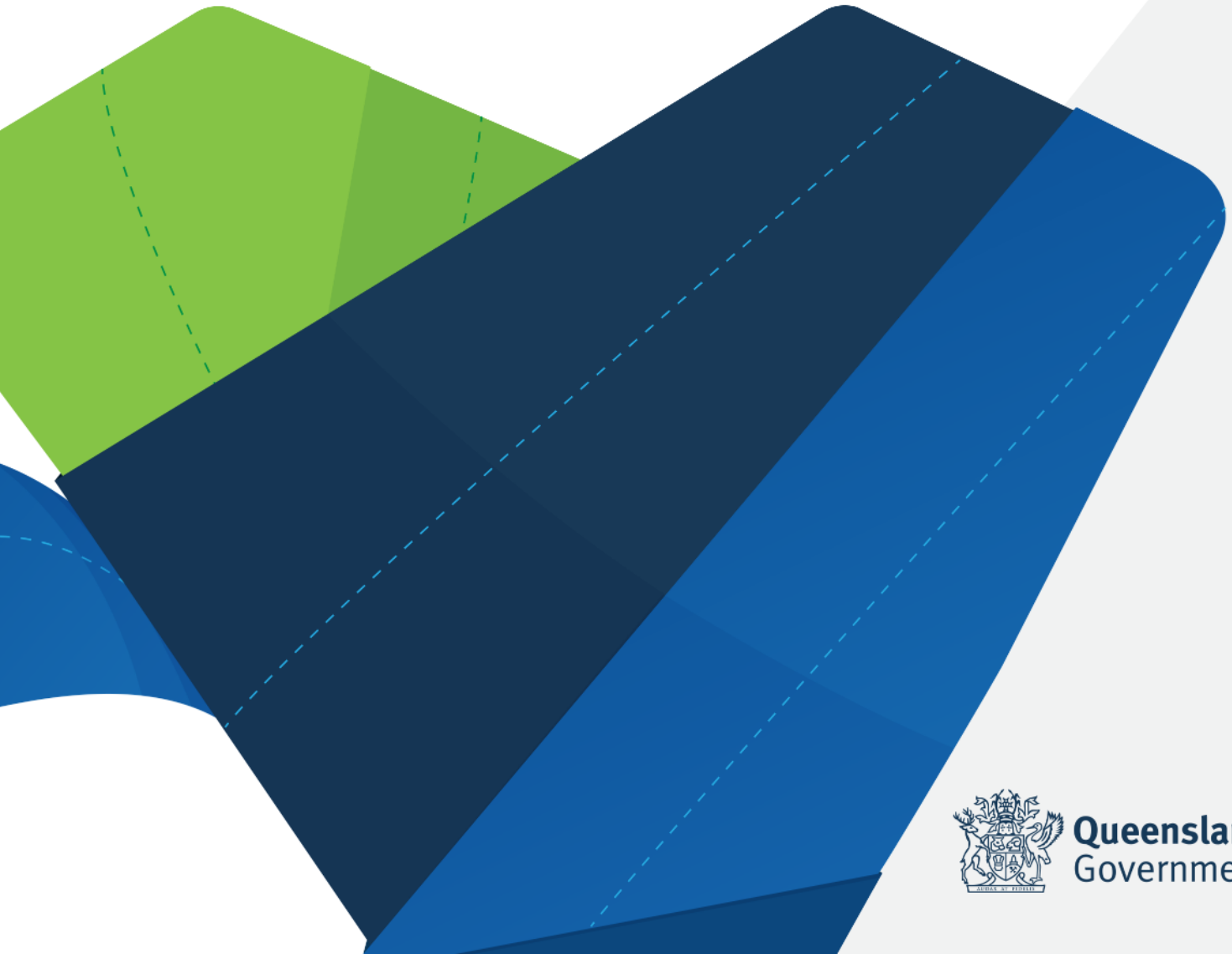
Written briefing

Inquiry into the opportunities to improve mental health outcomes for Queenslanders



Queensland Government

Contents

1. Purpose

This written briefing provides information to the Select Committee to assist in its consideration of key issues and matters relevant to the Inquiry into opportunities to improve mental health outcomes for Queenslanders.

While there are many determinants impacting mental health wellbeing and outcomes, this briefing focuses on providing an overview and information about the *treatment* service system – in particular, state-funded specialist treatment, care and support for individuals, their families and carers delivered through Queensland Health's Hospital and Health Services (HHSs), non-government organisations (NGOs) inclusive of Aboriginal and Torres Strait Islander community-controlled health organisations, and the Queensland Ambulance Service (QAS).

The state-funded treatment system operates in a complex policy, funding, legislative and service delivery environment and while this briefing is comprehensive, it anticipates the Select Committee may seek further information and detail about specific issues or content. This briefing also anticipates the Select Committee will garner further information from key national and state documents relating to mental health, alcohol and other drugs and suicide prevention to augment information provided in briefings and submissions.

Queensland Health will also be providing a submission the Select Committee addressing relevant aspects of the Terms of Reference of the Inquiry as they relate to challenges impacting the state-funded treatment system and opportunities for further improvement and growth.

2. Key points

The following provides a high-level overview of the key points this written briefing seeks to make.

- The State-funded MHAOD service system has a critical role in providing treatment, care and support for Queenslanders experiencing severe mental illness and/or substance misuse issues and responding to people experiencing mental health crisis and suicidal distress. However, reform across key aspects of the socio-economic determinants of health could help to prevent or reduce people's escalation into severe illness, problematic substance use, and crisis.
- There is an ongoing need to recognise and value the unique standing and contribution of Aboriginal and Torres Strait Islander peoples to Queensland and improve the relationship between First Nations peoples, non-Indigenous Queenslanders, and the system of governance, to ensure improved outcomes for Aboriginal and Torres Strait Islander peoples.
- The State-funded MHAOD service system needs to be supported to ensure that it is continues to be evidence-based, efficient, effective, and sufficient to meet need and deliver optimal outcomes for Queenslanders, their families, and communities. This relies on a range of critical factors and mechanisms including:
  - workforce
  - information technology and built infrastructure
  - policy, planning, funding, and commissioning
  - monitoring, evaluation, and research
  - governance
  - engaging with people who have lived experience of mental health, problematic alcohol and other drugs use, and suicidality
  - contributing to health equity and cultural safety outcomes for Aboriginal and Torres Strait Islander peoples
  - working together with other systems, sectors, stakeholders and services.
- Ongoing service improvement and reform of the State-funded MHAOD service system requires appropriate levels of investment to resolve existing gaps and meet growth in demand.
- Investment needs to be appropriately balanced across the critical factors and mechanisms listed above to ensure that contemporary and safe models of care and optimal service mix can be delivered.

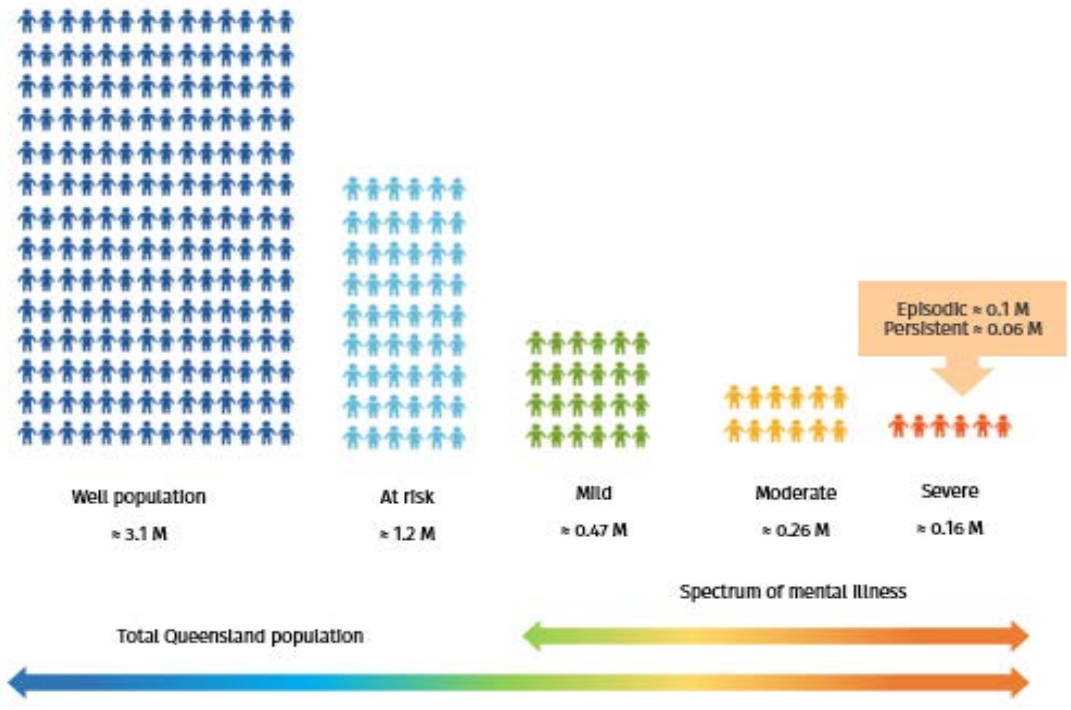
3. Overview

Mental illness is common with one in every two Queenslanders experiencing mental illness in their lifetime and in any one year, one in five Queenslanders will experience mental illness, including substance use disorders.

Of Queensland's 5.2 million population, it is estimated that about 880,000 (17 per cent) will experience a mental illness with about 470,000 (9 per cent) experiencing mild mental illness, 260,000 (5 per cent) experiencing moderate mental illness and 160,000 experiencing severe mental illness (3 per cent). A further 1.2 million (23 per cent) are at risk of developing a mental illness due to individual, social, economic, and/or environmental vulnerabilities or stressors.

See Diagram 1 below.

Diagram 1: Distribution of mental health/illness among the Queensland population[1]



Alcohol and other drug (AOD) use is common, and people use substances (legal and illicit) for a variety of reasons. Most people do not develop problems or experience harms, but for those that do, accessing treatment and support is essential to support recovery.

In 2019, 20 per cent of Queenslanders aged 14 years and over reportedly drank at levels that exceeded lifetime risk guidelines and 29 per cent reportedly drank at levels that exceed

[1] Adapted from the Australian Productivity Commission.

single occasion risk. These figures were higher than the national average. One in six or almost 17 per cent of Queenslanders reported using an illicit drug in the preceding 12 months. Cannabis was the most commonly used illicit drug.

According to data in the interim Queensland Suicide Register, as at 25 December 2021, there had been 804 suspected suicide deaths reported in Queensland. The average suicide death rate for all Queenslanders for the five-year period 2016 to 2020 was 15.4 deaths per 100,000 population, a small decrease from the previous period but Queensland remains above the national average (12.5 deaths per 100,000 population). According to the Australian Bureau of Statistics the rate for Aboriginal and Torres Strait Islander Queenslanders (2016-2020) was 28.0, 1.9 times higher than for non-Indigenous Queenslanders (14.6 per 100,000 population) and above the national Aboriginal and Torres Strait Islander suicide rate (25.6 deaths per 100,000). For every life lost to suicide it is conservatively estimated that there are about 20 suicide attempts for every life lost. Unfortunately, there is not robust data on suicide attempts, behaviour or ideation.

The Australian Productivity Commission's final report on its inquiry into mental health (PC Report) released in 2020 clearly articulates the social and economic costs of mental ill health and suicide in Australia including that the direct[2] economic costs were estimated to be between $43-$70 billion in 2018-19. Identified impacts included:

- higher expenditure of resources on human services (e.g., health care, education, employment, housing, justice, and social services)
- the informal care provided by families and friends
- a reduction in incomes and living standards from lower participation in the workforce, absenteeism, presenteeism, and less productive work
- pain and suffering impacting on physical and psychological wellbeing and premature death
- stigma, discrimination, and social exclusion which can lead to reluctance to seek treatment and support
- lowered social participation such as less contact with family, friends, and reduced community involvement.

The Australian Institute of Health and Welfare (AIHW) also provide a range of information on the impact of mental illness (see here), alcohol and other drug use (see here), and suicide and self-harm (see here).

The risk of and experience of mental illness and problematic AOD use is affected by and associated with a range of individual, social, economic, environmental conditions and circumstances and State and Commonwealth Government policies.

In Queensland, *Shifting minds: Queensland mental, alcohol and other drugs strategic plan 2018-2023* sets the whole-of-person, whole-of-community and whole-of-government approach to improving mental health and wellbeing of Queenslanders. It acknowledges the

[2] Direct economic costs included direct expenditure on healthcare and other supports and services; lower economic participation and lost productivity; informal care provided by family and friends.

importance of improving holistic service delivery to support people's individual needs and preferences and by removing barriers to social and economic participation; investing and intervening early in life, preventing issues from arising and intervening early when signs or symptoms arise; and whole-of-system improvement: supporting shared leadership and responsibility for continuing to deliver evidence-based services and intervention to improve mental health and wellbeing and to prevent and reduce mental illness, problematic AOD use, and suicide.

Whole of system approaches recognises that improving outcomes and reducing the impact of mental illness, problematic AOD use, and suicide behaviours and distress not only relies on treatment and support offered through the health system. Employment, housing, education, community supports, social welfare measures and public and population health initiatives also play a critical role in supporting overall individual, family and community and societal health, wellbeing and functioning.

These issues have been described in a range of reports over many decades. The most recent reports the Select Committee may wish to consider include (in order of release):

- the National Suicide Prevention Adviser's final advice (available here)
- Royal Commission into Victoria's Mental Health System (available here)
- the Australian Productivity Commission Inquiry Report – Mental Health (available here).

4. State funded specialist treatment, care and support

Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health alcohol and other drugs services (Connecting Care to Recovery) drives the policy, planning and service delivery priorities for the state-funded MHAOD system of care. Available here.

Treatment and responses for MHAOD and mental health crisis and suicidal distress take place in a complex health system which spans public, private, and non-government sectors; primary health care through to specialist care; and a wide range of interventions (e.g. promotion, prevention, early intervention, harm reduction, emergency care, acute care, ongoing care, psychosocial supports and rehabilitation). Diagram 2 provides a high-level overview of the continuum of care.

Associated with this are arrangements between the Australian and State/Territory governments determining roles and responsibilities for funding, policy, legislation, commissioning, accountability and delivery. These arrangements also differ between MH and AOD.

The State-funded MHAOD system interacts with a range of Commonwealth Government funded services and programs. Primarily these include subsidises for a range of fee-for-service, mental health-specific, health professional services through the Medicare Benefits Schedule (MBS), mental health-related pharmaceuticals through the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). The Commonwealth Government also pays for mental health services delivered to Australian veterans through the RPBS, Repatriation Medical Benefits (general practitioners, allied

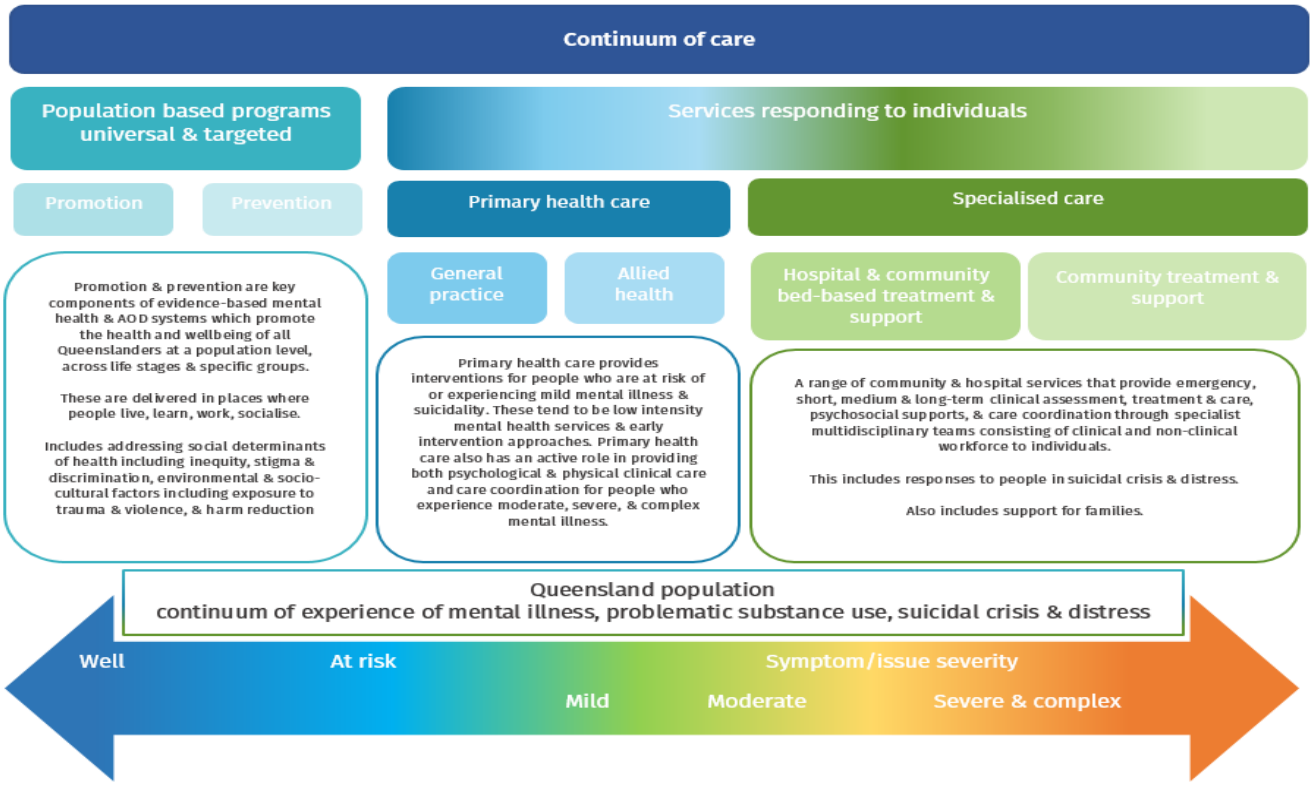
health professionals, and psychiatrists), services provided through public and private hospital and grants to a range of organisations delivering mental health related services. The Commonwealth Government also fund psychosocial supports through and beyond the National Disability Insurance Scheme. See Appendix 1 for further information on Commonwealth Government funded programs.

In response to the National Mental Health Commission's *Report of the National Review of Mental Health Programmes and Services*, the Commonwealth Government committed the then newly established Primary Health Networks (PHNs) to leading the planning and commissioning of primary mental health services.

There are seven PHNs in Queensland aligned to HHS boundaries. The aim of PHNs is to undertake planning and commissioning of health services including MHAOD across their regions. As planners and commissioners PHNs are expected to work closely with Queensland Health, the local HHS and local stakeholders to undertake joint planning and put in place mechanisms to connect health services for people to encourage better use of health resources and avoid duplication.

Strong and formal partnerships, collaboration, and integration with and across the broader health care system in Queensland and sectors outside of the health systems are required to respond holistically to people's needs, to improve the experiences of service delivery, and achieve improved outcomes. It is also critical for all stakeholders to understand and deliver on their respective roles and responsibilities.

Diagram 2: High level overview of the continuum of care



4.1 Queensland Health - structure and function

Queensland Health consists of the Department of Health (DoH), the Queensland Ambulance Service (QAS) and 16 independent HHSs situated across Queensland. The *Hospital and Health Boards Act 2011* (HHB Act) provides the overarching framework for the delivery of publicly funded health services in Queensland.

