

8. Remuneration

While sitting fees will not be offered to members, remuneration will be considered on a case by case basis. Consumers and/or carers will be remunerated in line with Queensland Department of Health guidelines.

Any remuneration for the time required to participate in MHAOD Clinical Network meetings will be negotiated between the member and their employer.

9. Performance Evaluation

The MHAOD Clinical Network will establish an annual work plan including key performance indicators to enable appropriate evaluation and reporting. Performance will be evaluated against the plan annually.

10. Review of Terms of Reference

The MHAOD Clinical Network will review the terms of reference annually. The terms of reference may be amended at any time by agreement of the MHAOD Clinical Network.

11. Endorsement

Dr Darren Neillie
Chair
Mental Health Alcohol and Other Drugs Clinical Network
August 2013

EXHIBIT 40

Department RecFind No:	
Division/HHS:	
File Ref No:	

Briefing Note for Noting
Director-General

Requested by: Lesley Dwyer, Chief Executive, West Moreton Hospital and Health Service **Date requested: 8 July 2013** **Action required by: 15 July 2013**

SUBJECT: Barrett Adolescent Strategy Meeting

Proposal
That the Director-General:

Note a meeting has been scheduled for 4pm on Monday 15 July 2013 between the Minister for Health, Dr Mary Corbett (Chair, West Moreton HHB), Lesley Dwyer (Chief Executive, West Moreton HHS) and Sharon Kelly (Executive Director, Mental Health and Specialised Services, West Moreton HHS) to discuss the next stages of the Barrett Adolescent Strategy.
And
Provide this brief to the Minister for information.

Urgency
1. Urgent. There is growing concern amongst stakeholders of the Barrett Adolescent Strategy, including patients and carers, to receive communication about the future of the Barrett Adolescent Centre (BAC).

Headline Issues
2. The top issues are:
   - The West Moreton Hospital and Health Board considered the recommendations of the Expert Clinical Reference Group on 24 May 2013.
   - West Moreton Hospital and Health Board approved the closure of BAC dependent on alternative, appropriate care provisions for the adolescent target group and the meeting with the Minister for Health.

Blueprint
3. How does this align with the Blueprint for Better Healthcare in Queensland?
   - Providing Queenslanders with value in health services – value for taxpayers money.
   - Better patient care in the community setting, utilising safe, sustainable and responsive service models – delivering best patient care.

Key Issues
4. There is significant patient/carer, community, mental health sector and media interest about a decision regarding the future of the BAC.
5. A comprehensive communication plan has been developed.
6. The Department of Health is urgently progressing planning for Youth Prevention and Recovery Care (Y-PARC) services to be established in Queensland by January 2014. This service type would provide an alternative care option for the adolescent target group currently accessing BAC.

Background
7. BAC is a 15-bed inpatient service for adolescent mental health extended treatment and rehabilitation that is located at The Park – Centre for Mental Health (the Park).
8. The BAC cannot continue to provide services due to the Park becoming an adult secure and forensic campus by 2014, and because the capital fabric of BAC is no longer fit-for-purpose. Alternative statewide service options are required.

Department RecFind No:	
Division/HHS:	
File Ref No:	

Consultation

9. Consultation about the proposed next stages of the Strategy and board decision for closure has been limited to Dr Peter Steer, Children's Health Services; and Dr Tony O'Connell Director General, Dr Michael Cleary and Dr Bill Kingswell, Health Services and Clinical Innovation, Department of Health.
10. A short verbal briefing has been provided to the Queensland Commissioner for Mental Health, Dr Lesley van Schoubroeck.
11. Agreement has been reached that the Strategy will be finalised through a partnership between West Moreton HHS, Children's Health Services and the Department of Health.

Attachments

12. Attachment 1: Agenda Barrett Adolescent Strategy.
13. Attachment 2: Issues and Incident Management Plan BAC.

EXHIBIT 40

Department RecFind No:	
Division/HHS:	
File Ref No:	

Recommendation
That the Director-General:

Note a meeting has been scheduled for 4pm on Monday 15 July 2013 between the Minister for Health, Dr Mary Corbett (Chair, West Moreton HHB), Lesley Dwyer (Chief Executive, West Moreton HHS) and Sharon Kelly (Executive Director, Mental Health and Specialised Services, West Moreton HHS) to discuss the next stages of the Barrett Adolescent Strategy.
And
Provide this brief to the Minister for information.

APPROVED/NOT APPROVED NOTED

DR TONY O'CONNELL
Director-General

/ /

To Minister's Office For Noting ☐

Director-General's comments

Author	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)
Dr Leanne Geppert	Sharon Kelly	Lesley Dwyer
A/Director of Strategy	Executive Director	Chief Executive
Mental Health & Specialised Services, WM HHS	Mental Health & Specialised Services, WM HHS	West Moreton HHS
		<Tel number>
8 July 2013		<Mob number>
	11 July 2013	<Date>

EXHIBIT 40

Department RecFind No:	
Division/HHS:	
File Ref No:	

Briefing Note

The Honourable Lawrence Springborg MP
Minister for Health

Requested by: Lesley Dwyer, Chief Executive, West Moreton Hospital and Health Service

Date requested: 8 July 2013

Action required by: 15 July 2013

SUBJECT: Barrett Adolescent Strategy Meeting

Recommendation

That the Minister:

Note a meeting has been scheduled for 4pm on Monday 15 July 2013 with the West Moreton Board Chair, Chief Executive and Executive Director of Mental Health to discuss the next stages of the Barrett Adolescent Strategy.

Note The West Moreton Board considered the recommendations of the Expert Clinical Reference Group on 24 May 2013, and approved the closure of the Barrett Adolescent Centre dependent on alternative, appropriate care provisions for the adolescent target group and the meeting with the Minister for Health.

Note There is significant patient/carer, community, mental health sector and media interest about a timely decision regarding the future of the Barrett Adolescent Centre. A comprehensive communication plan has been developed.

Note Consultation about the proposed next stages of the Strategy has been limited to Commissioner for Mental Health, Children's Health Services and Department of Health.

APPROVED/NOT APPROVED NOTED NOTED

LAWRENCE SPRINGBORG
Minister for Health

Chief of Staff

/ / / /

Minister's comments

Briefing note rating

1 2 3 4 5

1 = (poorly written, little value, and unclear why brief was submitted), 5 = (concise, key points are explained well, makes sense)

Please Note: All ratings will be recorded and will be used to inform executive performance.

EXHIBIT 40

Ruth Watkins

From: Sdlo
Sent: Friday, 23 January 2015 10:48 AM
To: Michael Cleary
Subject: Fwd: MD09150126 FW: requested documentation from last evening
Attachments: 20150123095030229.pdf; ATT00001.htm

FYI Michael

Helen Langborne
Senior Departmental Liaison Officer
Department of Health
Level 19, QH Building
147 Charlotte Street
Brisbane, 4000

Sent from my iPhone

Begin forwarded message:

From: "MD09-WestMoreton-HSD"
To: "Sdlo"
Cc: "MD09-WestMoreton-HSD" "Sharon Kelly" "Leanne Geppert"
Subject: FW: MD09150126 FW: requested documentation from last evening

Hello Helen

Please find attached further information regarding the closure of the Barrett Centre.
Don't hesitate to contact me if you require anything further.

Many thanks
Jen

Jenifer Lye
Correspondence Officer
Office of the Chief Executive
West Moreton Hospital and Health Services

T:
E:
Chelmsford Avenue/ PO Box 73
Ipswich Qld 4305
Australia

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Facebook: www.facebook.com/pages/West-Moreton-Hospital-and-Health-

EXHIBIT 40

West Moreton Hospital and Health Board

BOARD COMMITTEE AGENDA PAPER

Committee: West Moreton Hospital and Health Board			
Meeting Date:	28 June 2013	**Agenda Item Number:**	
Agenda Subject:	Barrett Adolescent Strategy – Update		
Action required:	☐ For Approval	☐ For Discussion	☒ For Noting
Author: Sharon Kelly	**Position:** Executive Director, Mental Health & Specialised Services	**Date:** 24 June 2013	

☐ Recommendation/s are consistent with Strategic Plan
☐ Funding Impacts are included within approved budget
☐ Risks are identified and mitigation/management strategies included
☐ Implications for patient and/or staff care and well-being have been identified

Proposal

That the West Moreton Hospital and Health Board:

Note actions attend within month of June to align with Board decision in principle to close Barrett Adolescent Service.
Note the verbal briefing between the Minister for Health, and the West Moreton Hospital and Health Board Chair and Chief Executive is diarised for Monday 15 July.

