QUEENSLAND MENTAL HEALTH COMMISSION

First Report of the Queensland Mental Health Commission Advisory Committee

January 2012

Queensland Government

FIRST REPORT OF THE
QUEENSLAND MENTAL HEALTH COMMISSION
ADVISORY COMMITTEE

16 January 2012

Queensland Mental Health Commission Transition
c/- Queensland Health
GPO Box 48
BRISBANE QLD 4001
E: QMHCTT@health.qld.gov.au
P: 3406 2676

The Committee wishes to express gratitude to all those who gave of their time and effort to make a submission or participate in the consultation process. This First Report would not be possible without the contributions of many individuals and organisations. My particular thanks go to those consumers, carers and families who shared their personal experiences and provided their valuable perspectives on what is required. We feel privileged to have represented you - these recommendations are for you and for all those you represent and care for now and in the future.

Sincere thanks must also go to the staff of the Department of Communities and Queensland Health and other government and non government agencies who have actively participated in processes which have provided a strong basis for the Committee's recommendations. The Committee was also grateful for the candid engagement of senior staff of the Western Australian Government in discussing the successes and challenges of establishing a robust mental health commission.

I wish also to pay tribute to my fellow Committee members. The vigour, energy, frank discussion and words of wisdom you have brought to the table leave me feeling confident that a bright future for reform exists. As representatives across the mental health and alcohol and other drug treatment sector, you have carefully considered and advocated for reform that is ambitious, yet sustainable and practical and will deliver to consumers, carers and their families a fundamental transformation of Queensland's mental health system and addiction treatment services. You can feel proud that these recommendations will ensure that the needs and human rights of people who are affected by mental disorders or who have problems associated with alcohol or drug use remain paramount at all times and that services will be increasingly accessible and better co-ordinated.

Finally, I thank the Project Sponsor and members of the Queensland Mental Health Commission Transition Team. The Committee is appreciative of your passion, hard work and professionalism.

PROFESSOR BEVERLEY RAPHAEL

CHAIR
JANUARY 2012

You can access the First Report of the Queensland Mental Health Commission Advisory Committee at http://www.health.qld.gov.au/mentalhealth/commission.asp.

Provide us with your views on our recommendations by completing our electronic feedback survey at: www.getinvolved.qld.gov.au.

Email – send us your views on our recommendations by attaching no more than two A4 pages (1000 words) in Word format to your email: QMHCTT@health.qld.gov.au.

Write to us with your views on your recommendations by attaching no more than two A4 pages (1000 words) in Word format to:

Queensland Mental Health Commission Transition Team
c/- Queensland Health
GPO Box 48
BRISBANE QLD 4001

TABLE OF CONTENTS

1. EXECUTIVE SUMMARY

On 11 October 2011, the Honourable Anna Bligh MP, Premier and Minister for Reconstruction, announced in Parliament that the Queensland Government would establish an independent Queensland Mental Health Commission (the Commission) from 1 July 2012 to drive improved performance, coordination and transparency in the delivery of mental health services in Queensland[1]. In announcing the Commission, the Premier noted that the Commission's functions will include:

- acting as a strong champion for mental health consumers and their families;
- improving the coordination, effectiveness and performance of mental health services;
- ensuring resources are being deployed to where they are most needed;
- developing a strong evidence base to support government investment; and
- promoting greater transparency in the allocation of resources.

It was also determined that the Commission will not:

- handle complaints otherwise handled by the Health Quality and Complaints Commission, Queensland Health's Ethical Standards Unit or professional registration bodies; or
- deliver services – Queensland Health will continue to be responsible for delivering acute and community-based clinical mental health services via Local Health and Hospital Networks from 1 July 2012. Community-based support services will also continue to be provided by non-government organisations.

The Queensland Mental Health Commission Advisory Committee was established in November 2011 to assist the Government in ensuring that consultation occurred with as many stakeholders as possible, and to translate the outcomes of the consultation process to shape a rigorous and workable model for the Commission.

Evidence from international mental health commissions suggests that dedicated, stand-alone mental health commissions can re-orient mental health systems towards a greater focus on the needs of individual consumers and sustainability of services, drive greater transparency in the allocation of resources and promote a stronger focus on evaluation to inform future investment in mental health.

ThisFirst Report has been prepared for the Health and Disability Reform Chief Executive Officers Committee (H&DRCEOC) and includes recommendations for the establishment of the Commission in relation to the:

- potential role and functions;
- most appropriate organisational structure;
- potential role in the purchasing of services;

[1] Queensland Premier Ministerial Media Statement – *Premier announces new independent Mental Health Commission* (11 October 2011).

- most appropriate governance structure to guide and support decision-making;
- engagement of consumers and carers; and
- potential role in relation to alcohol and other drug treatment services.

The recommendations of the Committee are informed by significant consultations reaching a total of 1378 stakeholders and experiences from existing or soon to be established mental health commissions, both within Australia and internationally.

Consistent with stakeholder feedback, the Committee recommends that the scope of the Commission is inclusive of alcohol and other drug programs and services (Recommendation 4). In this context, alcohol and other drug programs and services refers to drug and alcohol detoxification, treatment and other related harm minimisation activities. The inclusion of alcohol and other drug programs and services from the commencement of the Commission will continue the productive relationships established within the Mental Health Alcohol and Other Drug Directorate and will establish the Commission as a modern and progressive entity.

The recommendations of the Committee will deliver a commission which is independent, authoritative and has the necessary strength and levers to drive innovation and reform resulting in improved outcomes and services for consumers, carers and families.