The DoH is responsible for the overall management of Queensland's public health system at a statewide level. This includes strategic policy, system planning, funding, monitoring, and promoting improvements in the quality of health services. As the system manager, the DoH funds and enters into service agreements with HHSs and NGOs for the delivery of a range of health services, including specialist MHAOD treatment. The DoH is a significant commissioner of health, including MHAOD services directly from NGOs.

The vision and objectives of the DoH are outlined in its strategic plan for 2021-2025 available here.

HHSs were established as independent statutory bodies under the HHB Act from 1 July 2012. They assumed responsibility for the delivery of public hospital and health services previously provided by Health Service Districts. HHSs are independent statutory bodies, each governed by their own professional Hospital and Health Board (HHB) and managed by a Health Service Chief Executive (HSCE). HHSs are responsible for delivery of public sector health services to their designated geographic area.

The key principles governing the provision of public sector health services, as detailed in the HHB Act, are that HHSs will work with providers of private sector health services to achieve coordinated, integrated health service delivery across both sectors and that engagement with clinicians, consumers, community members and local primary healthcare organisations in planning, developing and delivering public sector health services is paramount. Further information can be accessed here.

The establishment, organisational structure, and functions of the Queensland Ambulance Service (QAS) is subject to the *Ambulance Service Act 1991*.

4.2 Mental Health Alcohol and Other Drugs Branch – role and function

The system-wide clinical, policy and planning advice and leadership to support the delivery of safe, quality, evidence-based clinical and non-clinical MHAOD services is undertaken by the Mental Health Alcohol and Other Drugs Branch within Clinical Excellence Queensland in the DoH.

The MHAOD Branch undertakes this role in consultation and collaboration with other areas of the DoH, HHSs, NGOs, other Queensland Government agencies, peak bodies and other key stakeholders. There is a commitment to actively involve the voice of lived experience in the work of and key projects undertaken by the MHAOD Branch.

The policy, planning and strategic functions for MH and AOD have been organisationally combined since 2012. Prior to that, these were separate functions within the DoH. This shift recognises the need for policy, planning and funding approaches to support integrated and

aligned treatment and service responses, including for individuals who have both a mental illness and problematic substance use.

In addition to the Queensland Health Strategic Plan, the strategic work of the MHAOD Branch is guided by *Shifting minds: Queensland mental health, alcohol and other drug strategic plans 2018-2023* (available here) and Connecting Care to Recovery which is available here. This work is also aligned to key national policies including the Fifth National Mental Health and Suicide Prevention Plan (available here) and the National Drug Strategy (available here).

4.3 Specialist MHAOD treatment and support service delivery

HHSs and NGOs deliver specialist MHAOD treatment and support services for people with severe mental illness and problematic substance use.

In HHSs, MHAOD services are organisationally combined under one service structure. HHSs provide a range of specialised assessment, clinical treatment and rehabilitation across inpatient, outpatient and community-based settings for both MH and AOD are provided. Generally, there are separate MH and AOD teams. However, since 2012, there has been a significant shift to bring service elements closer and integrate care for consumers, recognising the multi-morbidity across MH, AOD and physical health.

Mental health services delivered by NGOs include individual and group psychosocial support and counselling, family and carer support. AOD NGO delivered services include residential and non-residential rehabilitation, psychosocial intervention, residential withdrawal management, family support services, needle and syringe and other harm reduction programs and police and court diversion health interventions. The Queensland Opioid Treatment Program (QOTP) is also delivered by private prescribers (predominantly General Practitioners) and pharmacies.

4.4 Mental Health Crisis and Suicidal Distress

An important area of service delivery is responding to mental health crisis.

These are situations where a person (or someone else) believes they require immediate support, assistance, and care from an urgent or emergency mental health service. Such a crisis may be a deterioration in mental and physical health, an inability to draw on relationships or resources and/or precipitating secondary factors that may be psychological, social or substance related. Such a crisis is an emergency that requires an urgent response.

A person experiencing a mental health crisis may experience suicidal behaviours including suicidal thoughts or suicide attempt. A person experiencing a mental health crisis may or may not have a diagnosable mental illness or substance use disorder.

Through HHSs and NGOs, Queensland Health provides a range of supports and services for people experiencing mental health crises available in most parts of the state. These include services offered by emergency departments, acute, community and inpatient care teams. These teams assess, formulate, plan, and coordinate the delivery of crisis care in partnership with NGOs and primary care providers to support referral and follow-up care.

4.5 Service types across the MHAOD continuum

State-funded MHAOD services delivered by HHSs and NGOs are provided across six key categories. These categories align to the evidence-based treatment and care continuum for individuals who may require some or all of these elements of treatment and support during the course of their illness and recovery. Diagram 3 provides a high-level description of these categories.

Diagram 3: High level description of the six key service types

4.6 Queensland Ambulance Service

The QAS, as the legislated provider of pre-hospital emergency health care, has an important role in responding to people experiencing mental health crisis[3]. The QAS responds each year to over 1.3 million, time critical events, such as trauma, injury and medical related emergencies, with 13 per cent of these emergencies being for a mental health crisis.

[3] The QAS describes a mental health emergency as a broad range of situations (including high risk scenarios) such as an exacerbation of an existing mental health condition; a suicide crisis; significant life events; domestic violence; drug and alcohol use/issues; and aberrant type behaviours

Calls to Triple Zero (000) for people experiencing a mental health crisis equate to about 1 in 8 jobs most days for the QAS, usually the second most frequent call for service, after falls. In 2020 over 59,000 people called Triple Zero (000) experiencing a mental health emergency, this was a 15 per cent increase from 2019. The QAS has seen an upward trend for calls for mental health emergencies to Triple Zero (000) of between 15 per cent and 20 per cent per annum for the past five years.

These calls represent a broad range of situations, including high risk scenarios; an exacerbation of an existing mental health condition; a suicide crisis; significant life events; domestic violence; drug and alcohol use/issues; and aberrant type behaviours. Mental health crisis situations presenting to the QAS are often a complex interplay of physical, social and psychological factors. Over half of the calls to Triple Zero for people in mental health crisis involve a suicide crisis, including ideation, intent, suicide attempts or death by suicide; with the remaining experiencing distress, risk taking, emotional dysregulation or unmanageable or abnormal behaviours.

4.7 Legislative framework for mental health treatment

The Queensland *Mental Health Act 2016* (Mental Health Act) establishes a regulatory framework for the involuntary treatment, care and protection of persons who have a mental illness and who do not have capacity to consent to be treated. The objects of the Act are:

- to improve and maintain the health and wellbeing of persons who have a mental illness who do not have the capacity to consent to be treated
- to enable persons to be diverted from the criminal justice system if found to have been of unsound mind at the time of committing an unlawful act or to be unfit for trial
- to protect the community if persons diverted from the criminal justice system may be at risk of harming others.

The Chief Psychiatrist is the statutory officer, appointed by Governor-in-Council, who is responsible for, among other things, facilitating the proper and efficient administration of compliance with the *Mental Health Act*. The Chief Psychiatrist does not act under the control of the Minister or another person (e.g., the Director-General, Queensland Health) when exercising their functions.

The Chief Psychiatrist is required to issue policy or practice guidelines to support the operation of the *Mental Health Act*. The policies include requirements relating to the application of the treatment criteria to patients and alternatives to involuntary treatment (less restrictive ways), patient records and the treatment and care of patients subject to forensic orders. The policies are publicly available here.

More information on the legislative framework and the Chief Psychiatrist position are provided in Appendix 2. The Chief Psychiatrist Annual Report 2020-21 can be accessed here.

4.7.1 Authorised Mental Health Services

Involuntary patients in Queensland may be detained in Authorised Mental Health Services (AMHSs) which are declared by the Chief Psychiatrist under the *Mental Health Act*. An AMHS

must be a health service or part of a health service providing treatment and care to people with a mental illness. An AMHS may be comprised of both community based and in-patient mental health facilities. There are both public and private AMHSs in Queensland. The list of AMHSs is available here. See Appendix 2 for further detailed information.

4.8 Service activity information and data

The following section provides information on MHAOD service activity delivered by HHSs and the NGO sector. Some of this information is limited based on the nature of data collections held by Queensland Health.

4.8.1 MHAOD Services - HHS

In 2020-21, 132,000 individual Queenslanders accessed MHAOD services delivered directly by HHSs.

This resulted in 84,000 episodes of mental health care with 70 per cent of these occurring in community-based settings. One-quarter of referrals for mental health care were received from emergency departments and more than half of referrals were to an Acute Care Team. The three main reasons individuals were referred for assessment and treatment are emotional, behavioural, and mental health issues (30.4 per cent), suicide or self-harm related (22.5 per cent) and anxiety, depression, or coping issues (9.3 per cent).

For AOD, nearly 20,000 individuals accessed HHS delivered AOD services with 64 per cent of these being males. The most common age group of clients is 20-29 years. More than 24,000 episodes of treatment were for own drug use with the three main drugs for which clients sought treatment being alcohol (41 per cent), cannabis (30 per cent) and amphetamines (13 per cent). The most common treatment provided was assessment.

Key statistics in infographic form are provided at Appendix 3.

4.8.2 MHAOD Services - NGOs

For MH NGO activity, there were more than 257,000 individual service contacts across all activity delivered, with 79,000 attendances of which 21,000 were individual attendances and 58,000 group attendances. More than 12,000 bed days were utilised.

For AOD NGO activity, nearly 15,000 people accessed an AOD service with 60 per cent of these being males. The most common age group of clients is 20-29 years with nearly 19,000 treatment episodes for own drug use. The main three drugs for which clients sought treatment is cannabis (31.6 per cent), amphetamines (30.4 per cent) and alcohol (29.4 per cent). The most common treatment provided was counselling.

Key statistics in infographic form are provided at Appendix 3.

5. Funding models

In August 2011, the National Health Reform Agreement (NHRA) set out a model for funding public hospitals using Activity Based Funding (ABF) which means hospitals get paid for the

number and mix of patients they treat, taking complexity into account. The model provides for the Commonwealth Government contributing to the efficient growth of public hospital services.

This approach is used across admitted patients (acute, intensive care, sub and non-acute, mental health) and emergency department or emergency service presentations. Due to the nature of some public hospitals the ABF approach cannot be used, and instead these hospitals are funded by a block funding approach[4]. Block funding and grants are used to fund community-based services and a variety of health care programs/initiatives and service delivery-related activities (e.g., teaching, research). These are often based on historical budget allocations rather than a level of funding based on year-to-year changes in services delivered or demand for those services.

In Queensland, arrangements inform the negotiations of the 16 HHS Service Agreements and the public health services provided by the Mater Health Services, South Brisbane. The current service agreements and supporting documents can be accessed here.

5.1 HHS mental health service funding

Queensland Health utilises a mixed model to fund MH services which can be broadly categorised as:

- Admitted patient (separations)
  - Specialised admitted patient services in acute hospitals are funded via a per diem rate, with the rate varying based on the type of service (that is, general acute, child acute, secure rehab and so on)
  - Non-specialised mental health activity in acute hospitals that occurs outside of specialised units is funded via broader model (based on Diagnostic Related Groups)
  - All admitted activity that occurs in public psychiatric hospitals is block funded.
- Community
  - All community services are block funded.
- Residential
  - All residential services are block funded.

Nationally, the Independent Hospital Pricing Authority has led the development of the Australian Mental Health Care Classification (AMHCC) for pricing and funding admitted and community-based mental health services. This model has not yet been implemented although pricing for admitted patient services is intended to occur from the 2022-23 financial year. More information about the AMHCC and the overall ABF approach can be accessed here.

[4] Block funding refers to where services are provided with a 'block grant' often based on historical budget allocations rather than a level of funding based on year-to-year changes in services delivered or demand for those services.

5.2 HHS AOD service funding

Under the current Queensland model, AOD services delivered by HHSs are predominantly block funded using a population-base model for primary health and community services. However, there are AOD related groups identified as part of the Non-Admitted Patient Classification (referred to as Tier 2 clinics), and a subset of AOD services report to this classification.

5.3 NGO service funding

The DoH allocates funding to NGOs through service agreements for the provision of a range of healthcare services.

This includes for mental health community support services as well as other services such as community palliative care, environmental health, sexual health programs and Aboriginal and Torres Strait Islander health.

This program funding is held by the DoH for targeted investment in discrete programs and services to augment the broader service delivery provided by HHSs.

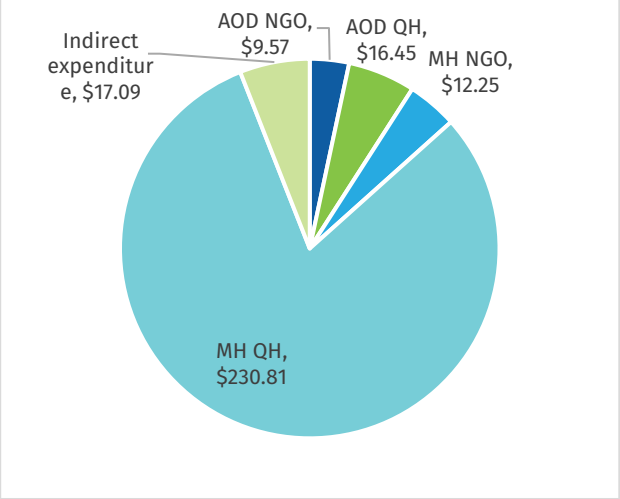
To support program investment outcomes and to ensure service continuity, service agreements with NGO providers are generally for a five-year term.

6. Expenditure

In 2020-21, Queensland Health spent an estimated $1.49 billion on MHAOD, equating to $286.17 per person. Most of the expenditure ($1.35 billion or 91 per cent) is for MH, with the remainder being expended on AOD (approximately $139 million). Diagram 4 shows the per capita distribution of expenditure[5] across MHAOD delivered across HHS and NGO service providers.

5 Indirect expenditure is expenditure that does not relate to service delivery (e.g. research or expenditure indirectly related to the delivery of mental health services that cannot be apportioned across the reporting establishments e.g. Hospital and Health Services corporate and support services).

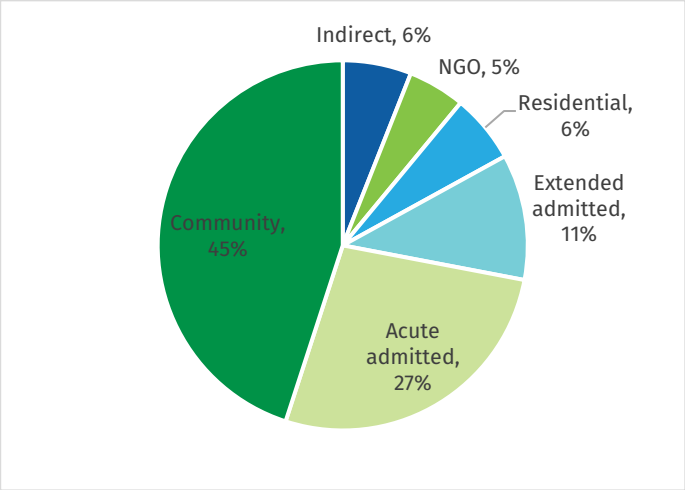
Diagram 4: Per capita expenditure on MHAOD services provided by HHSs and NGOs, 2020-21



6.1 Expenditure - MH services

Queensland Health expended approximately $1.35 billion on MH services in 2020-21, with about 89 per cent ($1.2 billion) spent on treatment delivered through HHSs. A further 5 per cent ($63.6 million) was spent on psychosocial support services delivered through NGOs. Diagram 5 shows mental health expenditure across the different service types.

Diagram 5: Mental health expenditure across service types, 2020-21



6.2 Expenditure - AOD services

Queensland Health expended approximately $139 million on AOD in 2020-21, with 61 per cent ($85.4 million) spent on treatment delivered through HHSs and a further 36 per cent ($49.7 million) for treatment delivered through the NGO sector.

6.3 Psychosocial supports

Queensland Health invests in community MH support services delivered by NGOs for individuals experiencing severe mental illness. These services are critical to an individual's treatment and assists Queenslanders to:

- meet their individual recovery goals
- live independently
- maintain the best possible social and emotional wellbeing
- live satisfying lives in the community.

From 1 July 2019, the Queensland Government invested $267.76 million over four years ($66.94 per annum) for the provision of these services.

In 2020-21 – the DoH spent $75.6 million on mental health community support services delivered by NGOs.

7. Available Beds

7.1 MH beds

Queensland has 32.3 MH beds per 100,000 persons in 2020-21 across hospital and community residential services. The majority of beds (53 per cent) are in the acute admitted setting, 27 per cent are in extended admitted (including forensic and secure rehabilitation beds) and the remaining 20 per cent are in community residential services. Queensland's beds per 100,000 persons has remained relatively stable over the past decade, with the investment in community residential beds under Connecting Care to Recovery, boosting the available bed stock. In 2019-20, at 32.0 beds per 100,000 Queensland had the lowest beds per 100,000, well below the national average of 37.1 beds per 100,000.

7.2 AOD beds

There are 16 specific HHS delivered inpatient AOD withdrawal beds (Hospital Alcohol and Drug Service unit, Royal Brisbane and Women's Hospital).

Residential rehabilitation and residential withdrawal management AOD treatment is delivered by specialist NGOs (and A&TSICCHOs). The DoH funds eight NGOs to deliver these services across several sites in Queensland.

There are currently an estimated 674 residential AOD treatment beds, noting these are funded from a variety of sources including self-generated revenue, client contribution, philanthropy and funding by governments including the Commonwealth Government.

New Queensland Government funded and purpose-built adult residential rehabilitation and withdrawal management services are being established in Bundaberg (28 beds) and Ipswich (45 beds) and the new service in Rockhampton (42 beds) commenced operations in

December 2021. A new youth AOD residential treatment service (10 beds) is being established in Cairns.

8. Staffing

The MHAOD workforce consists of a range of clinical and non-clinical staff across HHSs and NGOs including nurses, allied health professionals (psychologists, occupational therapists, social workers), psychiatrists, addiction medicine specialists, rural generalists (medical and allied health), allied health and nursing assistants, Aboriginal and Torres Strait Islander Health Workers, lived experience (peer) workers, psychosocial support workers and administrative, policy, program and support staff.

8.1 Mental health staffing

In 2020-21, there were 7,548.8 full time equivalent (FTE) positions in MH services delivered through HHSs. Nurses comprised the largest proportion (47 per cent), followed by allied health professionals (21 per cent), and administration and support staff (17 per cent). Medical officers accounted for 12 per cent of this workforce. This equated to 120.8 direct care[6] FTE per 100,000 population.

8.2 AOD staffing

In 2020-21, there were 524 FTE positions in AOD services delivered through HHSs. Again, the nurses making up the largest proportion (45 per cent) of this workforce, followed by administration staff (15 per cent), and social workers (11 per cent). Medical officers accounted for 6 per cent of this workforce.

8.3 Lived Experience (peer) workforce

The lived experience workforce accounted for two per cent of all the FTE positions. Although this workforce remains small, there are 12.9 Consumer Worker FTE positions and 4.4 Carer Worker FTE positions per 1,000 direct care FTE in Queensland, well above the national average of 7.0 and 2.5 respectively.

[6] Excludes administration and other personal care staff

9. Consumer and Carer Inclusion

9.1 Commitment and intent

The DoH and MHAOD Branch are committed to the inclusion, engagement and leadership of people with a lived experience of mental illness, problematic AOD use, and suicide and that of their families, carers, and supporters in the development, implementation of policies, programs and services.