Background

1. Refer to Board paper of 24 May agenda item 4.3

Key Issues or Risks

2. **WMHHS to engage with Children's Health services and the Mental Health Alcohol and Other Drugs Branch re planning for future model of care for adolescent services.**
   a. A meeting was held Tuesday June 11th between Lesley Dwyer, Chief Executive WMHHS, Dr Peter Steer, Chief Executive Children's Health Services, Leanne Geppert, Acting Director of Strategy MH&SS and Sharon Kelly ED MH&SS WMHHS.
      i. In principle agreement reached that Children's HHS will partner with The MHAOD Branch to progress a statewide service model.
      ii. Agreement noted that the timeliness of the development and implementation is a priority for WMHHS.

   b. A meeting was held Monday June 17th with the Director General (Dr O'Connell), DDG Health Services and Clinical Innovation (Dr Cleary), Lesley Dwyer, Sharon Kelly and Leanne Geppert.
      i. In principle support of the plan for closure of BAC with an understanding the new model of service is identified and developed.
      ii. Agreement of HSCI support for the shared model planning process.

3. **WMHHS to pursue discharge of appropriate current patients from Barrett Adolescent Centre with appropriate 'wrap around' services.**
   a. As identified at The Board, until a decision is confirmed in regards to the plans for BAC clinical services will continue to be provided and consumers discharged as appropriate. Any targeted discharge planning for current consumers that is related to closure of the service will raise concerns within the consumers, staff and families and potential wider community prior to a clear decision and communication strategy being in place and available.

4. Minister to be updated regarding proposed closure of Barrett Adolescent Centre, plan for development of alternatives and community engagement strategy as well as decision not to accept any further patients into BAC
   a. Meeting planned for Monday July 15th.
   b. Communication plan and strategy in draft development at current time.

c. Decision to not accept patients into BAC can only be advised to staff once decision to close the service and move to alternate model is known.

Consultation

5. All correspondence from stakeholders (email, ministerials etc) and media enquiries have and are being responded to in a timely manner with consistent key messages being utilised.

Financial and Other Implications

6. remains in alignment with previous papers on the topic.

Strategic and Operational Alignment

7. The closure of BAC and removal of adolescent services from The Park forensic site aligns with both the strategic direction of the HHS and the Queensland Plan for Mental Health 2007-17.

Recommendation

Note actions attend within month of June to align with Board decision in principle to close Barrett Adolescent Service.

Note the verbal briefing between the Minister for Health, and the West Moreton Hospital and Health Board Chair and Chief Executive is diarised for Monday 15 July.

EXHIBIT 40

Sharon Kelly2 - Fwd: URGENT - Briefing Note for DG Approval_Barrett Adolescent Strategy Meeting 15 July 2013_MD0920130151

From: Sharon Kelly
To: Bronwyn Mitchell; Leanne Geppert
Date: 12/07/2013 9:38 AM
Subject: Fwd: URGENT - Briefing Note for DG Approval_Barrett Adolescent Strategy Meeting 15 July 2013_MD0920130151
Attachments: BNA_BAC Strategy Meeting_MD0920130151.doc; Attachment 1 Agenda Barrett Adolescent StrategyMD0920130151.doc; Attachment 2 Issues and Incident Management Plan BAC_MD0920130151.doc

FYI

Sharon Kelly
Executive Director
Mental Health and Specialised Services

West Moreton Hospital and Health Service
T:
E:

The Park - Centre for Mental Health
Administration Building, Cnr Ellerton Drive and Wolston Park Road, Wacol, Qld 4076
Locked Bag 500, Sumner Park BC, Qld 4074

www.health.qld.gov.au

>>> MD09-WestMoreton-HSD 12/07/2013 9:26 am >>>
Good morning,

Please find attached Briefing note for urgent DG approval and forwarding to the Minister in preparation for a meeting scheduled with the Minister on Monday 15 July 2013 - 4pm.

Can you please advise of the registration number when available for tracking purposes.

Kind Regards
Annette

Office of the Chief Executive (MD09)
West Moreton Hospital &
Health Service

Ph: (
Fax:

EXHIBIT 40

Dear Team,

Can we please add a signature box for the CE Ipswich and West Morton HHS so that it is clear that the HHS is seeking this approval.

I would also suggest that we clarify if the Board of the HHS has considered and approved this.

We should also add a section in that indicated that subject to approval being provided that a project and communication plan will be developed and provided to the DG.

Kind regards
Michael Cleary
Friday, 2 November 2012

HSCID

Briefing Note for Appro

Director-General

Requested by: Deputy Director-General Health Service & Clinical Innovation Division Date

012

SUBJECT: Approval to close Barre Health

Proposal
That the Director-General:

Approve the closure of the Barre

Provide this brief to the Minister for noting.

Urgency
1. Critical: The West Moreton HHS Mental Health Service Executive Director is seeking approval from the West Moreton HHS Board to close the BAC in December 2012.

Headline Issues
2. The top issues are:
   - Service delivered through BAC cannot continue due to the following:

     i. The age and condition of the building has been identified by the Australian Council on Healthcare Standards as unsafe, necessitating urgent replacement.

     ii. Concerns have been raised about the co-location of BAC with adult forensic and secure services delivered by The Park Centre for Mental Health (TPCMH).

     iii. There is a clear policy direction to ensure that young people are treated close to their homes in the least restrictive environment with the minimum possible disruption to their families, educational, social and community networks.

     iv. The average bed occupancy rate for BAC is 43%. This is less than half of the 15 beds currently available in this unit.

Key Values
3. The key values that apply are the following:
☒ Better service for patients
☒ Better healthcare in the community
☐ Valuing our employees and empowering frontline staff
☐ Empowering local communities with a greater say over their hospital and local health services
☒ Value for money for taxpayers
☐ Openness

Key issues
4. The BAC delivers an extended treatment model of care that consists of both extended inpatient and day patient programs including education components. Recent sector advice proposes a re-scoping of the BAC service model and governance structure to ensure a contemporary evidence based model of care is being provided for adolescents with serious mental illness.

Department RecFind No:	
Division/District:	**HSCID**
File Ref No:	

5. Alternative services for this group of consumers will need to be considered immediately and will require a collaborative approach. The short term options to be considered may include the following:
    - Additional day programs attached to current adolescent acute units; and
    - Utilisation of non-government sector services for adolescents; and
    - The use of existing, unoccupied adolescent acute beds will also need to be considered where no other alternatives exist. Currently, acute child and adolescent beds are located in mental health services at the Gold Coast, Logan, Mater Child and Youth, Royal Brisbane and Women's Hospital, Toowoomba and Townsville (opening 2013) mental health services.

6. Longer term planning is required to align with the National Mental Health Service Planning Framework that recommends subacute community based services for adolescents.

7. It is anticipated that the West Moreton HHS will coordinate and facilitate alternative arrangements for adolescents currently accessing BAC services. West Moreton HHS has indicated that they will invite key stakeholders including the Mental Health Alcohol and Other Drugs Branch (MHAODB) to meet in November 2012 to expedite these arrangements.

8. The West Moreton HHS Mental Health Service executive management has commenced high level consultation and planning to progress the closure of BAC by December 2012. A meeting is scheduled on 2 November 2012 with key management staff of BAC to advise of imminent closure.

9. The West Moreton HHS Mental Health Service will use the planned closure of BAC during the Christmas period as a natural progression to permanent closure and will not re-open thereafter.

Background

10. Under the *Queensland Plan for Mental Health 2007-2017* (QPMH), it was determined that the development of a new model of care for BAC was required. There is some contention in the mental health sector and community around this issue.