The Committee also notes that these recommendations take account of the re-alignment of the health system under the *National Health Reform Agreement*[2] and the principles of the announced restructure of Queensland Health into two separate departments announced by the Honourable Anna Bligh MP, Premier and Minister for Reconstruction, on 12 December 2011[3].

2. SUMMARY OF RECOMMENDATIONS

Primary Objectives

RECOMMENDATION 1: That the overall objective of the Commission be to promote a whole of lifespan perspective, and influence and reform the whole mental health system and alcohol and other drug treatment services from early intervention, prevention, resilience building and mental health promotion to treatment and recovery. This overall objective will be underpinned by the *Australian Human Rights Framework* and the *United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.*

[2] Council of Australian Governments National Health Reform Agreement (19 August 2011).
[3] Queensland Premier Ministerial Media Statement – *Queensland Health we need a new beginning* (12 December 2011).

RECOMMENDATION 2: That the announced objectives of the Commission be refined to the following:

- act as a strong champion for consumers of mental health and alcohol and other drug programs and services, their carers and their families, for person-centred services that support recovery;
- improve the co-ordination, effectiveness and performance of mental health and alcohol and other drug programs and services;
- ensure resources are being deployed to where they are most needed;
- develop a strong evidence base to support government investment; and
- promote greater transparency in the allocation of resources.

Scope of Services

RECOMMENDATION 3: That the Commission's scope includes all functions in relation to mental health programs and services, including those provided in the community.

RECOMMENDATION 4: That the Commission's functions also apply to alcohol and other drug programs and services.

Key Roles and Functions of the Commission

RECOMMENDATION 5: That the core functions of the Commission be:

- engaging with consumers, carers, families, providers and other stakeholders;
- providing independent mental health and alcohol and other drug policy and planning advice to Government;
- articulating key outcomes and defining mental health and alcohol and other drug programs and services needed to achieve outcomes;
- determining the most effective allocation of resources for mental health and alcohol and other drug programs and services, including workforce planning and support;
- determining and approving the service agreements governing the type, mix and distribution of mental health, and alcohol and other drug programs and services;
- monitoring, evaluating and reporting on performance and outcomes;
- facilitating coordinated and seamless services systems for consumers;
- leading implementation of national and state reforms and driving service innovation;
- promoting social inclusion, tackling stigma and discrimination and raising public awareness and understanding;
- promoting and driving prevention and early intervention in relation to mental health and alcohol and other drug use;
- promoting best practice and high quality care and support;
- advocating for specific groups needing better outcomes, in particular, Aboriginal and Torres Strait Islander people; and
- working collaboratively with the National Mental Health Commission and other relevant agencies.

RECOMMENDATION 6: That the Commission should determine Service Agreements for mental health services, including the type, mix and distribution of services to be purchased from Local Health and Hospital Networks, and via contractual arrangements with the non-government sector for mental health and alcohol and other drug programs and services.

RECOMMENDATION 7: That the Commission should comprise, among other things, the policy and regulatory roles (functions and powers) of the Director of Mental Health (DMH) who is appointed under the *Mental Health Act 2000* (Qld) to promote improved quality and safety of mental health services.

Organisational Form

RECOMMENDATION 8: That the Queensland Government note the following key principles as integral to the organisational structure of the Commission:

- flexibility as broader health system reforms continue at a state and national level;
- independence within government, transparency and accountability to consumers, carers and their families;
- clear goals are identified and reported on to ensure system improvement;
- improving access to care via strong engagement with consumers, carers, families, providers and other stakeholders;
- strong and conducive relationships between the Commission and departments should be established and supported;
- that Queensland Government departments and the Commission will work collaboratively in developing agreed policy, planning, purchasing and performance reporting frameworks; and
- that a division of responsibilities between Local Health and Hospital Networks, Queensland Health and the Commission does not result in an additional layer of bureaucracy but rather enables streamlining of the mental health and alcohol and other drug programs and services.

RECOMMENDATION 9: That the Commission be established as a department of the Queensland Government.

RECOMMENDATION 10: That the Commission should be provided with the necessary authority, via stand-alone legislation, to:

- drive implementation of state reform through the *Queensland Plan for Mental Health 2007-2017,Supporting Recovery: Mental Health Community Services Plan 2011-17* and the *2011 and 2012 Queensland Drug Action Plan*;
- drive national reform by implementing the *Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-14*, the *Ten Year Roadmap for National Mental Health Reform*, and the *National Partnership Agreement on Supporting National Mental Health Reform* and interact with the National Mental Health Commission;
- directly influence cross-sector activity; and

- receive relevant information from any Queensland Government agency relevant to the performance of its functions.

RECOMMENDATION 11: That, in addition to annual reporting processes, the effectiveness of the Commission be independently reviewed within five years of commencement and at subsequent regular intervals.

RECOMMENDATION 12: That the organisational structure of the Commission include the establishment of an Advisory Council via legislation, which is inclusive of, but not limited to, representation from:

- those with a lived experience of mental illness;
- those with a lived experience of alcohol and/or other drug misuse;
- a carer or family member of a person with mental illness;
- a carer or family member of a person with alcohol or other drug misuse;
- the Aboriginal and Torres Strait Islander community;
- expertise in service delivery in regional, rural and remote areas;
- Culturally and Linguistically Diverse populations;
- the Gay, Lesbian, Bisexual and Transgender and Inter-sexed sector; and
- the Child, Youth and Older Persons' sectors.