Connecting Care to Recovery commits to lived experience engagement and participation and notes the value of the peer workforce in supporting the quality of Queensland's MHAOD treatment and support.

The *Queensland Health Mental Health Alcohol and Other Drugs Branch Lived Experience Engagement and Participation Strategy 2018-2021* (LEEP) seeks to support the MHAOD Branch to engage people with lived experience in state-wide policy and planning activities and support engagement practices by MHAOD services in HHSs. LEEP can be accessed here.

As part of this commitment, the MHAOD Branch in partnership with the Consumer and Carer Workforce Network (HHS based peer workers) also developed the *Queensland Health Mental Health Framework Peer Workforce Support and Development 2019* which aims to improve state-wide support and consistency for the MH peer workforce, provide greater role clarity for the peer workforce, including scope of practice and core competencies, improve supervision, support, training and education opportunities and alignment with national approaches in peer workforce development.

The MHAOD Branch has driven the establishment of a new peak for people with a lived experience of mental illness since the cessation of the previous consumer organisation Queensland Voice in 2017. This included stakeholder consultations throughout 2018 and 2019 and resulted in the Queensland Mental Health Commission (QMHC) being commissioned by the DoH from July 2020 to develop the groundwork for a new organisation.

As result, a Board and interim CEO have been recruited to *Mental Health Lived Experience Peak Queensland* (auspiced by the QMHC in the initial stages of operation). Substantial funding of nearly $1 million per annum has been committed by DoH to ensure effective operation of the new peak organisation, anticipated to be fully operational later in 2022.

There is ongoing activity to increase the participation, engagement and leadership by people with lived experience of AOD use (including families). In 2020, the DoH funded the Queensland Network of Alcohol and Other Drug Agencies (QNADA) to work with the Queensland Aboriginal and Islander Health Council (QAIHC) and the Queensland Injectors Voice for Advocacy and Action (QuIVAA) to deliver the Peer Peak Body Scoping Project. Findings from this work will inform further collaborative action. The final report can be accessed here.

9.2 Consumer and carer experiences of service

The active involvement of consumers and carers in the development, planning, delivery, and evaluation of services is a hallmark of a quality MHAOD health system. The collection of

consumer and carer experience data is a quality improvement activity, consistent with the National Safety and Quality Health Service (NSQHS) Standards, which have a strong focus on the rights of the consumer and carer to have their feedback considered in the planning, delivery and evaluation of services.

To maintain the involvement and collection of consumer and carer experience, Queensland Health has established the Mental Health Experience Surveys work program which includes a suite of three surveys which collect consumer, family and carer experiences to drive improvement in MH services. The surveys included in this suite are the:

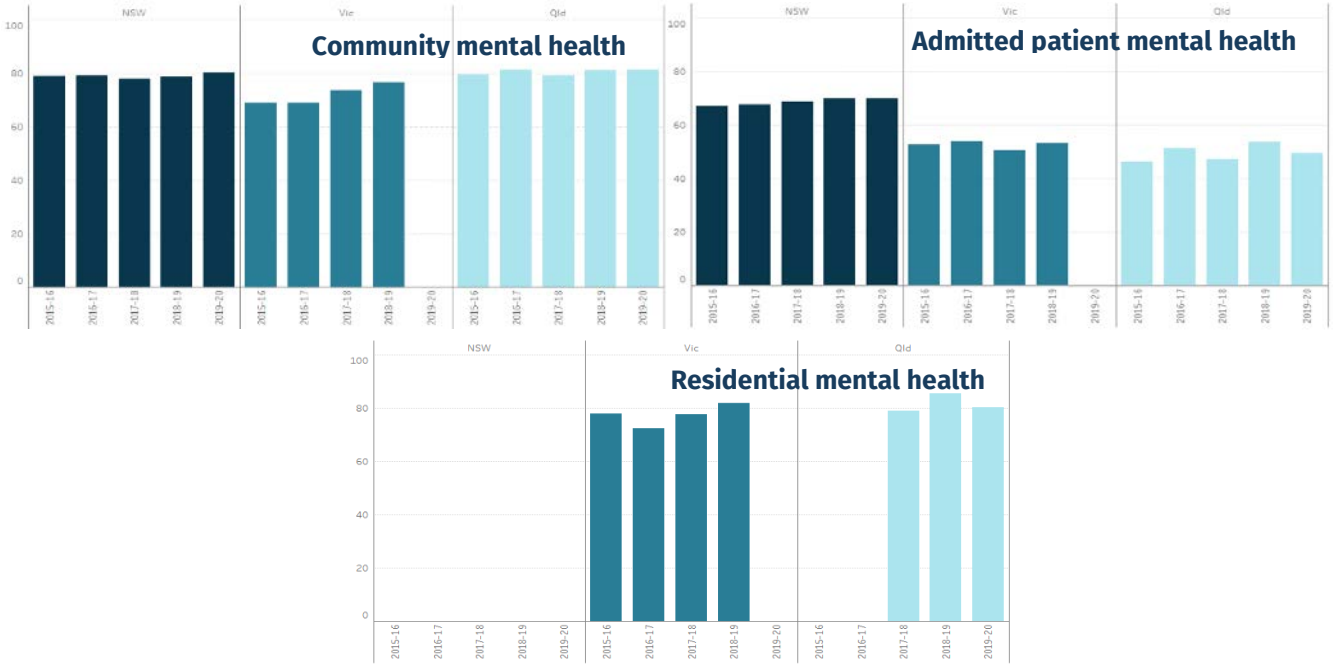
- Your Experience of Service (YES) survey
- Family of Youth (FoY) survey and
- Carer Experience Survey (CES).

The YES and FoY collections are offered on a 'snapshot' basis, i.e., for a six-week period each year whilst the CES if offered on a continuous basis throughout the year.

9.2.1 Your Experience of Service (YES) survey

The Your Experience of Service (YES) was implemented in Queensland in 2015. Queensland contributes to national pool of data that is published annually by the AIHW through the Your Experience of Service National Best Endeavours Data Set. The main statistic identifies the proportion of surveys where the consumer had a positive experience (Diagram 6).

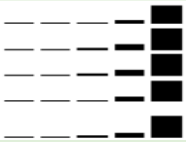
Diagram 6: Consumers with positive experience of service by state and setting, 2015-16 to 2019-20



In addition, a range of data sets and reports are made available to HHSs via the Mental Health and Addiction Portal. This information is used by HHSs to identify focus areas with the aim of improving the current and future experiences of consumers accessing services. An example report, which highlights the top and bottom five questions based on average

scores, is provided at Diagram 7. These reports highlight that it is often the questions about impact on outcomes that score more negatively than questions related to experience.

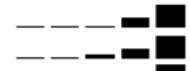
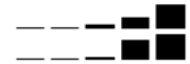
Diagram 7: Top 5 and bottom 5 response to the YES survey, 2021

Domain	Question	Average Rating (out of 5)	Proportion of responses scored 1 - 2 - 3 - 4 - 5	Last Year 's Rating (out of 5)
Top 5				
Valuing individuality	Your individuality and values were respected (Q6)	4.6		4.6
Showing respect	You felt welcome at this service (Q1)	4.5		4.6
Showing respect	Staff showed respect for how you were feeling (Q2)	4.5		4.5
Supporting active participation	Your opinions about the involvement of family or friends in your care were respected (Q10)	4.5		4.5
Showing respect	Your privacy was respected (Q4)	4.5		4.5
Bottom 5				
Providing information and support	Explanation of your rights and responsibilities (Q19)	3.8		3.8
Making a difference	The effect the service had on your overall well-being (Q25)	3.8		3.8
Providing information and support	Access to peer support (Q20)	3.8		3.8
Making a difference	The effect the service had on your hopefulness for the future (Q23)	3.8		3.7
Making a difference	The effect the service had on your ability to manage your day to day life (Q24)	3.7		3.7

9.2.2 Family of Youth (FoY) survey

The Family of Youth (FoY) survey is offered to parents or carers of child and youth consumers in adolescent inpatient units and child and youth community teams. The FoY survey was developed by the Mental Health Statistics and Improvement Program (MHSIP) and the National Research Institute of the National Association of State Mental Health Program Directors in the United States of America. It was developed with a high level of consumer and carer involvement and consultation. The FoY has been collected since 2010. This information is also reported via the Mental Health and Addiction Portal (MHAP) and utilised by HHSs to inform a program of work (see Diagram 8). As with the YES, it is often the questions about impact on outcomes that score more negatively than questions related to experience.

Diagram 8: Top 5 and bottom 5 response to the FoY survey, 2021

Domain	Question	Average Rating (out of 5)	Proportion of responses scored 1 - 2 - 3 - 4 - 5	Last Year 's Rating (out of 5)
Top 5				
Respect and safety	Staff treat me with respect (Q12)	4.7		4.7
Felt needs were met	Staff speak with me in a way that I understand (Q14)	4.7		4.7
Respect and safety	Staff are sensitive to my cultural/ethnic background (Q15)	4.4		4.4
Respect and safety	Staff respect my family's religious/spiritual beliefs (Q13)	4.4		4.4
Involvement in the process of care	I participate in my child's treatment (Q6)	4.4		4.4
Bottom 5				
Service outcomes	My child gets along better with friends and other people (Q18)	3.6		3.6
Service outcomes	Overall, my child feels better (Q22)	3.5		3.6
Service outcomes	My child is doing better in school and/or work (Q19)	3.4		3.5
Service outcomes	My child is better able to cope when things go wrong (Q20)	3.4		3.4
Service outcomes	I am satisfied with our family life right now (Q21)	3.3		3.3

9.2.3 Carer Experiences Survey (CES)

The role of carers and the need for carers and families to receive information, within the bounds of privacy and confidentiality, about the treatment and care provided to the consumer was recognised in the Fourth National Mental Health Plan. Following a national

project, a pilot collection of the Mental Health Carer Experience Survey (CES) was undertaken in several sites across Queensland HHS MH services in 2017 alongside the YES collection. Following the pilot, the CES was implemented across all Queensland HHS MH services from January 2019.

The CES provides carers with the opportunity to provide feedback on their experiences when engaging with Queensland HHS MH services. As with the YES and FoY surveys, this feedback provides mental health services with valuable information to implement improvement initiatives and supports better engagement with carers and family members to improve consumer and carer outcomes. Between January 2019 and June 2021, 868 CES have been received. Diagram 9 highlights the top and bottom five questions based on average scores. The questions flagging more negatively have been relatively consistent across reporting periods.

Diagram 9: Top 5 and Bottom 5 responses to the CES, January 2019 to June 2021

National Plan Domain	Question number and text	Average Rating (out of 5)	Peer Rating (out of 5)	Proportion of responses scored 1 - 2 - 3 - 4 - 5
Top 5				
Showing respect	Q9. You were identified as a carer of your family member, partner or friend	**4.5**	4.5	
Showing respect	Q7. Your opinion as a carer was respected	**4.3**	4.3	
Valuing individuality	Q14. Staff worked in a way that supported your relationship with your family member, partner or friend	**4.3**	4.3	
Supporting active participation	Q6. You were given the opportunity to provide relevant information about your family member, partner or friend	**4.3**	4.3	
Consumer want for carer involvement	Q27. Overall, during the last three months, did your family member, partner or friend want you involved in their care?	**4.2**	4.2	
Bottom 5				
Making a difference	Q25. Your overall wellbeing	**3.8**	3.8	
Valuing individuality	Q5. You were able to obtain cultural or language support (such as an interpreter) when you needed	**3.8**	3.8	
Making a difference	Q26. Overall, how would you rate your experience as a carer with this mental health service over the last three months?	**3.6**	3.6	
Valuing individuality	Q12. You were given the opportunity to enhance your abilities as a carer	**3.5**	3.5	
Providing information and support	Q2. You were given an explanation of any legal issues that might affect your family member, partner or friend	**3.2**	3.2	

10. Quality and safety

The DoH bases its approach to monitoring and promoting improvements in the quality of health services on the Australian Commission on Safety and Quality in Health Care (ACSQHC) accreditation framework which identifies the essential elements of quality care, as well as organisational functions integral in supporting the provision of care.

It is acknowledged that some components of the wider service system currently use different frameworks, which are compatible with the overarching ACSQHC National Safety and Quality Health Service (NSQHS) Standards. For example, for AOD, the *National Quality Framework for Drug and Alcohol Treatment Services* was developed in 2019 as a requirement for all providers across sectors. The Framework is available here. The Framework includes eight acceptable accreditation standards and nine guiding principles to support high quality and safe AOD treatment.

The MHAOD Branch supports patient safety and clinical quality improvement agendas for Queensland Health MHAOD services by identifying areas for potential improvement, monitoring quality, promoting improvement, and supporting and facilitating the dissemination of best practice clinical standards and processes.

Where treatment and support services are delivered by NGOs, the MHAOD Branch provides advice to other relevant areas within the DoH (such as the Community Services Funding Branch) to ensure service agreements reflect appropriate safety and quality requirements. There is a requirement for all NGO providers of MHAOD treatment and support to have third party accreditation under the *NGO Quality Requirements Framework*. This Framework supports accountability and compliance with recognised national quality standards, certified through independent third-party audits. It has been designed to streamline requirements and, where possible, enable NGOs or community service organisations to apply established quality standards to funded service delivery.

The MHAOD Branch works in partnership with consumers and carers, clinicians, and managers across HHSs to promote high quality and safe MHAOD services in alignment with contemporary clinical standards by:

- providing advice and direction in relation to quality improvement and safety initiatives at a state and national level
- leading the development of clinical policy, guidelines and supporting clinical tools
- facilitating collaborative learning and the sharing of best practice among MHAOD services
- supporting and working with HHSs to develop solutions for statewide implementation
- developing and implementing comprehensive and integrated MHAOD clinical incident management mechanisms focused on learning and improvement
- monitoring MHAOD service data to identify areas for improvement
- supporting statewide clinical governance systems and structures which raise risk awareness and promote a culture of safety at all levels.

A range of statewide mechanism exist to support collaborative health leadership and engage clinicians in continuous quality improvement. These are outlined at Appendix 4.

10.1 Consumer outcomes in MHAOD care

Since 2003, Queensland Health has routinely collected a standard suite of clinical measures to identify whether consumers' clinical symptoms and functioning have improved after receiving mental health care. The measures focus on clinical outcomes related to symptoms and functioning and where possible, should be complemented by one or more other measures of consumer outcomes (such as social inclusion and experience), that demonstrate the different perspectives on, and dimensions of, mental health consumer outcomes.

Nationally, consumer outcomes are measured based on change in clinical outcomes between two collection points. In Queensland in 2019-20, 73.4 per cent of persons discharged from acute inpatient care showed significant clinical improvement, similar to the national average of 72.2 per cent. For consumers leaving community mental health care 52 per cent showed a

significant clinical improvement, a further 40.7 per cent saw a change in clinical outcomes but it was not considered significant. Again, this is similar to the national averages of 50.7 per cent and 42.9 per cent respectively.

The outcome measures enable specific areas of symptomatology and functioning to be identified and monitored. Table 1 provides an overview of changes in issues identified as having a clinically significant impact on the consumer at commencement of the service episode, where the consumer saw a reduction in the level of rated clinical severity between commencing and ceasing treatment with the service. There is ongoing work to develop effective and consistent outcomes measures for specialist AOD treatment delivered across sectors. This is guided by the Queensland AOD Treatment and Harm Reduction Outcomes Framework (Available here).

Table 1. Change in clinical significance of selected HoNOS items, acute inpatient and community mental health inpatient care, 2020-21

Setting	Item	Clinically significant at Start	Clinically significant at End	Reduction in severity level of clinical significance
Acute inpatient	Non-accidental self-jury	33.4%	9.6%	90.4%
	Problem drinking or drug-taking	56.0%	26.2%	82.8%
	Problems with hallucinations and delusions	54.6%	21.6%	88.5%
Community	Non-accidental self-jury	15.9%	6.5%	82.9%
	Problem drinking or drug-taking	35.4%	25.5%	62.8%
	Problems with hallucinations and delusions	25.6%	11.2%	79.0%
	Other mental and behavioural problem	59.5%	37.1%	69.9%
	Problems with depressed mood	50.8%	26.3%	74.7%
	Problems with relationships	42.2%	26.8%	68.0%

There is ongoing work to develop effective and consistent outcomes measures for specialist AOD treatment delivered across sectors. This is guided by the Queensland AOD Treatment and Harm Reduction Outcomes Framework which is available here.

10.2 Performance reporting and monitoring

Queensland mental health services have a strong history in review and use of performance data to inform change and support reform. This is underpinned by state-wide frameworks, strategies and reporting. The overall approach for HHSs is outlined in the Queensland Health Performance and Accountability Framework 2020-2021 which can be accessed here.

A National Mental Health Performance Framework was developed in 2005 as a key strategy for facilitating a culture of continuous quality improvement in mental health service delivery. An overview of the full framework is available here.

There are 15 Tier 3 performance indicators related to the performance of Australian public mental health services. The AIHW provide information on the data available and make comparisons across the Australian jurisdictions where possible/appropriate. This information is available for the period 2005-06 to 2018-10. This information is available from here.

Through the annual Queensland Government budget process Queensland Health as a whole and HHSs separately report on the service area objective of mental health and alcohol and other drug services. Currently there are two effectiveness measures:

- Proportion of re-admissions to acute psychiatric care within 28 days of discharge (separated by Aboriginal and Torres Strait Islander or non-Indigenous status of patients).
- Rate of community mental health follow-up within one to seven days following discharge from an acute mental health inpatient unit (desegrated by Aboriginal and Torres Strait Islander or non-Indigenous status of patients).

Other measures include:

- percentage of the population receiving clinical mental health care
- ambulatory mental health service contact duration
- Queensland suicide rate (number of deaths by suicide/100,000)
- total weighted activity units – mental health.

Detailed information on this performance can be obtained from the Queensland Health Service Delivery Statement here.

The MHAOD Branch provides a substantial level of standardised reporting to Queensland Health's MH services, with frequency and specificity improving with technology enhancements. Reporting on AOD services delivered by HHSs has been improved with the transition of alcohol and other drug services utilising the Consumer Integrated Mental Health and Addiction (CIMHA) application.

A key principle of performance reporting includes increasing and maintaining transparency of how performance data is presented and accessed. The MHAOD Branch continue to improve access to performance reports, including the national performance indicators, through mechanisms such as the MHAP. MHAP is a business intelligence solution that provides the foundation for improved reporting, analysis and access to mental health alcohol and other drug data.

The MHAOD Branch also provides HHSs education, reports, resources, presentations and forums on the use of information to continue to build the culture of data-informed practice and support service development and improvement for better outcomes for consumers, family members and carers.

11. Technology and Information Management

Effective system performance and improvement, along with planning functions, are dependent on the availability of system enablers including data, information assets and

contemporary information technologies. The importance of information to the reform of the sector has been a continuing focus for national and state policy and planning.

Queensland Health's MHAOD program has an established information capability, including a statewide clinical electronic record, known as the CIMHA application and the MHAP, which provides business intelligence capability to the sector.

CIMHA is a statewide clinical electronic medical record that is used by approximately 12,000 mental health alcohol and other drugs clinical, managerial, and administrative staff. It captures clinical information, clinical outcome measures, patient-reported outcomes measures, activity and intervention data and clinical documentation for mental health, alcohol and other drugs consumers across 125 inpatient, outpatient, community and residential based care settings in accordance with mental health, alcohol and other drugs service delivery. Furthermore, it delivers legislatively mandated functions as the official Patient Record under the *Mental Health Act*.