11. The Redlands Adolescent Extended Treatment Unit (RAETU), funded under the QPMH, was intended to replace BAC. This project has ceased due to unresolved environmental issues and budget overruns and hence is no longer a sustainable capital works project for Queensland Health.

12. The deinstitutionalisation of services currently provided at TPCMH is part of the reform agenda under the QPMH and will result in only forensic and secure services being provided at the facility.

13. The National Mental Health Policy (2008) articulates that 'non-acute bed-based services should be community based wherever possible.'

14. The National Mental Health Service Planning Framework currently being developed by the Commonwealth Government, due for completion in July 2013 does not include provision for non-acute adolescent inpatient services. The Framework does include subacute community based services for adolescents.

Department RecFind No:	
Division/District:	**HSCID**
File Ref No:	

Consultation

15. Consultation has commenced with the Executive Director and Clinical Director of West Moreton HHS Mental Health Service. It is anticipated that the West Moreton HHS will be responsible for the coordination and implementation of change management processes and procedures including all staffing and IR related issues pertinent to the closure of BAC.

16. No formal consultation has occurred with staff of BAC.

17. No consultation has occurred with consumers of BAC and their families.

Financial implications

18. The operating costs of the BAC for 2011-12 were $4,264,948. A portion of this funding will be required to meet infrastructure costs at the BAC site until a decision regarding the future use of this site has been made. The remainder of the current operating costs of BAC will be used for alternative adolescent extended treatment services.

19. The cancellation of the RAETU results in recurrent funding savings of $1.8M. This will also be used for alternative adolescent extended treatment options.

Legal implications

20. There are no legal implications

Attachments

21. Nil.

Department RecFind No:	
Division/District:	**HSCID**
File Ref No:	

Recommendation
That the Director-General:

Approve the closure of the Barrett Adolescent Centre (BAC) by December 2012.

Provide this brief to the Minister for noting.

APPROVED/NOT APPROVED **NOTED**

DR TONY O'CONNELL
Director-General

/ /

To Minister's Office for Approval ☐
for Noting ☐

Director-General's comments

Author	Cleared by:	Cleared by: (SD/Dir)	Content verified by: (CEO/DDG/Div Head)	Content verified by: (CEO/DDG/Div Head)
Vaoita Turituri	Marie Kelly	Dr Leanne Geppert	Dr Bill Kingswell	Dr Michael Cleary
Senior Project Officer	Manager	Director	Executive Director	Deputy Director General
Intergovernmental Relations & Systems Redesign Unit, Mental Health, Alcohol and Other Drugs Branch.	Intergovernmental Relations & Systems Redesign Unit, Mental Health, Alcohol and Other Drugs Branch.	Intergovernmental Relations & Systems Redesign Unit	Mental Health Alcohol and Other Drugs Branch	Health Service and Clinical Innovation Division
26/10/2012	31/10/2012	1/11/2012	1/11/2012	

EXHIBIT 40

HSCI_Corro

From: DDGHSCI DDGHSCI
Sent: Thursday, 13 December 2012 10:18 AM
To: MD09-WestMoreton-HSD
Cc: MHD_dchocorro
Subject: HC000575: Barrret Adolescent Strategy Resource Report
Attachments: HC000575 - letterhead.pdf

Good morning,

Please find attached correspondence from DDGHSCI.

Kind regards,
Jeanie

Jeanie Tertzakian

Office of the Deputy Director-General
Health Service and Clinical Innovation Division

Phone:
Email:

EXHIBIT 40

Queensland Government

Queensland Health

Enquiries to: Joe Riverstone
Business Manager
Mental Health Alcohol and Other Drugs Branch
Telephone:
Facsimile:
File Ref: HC000575

Ms Lesley Dwyer
Chief Executive
West Moreton Hospital and Health Service
PO Box 73
IPSWICH QLD 4305

Dear Ms Dwyer

I refer to our meeting of 13 November 2012 regarding the project to investigate models for the future delivery of services currently delivered through the Barrett Adolescent Centre, and to your follow-up memorandum of 4 December 2012.

In your memorandum, you advise that the West Moreton Hospital and Health Service has engaged Ms Naomi Ford of Rowdy PR to act as its media and communications expert during delivery of the project. I note that Ms Ford will provide media and communications services for up to an equivalent of 20 working days at a rate of $80 per hour.

I can confirm that the Health Service and Clinical Innovation Division, through the Mental Health Alcohol and Other Drugs Branch, will provide the financial resources for this component of the project.

Invoices for Ms Ford's services may be forwarded to Dr Bill Kingswell, Executive Director, Mental Health Alcohol and Other Drugs Branch, at PO Box 2368, Fortitude Valley BC 4006, who will arrange their payment on receipt.

Yours sincerely

Dr Michael Cleary
Deputy Director-General
Health Service and Clinical Innovation Division
13/12/2012

Office
Queensland Health
16th floor
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EXHIBIT 40

WEST MORETON HOSPITAL & HEALTH SERVICE

West Moreton Hospital & Health Service	Memorandum		
To:	Dr Michael Cleary Deputy Director-General Health Service & Clinical Innovation		
Copies to:	Dr Bill Kingswell, ED Mental Health Alcohol and Other Drugs Branch Sharon Kelly, ED Mental Health & Specialised Services		
From:	Lesley Dwyer Chief Executive West Moreton Hospital & Health Service	Contact No: Fax No:	[redacted]
Subject:	Barrett Adolescent Strategy Resource Support		
		File Ref:	0412 DDG HSCI re BAC

I refer to our meeting on 13 November 2012, where we discussed the Barrett Strategy roles and responsibilities and resources required.

At this meeting you indicated resource support would be available from the System Manager, given the Barrett Strategy has Statewide service implications.

We have been able, so far, to utilise internal resources for the majority of planning and actions of the group, in partnership with the Mental Health Alcohol and Other Drugs Directorate.

As you can understand this is a highly sensitive issue and as such, we have engaged the services of Rowdy PR, Ms Naomi Ford, to act as our media and communications expert during this process.

We would now seek to confirm your commitment to providing the financial resource for this component of the project.

Ms Ford's costs are $80 per hour and on this project she can only work up to the equivalent of 20 days.

I look forward to your early response.

[redacted]

Lesley Dwyer
Chief Executive
West Moreton Hospital and Health Service
04 / 12 / 2012

West Moreton Hospital and Health Service

Expert Clinical Reference Group Recommendations

Barrett Adolescent Strategy

July 2013

Queensland Government

Adolescent Extended Treatment and Rehabilitation Services (AETRS) Recommendations Submitted to the West Moreton Hospital and Health Board

1. Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework

ECRG Recommendations	Planning Group Recommendations
a) Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.	**Accept with the following considerations.** The responsibility for this task at a statewide level sits with the Mental Health Alcohol and Other Drugs Branch and the Children's Health Services. A collaborative partnership is proposed.
b) Formal planning including consultation with stakeholder groups will be required.	**Accept with the following considerations.** This body of work should be incorporated into the statewide planning and implementation process (as above).

2. Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component

ECRG Recommendation	Planning Group Recommendation
a) A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.	**Accept with the following considerations.** Further work is needed to detail the service model for a Tier 3. Models involving a statewide, clinical bed-based service (such as the Barrett Adolescent Centre) are not considered contemporary within the National Mental Health Service Planning Framework *(in draft)*. However, there are alternative bed-based models involving clinical and non-clinical service components (e.g., Y-PARC in Victoria) that can be developed in

Terms of Reference: Expert Clinical Reference Group – Barrett Adolescent Strategy					
Date:	30.11.12	Review Date:	N/A	Version:	Final

1. Purpose:

1.1 The purpose of the Expert Clinical Reference Group is to:
Provide expert clinical advice to promote the development of a contemporary evidence based model of care to meet the needs of adolescent mental health consumers who experience severe and persistent psychiatric symptomatology that significantly interferes with social, emotional, behavioural and psychological functioning and development.