Consumers, Carers and Families

RECOMMENDATION 13: That consumers, carers and families are meaningfully engaged in all aspects of the Commission including decision-making forums and processes.

Initial Priorities of the Commission

RECOMMENDATION 14: That the initial priorities for the Commission be:

- overseeing the implementation of the *Queensland Plan for Mental Health 2007-17, Supporting Recovery: Mental Health Community Services Plan 2011-2017* and the *2011 and 2012 Queensland Drug Action Plan*;
- continuation and expansion of the innovative *Change Our Mind* stigma reduction campaign;
- development of strategic policy and planning to inform the next stage of alcohol and other drug programs and services on expiry of the *2011 and 2012 Queensland Drug Action Plan*;
- driving a cross-sector approach to the *National Partnership Agreement on Supporting National Mental Health Reform* and the *Ten Year Roadmap for Mental Health Reform*;
- undertaking the development of indicators, consistent with national reporting, for providing transparent measures of performance of mental health clinical services; and
- developing an ongoing reform agenda, sensitive and responsive to emerging priorities and needs.

3. CONTEXT

The Queensland Government has made significant investments in improving mental health programs and services over the last ten years. This includes an injection of new funding in the 2007-2011 period of $632.4 million under the *Queensland Plan for Mental Health 2007-2017* (QPMH), the highest level of new funding of any State or Territory over that period.

However, critical service gaps remain and more needs to be done particularly to provide better coordinated services for people with mental illness. We know that almost half the Queensland population aged 16–85 years reported an experience of a mental disorder in their lifetime in 2007, and that approximately 500,000 Queenslanders (one in five) had symptoms in the past 12 months[4].

Mental illness accounts for 13% of the total burden of disease in Australia, and is the largest single cause of disability, comprising 24% of the burden of nonfatal disease[5]. Mental illness, unlike any other chronic disease, affects people of all ages, with a significant impact on many young people. Those living with mental ill-health are one of the most marginalised groups in society and for many the disadvantage and exclusion they experience is more disabling than the mental illness. People with mental and behavioural conditions have very low workforce participation rates of around 42% compared to more than 80% for people without disability.

Since 2007, major initiatives have included $10.6 million to deliver promotion, prevention and early intervention initiatives including *Change our Minds*[6] (an innovative stigma reduction social marketing campaign); $380.6 million to integrate and improve the care system with an additional 569 community mental health clinical positions and up to 300 additional inpatient beds coming on line; and $110.6 million for extra support services including community housing and transitional recovery places. In 2011-12 alone, the Queensland Government is investing over $1 billion in mental health services throughout Queensland[7].

This investment in service delivery and reform is working. Queensland is progressing well towards the 10 year goal of providing a comprehensive, recovery-oriented mental health system that improves Queenslanders' mental health. A recent evaluation of the first four years of the *QPMH* has shown that this investment has:

- increased the capacity of mental health services
- built better links between treatment services and community supports
- provided more sustainable treatment
- enabled us to reach more people living with mental illness[8].

[4] Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing: Summary of results. Cat. no. 4326.0. ABS: Canberra; 2008.
[5] Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez A .,*The burden of disease and injury in Australia 2003, Australian Institute of Health and Welfare* (25 May 2007).
[6] www.changeourminds.qld.gov.au
[7] *Queensland State Budget 2011-12* - Queensland Health and Department of Communities.
[8] *Queensland Plan for Mental Health 2007-2017: Four Year Report* (October 2011).

Importantly, Queensland has the strategic policy framework in place to continue fundamental reform of the mental health system. Significant improvements can be expected under the second phase of the *QPMH*, and through implementation of *Supporting Recovery: Mental Health Community Services Plan 2011-2017* (*Supporting Recovery*).

The establishment of the Commission is a cornerstone of the Queensland Government's ongoing mental health reform agenda, and importantly, will play a central role in the implementation of phase two of the QPMH and Supporting Recovery and key actions under the *Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014* (Fourth National Mental Health Plan) and the Commonwealth's *Delivering National Mental Health Reform Package*[9].

The important role of the Commission regarding innovation, reform and greater co-ordination of care has required the Committee to consider the inter-relationship between mental health programs and services and alcohol and other drug programs and services. For these purposes, alcohol and other drug programs and services refers to drug and alcohol detoxification, treatment and other related harm minimisation activities.

In Queensland approximately $85million per annumis distributed across a total of 118 government funded alcohol and drug treatment agencies, of which 67 are non-government agencies[10]. Many of these non-government agencies also provide mental health programs and services, irrespective of a link to dual diagnosis services. Currently this funding and associated policy and program management is administered by the Alcohol and Other Drug Treatment Strategy Unit, Mental Health Alcohol and Other Drug Directorate, Queensland Health.

Access to ongoing responsive services, including a range of evidence-based treatment options, is needed to meet the diverse and often complex needs of people throughout Queensland with an alcohol and/or other drug problem, particularly those with a co-occurring mental health problem. The 2011 and 2012 *Queensland Drug Action Plan* will, over the next two years, build on and consolidate the gains made during the *Queensland Drug Strategy 2006-2010*.

4. QUEENSLAND MENTAL HEALTH COMMISSION ADVISORY COMMITTEE

The Queensland Mental Health Commission Advisory Committee was established to assist the Queensland Government in ensuring that consultation occurred with as many

[9] announced as part of the Commonwealth 2011-12 Budget

[10] Australian Institute of Health and Welfare (AIHW) 2011. *Alcohol and other drug treatment services in Australia 2009-10: findings from the National Minimum Data Set*.

stakeholders as possible, and to translate the outcomes of the consultation process to shape a rigorous and workable model for the Commission.