The MHAP is a business intelligence solution that leverages a data warehouse to collate, integrate and transform disparate data from multiple source systems. For users, MHAP enhances and creates efficiencies in creation, delivery and accessibility of mental health and alcohol and other drugs related data and analytics, creates a secure platform for access to a broad range of information that is utilised for service evaluation and planning, performance monitoring and investigation and to support clinical and business processes.

The MHAOD Branch is highly proficient at developing standardised, cleansed and quality assured structured data collections that allow for retrospective analysis, evaluation, planning and national reporting requirements.

While these structured data collections are effective for retrospective reporting and epidemiological analysis, as the MHAOD service sector seeks to transition to insight driven management and artificial intelligence (AI) augmented care, new and innovative ways will be required to source, link and curate data sets that can respond quickly to business and new environmental requirements.

Queensland Health MH services have a strong history in the use of performance data to inform change and support reform. This is underpinned by state-wide frameworks, strategies and reporting. Despite the comparatively low investment in MH services when compared to other jurisdictions, Queensland services have made major improvements in performance across a range of areas, such as improvements in formal care planning for consumers from 25 per cent in 2017-18 to 64 per cent in 2020-21.

The long-term goal is to continue to develop the infrastructure, capacity and culture that delivers mature, predictive analytics that support and drive planning, resource utilisation and clinical service delivery in real time. Transitioning to a more digitally capable service delivery system requires substantial planning and investment to realise the benefits achieved in other areas of digitally enabled healthcare delivery. In early 2021, the MHAOD Branch invested in the development of a Digital Information Strategy and Investment Roadmap for Mental Health and Alcohol and Other Drugs Healthcare as a key component for any future MHAOD plan.

Digital information is a fundamental pillar of effective and efficient MHAOD service provision. The MHAOD Branch has developed a MHAOD Digital Information strategy which

builds upon existing infrastructure and processes to deliver a contemporary MHAOD system that maximises the use of technology to:

- Optimise services through better use of resources.
  - Enhancing productivity and efficiency of service providers by reducing administrative work through the redesign of the ways of working and supporting digital tools.
  - Advocating for and enabling consumer, carer and family engagement in collaborative care.
- Transform services through collaboration, information sharing and use.
  - Assisting consumers and carers to better own their care outcomes and manage self-care using digital services.
  - Improving clinical outcomes by providing access to comprehensive and relevant information at the right time to support clinical decision-making.
- Grow effective, efficient and safe services that meet evolving consumer and community needs through a sustainable foundation.
  - Enabling consumers, carers and families, access to flexible, personalised supports and services and help them navigate options for treatment, care and support that recognises their diversity and individual needs.
  - Developing and sharing data analytics to provide services, system administrators and researchers with a wealth of information to ensure services are being delivered effectively and safely, where interventions and programs are working, and where more needs to be done.

The input provided by consumers, families, carers, and supporters through the consultation and collaboration undertaken to develop the Digital Information Strategy identified consumers expect and want technology to be used in ways that improve their service experience and the quality of services, make services more accessible and personalised, and give them more choice. This perspective is echoed by consumer input into the recent Royal Commission into Victoria's Mental Health System and Productivity Commission Inquiry into Mental Health.

12. Statewide planning and service development

Queensland has a strong history of planning and service development across the mental health system as part of ongoing reforms and improvements.

The Queensland Plan for Mental Health (QPMH) developed in 2007 set out ambitious targets for reform across our State-funded mental health system. Between July 2007 and June 2011, the QPMH guided investments of more than $632 million. Seventeen capital projects at a cost of $148 million delivered 277 new or redeveloped beds and produced a net gain of 146 new beds. An additional 569 staff were employed across mental health specialist community treatment services.

Connecting Care to Recovery released in 2016 and supported by an investment of more than $350 million over five years prioritised expanding access to a range of bed-based and

support services in the community, more specialist services, implementation of the *Mental Health Act 2016* and better use of ICT to enhance clinical practice. Planning for and enhancements for AOD were included for the first time (noting the QPMH was developed prior to MH and AOD being brought together organisationally).

Queensland, along with other States/Territories and the Commonwealth Government committed to development of joint regional MH and suicide prevention plans under the Fifth National Mental Health and Suicide Prevention Plan.

In Queensland, all PHNs and HHSs have completed foundational regional plans and are working towards comprehensive service development plans. These help to identify priorities for service development and investment and support effective service delivery across the health care continuum. Some of the PHN and HHS joint plans also include AOD priorities.

To support these commitments and ongoing planning for MHAOD, the MHAOD Branch has developed expertise in MHAOD planning including the use of evidence-based planning methodologies including the National Mental Health Service Planning Framework (NMHSPF) and the Queensland Drug and Alcohol Services Planning Model (Q-DASPM).

In this role, the MHAOD Branch provides support to HHSs for local area service planning and needs analysis to augment local HHS and PHN service planning. This planning role also supports implementation of key National and State policy, service development and identification of priority capital projects.

12.1 The National Mental Health Service Planning Framework

The NMHSPF is a key tool to assist in identifying, planning and resourcing state-funded mental health service needs. It provides national average benchmarks for optimal service delivery across the full spectrum of MH services.

All States/Territories along with the Commonwealth Government have committed to using the NMHSPF which was first developed in 2011. The latest version was released to all States/Territories along with PHNs in 2021 to assist with joint planning.

The NMHSPF describes the range of services required within a comprehensive mental health system (taxonomy) and assists with defining optimal levels and mix of services across both the specialist and primary health treatment system.

While the NMHSPF Planning Support Tool is only available to licensed users general information on the NMHSPF is available from the AIHW here.

12.2 Queensland Drug and Alcohol Services Planning Model

Between 2019 and 2021, Queensland Health commissioned the Drug Policy Modelling Program at the University of New South (UNSW) to adapt the national DASPM to suit Queensland. The Queensland DASPM (Q-DASPM) was finalised in 2021. This model is a decision support tool that provides estimates and projections on AOD treatment service

demand and resources for Queensland at a broad level (i.e., not specific to funder and HHS and PHN area level). It represents one part of the process for identifying service delivery needs. Use of the Q-DASPM is supported by a companion document developed by UNSW with an expert Queensland advisory group – A Framework for the planning and commissioning of Aboriginal and Torres Strait Islander AOD treatment services in Queensland.

The Q-DASPM is organised around five age groups (10 – 14 years; 15 – 19 years; 20 – 24 years; 25 – 64 years; 65 years and over) for treatment of problematic use of alcohol, cannabis, methamphetamine and opioids. The Q-DASPM includes 12 care packages and covers the core AOD treatment types (including:

- psychosocial interventions (counselling)
- withdrawal management
- residential rehabilitation
- day programs
- inpatient hospital admission for alcohol and other drug withdrawal
- medication assisted treatment of opioid dependence

While the model does not plan for very young children (aged under 10) or all drugs that are used problematically or poly-drug use, the Q-DASPM like the NMHSPF allows for a standard and consistent way to identify need and supports a more collaborative and coordinated process for planning and commissioning.

13. Achieving Health Equity

Aboriginal and Torres Strait Islander peoples continue to experience mental health and substance misuse issues more frequently than other population groups. Aboriginal and Torres Strait Islander peoples have higher rates of suicide compared to non-Indigenous Queenslanders and are also more likely to be hospitalised for psychoactive substance misuse and other psychotic disorders. They experience higher levels of morbidity from mental illness, assault, psychological distress and self-harm. Mental illness is a leading contributor to the Indigenous burden of disease in Queensland, contributing up to one-fifth of the total disease burden.

The State-funded MHAOD system also has a significant role in contributing to the aims and targets of *Making Tracks towards health equity with Aboriginal and Torres Strait Islander peoples – working together to achieve life expectancy parity by 2031* and the *National Agreement on Closing the Gap (2020)*.

For MHAOD, this includes developing and implementing ongoing strategies to reduce health inequities, improve cultural quality and safety, leadership by and partnerships with Aboriginal and Torres Strait Islander agencies, services, stakeholders and communities and the commissioning of MHAOD and social and emotional wellbeing services from the Aboriginal and Torres Strait Islander health services sector.

Queensland's Aboriginal and Torres Strait Islander Health Equity Framework places First Nations peoples and voices at the centre of healthcare service design and delivery in

Queensland. This public health system legislation has been enacted in Queensland through new provisions in the *HHB Act 2011* and HHB Regulation 2012, that is now supported through a robust and considered public policy environment.

Further information and legislative requirements put in place to support this can be found at the following:

- Amendment Regulation (available here)
- Hospital and Health Boards Act 2011 (available here)
- Hospital and Health Boards Regulation 2012 (available here)
- Health Service Directive (Available here).

14. Current challenges

The following are some key challenges currently impacting state-funded MHAOD system. These will be further expanded upon in Queensland Health's submission to the Select Committee.

14.1 Increasing service utilisation and demands

The proportion of the Queensland population accessing public MH services has had incremental increases over the past five years, increasing from 2.1 per cent in 2016-17 to 2.2 per cent in 2020-21. There has been a 15 per cent increase in the number of persons accessing services, compared to a six per cent growth in the Queensland population over the same period.

Over this same period there has been a 20 per cent increase in the number of referrals, however the number of referrals transitioning to ongoing care has reduced by 11 per cent, and overall, the number of open service episodes has reduced by three per cent.

This data highlights that increasing demand on MH services is impacting upon the capacity for care to be delivered, with a number of factors likely to impact up on this trend, including historically low investment and lack of alternative services (including primary care) in some areas.

14.2 Per capita expenditure

Historically, Queensland has had one of the lowest per capita expenditure on mental health services in Australia, being below the national average for the past ten years.

Further information to be provided.

14.3 Workforce and FTE

Queensland has consistently had one of the lowest direct care FTE per 100,000 persons for mental health service provision in Australia, being below the national average for most of the last decade.

Further information to be provided.

Securing a workforce to meet current and future service delivery demands is a challenge across the MHAOD service system. There are current significant or looming shortfalls across psychiatry, medical addiction specialists and nursing and allied health, but also for the psychosocial support workforce and ongoing challenges in attracting and recruiting and AOD workforce.

14.4 Impact of COVID-19

Over the past two years the COVID-19 pandemic and the responses have had substantial impacts on the mental health and wellbeing of Australians. Evidence suggests that the impact on people's mental health and wellbeing has not been felt evenly and has depended on the actual experiences of individuals, families, communities and industries. For some pre-existing risk/or conditions have been exacerbated.

The AIHW releases data and analysis on the impact of the COVID-19 pandemic on health and welfare issues relevant to Australians and its impact on the Australian health system. This includes impacts on mental health and wellbeing of Australians and the use of mental health services. Detailed information is available here.

In Queensland, there has been an increase in demand across public mental health and other drugs services during the pandemic period. Increased demand in services has been experienced in relation to eating disorders, anxiety, and alcohol and other drug problems with both child and youth and adult services being unable to meet demand. The mental health impacts of the COVID-19 pandemic are expected to continue with increasing demand for state-funded mental, alcohol and other drug services.

To date the COVID-19 pandemic does not appear to have impacted on the rate of suicide.

Appendices

Appendix 1: Commonwealth Government Funded Programs

Medicare

The Commonwealth Government subsidies a range of fee-for-service, mental health-specific, health professional services through the Medicare Benefits Schedule (MBS). This includes a range of general practitioner (GP), allied health professional, and specialist mental health treatment and care services. These subsidies are provided for services that are delivered in

community settings (e.g. consultation rooms) or for inpatient services (e.g. private hospitals). Unless bulk billed, many of these services attract a co-payment from the service user.

In 2019-20, 11.2 per cent of the Queensland population received a Medicare-subsidised mental health-specific service. This was second only to Victoria at 11.4 per cent. Queensland had a Medicare-subsidised mental health-specific service of 521.1 per 1,000 population, again second only to Victoria (542.6 per 1,000). Queensland had the third highest number of people receiving Medicare-subsidised psychiatric services (includes ECT) at 96,428, behind NSW (137,361) and Victoria (112,384) but at the highest rate with 1.9 per cent of the population.

In 2018-19, the latest time period for which data is available shows that Commonwealth Government expenditure on mental-health specific services in Queensland was almost $271.8 million, a per capita rate of $53.81. This per capita rate was second only to expenditure in Victoria ($57.94) and higher than the Australian average ($51.45).

Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme

The Commonwealth Government subsidises, through the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS) a wide range of mental health-related pharmaceuticals.

In 2018-19, in Queensland under the PBS and Repatriation PBS the Commonwealth Government's expenditure on mental health-related medications was $117,115 million or $23.19 per capita. While this was only the third highest overall expenditure (behind New South Wales and Victoria) this was the highest per capita expenditure. Under the PBS most people will make co-payments which depend on their concessional status and whether they have reached the safety net threshold.

Australian Veterans

The Commonwealth Government pays for mental health services delivered to Australian veterans through:

- the Repatriation Pharmaceutical Benefits Scheme (RPBS)
- Repatriation Medical Benefits (general practitioners, allied health professionals, and psychiatrists)
- services provided through public and private hospital
- grants to a range of organisations delivering mental health related services.

Supports for psychosocial disability

The Commonwealth Government contributes funding to the National Disability Insurance Scheme (NDIS) for the provision of services to people experiencing psychosocial disability. The Commonwealth Government also funds programs for people experiencing psychosocial disability and require supports who have either not yet applied for or received their NDIS package or have been deemed ineligible for an NDIS package. Information on the Commonwealth Government's approach to psychosocial supports is available here.

Grants to PHNs

The Commonwealth Government provides grants to PHNs for primary health care and under the Drug and Alcohol Program. These grants are determined factors such as PHN's population size, rurality, socio-economic disadvantage, relative access to Medicare funded psychological services. Information on the operation of the PHNs can be accessed here.

Appendix 2: Queensland mental health legislation framework and role of Chief Psychiatrist

Overview

The statutory position of Chief Psychiatrist in Queensland is held by Dr John Reilly. The Office of the Chief Psychiatrist which supports the functions of the Chief Psychiatrist is located within the MHAOD Branch.

The *Human Rights Act 2019* commenced on 1 January 2020. The *Mental Health Act* and associated policies and guidelines have been examined and assessed as compatible with the *Human Rights Act*.

The *Mental Health Act* has a strong focus on protection of individual rights. Any limitation on rights (e.g., assessment or treatment without consent of a person or the use of restrictive practices on a person) is subject to strict legislative criteria and requirements that serve to ensure the limitation is necessary and least restrictive in the circumstances.

Authorised Mental Health Services

Involuntary patients in Queensland may be detained in Authorised Mental Health Services (AMHSs) which are declared by the Chief Psychiatrist under the *Mental Health Act*. An AMHS must be a health service or part of a health service providing treatment and care to people with a mental illness. An AMHS may be comprised of both community based and in-patient mental health facilities. The current schedule of AMHSs is available here.

Under the *Mental Health Act*, the Chief Psychiatrist may also declare a public sector mental health service, or part of a public sector mental health service, to be a high security unit. A high security unit is subject to additional legislative requirements to protect the interests of patients and the wider community. This includes additional requirements in relation to the admission and discharge of patients, and the security of the facility. There are two declared high security units in Queensland.

Orders and authorities

Authorities (primarily made by health practitioners) and orders (made by Courts and/or the Mental Health Review Tribunal) authorise a person's detention and/or treatment or care in an AMHS. The *Mental Health Act* also establishes a pathway to transfer people requiring mental health treatment from correctional or custodial settings to an AMHS for assessment and/or treatment. Table A1 provides a description of the categories of authorities, orders, and statuses.

Table A1: Description of authorities, orders, status under the *Ļ dăşaκGdăışg Abş 5349#*

Category of authority/order/ status	Description of authority/order/status under Mental Health Act 2016
Involuntary assessment	When it is not possible to provide the required assessment or treatment with consent (i.e. consent given by the person or another person authorised to consent on their behalf) the involuntary processes in the Act may be applied. The involuntary process usually commences with a Recommendation for Assessment. A Recommendation for Assessment may be made by a doctor or authorised mental health practitioner. The purpose of the assessment is to decide whether a treatment authority should be made. The Mental Health Review Tribunal is also empowered to make examination authorities which provides for the involuntary examination of a person to determine if further assessment and/or treatment is required
Treatment Authorities	A treatment authority authorises the treatment and care of a person with a mental illness without the person's consent. The doctor must be satisfied that the treatment criteria apply and that there is no less restrictive way of providing treatment and care for the person. The person's views, wishes and preferences are considered. An authorised doctor must decide the category of the treatment authority - inpatient or community. An inpatient category of a treatment authority authorises the person's detention in an AMHS.
Forensic Orders	Forensic orders are made primarily by the Mental Health Court for persons charged with a serious offence who are found of unsound mind at the time of an alleged offence or unfit for trial, whether due to a mental condition, an intellectual disability, or dual disability. Persons on a forensic order may be treated or cared for without consent in the community if there is not an unacceptable risk to the safety of the community because of the person's mental condition, or if necessary, detained in an AMHS or the Forensic Disability Service. There are two types of forensic order made by the Court – a forensic order (mental health) and a forensic order (disability). A forensic order may also be made by the Mental Health Review Tribunal in limited circumstances, namely: • on referral from the Supreme Court or District Court following the making of a forensic order (Criminal Code) to decide whether to make a forensic order (mental health) or forensic order (disability), and • where the Tribunal transfers a person on the equivalent of a forensic order from interstate.
Treatment Support Orders	A treatment support order may be made by the Mental Health Court, for persons charged with a serious offence, if the Court decides a person was of unsound mind at the time of an alleged offence or is unfit for trial. Treatment support orders are made by the Court to protect the safety of the community in circumstances where a forensic order is not warranted. When the Mental Health Review Tribunal reviews a forensic order, the Tribunal may revoke the forensic order and make a treatment support order. The making of a treatment support order by the Tribunal acts as a 'step down' from a forensic order as part of a person's recovery. The category for treatment support orders must be a community category, unless it is necessary for the person to be an inpatient, having regard to the person's treatment and care needs, the safety and welfare of the person and the safety of others.
Classified	The classified patient provisions facilitate transport from custody and admission to an AMHS for access to mental health assessment, treatment and care where required. The Act also provides for the person's return to custody when they no longer require inpatient treatment and care. A classified patient admission can only occur on the recommendation of an authorised doctor or authorised mental health practitioner.

Mental Health Court

The *Mental Health Act* establishes the Mental Health Court and distinguishes Queensland as the only Australian jurisdiction with a dedicated Supreme Court for determining issues of unsoundness of mind (the 'insanity' defence) and fitness to plead.

The Mental Health Court makes decisions about whether a person charged with an offence that is not required to be determined by a Magistrate (a serious offence) and any associated offence is unfit for trial or was of unsound mind (and/or for the offence of murder, of diminished responsibility) when the offence was allegedly committed.

The Mental Health Court is able to fully investigate the relationship between a person's mental illness and alleged offences and isn't bound by the rules of evidence that govern other types of court proceedings. The Court does not test the facts of the case before it and may return a matter to the criminal court to proceed in the usual way if there is a substantial dispute about whether the person committed the alleged offence.

If the Mental Health Court decides a person was of unsound mind at the time of the offending or is permanently unfit for trial, the criminal charges are discontinued, and the court may make a forensic order, a treatment support order or neither. If the Mental Health Court decides a defendant is temporarily unfit for trial, the criminal proceedings are suspended while the person's fitness for trial is periodically reviewed by the Mental Health Review Tribunal. A forensic order or treatment support order must be made for the person.