2. Scope and functions:

2.1 The Expert Clinical Reference Group will consider that the model(s) of care:

- will clearly articulate a contemporary model(s) of care for subacute mental health treatment and rehabilitation for adolescents in Queensland
- will be evidenced based, sustainable and align with Queensland mental health policy, current statewide models of service, National mental health policy, National mental health service planning frameworks and future funding models.
- will take into account the Clinical Services Capability Framework (for Mental Health) and
- will replace the existing Statewide services provided by Barrett Adolescent Centre – The Park.

3. Membership (position held only):

3.1 Members:

- Dr Michelle Fryer, Faculty Child and Adolescent Psychiatry
- Dr James Scott, Consultant Psychiatrist Early Psychosis, Metro North HHS
- Dr David Hartman, Clinical Director, CYMHS, Townsville HHS
- Dr Trevor Sadler, Clinical Director, BAC, West Moreton HHS
- Professor Philip Hazell, Director, Infant Child and Adolescent Mental Health Services, Sydney and South Western Sydney Local Health Districts
- Ms Josie Sorban, Director of Psychology, CYMHS, Children's Health Qld HHS
- Ms Amanda Tilse, Operational Manager, Alcohol Other Drugs and Campus Mental Health Services, Mater Children's Hospital
- Ms Amelia Callaghan, State Manager Qld NT and WA, Headspace
- Ms Emma Hart, NUM, Adolescent Inpatient Unit and Day Service, Townsville HHS
- Mr Kevin Rodgers PSM, Principal, Barrett Adolescent Centre School
-
-

Carer Consultant will provide support to the consumer and representative will on the Expert Clinical Reference Group.

The Chair on behalf of the Expert Clinical Reference Group, will invite additional nominated National experts on an as needs basis to provide additional input into the development of a contemporary evidence based model of care.

3.2 Proxies:
Due to the time limited nature of this reference group, it is unlikely that the use of proxies will be effective.

4. Chairperson

4.1 Dr Leanne Geppert, Director Planning and Partnerships Unit, Mental Health Alcohol & Other Drugs Branch (MHAODB)

5. Secretariat (position held only):

5.1 MHAODB will provide the secretariat to the Expert Clinical Reference Group.

6. Reporting relationships:

6.1 The Expert Clinical Reference Group will provide its recommendation regarding contemporary model(s) of care to the planning group as per the Project Plan for the Barrett Adolescent Strategy.

7. Sub Committees:

7.1 Nil.

8. Frequency of meetings:

8.1 Given the expected short duration of this forum, it is anticipated that the Expert Clinical Reference Group will meet on at least a fortnightly basis (in person or tele/videoconference) until a recommended model of care is developed. It may reconvene on an as needs basis to examine plans regarding the implementation of an endorsed model of care.

9. Quorum:

9.1 The quorum for Expert Clinical Reference Group meetings will be half of membership plus one.

10. Authorisation:

These Terms of Reference may be altered following committee consultation and endorsement by the Chief Executive West Moreton HHS and A/Executive Director MHAODB on the recommendation of the Expert Clinical Reference Group.

Chairperson: Dr Leanne Geppert, Director Planning and Partnerships Unit, MHAODB

Date: Signature:

ECRG Recommendation	Planning Group Recommendation
	Queensland to meet the requirement of this recommendation. Contestability reforms in Queensland may allow for this service component to be provider agnostic.

3. Interim service provision if BAC closes and Tier 3 is not available is associated with risk

ECRG Recommendations	Planning Group Recommendations
a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.	**Accept.**
b) Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wrap-around care' for each individual will be essential.	**Accept with the following considerations.** While this may be a complex process for some consumers and their individual needs, it was noted that this course of action could start immediately, and that it was feasible. The potential to utilise current BAC operational funds (temporarily) to 'wrap-around' each consumer's return to their local community was noted as a significant benefit. The relevant local community should play a lead role in the discharge of the consumer from BAC and their return to home. The local services need to be consulted around their ability to provide 'wrap-around' care.
c) BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.	**Accept.** The ECRG and the Planning Group strongly supported this recommendation.

4. Duration of treatment

ECRG Recommendation	Planning Group Recommendation
a) 'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a suitable community residence for the young person. It is important to note that like all mental health service provision, there will be a range in the duration of admission.	**Accept with the following considerations.** This issue requires further deliberation within the statewide planning process. The duration of treatment needs some parameters to be set, however, this is primarily a clinical issue that is considered on a case-by-case basis by the treating team and the consumer.

5. Education resource essential: on-site school for Tiers 2 and 3

ECRG Recommendations	Planning Group Recommendations
a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.	**Accept with the following considerations.** The Planning Group recommends removing *"Band 7"* from the ECRG recommendation. All educational services need to be evaluated by Department of Education, Training and Employment (DETE) on a case-by-case basis, taking into consideration service model, location, student numbers and complexity. The Planning Group supports the statement that educational resources are essential to adolescent extended treatment and rehabilitation services. The Planning Group recommends consultation with DETE once a statewide model is finalised.

ECRG Recommendations	Planning Group Recommendations
b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).	**Accept with the following consideration.** The Planning Group recommends this statement should be changed to read as: Strong consideration should be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).

6. Residential Service: Important for governance to be with CYMHS; capacity and capability requires further consideration

ECRG Recommendations	Planning Group Recommendations
a) It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.	**Accept with the following consideration.** Note that this service could be provider agnostic.
b) Governance should remain with the local CYMHS or treating mental health team.	**Accept.**
c) It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.	**Accept.**

EXHIBIT 40

7. Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas)

ECRG Recommendations	Planning Group Recommendations
a) Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.	**Accept.**
b) If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.	**Accept.**

EXHIBIT 40

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EXHIBIT 40

EXHIBIT 40

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Proposed Service Model Elements
Adolescent Extended Treatment and Rehabilitation Services (AETRS)

Preamble

Mental health disorders are the most prevalent illnesses affecting adolescents today. Of particular note is the considerable evidence that adolescents with persisting and severe symptomatology are those most likely to carry the greatest burden of illness into adult life. Despite this, funding for adolescent (and child) mental health services is not proportional to the identified need and burden of disease that exists.

In the past 25 years, a growing range of child and youth mental health services have been established by Queensland Health (and other service providers) to address the mental health needs of children and adolescents. These services deliver mental health assessment and treatment interventions across the spectrum of mental illness and need, and as a service continuum, provide care options 24 hours a day, seven days a week. No matter where an adolescent and their family live in Queensland, they are able to access a Child and Youth Mental Health Service (CYMHS) community clinic or clinician (either via direct access through their Hospital and Health Service, or through telehealth facilities). Day Programs have been established for adolescents in South Brisbane, Toowoomba and Townsville. Acute mental health inpatient units for adolescents are located in North Brisbane, Logan, Robina, South Brisbane and Toowoomba, and soon in Townsville (May/June 2013). A statewide specialist multidisciplinary assessment, and integrated treatment and rehabilitation program (The Barrett Adolescent Centre [BAC]) is currently delivered at The Park Centre for Mental Health (TPCMH) for adolescents between 13 and 17 years of age with severe, persistent mental illness. This service also offers an adolescent Day Program for BAC consumers and non-BAC consumers of West Moreton Hospital and Health Service.

Consistent with state and national mental health reforms, the decentralisation of services, and the reform of TPCMH site to offer only adult forensic and secure mental health services, the BAC is unable to continue operating in its current form at TPCMH. Further to this, the current BAC building has been identified as needing substantial refurbishment. This situation necessitates careful consideration of options for the provision of mental health services for adolescents (and their families/carers) requiring extended treatment and rehabilitation in Queensland. Consequently, an Expert Clinical Reference Group (ECRG) of child and youth mental health clinicians, a consumer representative, a carer representative, and key stakeholders was convened by the Barrett Adolescent Strategy Planning Group to explore and identify alternative service options for this target group.