The Advisory Committee was established in November 2011 by the Queensland Government, with Terms of Reference (refer Appendix 13.1) to:

- advise the Health and Disability Reform Chief Executive Officer Committee (H&DRCEOC) regarding the most appropriate functions to belong in the Commission;
- advise the H&DRCEOC regarding an appropriate legislative or departmental mandate for the Commission;
- advise of appropriate strategies for community and stakeholder engagement;
- develop a report including recommendations regarding the strategic direction of the Commission;
- advise H&DRCEOC on any significant issues identified through targeted and community and stakeholder consultation;
- provide a forum for members to raise issues for group input and discussion;
- provide a forum for collective decision making regarding the functions of the Commission;
- adhere to timeframes identified by Government as applicable to functions of the Committee; and
- be time limited in nature.

The Advisory Committee consisted of 17 members, combining a wide range of experience and expertise across mental health and alcohol and other drug programs and services with representation of key target groups including consumers, carers, Aboriginal and Torres Strait Islander peoples, child and youth, general practice, the non-government sector and clinical expertise (refer to Appendix 13.2).

5. CONSULTATION

Queenslanders' personal and professional experiences of the mental health system are integral to informing the establishment of a Commission effective in acting as an champion for people living with mental illness and alcohol and other drug addiction. The consultation process undertaken to date was successful in capturing a range of perspectives, suggestions and experiences to inform the Committee's recommendations.

On 21 November 2011, the consultation process commenced with the release of a structured survey through the Queensland Government Get Involved website[11]. Face-to-face consultations commenced on 22 November 2011 in metropolitan and regional and rural Queensland.

Participation in the consultation process has been high, indicating a significant level of community and sector interest in the Commission. A total of 1134 people attended face-

[11] www.getinvolved.qld.gov.au/gi/consultation/200/view.html

to-face consultations, 199 people completed the online survey and a further 45 submissions were received for consideration. A summary of the consultation outcomes is included at Appendix 13.3.

The themes emerging from the consultation process have included –

- confirmation of the already defined primary objectives and key functions of the Commission;
- support for a strong independent Commission, enabled to effectively operate as a champion for consumers, carers and families;
- that the Commission should have a broad focus across the full span of the consumer, carer and family journey, and that it should work to improve integration and collaboration between the disparate bodies providing services to individuals at various points throughout their individual journeys;
- a recognition that, whilst the Commission requires a lever to drive innovation and reform, too great an involvement in service delivery may detract from a strategic focus and create a conflict of interest in identifying key areas for improvement;
- a clear need for transparency and accountability with regard to funding of mental health and alcohol and other drug programs and services, with many identifying a specific requirement for the Commission to be either the funder or purchaser of services;
- that the geographic challenges of Queensland should be taken into account through a regional and rural perspective and representation within the Commission; and
- support for the inclusion of alcohol and other drug programs and services within the scope of the Commission.

6. MENTAL HEALTH COMMISSIONS IN AUSTRALIA AND AROUND THE WORLD

Several Australian jurisdictions have established or are in the process of establishing mental health commissions to perform many of the functions that are currently performed by the Mental Health Alcohol and Other Drugs Directorate, Queensland Health and the Community Mental Health Branch, Department of Communities.

The Western Australia Mental Health Commission was established in 2010, the National Mental Health Commission commenced operations on 1 January 2012 and the legislation for the establishment of the *New South Wales Mental Health Commission Bill 2011* (NSW) currently before the New South Wales Parliament[12].

[12] Introduced by the Honourable Kevin Humphries MP, Minister for Mental Health, Minister for Healthy Lifestyles, and Minister for Western New South Wales on 24 November 2011.

This contemporary trend arises from evidence-based international best practice. Canada, New Zealand, Ireland and Scotland have all established mental health commissions as a driver of reforms for service delivery. The form of these mental health commissions is varying in nature, however consistently the objectives and functions of these commissions are consistent with those announced for the Queensland Mental Health Commission. Appendix 13.4 provides a comparison of the functions across existing mental health commissions, with Appendix 13.5 providing a more detailed overview of each commission's functions.

The comparative analysis indicates that:

- the mandate/authority for establishing commissions varies across jurisdictions with New Zealand having a separate and dedicated piece of legislation (*Mental Health Commission Act 1998*); Ireland established their Commission under the *Mental Health Act 2001*, while other jurisdictions have established their commissions under respective Public Services Acts or their equivalent.
- the roles and responsibilities of commissions vary considerably across jurisdictions. However, the most common functions include: enhancing social inclusion and active participation of people with mental illness; promoting mental health and tackling stigma and discrimination; policy development and implementation, promoting and facilitating collaboration; monitoring and reporting on the progress of reform and standards of care; stimulating and undertaking research and evaluation. These are also currently considered as core to the Commission.
- other functions of Commissions include: setting service activity levels and benchmarks; setting resourcing levels; purchasing services; visiting and investigating care services; safeguarding the rights of people with mental illness in care; providing advice and information to consumers, carers and general public.
- the Commissioner/s or Chief Executive Officers of mental health commissions usually report to Ministers of Health or as is the case in Western Australia to the Minister for Mental Health. Uniquely, the Scottish Commission reports directly to the Parliament.
- New Zealand has three Commissioners with one person occupying the Executive Chair Commissioner role. The three positions have been established to ensure that a person who is Maori occupies at least one commissioner position.
- All Commissions reviewed have either a Board of Commissioners or an Advisory Board or Council with a formally appointed Chair and in some cases, as is the case in Western Australia, Deputy Chairs. The number of Board members varies between as many as 18 in Canada and as few as eight in Scotland with the duration of appointment varying between three and five years.
- The composition of the Board membership also varies between jurisdictions with Ireland and Western Australia having the majority of their Board comprising people with mental health professional groupings such as doctors, nurses, psychologists, social workers and health administrators, while other mental health commissions such as in Canada have structured their Board to have the majority made up of non-government members, including consumers and carers.