A person on a forensic order or treatment support order is completely diverted from the criminal justice system to the health system in relation to those charges. For this reason, these orders do not have defined durations and a person remains liable to be detained until the order is revoked by the Mental Health Court or Mental Health Review Tribunal after consideration of treatment needs and risk issues.

Mental Health Review Tribunal

The Mental Health Review Tribunal is an independent decision-making body which has the primary purpose of reviewing the involuntary status of persons with a mental illness and/or intellectual disability. The Tribunal also provides approval for the performance of electroconvulsive therapy and non-ablative neurosurgical procedures and can make involuntary examination authorities where there are serious concerns about a person's mental health and wellbeing.

The Tribunal consists of a President, Deputy President and approximately 100 members. There is also an Executive Officer and other staff necessary for the Tribunal to exercise its jurisdiction.

The Tribunal has three different categories of membership:

- Legal members – lawyers of at least 5 years standing
- Medical members – registered psychiatrists
- Community members - a person with qualifications and experience relevant to exercising the Tribunal's jurisdiction.

The Office of Health Statutory Agencies (OHSA) within Queensland Health provides support and advice to the Director-General and Minister for Health and Ambulance Services in

relation to the statutory governance compliance requirements, including member appointments, and obligations of the Tribunal.

Assessment and Risk Management

The Chief Psychiatrist has issued a policy under the *Mental Health Act* for the treatment and care of patients subject to a forensic order, treatment support order or other identified higher risk patients. Under this policy, Administrators of AMHSs must establish an Assessment and Risk Management Committee for the service. This committee is a clinical body that has the function of peer reviewing the treatment and care of this cohort of patients. The policy, which includes terms of reference for the Assessment and Risk Management Committees, is available here.

The Assessment and Risk Management Committees operate in a way which must be consistent with the Queensland Health Violence and Risk Management (VRAM) Framework. This framework provides Queensland Health mental health services with a systematic approach for the identification, assessment and management of consumers who may pose a risk of violence towards others that supports clinical practice and governance.

The VRAM Framework aims to support a structured and standardised approach to risk assessment and management through the provision of a three-tiered approach, principles of good practice, clinical tools to underpin clinical expertise, training, and a quality assurance cycle for continuous improvement.

The VRAM Framework is available here.

Restrictive practices

The *Mental Health Act* provides a regulatory framework for the use of mechanical restraint, seclusion, and physical restraint on involuntary patients in an AMHS. This framework promotes the national and state priority of reducing and eliminating restrictive practices and promotes the use of less restrictive interventions.

The Act also provides a framework for the Chief Psychiatrist to monitor these practices within AMHSs by requiring the making of policies and practice guidelines regarding restrictive interventions. These guidelines are supported by a compliance monitoring framework managed by the Office of the Chief Psychiatrist. Additionally, the Office of the Chief Psychiatrist supports mental health and alcohol and other drug service safety and quality initiatives and programs to prevent and address patient harm and enhance quality and safety of care. The MHAOD Branch has a range of strategies to engage clinicians in collaborative mechanisms to drive sharing of good practice and engagement and promotion of quality and safety initiatives.

Mechanical restraint is the application of a device to restrict movement of a person's body or a limb. Seclusion is the confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented. These practices significantly affect patient rights and liberty and therefore can only be authorised as a last resort to prevent imminent and serious risk of harm to patients and staff, where less restrictive interventions have been unsuccessful or are not feasible.

Physical restraint generally refers to the use by a person of their body to restrict the patient's movement. However, physical restraint does not include the giving of physical support or assistance reasonably necessary to enable the patient to carry out daily living activities, or to redirect the patient because the patient is disoriented. Physical restraint is also to be used as a last resort where less restrictive interventions are insufficient to protect a patient, or others, from physical harm, provide necessary treatment and care to a patient, prevent serious damage to property, or prevent a patient detained in an AMHS from leaving the service without approval.

The *Mental Health Act* also makes it an offence for a person to administer medication to a patient unless the medication is clinically necessary for the patient's treatment and care for a medical condition. Treatment and care of a medical condition includes preventing imminent serious harm to the patient, or others. Medication includes the use of sedation. AMHSs are responsible for the quality use of medicines (QUM) under the National Strategy for QUM, within the National Medicines Policy. In addition, AMHSs must comply with the National Safety and Quality Health Service Standards.

Regulated treatments

Electroconvulsive therapy (ECT) and non-ablative neurosurgical procedures are 'regulated treatments' under the *Mental Health Act*. This means they are subject to additional approval and monitoring requirements.

ECT is an evidence-based treatment for certain severe psychiatric disorders. It can also be used as a maintenance treatment for certain severe psychiatric disorders.

ECT may only be performed with the informed consent of an adult patient, with the approval of the Mental Health Review Tribunal (MHRT), or in emergency situations under prescribed circumstances.

The Chief Psychiatrist has issued a policy for AMHSs in relation to the use of ECT which is available here. The coordination of initiatives to improve ECT quality and safety are monitored and led by the Queensland ECT Committee which provides expert and evidence-based content advice about ECT safety, policy and practice guidelines.

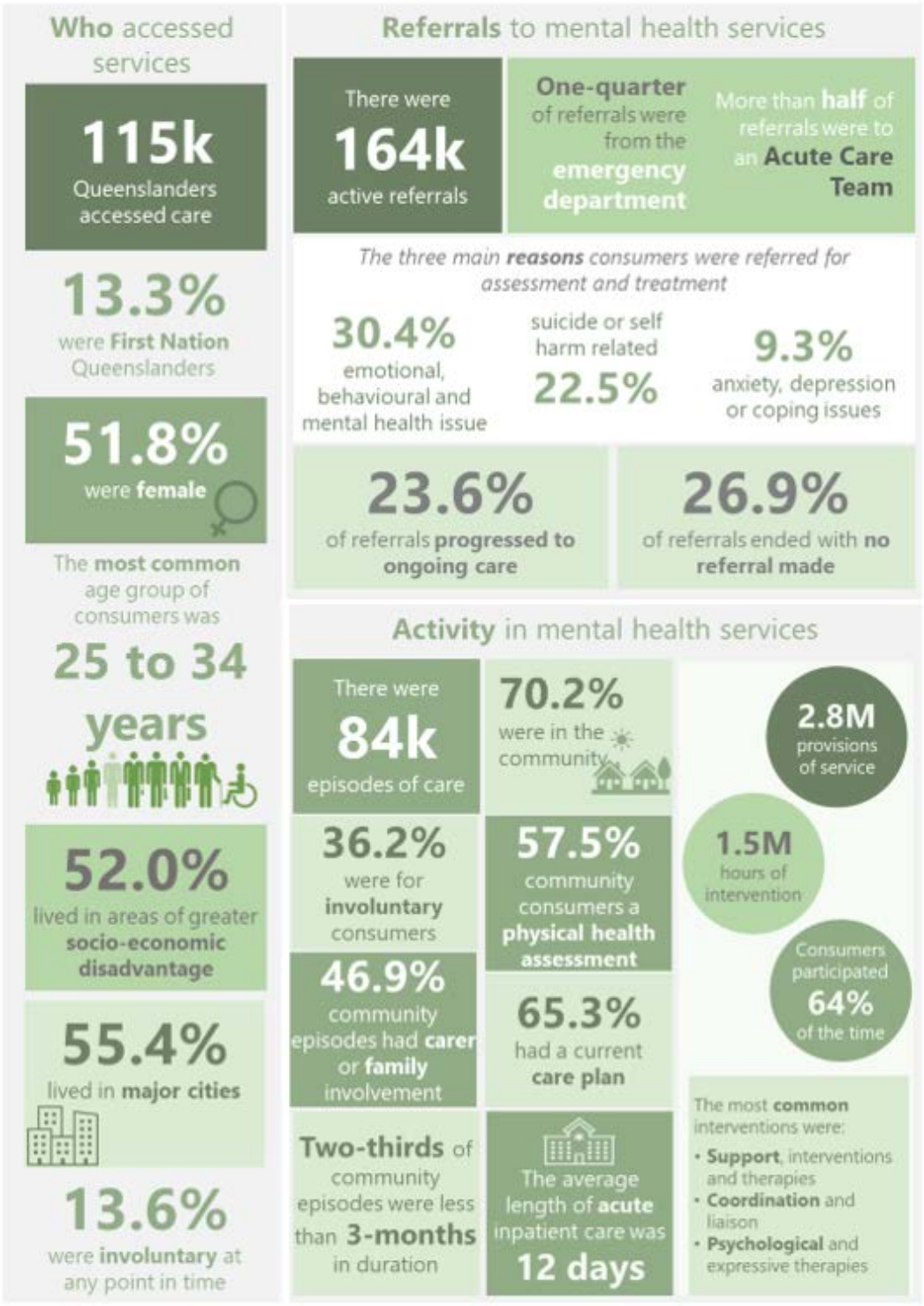
A non-ablative neurosurgical procedure is a procedure on the brain for the treatment of a mental illness that does not involve deliberate damage to or removal of brain tissue. An example of this is a deep brain stimulation procedure. Non-ablative neurosurgical procedures can only be performed with the informed consent of the person and the approval of the Mental Health Review Tribunal.

Queensland Forensic Disability Service

The Queensland Forensic Disability Service (FDS) is a discrete ten bed secure facility operated by the Department of Seniors, Disability Services, and Aboriginal and Torres Strait Islander Partnerships that is declared under the *Forensic Disability Act 2011* (Forensic Disability Act). The FDS provides rehabilitative services to address forensic and disability related needs, and not medical treatment pursuant to the *Forensic Disability Act*. It is a requirement that consumers detained to the FDS are currently subject to a Forensic Order (Disability). The FDS is explicitly transitional, reflecting the intent that with the delivery of appropriate services, clients will develop the requisite skills to live in a non- secure setting.

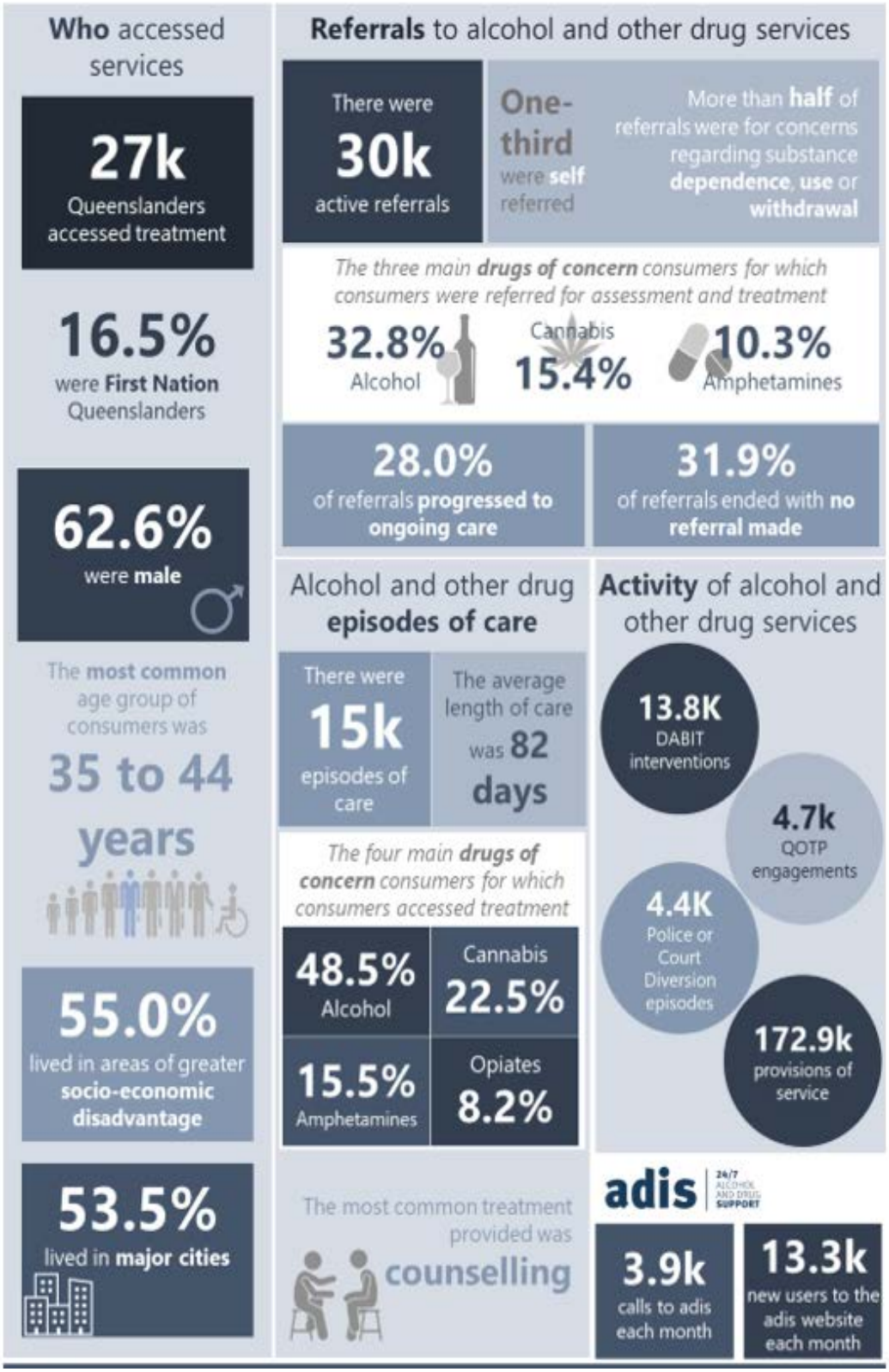
Appendix 3: Infographics on MHAOD HHS service provision for 2020-21

Infographic A3(A): Mental health service provision in HHSs

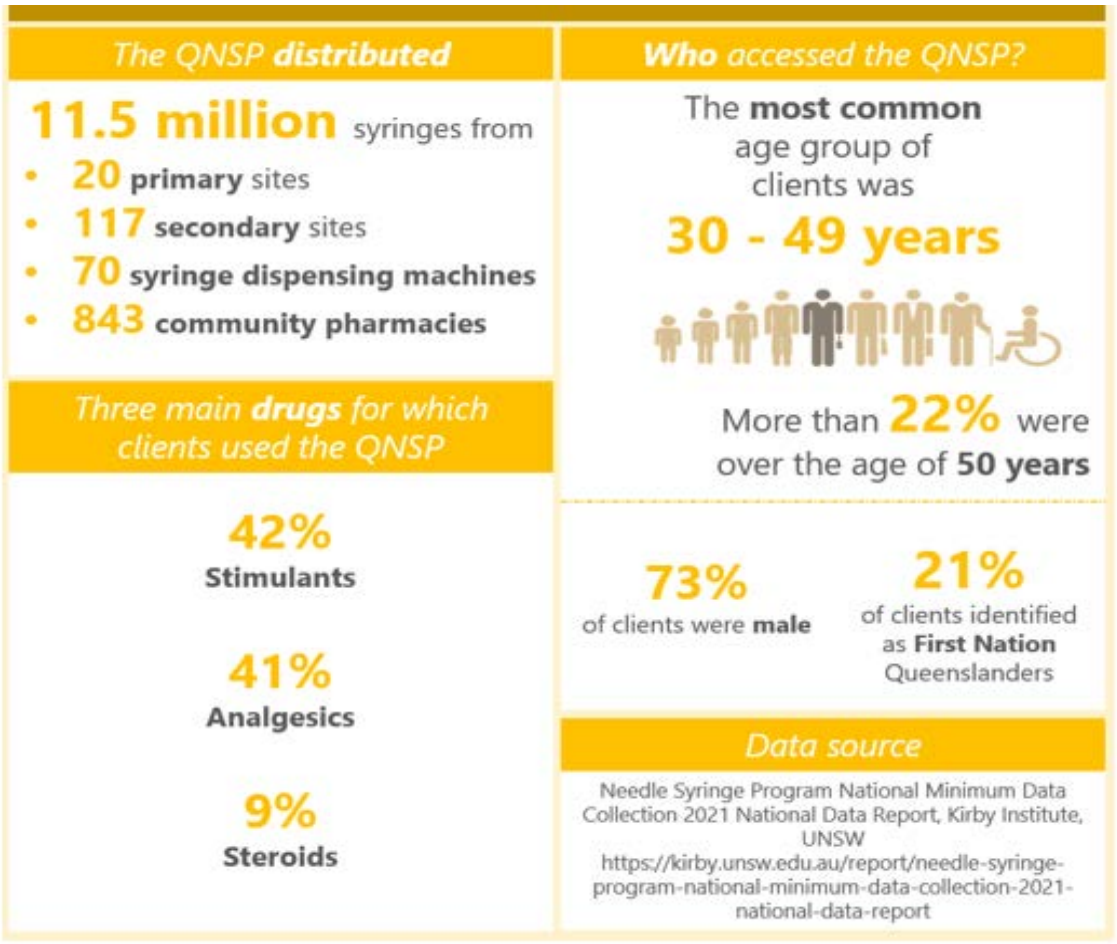


Infographic A3(B): AOD service provision in HHSs

Nb: proportion of service provision for cannabis due to inclusion of data from Police Diversion interventions



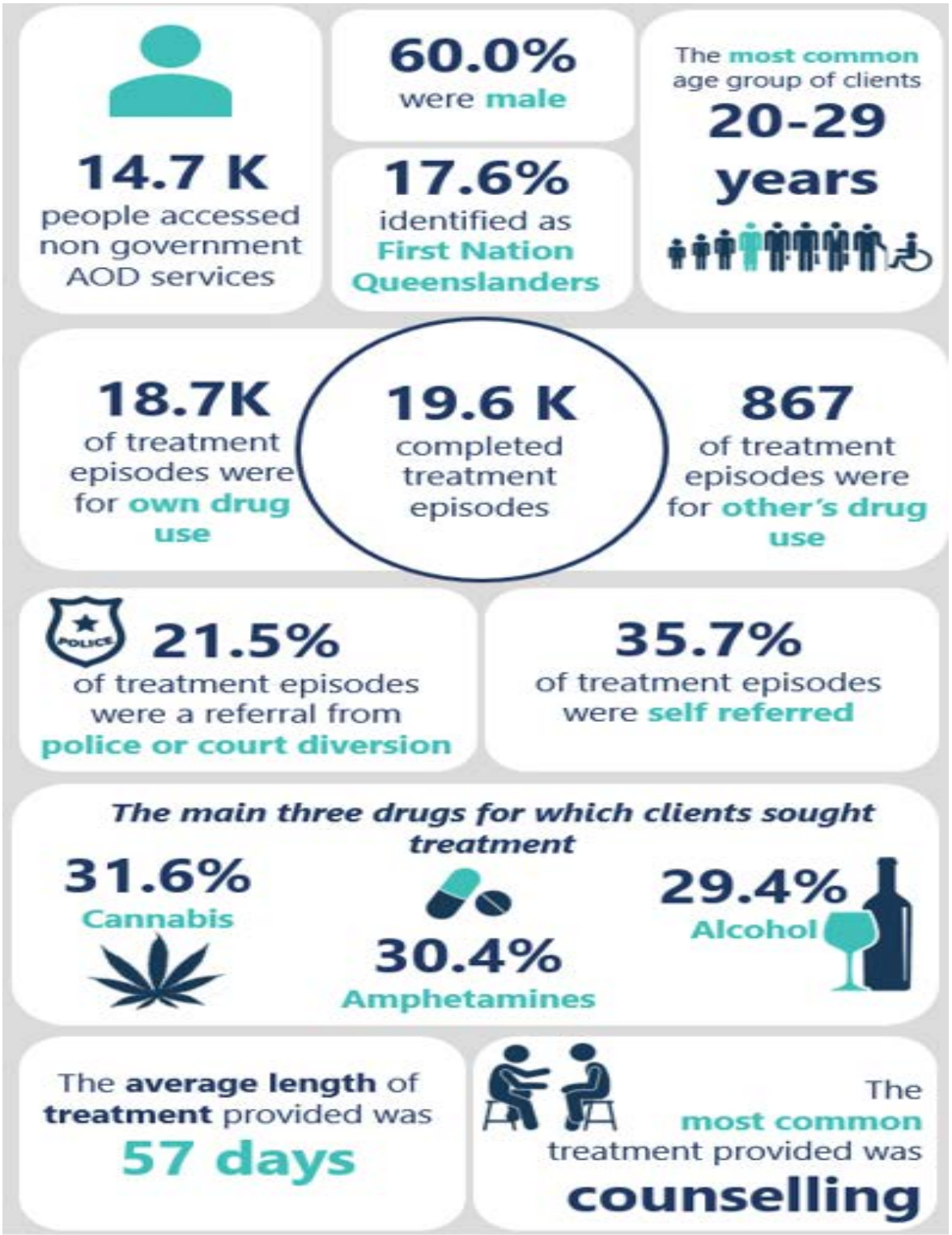
Infographic A3(C): Queensland Needle and Syringe Program



Infographic A2(d): Mental health service provision by NGOs

Infographic A3(D): AOD service provision by NGOs

Nb: proportion of service provision for cannabis due to inclusion of data from Police Diversion interventions



Appendix 4: Quality and safety systems, structures and priorities

MHAOD Statewide Clinical Network

The MHAOD Statewide Clinical Network (Clinical Network) supports clinical governance through the following actions.