Between 1 December 2012 and 24 April 2013 the ECRG met regularly to define the target group and their needs, conduct a service gap analysis, consider community and sector feedback, and review a range of contemporary, evidence-based models of care and service types. This included the potential for an expanded range of day programs across Queensland and community mental health service models delivered by non-government and/or private service providers. The ECRG

have considered evidence and data from the field, national and international benchmarks, clinical expertise and experience, and consumer and carer feedback to develop a service model elements document for Adolescent Extended Treatment and Rehabilitation Services in Queensland. This elements document *is not a model of service* – it is a conceptual document that delineates the key components of a service continuum type for the identified target group. As a service model elements document, it will not define how the key components will function at a service delivery level, and does not incorporate funding and implementation planning processes.

The service model elements document proposes four tiers of service provision for adolescents requiring extended mental health treatment and rehabilitation:

- **Tier 1** – Public Community Child and Youth Mental Health Services (existing);
- **Tier 2a** – Adolescent Day Program Services (existing + new);
- **Tier 2b** – Adolescent Community Residential Service/s (new); and
- **Tier 3** – Statewide Adolescent Inpatient Extended Treatment and Rehabilitation Service (new).

The final service model elements document produced was cognisant of constraints associated with funding and other resources (e.g., there is no capital funding available to build BAC on another site). The ECRG was also mindful of the current policy context and direction for mental health services as informed by the National Mental Health Policy (2008) which articulates that *'non acute bed-based services should be community based wherever possible'.* A key principle for child and youth mental health services, which is supported by all members of the ECRG, is that young people are treated in the least restrictive environment possible, and one which recognises the need for safety and cultural sensitivity, with the minimum possible disruption to family, educational, social and community networks.

The ECRG comprised of consumer and carer representatives, and distinguished child and youth mental health clinicians across Queensland and New South Wales who were nominated by their peers as leaders in the field. The ECRG would like to acknowledge and draw attention to the input of the consumer and carer representatives. They highlighted the essential role that a service such as BAC plays in recovery and rehabilitation, and the staff skill and expertise that is inherent to this particular service type. While there was also validation of other CYMHS service types, including community mental health clinics, day programs and acute inpatient units, it was strongly articulated that these other service types are not as effective in providing safe, medium-term extended care and rehabilitation to the target group focussed on here. It is understood that BAC cannot continue in its current form at TPCMH. However, it is the view of the ECRG that like the Community Care Units within the adult mental health service stream, a design-specific and clinically staffed bed-based service is essential for adolescents who require medium-term extended care and rehabilitation. This type of care and rehabilitation program is considered life-saving for young people, and is available currently in both Queensland and New South Wales (e.g., The Walker Unit).

The service model elements document (attached) has been proposed by the ECRG as a way forward for adolescent extended treatment and rehabilitation services in Queensland.

There are seven key messages and associated recommendations from the ECRG that need to underpin the reading of the document:

1. Broader consultation and formal planning processes are essential in guiding the next steps required for service development, acknowledging that services need to align with the National Mental Health Service Planning Framework

- The proposed service model elements document is a conceptual document, not a model of service. Formal consultation and planning processes have not been completed as part of the ECRG course of action.
- In this concept proposal, Tier 2 maps to the Clinical Services Capability Framework for Public and Licensed Private Health Facilities Version 3.1 (CSCF) Level 5 and Tier 3 maps to CSCF Level 6.

Recommendations:

a) Further work will be required at a statewide level to translate these concepts into a model of service and to develop implementation and funding plans.

b) Formal planning including consultation with stakeholder groups will be required.

2. Inpatient extended treatment and rehabilitation care (Tier 3) is an essential service component

- It is understood that the combination of day program care, residential community-based care and acute inpatient care has been identified as a potential alternative to the current BAC or the proposed Tier 3 in the following service model elements document.
- From the perspective of the ECRG, Tier 3 is an essential component of the overall concept, as there is a small group of young people whose needs cannot be safely and effectively met through alternative service types (as represented by Tiers 1 and 2).
- The target group is characterised by severity and persistence of illness, very limited or absent community supports and engagement, and significant risk to self and/or others. Managing these young people in acute inpatient units does not meet their clinical, therapeutic or rehabilitation needs.
- The risk of institutionalisation is considered greater if the young person receives medium-term care in an acute unit (versus a design-specific extended care unit).
- Clinical experience shows that prolonged admissions of such young people to acute units can have an adverse impact on other young people admitted for acute treatment.
- Managing this target group predominantly in the community is associated with complexities of risk to self and others, and also the risk of disengaging from therapeutic services.

Recommendation:

a) A Tier 3 service should be prioritised to provide extended treatment and rehabilitation for adolescents with severe and persistent mental illness.

3. Interim service provision if BAC closes and Tier 3 is not available is associated with risk

- Interim arrangements (after BAC closes and before Tier 3 is established) are at risk of offering sub optimal clinical care for the target group, and attention should be given to the therapeutic principles of safety and treatment matching, as well as efficient use of resources (e.g., inpatient beds).
- In the case of BAC being closed, and particularly if Tier 3 is not immediately available, a high priority and concern for the ECRG was the 'transitioning' of current BAC consumers, and those on the waiting list.
- Of concern to the ECRG is also the dissipation and loss of specialist staff skills and expertise in the area of adolescent extended care in Queensland if BAC closes and a Tier 3 is not established in a timely manner. This includes both clinical staff and education staff.

Recommendations:

a) Safe, high quality service provision for adolescents requiring extended treatment and rehabilitation requires a Tier 3 service alternative to be available in a timely manner if BAC is closed.

b) Interim service provision for current and 'wait list' consumers of BAC while Tier 3 service options are established must prioritise the needs of each of these individuals and their families/carers. 'Wrap-around care' for each individual will be essential.

c) BAC staff (clinical and educational) must receive individual care and case management if BAC closes, and their specialist skill and knowledge must be recognised and maintained.

4. Duration of treatment

- A literature search by the ECRG identified a weak and variable evidence base for the recommended duration of treatment for inpatient care of adolescents requiring mental health extended treatment and rehabilitation.
- Predominantly, duration of treatment should be determined by clinical assessment and individual consumer need; the length of intervention most likely to achieve long term sustainable outcomes should be offered to young people.
- As with all clinical care, duration of care should also be determined in consultation with the young person and their guardian. Rapport and engagement with service providers is pivotal.

Recommendation:

a) 'Up to 12 months' has been identified by the ECRG as a reasonable duration of treatment, but it was noted that this depends on the availability of effective step-down services and a

suitable community residence for the young person. It is important to note that like all mental health service provision, there will be a range in the duration of admission.

5. Education resource essential: on-site school for Tiers 2 and 3

- Comprehensive educational support underpins social recovery and decreases the likelihood of the long term burden of illness. A specialised educational model and workforce is best positioned to engage with and teach this target group.
- Rehabilitation requires intervention to return to a normal developmental trajectory, and successful outcomes are measured in psychosocial functioning, not just absence of psychiatric symptoms.
- Education is an essential part of life for young people. It is vital that young people are able to access effective education services that understand and can accommodate their mental health needs throughout the care episode.
- For young people requiring extended mental health treatment, the mainstream education system is frequently not able to meet their needs. Education is often a core part of the intervention required to achieve a positive prognosis.

Recommendations:

a) Access to on-site schooling (including suitably qualified educators), is considered essential for Tiers 2 (day programs) and 3. It is the position of the ECRG that a Band 7 Specific Purpose School (provided by Department of Education, Training and Employment) is required for a Tier 3 service.

b) As an aside, consideration should also be given to the establishment of a multi-site, statewide education service for children/adolescents in acute units (hub and spoke model).

6. Residential Service: Important for governance to be with CYMHS; capacity and capability requires further consideration

- There is no true precedent set in Queensland for the provision of residential or bed-based therapeutic community care (by non-government or private providers) for adolescents (aged up to 18 years) requiring extended mental health care.
- The majority of ECRG members identified concerns with regard to similar services available in the child safety sector. These concerns were associated with:
  - Variably skilled/trained staff who often had limited access to support and supervision;
  - High staff turn-over (impacting on consumer trust and rapport); and
  - Variable engagement in collaborative practice with specialist services such as CYMHS.