- Only the New Zealand Mental Health Commission also includes addiction services, while all others have a role with dual diagnosis issues they do not formally take responsibility for stand alone addiction services. However, some Commissions such as Canada, are considering the inclusion of addiction services.

7. PRIMARY OBJECTIVES OF THE COMMISSION

The Honourable Anna Bligh MP, Premier and Minister for Reconstruction, has announced that the Commission will be the cornerstone of ongoing reform of the Queensland mental health system and position Queensland to better respond to emerging priorities, pressures and opportunities and to drive ongoing reform locally and nationally[13].

In response, stakeholders have revealed a definitive expectation for an independent Commission, with an ability to focus on strategic issues, innovation and reform.

It is recommended that the Commission be implemented as a model of proactive system-wide consultation and surveillance and arm's-length monitoring to ensure a transparent accountability mechanism independent of service providers and management, as is the case in New Zealand, Canada and Western Australia. This model is more effective in applying more direct leverage with governments than the narrow and restricted model serving regulatory, inspectorial, medico-legal and inquisitorial functions (eg. Ireland and Scotland).

RECOMMENDATION 1: That the overall objective of the Commission be to promote a whole of life perspective, and influence and reform the whole mental health system and alcohol and other drug treatment services from early intervention, prevention, resilience building and mental health promotion to treatment and longer term recovery. This overall objective will be underpinned by the *Australian Human Rights Framework* and the *United Nations Principles for the Protection of Persons with Mental Illness and and for the Improvement of Mental Health Care*.

As an independent body, the Commission should provide strong leadership and advocacy, and will focus on streamlining the mental health and alcohol and other drug programs and services rather than adding another layer of bureaucracy.

The Commission will be responsible for –

- acting as a strong champion for consumers, carers and their families;
- improving the coordination, effectiveness and performance of mental health and alcohol and other drug programs and services;
- ensuring resources are being deployed to where they are most needed;
- developing a strong evidence base to support government investment; and
- promoting greater transparency in the allocation of resources.

[13] Queensland Premier Ministerial Media Statement – *Premier announces new independent mental health commission* (11 October 2011).

The Queensland Government had also determined that the Commission will not:

- handle complaints otherwise handled by the Health Quality and Complaints Commission, the Queensland Health Ethical Standards Unit or professional registration bodies; or
- deliver services – Queensland Health will continue to be responsible for delivering acute and community-based clinical mental health services via Local Health and Hospital Networks. Community-based services will continue to be provided by non-government organisations.

Consumers, carers and their families are strongly enabled by the *Australian Human Rights Framework* and the *United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*. These frameworks should underpin the objectives and functions of the Commission.

The Committee is supportive of overall objectives with refinement to incorporate alcohol and other drug programs and services (Recommendation 4).

RECOMMENDATION 2: That the announced objectives of the Commission be refined to the following:

- act as a strong champion for consumers of mental health and alcohol and other drug programs and services, their carers and their families for person-centred services that support recovery;
- improve the co-ordination, effectiveness and performance of mental health and alcohol and other drug programs and services;
- ensure resources are being deployed to where they are most needed;
- develop a strong evidence base to support government investment; and
- promote greater transparency in the allocation of resources.

In the achievement of these objectives, the Commission will need to engage continuously with consumers, families, service providers and other stakeholders, ensuring that consumers' needs and human rights remain paramount at all times and that services remain accessible and well coordinated.

8. SCOPE OF PROGRAMS AND SERVICES

A significant challenge facing the mental health sector, is a shift from reactionary crisis driven management to community based care and interventions. Both Queensland and national reform priorities and strategic directions are focused on a fundamental shift in the ways in which mental health and alcohol and other drug programs and services are delivered.

8.1. Mental Health Programs and Services

RECOMMENDATION 3: That the Commission's scope includes all functions in relation to mental health programs and services, including those provided in the community.

The ability of the Commission to drive reform in both clinical mental health services and community responses, including those provided in the non-government sector is critical to driving systemic reform. The *QPMH* and *Supporting Recovery* inter-relate to provide a whole-of-life approach to mental health. Whilst the Commission will be responsible for a whole-of-government co-ordination of programs and services to mental health, these two areas must be incorporated within the scope of the Commission.

The most recent published comparisons of Queensland's mental health services with those of other States and Territories[14] indicates that Queensland has provided the second-lowest rate of supported housing places (six per 100,000, well below the national average of 19 beds per 100,000. The recent investment in supported accommodation options in Queensland, such as the Housing and Support Program, has seen an improvement in performance, with a current provision of 10.71 places per 100,000[15].

By way of example, a snapshot of bed blockage within Queensland clinical mental health services demonstrates that at a single point in time (census day of 29 October 2008) bed occupancy was at 93.5%, with 23.7% (269 patients) ready or assumed ready for discharge[16]. The ability for the Commission to directly influence a significant improvement in community-based programs and services such as supported accommodation options would have a positive effect in improving outcomes for consumers and reducing the ongoing pressure on clinical inpatient beds.