- Providing an opportunity for clinicians and other stakeholders, including those with a lived experience, to participate and collaborate in planning, priority setting, information sharing and system improvement activities within the remit of the Network.
- Promoting the use of the best available evidence, and the experience and knowledge of consumers, carers and clinicians, in continuously improving the safety and quality of Queensland Health MHAOD services.
- Contributing to quality improvement reform across the MHAOD service system.

A number of statewide clinical speciality groups link with the Clinical Network to progress service improvement agendas in key areas such as child and youth MHAOD services, older persons MHAOD services, specialist alcohol and other drugs treatment and care and other specialised areas.

In 2019, the Clinical Network initiated the Brief Breakthrough Collaborative (BBC), an improvement program that engages clinicians from across MHAOD services in local quality improvement activities.

The BBC program enables the Clinical Network to adopt a systematic approach to supporting quality improvement initiatives. The program is implementing and evaluating a short-format, multi-site collaborative service improvement model which uses some elements of the Breakthrough Series Model pioneered by the U.S. Institute for Healthcare Improvement.

Key aims of the BBC program are to enhance service capability in the use of improvement science and collaborative learning methodology, and to produce measurable and sustainable outcomes in identified clinical topics within participating sites, with the potential for the spread of successful initiatives within and across services.

The BBC program supports broader quality improvement reform priorities led by the MHAOD Branch, in particular a focus on strengthening key elements of comprehensive care in alignment with the National Safety and Quality Health Service Standards.

MHAOD Quality Assurance Committee

The role of the MHAOD Branch in providing direction and driving improvements is supported by the MHAOD Quality Assurance Committee. A recommendation from the report *When mental health care meets risk: a Queensland sentinel events review into homicide and public sector mental health services 2015*, the MHAOD Quality Assurance Committee was established to provide an external and objective mechanism for the analysis and review of health care to improve the safety and quality of public MHAOD services.

Quality Assurance Committees are established under Part 6 of the *Hospital and Health Boards Act 2011* as privileged committees reporting to the Director-General Queensland Health.

The functions of a Quality Assurance Committee must include:

- assessing and evaluating health services
- reporting and making recommendations concerning the quality of health services
- monitoring the implementation of its recommendations.

The MHAOD Quality Assurance Committee seeks to improve the quality and safety of health care by identifying state-wide system gaps and informing effective state-wide strategies for system improvements to clinical care at both the system manager and HHS level.

To date, the MHAOD Quality Assurance Committee has issued guidance on clinical incident review practices; a culture of reporting, monitoring and learning from adverse incidents; and oversight and external governance of the review process for a statewide review of the Queensland Health suite of environmental safety guidelines. It has identified the importance of a restorative just culture for MHAOD service improvement.

Zero Suicide in Healthcare Multi-Site Collaborative

The Zero Suicide in Healthcare Multi-Site Collaborative (ZSiH MSC) is a system-wide collaboration between the MHAOD Branch and HHSs to improve care and outcomes for people at risk of suicide who are receiving healthcare. The ZSiH MSC is guided by the seven elements of the Zero Suicide in Healthcare framework:

1. Lead: Create a leadership-driven, safety–oriented culture committed to aspiring to eliminate suicide among people receiving healthcare. Include suicide attempt and loss survivors in leadership and planning roles.
2. Train: Develop a competent, confident and caring workforce.
3. Identify: Systematically identify and assess suicide risk among people receiving care.
4. Engage: Ensure every person has a suicide care management plan or pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
5. Treat: Use effective, evidence-based treatments that directly target suicidality.
6. Transition: Provide continuous contact and support, especially after acute care.
7. Improve: Apply a data driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

Key priorities for the collaborative have been the design and implementation of localised Suicide Prevention Pathways, detailing a structured and evidence-based approach to providing suicide-related care to people at risk.

New training options and resources have been developed to support clinical teams to provide care to people at risk, including a Suicide Prevention Practice Guideline and new tools to help identity and monitor the care of consumers placed on a Suicide Prevention Pathway.

An independent evaluation of the ZSiHC MSC finalised in late 2020 found that the collaborative supported problem solving, knowledge transfer and sharing of resources. Both

clinical leaders and clinicians reported that procedures for responding to suicide had become clearer in their services since the collaborative commenced and that they had seen improvements in how their services supported them as a care provider. Clinical staff also reported that the implementation of their local pathway has resulted in a more consistent coordinated approach care for people experiencing suicidality. For example, a review of clinical records found that the number of consumers engaged in collaborative safety planning, a key evidence-based intervention for reducing suicide risk, has increased.

Mental Health Clinical Collaborative

The MHAOD Branch funds the Mental Health Clinical Collaborative (MHCC) hosted by Metro North HHS to bring MHAOD service staff together to understand and drive improvement in a specific clinical area through working toward common goals, sharing information, ideas and experiences.

The MHCC was formed in October 2005 to:

- promote the utilisation of best clinical practice and innovative approaches in clinical topic areas identified by members as requiring state-wide improvement.
- support clinicians and service managers to implement and review local service improvement initiatives through the development of clinical indicators.

HHSs actively participate in state-wide forums and engage in local service improvement activities. Since 2012, the MHCC has largely focused on the provision of physical health interventions by MHAOD services and improving consumer outcomes in smoking cessation, where its processes are seen nationally as exemplars, with high impact on the service system.

Queensland Mental Health Benchmarking Unit

The MHAOD Branch also funds the Queensland Mental Health Benchmarking Unit (QMHBU) hosted by West Moreton HHS to assist selected specialised service types, including extended treatment and residential bed-based mental health services, to improve consumer outcomes. QMHBU-facilitated Statewide Learning Networks provide a platform to:

- work collaboratively on areas identified through benchmarking to improve service delivery and consumer outcomes
- promote continuity of services provided to consumers across the State
- share knowledge which will lead to improved performance and efficiencies.

MHAOD Branch support to HHSs

The MHAOD Branch provides HHSs with education, reports, and other support in the utilisation of information to build the culture of data-informed practice and support service development and improvement for better outcomes for consumers, family members and carers.

Reports are tailored to audiences ranging from clinicians involved in direct care to Executive Directors of services and can provide a state-wide Service Organisation comparison on current performance on Service Agreement Key Performance Indicators or a clinician and

consumer specific report on current diagnoses, interventions and outcomes. Benchmarking reports are also provided to statewide clinical speciality groups and in response to local requests from HHSs to support local quality improvement projects.

Safety Priorities

The Fifth National Mental Health and Suicide Prevention Plan made a commitment to update the National Safety Priorities in Mental Health (2005).

In 2020, on behalf of state, territory and the Commonwealth Governments, the Queensland Office of Chief Psychiatrist led the development of the draft National Safety Priorities in Mental Health: Second Edition. The six priorities were informed by a review of mental health safety literature, analysis of available safety and harms data, and consultations with over 300 consumers, carers, families, consumer representatives, clinical and non-clinical mental health staff, as well as emergency services, law enforcement staff and oversight bodies.

These six priorities for improving safety and reducing potential and actual harms that may occur in mental health care are:

- partnering for improved safety
- enhancing responses to deterioration
- providing trauma-informed care
- improving medication safety
- reducing suicide and self-harm
- increasing the safety of transitions.

A Queensland consultation on the National Safety Priorities in Mental Health: Second Edition is planned across both MHAOD services with the intent of Queensland Health adopting the revised National Safety Priorities in Mental Health to drive the clinical reform agenda in Queensland's MHAOD services. This will include a focus on safety priorities in alcohol and drugs services to ensure applicability of these priorities across both mental health and alcohol and other drugs services in Queensland.

The National Safety Priorities in Mental Health complement the Australian Safety and Quality Framework for Health (the Framework) and the NSQHS Standards. Where the Framework and NSQHS Standards outline a comprehensive set of standards all health services must meet, the National Safety Priorities in Mental Health sets an agreed agenda for improving safety in mental health and alcohol and other drugs care in key priority areas in Queensland.

Clinical Quality Improvement Priorities

The MHAOD Branch supports quality improvement in MHAOD services through targeted statewide improvement initiatives supported by statewide clinical groups. Key priorities include medication safety, safety and quality of electroconvulsive therapy (ECT), the provision of comprehensive care and a focus on multi-morbidity.

Medication safety

The Queensland Psychotropic Medication Advisory Committee (QPMAC) provides expert technical advice and recommendations to the Chief Psychiatrist on the quality use of

psychotropic medicines and guides medication-focused quality improvement activities in MHAOD services.

Quality improvement initiatives led by QPMAC include the development of best practice clinical guidelines, monitoring the occurrence of medication incidents, and promoting the use of safety systems and processes to manage medications, including prescribing, dispensing, and providing information to consumers to support their effective use of medicines.

Electroconvulsive therapy (ECT) safety

The Queensland ECT Committee provides expert technical advice and recommendations on the delivery of ECT in Queensland to guide service development and quality improvement activities in both public and private AMHSs. The delivery of ECT is monitored by the Office of the Chief Psychiatrist through administration of the *Mental Health Act 2016.*

Comprehensive Care

The MHAOD Branch in collaboration with clinicians from across Queensland have partnered to deliver the Comprehensive Care initiative – partnerships in care and communication in November 2020. The initiative aims to assist services to meet National Safety and Quality Health Services Standards, which includes standards to ensure that health services provide comprehensive and coordinated care that is aligned with the goals and needs of the consumer.

The Comprehensive Care initiative aims to improve the quality and safety of care provided by MHAOD services through a systematic approach to the delivery and documentation of care across services. The standardisation of clinical documentation accessible via a single statewide MHAOD electronic record system enables efficient use of clinical records to improve consumer outcomes.

The linked MHAOD clinical documentation is modularised in line with the stages of care, with options within each module to allow for flexibility and responsiveness to consumer needs.

The focus on improving comprehensive care has been supported by workforce development activities, including a series of educational webinars, factsheets and a case history library demonstrating best practice principles in comprehensive care.

Central to the Comprehensive Care initiative is the enhanced focus on data driven care and quality improvement. Standardisation of documentation and processes enables the services and frontline clinicians to evaluate their progress in implementing improvements in comprehensive care.

Preventing and treating multimorbidity

Consumers of MHAOD services experience health inequality. People with substance use disorders and/or other mental health disorders have a life expectancy 10-20 years shorter than the general population. The greatest contributor to this life expectancy gap is the high rates of chronic disease. The co-occurrence of chronic diseases, substance use disorders and/or other mental health disorders is termed 'multimorbidity'.

Building on the work of the Queensland Mental Health Clinical Collaborative, improving the physical health of consumers of MHAOD services is a clinical improvement priority.

In 2020, the MHAOD Branch conducted state-wide consultation with Queensland Health services, NGOs and Primary Health Networks to inform approaches to improving the physical health and wellbeing of consumers. Service development initiatives to improve health outcomes of consumers were common in larger services, however capacity issues were seen as a barrier to development in smaller services, often regional. Better integration with primary care was commonly identified as a high priority. Initiatives focusing on improving physical health of MHAOD service consumers tended to be localised and lacked a consistent approach even within HHSs.

The MHAOD Branch is supporting an increased focus on preventing and managing multimorbidity across all MHAOD services through the release of the *Co-occurring substance use disorders and other mental health disorders: policy position statement for Mental Health Alcohol and Other Drugs Services 2021,* the ongoing implementation of the *Comprehensive Care Initiative* and enabling bottom up quality and safety improvements in care addressing multimorbidity to be progressed through ongoing service led quality improvement.

Appendix 5: Key reforms and programs

Responding to people experiencing mental health crisis and suicidal distress

Demand for mental health crisis care has increased over the last decade, placing significant pressure on existing services. Increasing demand on existing acute services and a lack of alternative options has resulted in increasing Emergency Department presentations for mental health crises, including crisis that may be better managed in a home or community setting.

It is widely acknowledged, by service providers and people with lived experience alike, that Emergency Departments are not ideal locations for people who are experiencing a mental health crisis. It is also acknowledged that when provided with the right support and within the right context, many people can move through an immediate crisis period quickly without the need for emergency department or hospital-based care.

A range of alternative crisis care models exists that may reduce need for emergency care and improve consumer satisfaction and positive outcomes. Queensland Health is trialling several models with a view to expanding the range of mental health crisis care options available, reducing demand on emergency departments, improving access to and co-ordination of care, and improving consumer experiences and outcomes.

Crisis System Reform

The 2019-20 Queensland Budget allocated funding for the development of an adaptable model of suicide and mental health crisis care for Queensland.

A Mental Health Crisis Service System framework for Queensland is under development, along with tools to enable services to assess and identify local service system gaps and reform priorities. The framework and associated tools are being informed by clinical and lived experience expertise.

The framework will incorporate the implementation and evaluation of new innovations in crisis care including Crisis Support Spaces, a Crisis Stabilisation Facility and suicide aftercare services.

Crisis Support Spaces

The 2019-20 Queensland Budget allocated $10.8 million over four years to establish and operate eight Crisis Support Spaces providing support for adults experiencing mental distress and/or suicidality. Located near a hospital emergency department, Crisis Support Spaces are both an alternative and an adjunct to the emergency department. Crisis Support Spaces offer a less medicalised, or 'home-like', setting with support provided by a combination of clinicians and peer workers.

Crisis Support Spaces seek to prevent avoidable emergency department presentations and/or inpatient admissions and provide an improved consumer experience of crisis care.

As at 31 December 2021, six state-funded Crisis Support Spaces had commenced operations:

- Mackay Base Hospital: December 2020

- Prince Charles Hospital: January 2021
- Cairns Hospital: February 2021
- Princess Alexandra Hospital: April 2021
- Ipswich Hospital: September 2021
- Southport Health Precinct: October 2021

The remaining two Spaces in Townsville and Hervey Bay Hospitals will be operational early 2022. An estimated 240 people sought support through a Crisis Support Space between March and September 2021.

Crisis Stabilisation

The 2019-20 Queensland Budget allocated $11.3 million over three years to establish and operate a crisis stabilisation facility in the Gold Coast Hospital and Health Service. This crisis stabilisation facility provides an alternative to the emergency department for adults experiencing mental distress and/or suicidality, with the ability to support adults with a higher level of acuity than Crisis Support Spaces.

Like Crisis Support Spaces, the crisis stabilisation facility seeks to prevent avoidable emergency department presentations and/or inpatient admissions and provide an improved consumer experience of crisis care. Unlike Crisis Support Spaces, the Queensland Ambulance Service can transport people experiencing mental health crisis directly to the crisis stabilisation facility, increasing the facility's potential to divert emergency department presentations.

The Gold Coast Hospital and Health Service's Crisis Stabilisation Facility commenced operations in August 2021. The facility is based on the Robina Hospital campus. The facility comprises three components – a crisis care coordinator role, a short-term (up to 23-hour) chair-based Crisis Stabilisation Unit, and eight short stay beds with a length of stay up to 72-hours. The facility is staffed with a combination of clinical and peer workers.

A total of 850 people sought support through the Crisis Stabilisation Unit between August and December 2021.

Suicide prevention in health services

Suicide is a complex and challenging issue with no single solution to reduce suicide or its impact. A suicide death is rarely attributed to a single cause. Suicide is a multifaceted interaction of individual, social, and other factors, with no single factor solely responsible for suicidal behaviour. Factors include social isolation, unemployment, financial hardship, stigma and discrimination, unstable housing, and adverse life events.

While some people and groups are more vulnerable to suicide than others, suicide occurs across all demographics. Suicide prevention therefore needs to be considered from a whole of population perspective, that uses a whole-of-government, cross-sectorial approach to planning, strategic policy development and service delivery.

Under *Shifting minds*, the Queensland Mental Health Commission developed a renewed whole-of-government, cross-sectorial suicide prevention plan which was launched in September 2019. *Every life: The Queensland Suicide Prevention Plan 2019-2029* (Every life) is being implemented in three phases. The first phase of the plan from 2019 to 2022 includes 60 specific actions being led by 15 Queensland Government departments and agencies

requiring partnerships with government and non-government agencies as well as community and private sectors. Whilst some of these actions have an identified investment, others are being progressed as part of business as usual of the lead agency.

Queensland Health data shows that 25 per cent of people who died by suspected suicide received care from a Queensland Health service within one month prior to their death. This includes care from an emergency department, mental health alcohol and other drug service, and/or care as an inpatient. Research also indicates that a significant proportion of people who die by suicide had recent contact with a primary healthcare provider prior to their death. Therefore, Hospital and Health Services and Primary Health Networks play an important leadership role in partnering with other local service providers and people with a lived experience to improve the health system's capacity to respond to people at risk of suicide.

The provision of safe, high quality health services is important in the prevention of suicide amongst people receiving healthcare. Patient safety and clinical quality improvement initiatives, systems and structures pertaining to Queensland Health mental health alcohol and other drug services are outlined in Appendix 3. This includes the Zero Suicide in Healthcare Multisite Collaborative under the Suicide Prevention in Health Services program supported by the Mental Health Alcohol and Other Drugs Branch.

The program also includes the trial of a new model of care to enhance support for people caring for a loved one experiencing a suicidal crisis. Crossing Paths, designed in partnership with Roses in the Ocean and implemented by Wesley Mission Queensland on the Gold Coast, is a peer-led, community-based service consisting of one-on-one and group-based carer peer support, information tools and practical resources, and structured educational and activity-based workshops. It works closely with existing local services and supports such as The Way Back Support Service and the Gold Coast HHS suicide prevention pathway.