Recommendations:

a) It is considered vital that further consultation and planning is conducted on the best service model for adolescent non-government/private residential and therapeutic services in community mental health. A pilot site is essential.

b) Governance should remain with the local CYMHS or treating mental health team.

c) It is essential that residential services are staffed adequately and that they have clear service and consumer outcome targets.

7. Equitable access to AETRS for all adolescents and families is high priority; need to enhance service provision in North Queensland (and regional areas)

- Equity of access for North Queensland consumers and their families is considered a high priority by the ECRG.

Recommendations:

a) Local service provision to North Queensland should be addressed immediately by ensuring a full range of CYMHS services are available in Townsville, including a residential community-based service.

b) If a decision is made to close BAC, this should not be finalised before the range of service options in Townsville are opened and available to consumers and their families/carers.

EXHIBIT 40

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Proposed Service Model Elements Adolescent Extended Treatment and Rehabilitation Services (AETRS)	
Attribute	**Details**
Service Delivered	The aim of this platform of services is to provide medium term, recovery oriented treatment and rehabilitation for young people aged 13 – 17 years with severe and persistent mental health problems, which significantly interfere with social, emotional, behavioural and psychological functioning and development. The AETRS continuum is offered across a range of environments tailored to the individual needs of the young person with regard to safety, security, structure, therapy, community participation, autonomy and family capacity to provide care for the young person. The AETRS functions as part of the broader, integrated continuum of care provided for young Queenslanders, that includes acute inpatient, day program and community mental health services (public, private and other community-based providers).
Over-arching Principles	The delivery of an Adolescent Extended Treatment and Rehabilitation Service continuum will: • develop/maintain stable networks • promote wellness and help young people and their families in a youth oriented environment • provide services either in, or as close to, the young person's local community • collaborate with the young person and their family and support people to develop a recovery based treatment plan that promotes holistic wellbeing • collaborate with other external services to offer continuity of care and seamless service delivery, enabling the young person and their family to transition to their community and services with ease • integrate with Child and Youth Mental Health Services (CYMHS), and as required, Adult Mental Health Services • recognise that young people need help with a variety of issues and not just illness • utilise and access community-based supports and services

	where they exist, rather than re-create all supports and services within the mental health setting • treat consumers and their families/carers in a supportive therapeutic environment provided by a multidisciplinary team of clinicians and community-based staff • provide flexible and targeted programs that can be delivered across a range of contexts and environments • have the capacity to deliver services in a therapeutic milieu with family members; support and work with the family in their own environment; and keep the family engaged with the young person and the mental health problems they face • have capacity to offer intensive family therapy and family support • have flexible options from 24 hour inpatient care to partial hospitalisation and day treatment with ambulant approaches; step up/step down • acknowledge the essential role that educational/vocational activities and networks have on the recovery process of a young person • engage with a range of educational or vocational support services appropriate to the needs of the young person and the requirements of their treatment environment, and encourage engagement/reengagement of positive and supportive social, family, educational and vocational connections.
Key Distinguishing Features of an AETRS	Services are accessed via a tiered, least-restrictive approach, and may involve combinations of service types across the tiers. **Tier 1:** **Public Community Mental Health Services (Sessional)** • Existing Locations: All Hospital and Health Services (HHSs). • Access ambulatory care at a public community-based mental health service, within the local area. • Interventions should consider shared-care options with community-based service providers, e.g. General Practitioners and *headspace*. **Tier 2a: Level 5 CSCF.** **Day Program Services (Mon – Fri business hours).** • Existing Locations: Townsville (near completion), Mater, Toowoomba, Barrett Adolescent Centre (BAC). • Possible New Locations: Gold Coast, Royal Children's Hospital CYMHS catchment, Sunshine Coast. Funds from existing

	operational funds of BAC and Redlands Facility. Final locations and budget to be determined through a formal planning process. • Individual, family and group therapy, and rehabilitation programs operating throughout (but not limited to) school terms. • Core educational component for each young person – partnership with Education Queensland and vocational services required. This may be provided at the young person's school/vocational setting, or from the day program site. • Flexible and targeted programs with attendance up to 5 days (during business hours) a week, in combination with integration into school, community and/or vocational programs. • Integrated with local CYMHS (acute inpatient and public community mental health teams). • Programs are delivered in a therapeutic milieu (from a range of settings including day program service location, the family home, school setting etc.). • Programs will support and work with the family, keeping them engaged with the young person's recovery. • Consumers may require admission to Adolescent Acute Inpatient Unit (and attend the Day Program during business hours). • Proposal of 12 - 15 program places per Day Program (final places and budget should be determined as part of formal planning process). **Tier 2b:** **[1]Community Residential Service (24h/7d).** • Existing Locations: Nil services currently. Note: Cairns Time Out House Initiative for 18y+. • Possible New Locations: Sites where Day Programs are currently delivered; Townsville identified as a priority in order to meet the needs of North Queensland families. Funding from existing operational funds of BAC and Redlands Facility. Final locations and budget to be determined through a formal

[1] Note: The Department of Health takes a 'provider agnostic' view in determining non clinical support and accommodation services. Decisions to contract service providers will be determined by service merit, consumer need and formal planning and procurement processes.

	planning process. • Day Program attendance as in Tier 2a during business hours. • This tier incorporates a bed-based residential and respite service for adolescents after-hours and on weekends (in the community). • There is potential for one or more of these services to provide 'family rooms', that will temporarily accommodate family members while their young person attends the Day Program or the Adolescent Acute Inpatient Unit (for example, in Townsville). • Integrated with local CYMHS (acute inpatient, day program and public community mental health teams). • Residential to be a partnership model for service delivery between a community-based service provider and QH – multidisciplinary staffing profile including clinical (Day Program) and community support staff (community-based provider). Partnership to include clinical governance, training and in-reach by CYMHS. • Residential component only provides accommodation; it is not the intervention service provider but will work closely with the intervention service provider to maintain consistency in the therapeutic relationship with the young person. • On-site extended hours visiting service from CYMHS Day Program staff. **Tier 3: Level 6 CSCF.** **Statewide Inpatient Extended Treatment and Rehabilitation Service (24h/7d)[2].** • Possible Location: S.E. Qld. Source of capital funding and potential site not available at current time[3]. Acknowledge accessibility issues for young people outside S.E. Qld.

[2] The Department of Health acknowledges the dedicated school and expertise provided by the Department of Education Training and Employment (DETE). The Department of Health values and supports partnership with DETE to ensure that adolescents have access to appropriate educational and vocational options to meet their educational/vocational needs.

[3] Until funding and location is available for Tier 3, all young people requiring extended treatment and rehabilitation will receive services through Tiers 1 and 2a/b (i.e., utilising existing CYMHS community mental health, Day Programs and Acute Inpatient Units until the new Day Programs and residential service providers are established). It is emphasised that this is not proposed to be a clinically preferred or optimal solution, and significant risks are associated with this interim measure.

	• For young people whose needs could not be met by Tiers 1 and 2 above, due to risk, severity or need for inpatient extended treatment and care. These young people's needs are not able to be met in an acute setting. • In-patient therapeutic milieu, with capacity for family/carer admissions (i.e. family rooms). • All other appropriate and less restrictive interventions considered/tested first. • Proposal for approximately 15 beds – this requires formal planning processes. • Medium term admissions (approximately up to 12 months; however, length of stay will be guided by individual consumer need and will therefore vary). • Delivers integrated care with the local CYMHS of the young person. • Individualised, family and group rehabilitation programs delivered through day and evening sessions, available 7 days/week. These must include activity based programs that enhance the self esteem and self efficacy of young people to aid in their rehabilitation. As symptoms reduce, there is a focus on assisting young people to return to a typical developmental trajectory. • Consumers will only access the day sessions (i.e. Day Program components) of the service if they are an admitted consumer. • Programs maintain family engagement with the young person, and wherever possible adolescents will remain closely connected with their families and their own community. • Young people will have access to a range of educational or vocational support services delivered by on-site school teachers and will be able to continue their current education option[4]. There is an intentional goal that young people are integrated back to mainstream community and educational/vocational activities. • Flexible and targeted programs will be delivered across a range of contexts including individual, school, community, group and family.
Service specifications and other descriptors to illustrate service elements	

[4] The provision of education at this level requires focused consideration; an on-site school and education program is proposed as a priority.