Significant reform will only be achieved through continuing alignment of both clinical mental health programs and services and community responses. This is further supported by the Commission's role in driving national mental health reform, including the *National Partnership Agreement on Supporting National Mental Health Reform* (subject to final agreement by the Council of Australian Governments) which prioritises increased housing and support, transitional recovery and support services.

[14] Steering Committee for the Review of Government Service Provision 2011, *Report on Government Services 2011, Productivity Commission*, Canberra. (2008-09 data)
[15] Department of Communities, *Final Evaluation Report of the Queensland Government Housing and Support Program* (November 2010).
[16] Queensland Health, *Queensland Mental Health Inpatient Snapshot Survey 2008 Report* (August 2009).

8.2. Alcohol and Other Drug Programs and Services

Thirty-five per cent of people who use drugs also have a co-occurring mental illness and although people with mental illness benefit from alcohol, tobacco and other drug treatments, they have poorer physical and mental health and poorer social functioning following treatment than other people[17]. The cost of drug use in Australia has been estimated at almost $56.1 billion per annum[18]. On a population basis, the annual cost of drug use to the Queensland community is estimated to have reached $10.9 billion. These costs include health care, loss of productivity, law enforcement, crime, and the impact of premature death.

In Queensland approximately $85 million per annum is distributed across a total of 118 government funded alcohol and other drug treatment agencies, of which 67 are non-government agencies[19]. Many of these non-government agencies also provide mental health programs, irrespective of a link to dual diagnosis services.

The whole-of-Government policy for addressing alcohol and other drug issues in Queensland, *Queensland Drug Strategy* 2006-2010 expired on 31 December 2010. Significant gains have been made through the implementation of the Strategy, however the harmful effects of alcohol, tobacco and other drug use – including ill-health, injury, violence and premature death – continue to impact on Queensland individuals, families, the community and the economy. Beyond the personal and family stories of drug-related problems, is the added burden to the community of increased costs to the health system, police service and criminal justice system. The 2011 and 2012 *Queensland Drug Action Plan* will, over the next two years, build on and consolidate the gains made during the Strategy.

Whilst only relatively recent, the relocation of the Alcohol and Drug Treatment Strategy Unit to create the Mental Health Alcohol and Other Drug Directorate within Queensland Health is leading to improved outcomes for consumers, carers and families. Currently the Alcohol and Drug Treatment Strategy Unit provides leadership for state-wide reform, improvement and development of innovative programs of treatment services in community settings, including the *2011 and 2012 Queensland Drug Action Plan*. The Unit is also responsible for delivering policy and program advice and monitoring and reporting on system quality and performance. The Unit's responsibilities relate to policy, planning and service reform in relation to drug and alcohol detoxification, treatment and other related harm minimisation activities as well as a policy role in relation to demand and supply minimisation activities.

The feedback provided during the consultation process has indicated a strong desire for the inclusion of alcohol and other drug programs and services within the Commission.

---

[17] *The National Drug Strategy 2010-2015*

[18] Collins and Lapsley (2008), *The cost of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05,* National Drug Strategy Monograph Series, No 64; Canberra: Australian Government Department of Health and Ageing.

[19] Australian Institute of Health and Welfare (AIHW) 2011. *Alcohol and other drug treatment services in Australia 2009-10: findings from the National Minimum Data Set*.

The Committee is confident that improved outcomes for consumers, carers and families in the alcohol and other drug sector can be achieved through the recommended objectives and functions of the Commission.

Further, the primary objectives and functions of the Commission would be instrumental in delivering on the goal of the *2011 and 2012 Queensland Drug Action Plan* to build safe and healthy communities by minimising alcohol, tobacco and other drug related health, social and economic harms. Improving the integration and quality of care provided to people who have a co-existing mental illness and alcohol and/or drug issues is also a priority of both the *QPMH* and the *Fourth National Mental Health Plan* (Priority Areas 2 and 3).

RECOMMENDATION 4: That the Commission's functions also apply to alcohol and other drug programs and services.

The Committee notes that only the New Zealand Mental Health Commission originally included alcohol and other drug services within its original scope. However, other jurisdictions such as Western Australia and Canada have been gradually expanding the ambit of their Commission to include substance misuse and addiction services. The inclusion of alcohol and other drug treatment programs and services from the commencement of the Commission will continue the productive relationships established within the Mental Health Alcohol and Other Drug Directorate and will establish the Commission as a modern and progressive entity.

The Committee's recommendation for the inclusion of alcohol and other drugs within the Commission is further supported by the recommendations of *Achieving Balance: Report of the Review of Fatal Mental Health Sentinel Events* (March 2005) and the *Queensland Health Systems Review* (September 2005) for increased integration of mental health and drug and alcohol services.

However, the Committee also cautions that in including alcohol and other drug programs and services within the scope of the Commission, care should be exercised to ensure that the alcohol and other drug treatment sector's philosophy of care remains distinct, as it differs from the philosophy that underpins the mental health sector.

The Committee is not recommending that the Queensland Government consider a renaming of the Commission to incorporate alcohol and other drug programs and services, however benefit may exist in giving consideration to the portfolio responsibilities of the Minister responsible for the Commission incorporating a reference to alcohol and other drug programs and services. This is the case in South Australia with the appointment of the Honourable John Hill MP, as Minister for Mental Health and Substance Abuse and in the Northern Territory with the appointment of the Honourable Delia Phoebe Lawrie MLA as the Minister for Alcohol Policy.