An evaluation of the 12-month pilot of Crossing Paths undertaken by Beacon Strategies found that the program was able to identify and connect with carers of a person experiencing a suicidal crisis, evidenced through a total of 105 inward referrals received. Around 70 carers were engaged and supported by the program which made a total of 1,796 contacts at an average of 150 service contacts per month. Almost all respondents to a follow-up survey reported that the program was accessible, inclusive, made them feel heard and respected, and would recommend it to others. Qualitative insights shared by carers highlighted examples of the program leading to positive impact in capability and capacity, peer belonging and connection, and wellbeing of carers.

In the 2019 State Budget, $61.93 million over four years was allocated under the *Shifting minds: taking action to reduce suicides in Queensland initiative* to enhance the mental health crisis service system. This includes the provision of aftercare services (The Way Back Support Service) supporting people separating from an Emergency Department following a suicide attempt or crisis and the trial of two new crisis care options (Crisis Support Spaces and the Crisis Stabilisation Service) to enable better access to mental health crisis services complementary to the hospital Emergency Department.

Included in the *Shifting Minds* budget allocation was $7.6 million over four years to establish seven The Way Back Support Services across Queensland. This funding matched the Commonwealth Government allocation for aftercare services in Queensland made in the 2018/19 Federal Budget. Matched funding is provided to June 2022.

The Way Back Support Service provides psychosocial, one-on-one aftercare support for up to three months for people who present to a referring hospital following a suicide attempt or suicidal crisis. The Way Back Support Services are operated by non-government organisations, commissioned through the Primary Health Network in partnership with Queensland Health.

There are 10 The Way Back Support Services across Queensland – seven are funded by both the Queensland and Commonwealth Governments, whilst three are funded by the Commonwealth Government. From July 2020 to November 2021, 3,682 people were referred into The Way Back Support Services across Queensland, with 2,334 people supported through a service episode.

A National Evaluation of The Way Back Support Service, commissioned by Beyond Blue and delivered by Nous, is due in December 2022. The mid-term National Evaluation indicates clients are experiencing significant reduced psychological distress and suicidal ideation respectively between their first and last assessment.

Partners in Prevention: Understanding and Enhancing Responses to Suicide Crisis Situations

Partners in Prevention is a program of research originally funded by Queensland Health under the Suicide Prevention Health Taskforce, and subsequently through competitive grant funding provided by the National Health and Medical Research Council and Defence Health Foundation, salary support from Queensland Centre for Mental Health Research, as well as in-kind support from Queensland Ambulance Service and Queensland Police Service.

Partners in Prevention is a collaborative initiative between Queensland Health, Queensland Police Service, Queensland Ambulance Service, Queensland Mental Health Commission, Queensland Alliance for Mental Health, Roses in the Ocean, and Brisbane North PHN.

Its primary aims were to undertake research to examine suicide crises which sit at the nexus of an individual's journey before and after a crisis event, and the individual, institutional and economic resources that police and ambulance services supply to the event and translate outcomes into service and systems enhancements.

The first phase of the project encompassed five programs of work:

- literature reviews
- establishment of a linked dataset identifying demand, characteristics, pathways and outcomes of individuals who have a suicide-related contact with police or paramedics
- knowledge, skills, attitudes and confidence of police
- service mapping of collaborative suicide crisis responses in Queensland
- gathering of lived experience perspectives on optimal first responses to suicide crisis situations

The second phase of the project has encompassed:

- production of training videos for police, paramedics and clinicians
- detailed sub-group analysis, focussing on women during and around the time of pregnancy; children and adolescents; and defence-related personnel.

- Commencement of analysis of data available from the AIHW, namely, MBS, PBS and NDI data.
- Extension of the linked dataset for an updated cohort.

Further information about Partners in Prevention can be accessed here.

Collaborative mental health, police, and ambulance crisis response services

QAS Mental Health Liaison Service

The QAS Mental Health Liaison Service (MHLS) is delivered out of the Brisbane Operations Centre and is available state-wide 24 hours a day. The MHLS involves a Senior Mental Health Clinician working in the Brisbane Operations Centre to provide information, advice and assistance to EMDs, supervisors, managers, paramedics across the entire state. This service supports the timely and appropriate dispatch of resources to people in a mental health crisis, whilst also assisting clinical decision by the attending paramedics.

The clinicians have access to Queensland Health clinical data bases, including the Consumer Integrated Mental Health and Addictions (CIMHA) application, therefore providing timely information regarding a person's mental health history, treatment plans, management plans and other pertinent information that will help and support the clinical decision making if the person is known by public mental health services. The clinicians will use this information to assess the needs of the person experiencing a mental health crisis and to provide the most appropriate management and treatment plans, considering resources outside of the hospital system if available.

The MHLS also provides direct clinical support to patients experiencing a mental health crisis via telemedicine including, de-escalation; risk assessment and management; advice, information, psycho education regarding symptom management and guidance around appropriate referral options.

During October 2021, following active intervention by the MHLS clinicians, an ambulance attendance was avoided (and possible subsequent transport to hospital for further interventions) for 306 people who called Triple Zero (000) with a mental health emergency. Additionally, the clinicians provided real time risk assessment and management for 406 calls from people who were expressing ideas of ending their own life by suicide, including three who were at the time actively engaging in an behaviour to end their own life.

QAS Mental Health Co-Responder (MH CORE) Program

The QAS MH CORE pairs a senior Queensland Health Mental Health clinician working alongside a QAS paramedic within specific geographic areas. As of December 2021, Gold Coast, West Moreton, Metro South, Metro North, Sunshine Coast, Cairns and Townsville have MH CORE response programs.

The service aims to be a first and only health response to people who are experiencing a mental health crisis in the community, consistent with the views and wishes of consumers and carers in the mental health sector. The QAS MH CORE provides timely and thorough physical health, mental state and risk assessment. Management and treatment plans are developed for people in their own home, using their own resources and supports. The QAS MH CORE can facilitate access to appropriate follow up and referrals. Between 60 and 70 per

cent of the time the consumer avoids hospital presentation by identifying and implementing appropriate treatment pathways for people experiencing a mental health crisis.

While the QAS MH CORE does not affect demand for QAS services, as the QAS would need to respond to all received requests for attendance, the efficiencies and potential cost savings across the health care system can be identified. Potential direct savings for the QAS occur due to the timely dispatch of clinically appropriate resources to persons experiencing a mental health crisis. Being a first and only response crew to people experiencing a mental health crisis by providing specialised mental health care allows acute ambulance crews to respond to the next emergency within the community, therefore increasing the QAS's resource capacity.

The capacity release savings associated with the QAS MH CORE model are further enhanced by savings to the emergency health system, resulting from providing targeted assessment and treatment to people experiencing a mental health crisis in their own environment and, potentially, removing the need for transportation to hospital. Additional downstream savings to the broader health system may also be considered. This includes cost avoidance savings aligned with the diversion away from emergency department presentations to more targeted care, which is informed by and aligned with existing management plans, where relevant or more appropriate care/treatment alternatives.

The QAS MH CORE program has been expanded from three pilot sites in 2019 to recurrent funding for 17 additional sites throughout the state by 2024.

A further investigation of the QAS MH CORE (in conjunction with the Queensland Police Service mental health response programs) is currently underway, examining the qualitative and quantitative outcomes of the programs.

Mental Health Liaison Service – Police Communications Centre

The Mental Health Liaison Service – Police Communications Centre (MHLS-PCC) model is an embedded mental health consultation-liaison role. The MHLS-PCC service co-locates experienced mental health clinicians from the Queensland Forensic Mental Health Service within the Brisbane Police Communication Centre (BPCC) from 3.30 pm daily Monday-Friday and 8 am to midnight on weekends and public holidays, with on-call psychiatrists available outside of these hours. The BPCC receives emergency triple zero (000) calls that are directed to police. BPCC call-takers and their supervisory team assess caller needs, prioritise call urgency, and organise dispatch of Queensland Police Service resources. The embedded MHLS-PCC clinicians can be consulted by referral via the Queensland Police Service State Duty Officer. MHLS-PCC clinicians liaise with police and mental health services, enabled under a Memorandum of Understanding: Mental Health Collaboration (State of Queensland, 2016) between Queensland Health and Queensland Police Service. The level of information supplied to Queensland Police Service by the MHLS-PCC clinician is based on whether the clinician considers the situation to properly constitute a 'mental health crisis'. MHLS-PCC clinicians do not provide case management, primary care, or have direct contact with the consumer, with the caller, or with any person who is the subject of a call to emergency services.

Police-Mental Health Co-responder models

The co-responder model combines policing and health services capability to respond to mental health and suicide crises. The concept is co-response to mental health crisis

situations, meaning that police and health services are paired and co-deployed to identified crisis events in order to better assess and respond to community safety and health needs within the situation. The co-responder model has been implemented in Queensland as a multi-disciplinary secondary response to mental health crisis situations, in which health services and police officers work together as a response unit.

Mental Health Intervention Program

The Mental Health Intervention Program (MHIP) originated as a tri-agency partnership between Queensland Police Service, Queensland Ambulance Service, and Queensland Health in 2005. The Mental Health Intervention Program comprises four elements:

- delivery of specialised mental health training
- Mental Health Intervention Coordinator positions established within three agencies
- information sharing between Queensland Health and Queensland Police Service to assist with the safe resolution and care of people with mental illness who come in contact with police
- localised tri-agency collaboration.

Perinatal, infant, child and youth MHAOD services

Queensland Health funds the Queensland Centre for Perinatal and Infant Mental Health (QCPIMH) that centrally coordinates service development, in collaboration with the DoH and HHSs, to establish a continuum of care for specialist PIMH services across Queensland. Specialist perinatal and infant mental health services are necessary to support existing primary and secondary health care providers such as maternity, midwifery and child health.

Queensland Health currently provides a continuum of specialist PIMH services including:

- the Lavender Mother and Baby Unit, a four-bed specialist state-wide mental health inpatient unit located at Gold Coast University Hospital
- community based clinicians
- Together in Mind Day Program
- ePIMH telepsychiatry service
- non-government support services (Peach Tree Perinatal Wellness and Early Social Emotional Wellbeing service).

The current continuum of state-funded mental health services for children and young people includes community based child and youth mental health services (community CYMHS) across Queensland, acute inpatient mental health units, Jacaranda Place (the Queensland Adolescent Extended Treatment Centre), community bed-based services (e.g. Youth Residential Rehabilitation and Youth Step Up Step Down services), and a range of specialised services including Assertive Mobile Youth Outreach Services, forensic services, Evolve Therapeutic Services (funded by the Department of Children, Youth Justice and Multicultural Affairs), Adolescent Day Programs and the Ed-LinQ program.

Queensland Health also provides alcohol and other drug (AOD) treatment and harm reduction services for young people (aged up to 25 years) through HHSs and NGOs funded through service agreements with the Department of Health.

Mental Health Programs for Regional and Rural Queensland

Queensland Health is responsible for three separate programs that specifically target people and communities in regional and rural Queensland dealing with mental health and suicide issues linked to regional adversities.

Tackling Regional Adversity through Connected Communities (TRACC) Program

In 2015-16, the then Minister for Health provided $3.5 million recurrent funding to nine HHSs to address the mental health and suicide issues of people in communities dealing with drought, natural disasters, and other significant regional crises.

The funding is for nine senior mental health clinicians and an annual grants program of $600,000. It is based around the following four key priority areas:

- Connecting people dealing with moderate to severe mental health issues to the right level of treatment, care and support at the right place and at the right time.
- Working with affected communities to improve help seeking behaviour by improving mental health literacy and reducing stigma.
- Working with front-line agencies and community stakeholders to identify and improve referral pathways to the right level of care and support across the whole HHS.
- Working with local communities to build their resilience through programs like the TRACC Grants which enable communities to be better prepared to deal with current and future adversities.

The TRACC Grants program offers up to $66,000, per HHS, to identify a target community based on a needs assessment for a co-design process to develop initiatives to address the mental health and suicide prevention needs of the community.

The Mental Health Disaster Recovery Program

The Mental Health Disaster Recovery (MHDR) Program is jointly funded by the Australian and Queensland Governments under the Disaster Recovery Funding Arrangement (DRFA) for communities impacted by significant natural disasters.

Funding provided to Queensland Health is primarily for senior mental health clinicians and community engagement officers who work across a stepped care model of service that links early Psychological First Aid to community rebuilding and reconnection and where necessary to targeted psychological support for moderate mental health need and specialist mental health treatment for complex trauma type conditions linked to the specific disaster.

Since 2017, the MHAOD Branch has developed and managed 14 MHDR Programs across ten separate Hospital and Health Services in response to four separate natural disaster events: Severe Tropical Cyclone Debbie (2017); Central Queensland Bushfires (2018), North West Monsoon Trough (2019), Eastern Queensland Bushfires (2019).

Drought Wellbeing Service

Queensland Health commenced recurrent funding of $1 million per annum to the Royal Flying Doctor Service (RFDS) in 2018/19 after years of one-off funding from the Commonwealth Government through the Drought Assistance Scheme.

The stability of funding has allowed the RFDS to develop a more responsive Drought Wellbeing Service for rural and remote Queensland and offer a primary mental health outreach program that seeks to identify, respond and refer people (usually primary producers) dealing with the mental health consequences of long term drought. RFDS clinicians work closely with Queensland Health staff, primarily the RACs from the TRACC program to connect people to the right level of care at the right time and place.

Other AOD programs

Queensland Government commitments to new AOD capital programs for residential services

As part of recent capital planning for AOD (and as State Election Commitments) the Queensland Government has established a new adult Residential Rehabilitation and Withdrawal Management service in Rockhampton (commenced December 2021) with two more adult services of this kind to be established in Bundaberg and Ipswich and a youth AOD residential (and non-residential) service in Cairns.

AOD treatment programs for people involved in the criminal justice system

Police and Court Diversion

For over 20 years, Queensland Health has been responsible for the delivery of drug and alcohol brief interventions to people referred through the Police Drug Diversion Program and Illicit Drugs Court Diversion Program which aim to provide increase the number of people diverted away from the criminal justice system into alcohol and other drug treatment. Delivered across the state by a mix of HHSs and state funded NGOs and operating under a legislative framework, the programs include:

- The Police Drug Diversion Program must be offered to any adult or young person found in possession of 50 grams or less of cannabis and/or possessing a thing for use for smoking cannabis, and who meet specific eligibility criteria, rather than being charged for the offence.
- The Illicit Drugs Court Diversion Program gives magistrates the discretion to offer diversion to individuals who plead guilty to an eligible illicit drug offence.
    - Since 2014, Queensland Health has also delivered, through state funded NGOs brief interventions to people referred through the Drug and Alcohol Assessment and Referral (DAAR) program. DAAR is available to people appearing in Magistrates Courts, who identify alcohol and other drug use as a contributing factor to their offending. Participation in DAAR can be as a condition of bail or as part of a recognisance order for people who are 18 years and above.

Court Link

Queensland Health provides dedicated specialist alcohol and other drug treatment services including psychosocial interventions involving individual counselling and medication assisted treatment for people referred through the Court Link program at Redcliffe, Caboolture and Maroochydore. Court Link is a voluntary bail-based program for up to 12 weeks providing referral and case management services connecting participants to supports including housing, employment and health services to reduce recidivism and improve health and wellbeing.

Queensland Drug and Alcohol Court

Queensland Health provides intensive drug and alcohol treatment for adults through the Queensland Drug and Alcohol Court which commenced in January 2018 as part of the Government's commitment to reinstate specialist courts as evidenced in the *Drug and Specialist Courts Review: Final Report 2016*. The Drug and Alcohol Court is based at Brisbane and is an intensive post-sentence program involving judicial monitoring and a multi-agency partnership to address offending behaviour linked to a person's severe substance use.

Opioid Substitution Treatment (OST) in Correctional Centres

Queensland Health and Queensland Corrective Services are implementing an OST program across Queensland Correctional Centres to deliver on Recommendation 31 of the Queensland Parole System Review (2016). OST is currently delivered across all women's Centres and the two men's Centres in Northern Queensland (Lotus Glen and Townsville).

The program will be implemented in remaining centres in 2022.

AOD state-wide services

Queensland Health also has three key state-wide services:

- Adis 24/7 Alcohol and Drug Support delivers state-wide telephone and online assistance for any Queenslander concerned about their own or someone else's alcohol or other drug use through its 1800 number and a website accessible here.
- Insight Training and Education provides specialist AOD training, education, advice and resources for health and community service workers across Queensland (Further information available here).
- Dovetail provides clinical advice and specialist support to workers, services and communities across Queensland who engage with young people affected by AOD use. Dovetail has an online information clearinghouse, develops good practice guides for youth AOD interventions, conducts training events, facilitates the development of local youth AOD action plans, and provides specific advice. (Dovetail can be accessed here).

Appendix 5: Key reference documents

National documents

The following table identifies some of the key documents including reports, policies, frameworks, and strategies that inform and guide the operation of the mental health, alcohol and other drug treatment services and responses to people in suicidal crisis and distress in Queensland.