EXHIBIT 40

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Target Age	• 13 - 17 years, with flexibility in upper age limit depending on presenting issue and developmental (as opposed to chronological) age.
Diagnostic Profile	• Severe and persistent mental health problems that significantly interfere with social, emotional, behavioural and psychological functioning and development. • Treatment refractory/non responsive to treatment - have not been able to remediate with multidisciplinary community, day program or acute inpatient treatment. • Mental illness is persistent and the consumer is a risk to themselves and/or others. • Medium to high level of acuity requiring extended treatment and rehabilitation.
Suggested modelling attributes	
Average duration of treatment	**Tier 2a:** **Level 5 Day Program Services (Mon – Fri business hours)** • Up to 12 months; flexibility will be essential. • There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this. **Tier 2b:** **Community Residential (24h/7d)** • Up to 12 months; flexibility will be essential. • There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this. • Access to a community residential service requires the young person to be actively participating in a program with CYMHS. **Tier 3:** **Level 6 Statewide Inpatient Extended Treatment and Rehabilitation Service (24h/7d)** • Up to 12 months; flexibility will be essential. • There will be wide variation in individual consumer need and their treatment program; length of stay will need to be responsive to this. • Young people may be discharged from this Service to a Day Program in their local community.

EXHIBIT 40

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Staffing Profile	**Tier 2a:** **Level 5 Day Program Services (Mon – Fri business hours)** • Multidisciplinary, clinical. • Plus staffing from community sector. • DETE. **Tier 2b:** **Community Residential Service (24h/7d)** • Multidisciplinary, clinical. • Plus staffing from community sector. **Tier 3:** **Level 6 Statewide In-patient Extended Treatment and Rehabilitation Service (24h/7d)** • Multidisciplinary, clinical. • DETE.
Additional notes	
Referral Sources and Pathways	While service provision across all Tiers of this AETRS continuum is based on interdisciplinary collaboration and cross-agency contribution, a referral to Tiers 2a, 2b and/or 3 will require a CYMHS assessment (i.e., single point of entry). Increased accessibility to AETRS for consumers and their families across the State is a key priority. The Tier 3 statewide service will establish a Statewide Clinical Referral Panel. All referrals will be received and assessed by the Panel, which has statewide representation from multidisciplinary mental health clinicians and the community sector.
Complexities of Presentation	• Voluntary and involuntary mental health consumers. • The highest level of risk and complexity.

This document was endorsed by the Expert Clinical Reference Group of the Barrett Adolescent Strategy on 8 May 2013.
Please read in conjunction with the v5 Preamble.

EXHIBIT 40

Queensland Government

Barrett Adolescent Strategy

Expert Clinical Reference Group

Dr Leanne Geppert
Chair, Expert Clinical Reference Group

EXHIBIT 40

West Moreton Hospital and Health Service
PROJECT PLAN

Author:	**Chris Thorburn, Director Service Redesign**	**Executive Sponsor:**	**Sharon Kelly, ED MH&SS**	**Executive Delegate:**	**Lesley Dwyer, CE WMHHS**
Start Date:	16 November 2012	**Approval:**	☐ West Moreton Hospital and Health Board		
End Date:	TBD				

Description of Project: Barrett Adolescent Strategy

BACKGROUND of PROJECT	• Barrett Adolescent Centre (BAC) is located within The Park – Centre for Mental Health (The Park) and provides a state wide service of extended treatment and rehabilitation[1] for up to 15 adolescents with severe and complex mental health disorders.
	• As part of the *Queensland Plan for Mental Health 2007-2017* (QPMH), a capital allocation had been approved to rebuild BAC in a new location as:
	  o The capital fabric of BAC is no longer able to meet the requirements of a contemporary model of care for adolescent extended treatment and rehabilitation and
	  o The Park will become exclusively a High Secure and Secure Rehabilitation Mental Health Service for adults (by end of 2013).
	• Initial consultation with stakeholders (about a replacement service for BAC) commenced as part of the planning for Stage 1 of the QPMH (approximately 2005-06).
	• Planning associated with the QPMH incorporated in a new capital project to be delivered at Redlands, which would replace the BAC. The Adolescent Extended Treatment and Rehabilitation Unit was to be built adjacent to the Redlands Hospital. It was to be commissioned in 2014. Due to environmental and other issues, the project could not proceed and has now ceased.
	• The capital allocation previously attached to the rebuild of BAC has been redirected to other Queensland Health capital priorities; this capital funding is currently no longer available for a rebuild of BAC at an alternative site.

[1] While currently classified as an extended treatment and rehabilitation model of service, the replacement model of service for BAC will likely be classified as either a subacute rehabilitation or community residential program. The classification will need to align with national and state classification frameworks, and relevant funding models.

	• It has become imperative that:
	  o alternative contemporary, statewide model(s) of care be developed to replace the services currently provided by BAC; and
	  o an implementation plan be developed to achieve the alternative statewide model(s) of care.
	• This project plan will articulate the required steps to achieve the above points.

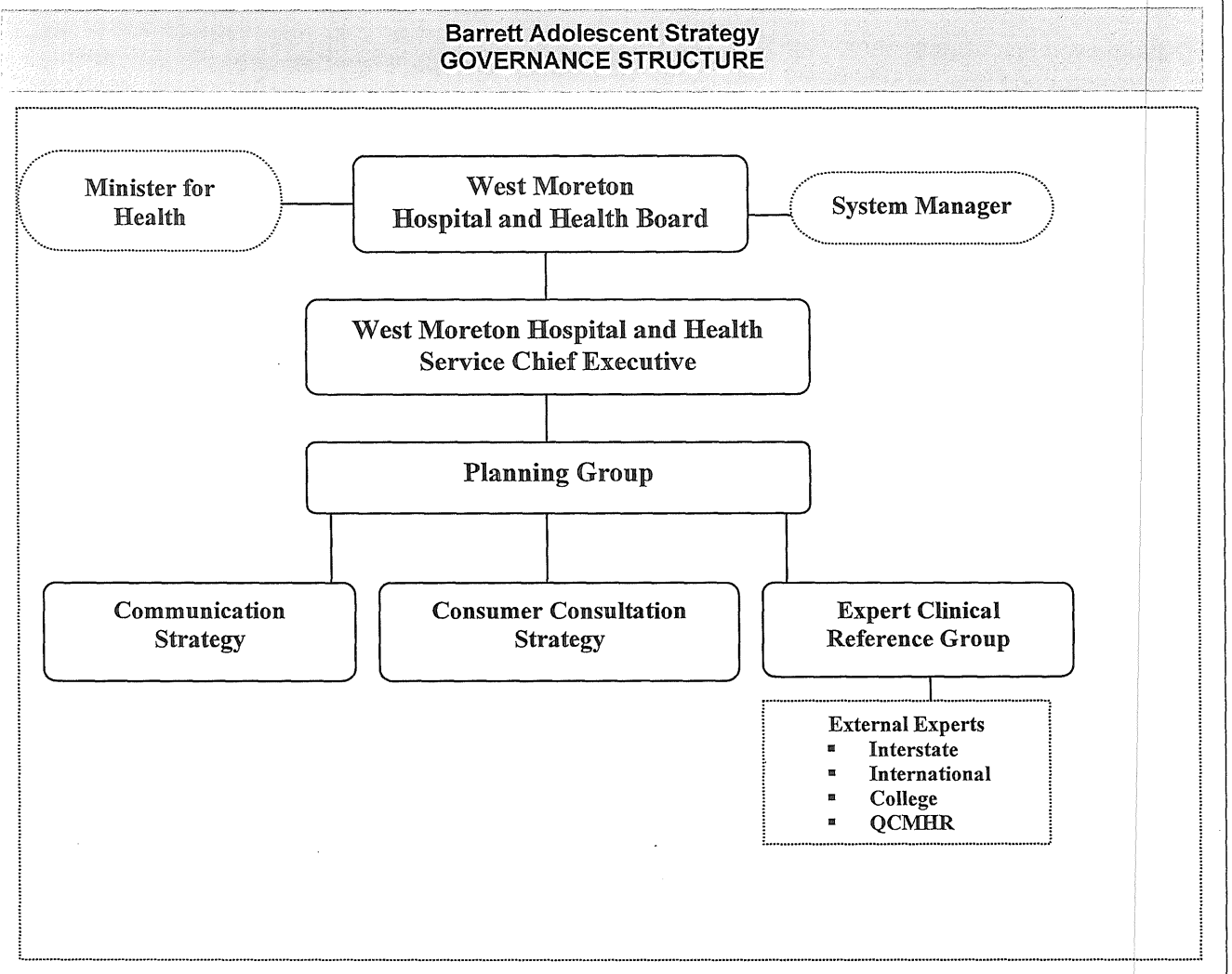
OBJECTIVES	• Through the formation of a planning group, with input from a multidisciplinary expert clinical reference group:
	  o alternative contemporary, statewide model(s) of care will be developed to replace the services currently provided by BAC and will also include the appropriate provision of educational services;
	  o an implementation plan will be developed to achieve the alternative model(s) of care; and
	  o a defined strategy will be articulated outlining the plan to achieve an alternative model of care for the current patients of the BAC.
	• Through the development and implementation of an effective communication and engagement strategy, all identified stakeholders will:
	  o be kept informed in a timely manner; and
	  o have appropriate opportunities to provide input to the process.
	• Through agreed governance and approval processes by the West Moreton Hospital and Health Board, the alternative statewide model(s) of care and implementation plan will be endorsed. This will be achieved through partnership with the System Manager.