9. KEY ROLES AND FUNCTIONS OF THE COMMISSION

In announcing the establishment of the Commission, the Honourable Anna Bligh MP, Premier and Minister for Reconstruction, confirmed the following functions as critical to the effective operation of the Commission:

- engaging with consumers, families, providers and other stakeholders;
- providing independent mental health policy and planning advice to Government;
- articulating key outcomes, defining services needed to achieve outcomes and ensuring the most effective allocation of mental health resources;
- facilitating coordinated and seamless services for consumers;
- monitoring, evaluating and reporting on performance;
- leading implementation of national and state reforms and driving service innovation;
- promoting awareness and social inclusion and combating stigma and discrimination;
- promoting best practice and high quality care and support; and
- working collaboratively with the National Mental Health Commission and other agencies[20].

These functions are consistent across a number of existing mental health commissions (refer Appendix 13.4 and 13.5) and were strongly supported by stakeholders. The amended functions are consistent with the purpose and broad objectives of the Commission (subject to Recommendation 2), altering only to the extent of to being inclusive of alcohol and other drug programs and services, more clearly articulating some functions and incorporating funding and purchasing responsibilities.

RECOMMENDATION 5: That the core functions of the Commission be:

- engaging with consumers, carers, families, providers and other stakeholders;
- providing independent mental health and alcohol and other drug policy and planning advice to Government;
- articulating key outcomes, defining mental health and alcohol and other drug programs and services needed to achieve outcomes;
- determining the most effective allocation of resources for mental health and alcohol and other drug programs and services, including workforce planning and support;
- determining and approving the service agreements governing the type, mix and distribution of mental health alcohol and other drug programs and services;
- monitoring, evaluating and reporting on performance;
- facilitating coordinated and seamless services for consumers;
- leading implementation of national and state reforms and driving service innovation;

[20] Queensland Premier Ministerial Media Statement – *Premier announces new independent Mental Health Commission* (11 October 2011).

- promoting social inclusion, tackling stigma and discrimination and raising public awareness and understanding;;
- promoting and driving prevention and early intervention in relation to mental health and alcohol and other drug use;
- promoting best practice and high quality care and support;
- advocating for specific groups needing better outcomes, in particular, Aboriginal and Torres Strait Islander people; and
- working collaboratively with the National Mental Health Commission and other relevant agencies.

The core functions of the Commission should account for particularly vulnerable cohorts. Mental disorders are estimated to explain at least 8% of the drivers of the health gap between Aboriginal and Torres Strait Islander and non-Aboriginal and Torres Strait Islander Queenslanders[21].

9.1. Driving Innovation and Reform – Funding and Purchasing

Stakeholders have expressed significant interest in mental health funding and purchasing arrangements. Some mental health advocates, including Professor McGorry, former Australian of the Year 2010, have called for mental health funding to be quarantined from acute hospital budgets.

The consultation process has revealed a consensus expectation across all stakeholders for an independent Commission, with an ability to focus on strategic issues. However, stakeholders have also remained adamant that the Commission must have an appropriate lever to instigate and maintain reform processes. The direct involvement of the Commission in funding and purchasing of mental health and alcohol and other drug programs and services will provide a strong lever for innovation, reform and improvements in standards of care, safety and quality.

RECOMMENDATION 6: That the Commission should determine Service Agreements for mental health services, including the type, mix and distribution of services to be purchased from Local Health and Hospital Networks and via contractual arrangements with the non-government sector for mental health and alcohol and other drug programs and services.

The Western Australia Mental Health Commission has established rigorous contracting arrangements with both government and the non-government sectors. This purchasing function, on agreed values and evidence of cost-effectiveness, is enabled by the Commission also holding the mental health budget separately to the general health budget. Quarantining mental health and alcohol and other drug program and service funds from other government funds is necessary for the Commission to effectively and

[21] *Making Tracks: toward closing the gap in health outcomes for Indigenous Queenslanders by 2033 Policy and Accountability Framework*.

flexibly allocate resources between service providers to meet client needs and to achieve the Government's fundamental reform objectives. The ability for the Commission to be a funding and purchasing authority was also a key factor in the recommendation that the Commission be established as a department (discussed further in section 8 – Organisational form).

It is critical that the Commission be in a position to determine the level and mix of both non-government and public services to be purchased. This would require full, or to the greatest extent possible, quarantining of funds currently allocated to Queensland Health mental health services ($950.7 million in 2011-12), Queensland Health alcohol and other drug treatment services ($85 million in 2011-12) and Department of Communities funded non-clinical mental health services ($70 million in 2011-12), which would have financial implications for both agencies.

The Committee wishes to acknowledge the concerns of some stakeholders that the provision of funding and purchasing responsibilities with the Commission may distract from strategic directions and limit the Commission's ability to objectively monitor, assess and report on how the system is performing. However, the benefits that can be achieved by the inclusion of the funding and purchasing responsibilities outweigh potential conflicts and appropriate safeguards will be implemented.

It is outside the scope of the Committee to advise as to the technical and operational aspects of funding and purchasing arrangements; however the Committee wishes to note that in the case of both the non-government and public sector, every attempt should be made for a streamlining of funding and purchasing arrangements. The establishment of the Commission should not lead to additional red-tape and bureaucracy in terms of service agreements and performance reporting.

9.2. Driving Innovation and Reform Statutory role of Director of Mental Health

RECOMMENDATION 7: That the Commission should comprise, among other things, the policy and regulatory roles (functions and powers) of the Director of Mental Health (DMH) who is appointed under the *Mental Health Act 2000* (Qld) to promote improved quality and safety of mental health services.