Document Name	Description	Link
National Reports		
National Suicide Prevention Adviser's – Final Advice (2021)	The Final Advice provides a collection of resources produced by the National Suicide Prevention Adviser and National Suicide Prevention Taskforce to support a refocussed approach to suicide prevention. Provides four essential enablers and four further priority shifts to support suicide prevention across Australia. The four essential enablers being: • leadership and governance to drive whole-of-government approach • lived experience knowledge and insight • data and evidence to drive outcomes • workforce and community capability. The four key shifts being: • responding earlier to distress • connecting people to compassionate services • targeting groups that are disproportionately affected by suicide delivering policy responses that improve security and safety.	National Suicide Prevention Adviser – final advice | Commonwealth Government Department of Health
Productivity Commission Inquiry Report – Mental Health (2020)	This report discusses the key influences on people's mental health, examines the effect of mental health on people's ability to participate and prosper in the community and workplace, and the implications of mental health issues on the Australian economy and productivity more generally. Identifies 21 recommendations across five key areas: • prevention and early intervention • training and work • recovery focused healthcare	Inquiry report - Mental Health Productivity Commission (pc.gov.au)

Document Name	Description	Link
	• services beyond health • enablers.	
Final Report of the National Ice Taskforce (2015)	The final report of the National Ice Taskforce established to advise the Commonwealth Government on the impacts of ice in Australia and to drive the development of a National Ice Action Strategy. The report made 38 recommendation across the following five areas of priority: • support families, workers and communities • target prevention • tailor services and support • strengthen law enforcement • improve governance and build better evidence.	Final Report of the National Ice Taskforce (pmc.gov.au)
Contributing lives, thriving communities: Review of mental health programs and services (2014)	This is the report of a review of mental health programs conducted by the National Mental Health Commission It made 25 recommendations across nine strategic directions to improve the mental health system. The nine strategic directions are: • set clear roles and accountabilities to shape a person-centred mental health system • agree and implement national targets and local organisational performance measures • shift funding priorities from hospitals and income support to community and primary health care services • empower and support self-care and implement a new model of stepped care across Australia • promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life • expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people • reduce suicide attempts by 50 per cent over the next decade • build workforce and research capacity to support systems change • improve access to services and support through innovation technology.	2014 Contributing Lives Review - National Mental Health Commission

Document Name	Description	Link
New Horizons: The review of alcohol and other drug treatment services in Australia (July 2014)	Report of a review commissioned by the Commonwealth Government Department of Health which describes the alcohol and other drug treatment system and funding processes in Australia and provides options for future funding to respond to the needs of individuals, families and communities.	New Horizons: review of alcohol and other drug treatment services | Commonwealth Government Department of Health
National Policies, Plans, Frameworks		
National Mental Health Strategy (1992)	The National Mental Health Strategy was agreed to by all Australian Health Ministers in 1992. The Strategy was initially articulated in the following four documents: • the National Mental Health Policy • the Mental Health Statement of Rights and Responsibilities • the National Mental Health Plan • the Medicare Agreements (1993-1998)	
Fifth National Mental Health and Suicide Prevention Plan (2017)	This plan outlines a commitment from all Commonwealth Government to work together to achieve integrated planning and service delivery of mental health and suicide prevention related services. Identifies agreed actions under the following eight priority areas: • achieving integrated regional planning and service delivery • suicide prevention • coordinating treatment and supports for people with severe and complex mental illness • improving Aboriginal and Torres Strait Islander mental health and suicide prevention • improving the physical health of people living with mental illness and reducing early mortality • reducing stigma and discrimination • making safety and quality central to mental health service delivery • ensuring that the enablers of effective system performance and system improvement are in place.	Fifth National Mental Health and Suicide Prevention Plan - National Mental Health Commission

Document Name	Description	Link
	The fifth plan builds on the existing commitments made under previous plans.	
Gayaa Dhuwi (Proud Spirit) Declaration (2015)	Gayaa Dhuwi provides a framework for Indigenous leadership in addressing Aboriginal and Torres Strait Islander mental health.	gayaa_dhuwi_declaration_A4.pdf (natsilmh.org.au)
National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing (2017)	This Framework is intended to guide and inform Aboriginal and Torres Strait Islander mental health and wellbeing reforms. It articulates nine principles to guide action and identifies five priority areas for action: • strengthen foundations • promote wellness • build capacity and resilience in people and groups at risk • provide care for people who are mildly or moderately ill • care for people living with a severe mental illness.	National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023 (niaa.gov.au)
Closing the Gap National Agreement (2020)	The objective of the National Agreement on Closing the Gap (the National Agreement) is to enable Aboriginal and Torres Strait Islander people and governments to work together to overcome the inequality experienced by Aboriginal and Torres Strait Islander people, and achieve life outcomes equal to all Australians. It has 17 national socio-economic targets across areas that have an impact on life outcomes for Aboriginal and Torres Strait Islander people. While improvements across all outcomes will assist to improve the mental health outcomes of Aboriginal and Torres Strait Islander peoples Outcome 14 focuses specifically on social and emotional wellbeing with a target of significant and sustain reduction in suicide of Aboriginal and Torres Strait Islander people towards zero.	National Agreement on Closing the Gap | Closing the Gap
National Mental Health and Wellbeing Pandemic response Plan (2020)	The National Mental Health and Wellbeing Pandemic Response Plan responds to the mental health and wellbeing needs of all Australians during the response and in recovery from the COVID-19 pandemic. This plan identified three immediate actions: • data modelling – immediate monitoring and modelling of the mental health impact of COVID-19 • outreach – adapt models of care to changing sites of service delivery • connectivity – improve service linkages and coordination	National Mental Health and Wellbeing Pandemic Response Plan (mentalhealthcommission.gov.au)

Document Name	Description	Link
The National Children's Mental Health and Wellbeing Strategy (2021)	The National Children's Mental Health and Wellbeing Strategy provides a framework to guide critical investment in the mental health and wellbeing of children and families. It focuses on children from birth through to 12 years of age, their families and communities.	national-childrens-mental-health-and-wellbeing-strategy-report-25oct2021 (mentalhealthcommission.gov.au)
National Disability Insurance Scheme: Psychosocial Disability Recovery-Oriented Framework (2021)	The Psychosocial Disability Recovery-Oriented Framework has been developed to ensure that the NDIS is more responsive to participants living with psychosocial disability, their families and carers.	Mental health and the NDIS | NDIS
National Statement of Principles for Forensic Mental Health 2006 (2007)	The National Statement of Principles for Forensic Mental Health aims to provide cohesion and credibility so that optimal diagnosis, treatment and rehabilitation can be provided to clients of forensic mental health services.	National Statement of Principles for Forensic Mental Health (aihw.gov.au)
National Safety and Quality Health Service Standards	A suite of standards developed by the Australian Commission on Safety and Quality in Health Care in collaboration with the Commonwealth Government, states and territories, private sector providers, clinical experts, patients and carers to protect the public from harm and to improve the quality of health service provision.	The NSQHS Standards | Australian Commission on Safety and Quality in Health Care
National Drug Strategy 2017-2026	A national framework for building, safe health and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug related health, social and economic harms among individuals, families and communities. Supports a balanced approach across the three pillars of harm minimisation: • demand reduction • supply reduction • harm reduction. Identifies four underpinning strategic principles: • partnerships • coordination and collaboration	National Drug Strategy | Commonwealth Government Department of Health

Document Name	Description	Link
	• national direction, jurisdictional implementation • evidence-informed responses. There are six sub-strategies: • National Aboriginal and Torres Strait Islander peoples Drug Strategy 2014-2019 • National Alcohol and Other Drug Workforce Development Strategy 2015-2018 • National Alcohol Strategy 2019-2028 • National Fetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028 • National Ice Action Strategy 2015 • National Tobacco Strategy 2012-2018	
National Framework for Alcohol, Tobacco and Other Drug Treatment 2019-2029 (2019)	This framework seeks to: • provide a nationally endorsed shared understanding, and common reference point for alcohol, tobacco and other drug treatment funders, treatment providers and practitioners, and people who use substances and their families, friends and significant others • facilitate strategic planning for the Australian treatment service system and provides the context for national and state treatment processes, programs and policies.	National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–29 | Commonwealth Government Department of Health
National Quality Framework for Drug and Alcohol Treatment Services (2019)	Framework provides a national agreement on a quality benchmark for the delivery of AOD treatment services which allows for implementation based on funding sources and jurisdictional regulatory and non-regulatory approaches	National Quality Framework for Drug and Alcohol Treatment Services | Commonwealth Government Department of Health

Queensland documents

The following table identifies some of the key Queensland documents inform and guide the operation of the mental health, alcohol and other drug treatment services and responses to people in suicidal crisis and distress and influence broader outcomes.

Document Name	Description	Link
Queensland Reports		
Changing the sentence: Overseeing Queensland's youth justice reforms (2021)	This is a report of the Queensland Family and Child Commission after it was requested by the Department for Youth Justice asked it to help monitor initiatives linked to recent youth justice reforms and to examine options for reform. The report makes 13 findings on the following two key questions. • Are youth justice reforms ensuring there is a reliable, trusted system built on shared connections and commitment? • Are youth justice reforms ensuring children's rights, well-being and safety are being upheld and protected?	QFCC Changing the Sentence lo res spreads.pdf
Highly vulnerable infants, children, and young people: A joint child protection mental health response to prevent suicide report (2021)	Research undertaken by Professor Brett McDermott which provides insights into the drivers behind suicide among children and young people known to the child protection system.	QFCC PREVENTING SUICIDE REPORT (cdrb.qld.gov.au)
Don't judge, and listen: Experiences of stigma and discrimination related to problematic alcohol and other drug use (2020)	Report on research commissioned by the Queensland Mental Health Commission into the impact of stigma and discrimination on Aboriginal and Torres Strait Islander people experiencing problematic alcohol and other drug use.	Impact on Indigenous Australians | Queensland Mental Health Commission (qmhc.qld.gov.au)
Suicide in Queensland (various reports)	Annual and triannual reports on data on confirmed and suspected suicides in Queensland from the Queensland Suicide Register and interim Queensland Suicide Register.	Current version QSR (griffith.edu.au) Previous versions QSR-publications-26.11.2020.pdf (griffith.edu.au)
Final report: Inquiry into Imprisonment and recidivism (2019)	The report of the Queensland Productivity Commission into imprisonment and recidivism with a focus on the key policy and institutional changes that were likely to provide the greatest net benefit for the community. It considered illicit drug policy reform.	Former Queensland Productivity Commission - Queensland Treasury

Document Name	Description	Link
Changing attitudes, changing lives: Options to reduce stigma and discrimination for people experiencing problematic alcohol and other drug use (2018)	Report prepared by the Queensland Mental Health Commission to examine ways to reduce stigma and discrimination which as a negative impact on the mental health and wellbeing of people experiencing problematic alcohol and other drug use. Outlines 18 options for reform to address systemic issues associated with stigma and discrimination.	Changing attitudes, changing lives | Queensland Mental Health Commission (qmhc.qld.gov.au)
Queensland Drug and Specialist Courts Review: Final Report (2017)	This report provides options for the reinstatement of a drug court in Queensland and the development of an overarching framework for Queensland's specialist courts and court programs and that a reinstated Drug Court would be evidence-based, cost-effective and reflect modern best-practice in relation to drug-related offending.	Drug and Specialist Courts Review | Queensland Courts
Barrett Adolescent Centre Commission of Inquiry Report (2016)	Report of the inquiry into the closure of the Barrett Adolescent Centre and the transition of existing patients	Barrett Adolescent Centre Commission of Inquiry - Barrett (barrettinquiry.qld.gov.au)
Queensland Policies, Frameworks and Plans		
Shifting minds: Queensland mental, alcohol and other drugs strategic plan 2018-2023 (2018)	The Strategic Plan outlines the five-year direction for a whole-of-person, whole-of-community and whole-of-government approach to improving mental health and wellbeing of Queenslanders. The Strategic Plan identifies three focus areas: • better lives: achieved through the improving holistic service delivery to support people's individual needs and preferences and by removing barriers to social and economic participation • invest to save: strengthening the mental health and wellbeing of Queenslanders and reducing costs by intervening early in life, preventing issues from arising and intervening early when signs or symptoms arise • whole-of-system improvement: supporting shared leadership and responsibility for continuing to deliver evidence-based services and intervention to improve mental health and wellbeing and to prevent and reduce mental illness, problematic alcohol and other drug use, and suicide.	2018-2023 Strategic Plan | Queensland Mental Health Commission (qmhc.qld.gov.au)

Document Name	Description	Link
Every life: the Queensland suicide prevention plan 2019-2029 (phase one) (2019)	Every life articulates the four key action areas required to support the prevention of suicide in Queensland. It focuses on four action areas: • building resilience to improve wellbeing in people and communities • reducing vulnerability to support people who are vulnerable to suicide • enhancing responsiveness of approaches to people experiencing distress and suicidality • working together in a coordinated and collaborative approach to achieve more.	Every life: The Queensland Suicide Prevention Plan 2019-2029 | Queensland Mental Health Commission (qmhc.qld.gov.au)
My health, Queensland's future: Advancing health 2026 (2016)	Advancing Health 2026 was developed to guide Queensland government investment into health over the longer term and reorient the system to be flexible and innovative in taking advantage of new technologies, while improving health outcomes for Queenslanders.	My health, Queensland's future: Advancing health 2026
Queensland Health: System Outlook to 2026 for a sustainable health service (2019)	This System Outlook sets out strategies that will be implemented by the Department of Health and Hospital and Health Services to: • transform health services to improve health outcomes • optimise the system to make the best use of resources • grow the system to maintain access.	System Outlook to 2026 - for a sustainable health service (publications.qld.gov.au)
Making Tracks Together: Queensland's Aboriginal and Torres Strait Islander Health Equity Framework	Outlines the strategic framework to drive health equity, eliminate institutional racism across the public health system and achieve life expectancy parity for First Nations Queenslanders by 2033.	health-equity-framework.pdf
Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health alcohol and other drugs services (2016)	Connecting Care to Recovery is the most recent plan for setting the directions and highlighting the priorities for action and investment across Queensland's State-funded mental health, alcohol and other drug service system. It identified five priority areas: • access to appropriate services as close to home as practicable and at the optimal time • workforce development and optimisation of skills and scope • better use of ICT to enhance clinical practice, information sharing, data collection and performance reporting • early identification and intervention in response to suicide risk • strengthening of patient's rights *Mental Health Act 2016.*	Connecting care to recovery 2016-2021 :: A plan for Queensland's State-funded mental health, alcohol and other drug services

Document Name	Description	Link
Measurement Strategy for Connecting Care to Recovery 2016-2021: A plan for Queensland's State-funded mental health, alcohol and other drug services (2017)	This measurement strategy provides a framework for the regular monitoring of the implementation of Connecting care to recovery, performance of services and the individual outcomes associated with receiving mental health and alcohol and other drugs care.	A Measurement Strategy for Connecting Care to Recovery (health.qld.gov.au)
Queensland Alcohol & Other Drug Treatment & Harm Reduction Outcomes Framework (2019)	The Queensland Alcohol and other Drug Treatment and Harm Reduction Outcomes Framework (THROF) describes the way Queensland alcohol and other drugs (AOD) treatment and harm reduction services can measure their impact. It suggests a series of outcome indicators that, when measured and considered in the context of each other and specific treatment types, help to inform service quality.	1552364369_queensland-alcohol-and-other-drug-treatment-and-harm-reduction-outcomes-frameworkpdf.pdf (amazonaws.com)
Action on Ice: The Queensland Government's plan to address use and harms caused by crystal methamphetamine (2018)	Outlines the Queensland Government's plan to address the use and harms cause by crystal methamphetamine (ice). It outlines a response based on: • reducing the supply of ice • reducing the demand for ice • reducing the harms from ice.	Action on ice | Queensland Health
Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021 (2016)	This strategy seeks to eliminate the gap in mental health outcomes between Aboriginal and Torres Strait Islander Queenslanders and non-Indigenous Queenslanders.	Queensland Health Aboriginal and Torres Strait Islander Mental Health Strategy 2016-2021
The Youth Needs Census Queensland (2017)	The Youth Needs Census - Queensland (ThYNC-Q) provides a state-wide snapshot of young people (aged 12-25) utilising youth alcohol and other drug (AOD) services on a nominal day in 2017.	The Youth Needs Census - Queensland (ThYNC-Q) | Dovetail
Queensland Alcohol and Other Drug Treatment Service Delivery Framework (2015)	This framework document describes the 'common ground' underpinning alcohol and other drug (AOD) treatment service delivery in Queensland. It outlines the mission, aims, objectives, values, understandings, established tools, therapeutic approaches, practice principles and standards that inform the state's AOD treatment sector.	QldAODTreatmentFramework_March2015FINAL (amazonaws.com)

Document Name	Description	Link
A great start for all Queensland Children – An early years plan for Queensland (2020)	This plan a whole-of-government early years plan for Queensland, setting out the state's vision for children in their early years and placing children at the centre of our community responses. The plan focuses the strategies and actions that can be pursued by families, government and the broader community to guide and support children in the key phases of their early years. • Nurturing in the first 1000 days (conception to two years of age) • Thriving in the wider world (three to four years of age) • Enriching young minds (five to eight years of age).	Early Years Plan (qed.qld.gov.au)
Queensland Health Digital Health Strategic Vision for Queensland 2026 (2017)	This vision seeks to advance health care for consumers, clinicians, and the Queensland community through digital innovation.	Digital Health Strategic Vision for Queensland 2026 - eHealth Queensland
Queensland Health Telehealth Strategy (2021)	This strategy sets out the future direction of the Queensland Health Telehealth Program to enable consumer-centred care delivery for any model of care or physical location.	Telehealth Strategy 2021-2026 | Queensland Health
Queensland Housing Strategy 2017-2027 (2017)	This strategy sets out the Queensland Government's commitment to work with communities, industry and the housing sector to deliver a better housing future for all Queenslanders. Is supported by the Aboriginal and Torres Strait Islander Housing Action Plan 2019-2023 and the Housing and Homelessness Action Plan 2021-2025	About the Queensland Housing Strategy 2017-2027 | Department of Communities, Housing and Digital Economy (chde.qld.gov.au)

Documents from other jurisdictions

The following table identifies some of the key documents which may help to inform and guide deliberations of the Mental Health Select Committee.

Document Name	Description	Link
United Nations		
Convention on the Rights of Persons with disabilities (2008)	The purpose of this Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by people with disabilities, and to promote respect for their inherent dignity. This includes people who have long-term physical, mental, intellectual or sensory impairments.	OHCHR | Convention on the Rights of Persons with Disabilities
Principles for the protection of person with mental illness and the improvement of mental health care (1991)	Identifies 25 principles for the protection of people living with mental illness and the provision of mental health care.	OHCHR | Principles for the protection of persons with mental illness
Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (1984)	Outlines member States commitment to prohibiting acts that constitute serious violations of human rights.	OHCHR | Convention against Torture
Optional Protocol to the Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (2006)	Outlines additional measures necessary to achieve the purpose of the Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment	OHCHR | Optional Protocol to the Convention against Torture

Document Name	Description	Link
World Health Organization		
The WHO Special Initiative for Mental Health (2019-2023) Universal Health Coverage for Mental Health	A five year strategy to advance mental health policies, advocacy and human rights, and scale up quality interventions and services for individuals with mental health conditions, including substance use and neurological disorders.	WHO-MSD-19.1-eng.pdf
Comprehensive mental health action plan 2013-2020 (2013)	An action plan for member states which takes a comprehensive and multisectoral approach through coordinated services from the health and social sectors, with an emphasis on promotion, prevention, treatment, rehabilitation, care and recovery.	Microsoft Word - A66_R8-en.docx (who.int)
New South Wales		
Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants	A report on the nature, prevalence and impact of crystal methamphetamine and other illicit amphetamine-type stimulants, the adequacy of existing measures to target these substances in NSW, and options to strengthen the response to crystal methamphetamine and illicit ATS, including law enforcement, education, treatment and rehabilitation responses. The report made 109 recommendation in relation to issues such as: • greater coordination of alcohol and other drug policy • decriminalisation • reframing substance use as a health issue • a greater investment in treatment, diversion, and workforce initiatives • education and prevention programs • better data, reporting and research • a clear focus on priority populations.	The Special Commission of Inquiry into the Drug 'Ice' - Premier & Cabinet (nsw.gov.au)

Document Name	Description	Link
State Coroner's Court of New South Wales: Inquest into the death of six patrons of NSW music festivals	The report on the inquest into the deaths of six young people who died during or just after attending music festivals in New South Wales (NSW) during a 13-month period from December 2017 until January 2019. In each case, post-mortem toxicology results showed that an amount of the drug MDMA was found in their blood at a toxic level. The Coroner made a series of recommendations to the: • NSW Department of Premier and Cabinet • NSW Department of Health • NSW Police Force • NSW Department of Communities and Justice • Australian Festivals Association • NSW Education Standards Authority • EMS Event Medical.	Inquest into the death of six patrons of NSW music festivals
Victoria		
Royal Commission into Victoria's Mental Health System (March 2021)	The Royal Commission was established in February 2019 to inquire and report on: • how to prevent mental illness and suicide and support recovery through Victoria's mental health system • how to deliver the best mental health outcomes and improve access to Victoria's mental health system • how to best support the needs of family members and carers of people living with mental illness. The Royal Commission delivered nine recommendations in its interim report and 65 recommendations in its final report.	Home | Royal Commission into Victoria's Mental Health System
Inquiry into Drug Law Reform (March 2018)	In November 2015 the Law Reform, Road and Community Safety Committee of the Parliament of Victoria was required to inquiry into, consider and report on the effectiveness of laws and procedures relating to illicit and synthetic drugs and prescription medication. It examined the practice of other Australian states and territories and overseas jurisdictions. The report made 50 recommendations finding that more needs to be done to make treatment and support readily available to keep people safe and for law enforcement responses to focus on trafficking and criminal behaviour arising from use rather than personal possession for use.	Parliament of Victoria - Inquiry into Drug Law Reform