OUTCOMES	• The final endorsed model(s) of care will clearly articulate a contemporary model(s) of care for extended treatment and rehabilitation for adolescents in Queensland.
	• The final endorsed model(s) of care will be evidenced based, sustainable and align with statewide mental health policy, service planning frameworks and funding models.
	• The final endorsed model(s) of care will replace the existing services provided by BAC.
	• The implementation plan will clearly identify:
	  o Stakeholders
	  o Communication and Engagement strategies
	  o Time frames and steps of implementation
	  o Human, capital and financial resources
	  o Risks, issues and mitigation strategies
	  o Evaluation strategy and criteria attached to the implementation

PROJECT SCOPE	• This project has a statewide focus, as the final endorsed model(s) of care must meet the needs of adolescents in Queensland requiring extended treatment and rehabilitation.
OUT OF SCOPE	• As there is no longer a current capital allocation to rebuild BAC on another site, the model(s) of care to be developed must exclude this as an option.
ASSUMPTIONS	• A significant assumption is that the services currently provided by BAC will not remain on the campus of The Park post June 2013. Once the implementation plan has achieved the endorsed model(s) of care for the current patients, the building that houses the service of BAC will be de-commissioned. • It is assumed that the endorsed model(s) of care will be incorporated into forward planning for the implementation of components of the remainder of the *Queensland Plan for Mental Health 2007-2017*. • It is assumed that there will be robust evaluation criteria applied to determine the quality and effectiveness of the endorsed model(s) of care. • It is assumed that the endorsed model of care will be implemented in a two staged process, ie it will initially be applied to meet the needs of the current consumers in BAC and then implemented more widely across the state as per the parameters of the endorsed model of care. • It is assumed that the existing recurrent funding for BAC and the additional future funding earmarked for the former Redlands Unit will be utilised to fund the endorsed model(s) of care for this adolescent consumer group.
CONSTRAINTS	• It is possible that the project may be constrained by a number of factors including: o Resistance to change by internal and external stakeholders o Insufficient recurrent resources available to support a preferred model of care o Insufficient infrastructure across parts of the State to support a changed model (eg skilled workforce, partnerships with other agencies and accommodation requirements) o A delay in achieving an endorsed model of care.
DEPENDENCIES	• The final model of service delivery for adolescent mental health extended treatment and rehabilitation services across Queensland will be informed by this project. • This project is dependent upon the risks, issues and constraints being appropriately addressed. • There are interdependencies between this project and the available, contemporary service planning frameworks at national and state levels. This includes the QPMH.

Accountability of Project:

PROJECT GOVERNANCE:



REPORTING	• The Planning Group will be a time limited group and it will report to the West Moreton Hospital and Health Service Chief Executive, who in turn will report to the West Moreton Hospital and Health Board. • The Planning Group will consist of representation from West Moreton HHS, Mental Health Alcohol and Other Drugs Branch, another QLD HHS service, Department of Education, a child psychiatrist and a Communication expert. • It is anticipated the Planning Group will meet initially to finalise the project plan and then meet on a regular basis to monitor progress regarding the development of a model(s) of care, the implementation of the communication and engagement plan and the develop the implementation plan. • The Expert Clinical Reference Group will be a time limited group and will consist of a representative group of multidisciplinary child and youth clinicians. In the development of a contemporary model(s) of care, the Expert Clinical Reference Group will seek the assistance of external experts at key points in the consideration of a model(s) of care for extended treatment and rehabilitation for adolescents. • The attached Communication Plan (Appendix 1) outlines the objectives, methods, frequency, target audiences and an action plan. • A specific Consumer Consultation Strategy will be developed consistent with the Communication Plan.

Project Resources:

The Planning Group: With the exception of the communication expert, there is no additional labour cost associated with the Project. The costs incurred through engagement of the communication expert will be met by the Division of Health Service and Clinical Innovation.

The Expert Clinical Reference Group: There is no expected financial cost to be incurred by West Moreton Hospital and Health Service.

Implementation of the Communication Plan: Resources associated with the implementation of the communication plan will be met by the Division of Mental Health & Specialised Services, West Moreton Hospital and Health Service.

Risk Analysis:

Risk Event and Impact	Likelihood	Severity	Risk rating	Treatment
Time frames in the gant chart are not met, leading to loss of confidence from stakeholders	Likely	Minor	Medium	Executive Sponsor EDMH&SS to closely oversight activities in gant chart to minimise this risk
Expert Clinical Reference Group do not agree on a preferred Model of Care, causing delays to the development of an implementation plan	Possible	Moderate	Medium	Input from external experts and reviewing evidence based models of care will minimise this risk
Preferred Model of Care can not be endorsed, causing implementation delays	Possible	Major	High	Close collaboration between West Moreton HHS, other HHS and the System Manager will minimise this risk as existing resources, capacity etc will be confirmed
Communication of Project objectives, scope and progress is not effective, leading to stakeholder dissatisfaction	Possible	Moderate	Medium	Implementation of the communication plan will minimise this risk.
Endorsed Implementation plan is delayed, delaying stage 1 implementation for current BAC consumers	Likely	Moderate	High	Effective project management and broad stakeholder engagement with minimise this risk

GANTT CHART:

Activities		Fortnight Ending													
		16/11	30/11	14/12	28/12	11/1	25/1	8/2	22/2	8/3	22/3	5/4	19/4	3/5	
Project Sponsorship established		x													
Planning Group established	*Endorsed by CE*	x													
Expert Clinical Reference Group identified	*Endorsed by CE*		x												
External Experts identified			x												
Communication Plan developed	*Endorsed by CE*		x												
Project Plan endorsed	*Endorsed by CE & WMHH Board*		x												
Planning Group meets			x	x	x	x	x								
Expert Clinical Reference Group meets				x	x			x	x						
External Experts provide advice to Expert Clinical Reference Group					x	x									
Model of Care options developed						x									
Cost Benefits of options undertaken						x									
Consultation with stakeholders regarding preferred model							x	x	x						
Endorsement of preferred model	*Endorsed by CE, WMHH Board & System Manager*								x						
Development of project and change management plan to implement model, in a two staged process	*CE supported by System Manager*									x					
Communication regarding implementation plan	*CE supported by System Manager*									x					
Endorsement of implementation plan	*Endorsed by CE*										x				
Commence Stage 1 implementation											x	x	x	x	