The Director of Mental Health (DMH) is appointed under the *Mental Health Act 2000* (Qld) (MH Act) as an independent position not subject to ministerial direction in the performance of duties under the Act[22]. The DMH establishes a state-wide statutory system that interacts with, but in general, is at 'arms length' from service providers in public and private sector health services. The only instances where the DMH is involved in individual decisions relate to high risk patients, for example, forensic patient transfers. Most importantly, a distinction must be made between the DMH's functions

[22] *Mental Health Act 2000* (Qld) s491

(and powers), and mental health services which are regulated under the MH Act, for example, assessment, admission and treatment services (refer to Appendix 13.6 for the relationship between the DMH and direct service provision).

The DMH functions promote a fair, safe and a quality standard of care within mental health services through oversight, development of strategic policies and guidelines, monitoring and investigation activities.

The DMH has powers and performs functions that, when aligning the objectives and functions of the Commission, are within the scope of the Commission. In particular, targeted consultation with clinicians within the forensic mental health sector has found strong support for the role and functions of the DMH to be based in the Commission. The sector recognises that while in general the MH Act regulates many aspects of clinical practice, the DMH role is focused on high order, systemic issues, as well as, protecting individual involuntary patient rights via oversight functions.
Existing mental health commissions have taken various approaches to the inclusion of functions and powers equivalent to those of the DMH.

Western Australia (WA) is developing a quality framework, which involves amending the *Mental Health Act 1996* (WA) to give the WA Mental Health Commission increased powers, including the incorporation of the Chief Psychiatrist's statutory quality assurance functions[23]. Although the WA Chief Psychiatrist's responsibilities depart slightly from the DMH functions and powers, the WA experience supports state-wide statutory functions being co-located in the agency responsible for other state-wide, strategic functions.

Other commissions in developed countries that perform statutory functions include:

- Mental Health Commission, Ireland, which has been incorporated into the Regulation and Quality Improvement Authority, an independent body responsible for monitoring and inspecting the availability and quality of health (including mental health) and social care services;
- Mental Welfare Commission, Scotland, established under the *Mental Health (Care and Treatment) (Scotland) Act 2003* with a mandate to safeguard the rights and welfare of people with a mental illness, learning disability or other mental disorder by monitoring and reporting on care and treatment services; and
- Care Quality Commission, England and Wales, an independent body which is exclusively responsible for the inspection, monitoring and regulation of health and social care in England and Wales, and protects the rights of people under the *Mental Health Act 1983*.

Statutory functions similar to the DMH are not relevant to the National Mental Health Commission or the Canadian MHC as neither have a service delivery function and

[23] On 16 December 2011 the WA Minister for Mental Health, Hon Helen Morton MLC, launched the Mental Health Bill 2011: Draft Bill for Public Comment. Consultation closes on 9 March 2012.

therefore no statutory functions (services provided by State and Territory or equivalents).

Should the DMH role be incorporated within the Commission, it is not proposed that the current roles and functions of the DMH be amended. A range of benefits will be achieved by including the DMH within the Commission, including that the Commission will achieve:

- greater independence and strength, as the DMH is the only truly independent role in the mental health system;
- a well coordinated, integrated, timely and direct lever for service reform and innovation in response to emerging priorities, pressures and opportunities;
- a minimisation of bureaucracy by avoiding duplication of activities (e.g. with respect to data collection, analysis, public reporting and responses to resourcing issues relating to planning, funding and purchasing functions);
- a co-ordinated response to service delivery priorities, potentially avoiding conflicting views or actions between QH and the Commission;
- recognition that the DMH strategic policy functions of the DMH is central to broader strategic mental health reforms across the State;
- protection for the rights of some of the most vulnerable people in the mental health system (i.e. involuntary patients);
- a reduction in potential complications of providing advice and reports to multiple Ministers with potentially conflicting priorities; and
- continuation of the existing alignment and integration of DMH related activity with other strategic mental health functions to be transferred to the Commission.

10. ORGANISATIONAL FORM

RECOMMENDATION 8: That the Queensland Government note the following key principles as integral to the organisational structure of the Commission:

- flexibility as broader health system reforms continue at a state and national level;
- independence within government, transparency and accountability to consumers, carers and their families;
- clear goals are identified and reported on to ensure system improvement;
- improving access to care via strong engagement with consumers, carers, families, providers and other stakeholders;
- strong and conducive relationships between the Commission and departments should be enabled and supported;

- that Queensland Government departments and the Commission will work collaboratively in developing agreed policy, planning, purchasing and performance reporting frameworks; and
- that a division of responsibilities between Local Health and Hospital Networks, Queensland Health and the Commission does not result in an additional layer of bureaucracy but rather enables streamlining of the mental health and alcohol and other drug programs and services.

Existing mental health commissions have been established in varying forms (refer Appendix 13.5). Generally mental health commissions report directly to the relevant Minister, who in turn reports to Parliament, rather than through multiple layers of bureaucracy to shorten the chain of accountability and increase the responsiveness to the needs of Government.

An independent Commission, can be achieved via two forms as either a:

- department with advisory and purchasing functions; or
- statutory body with advisory functions.

A comparative analysis of the described organisational forms across a range of legislative, governance and operational factors is provided at Appendix 13.7.

Creating the Commission as standalone department, allows the department's functions and budget to be quarantined from other health expenditure (refer Recommendation 9) and establishes the Commission as a jurisdiction's recognisable centre of expertise in mental health policy, program development and service effectiveness. This will greatly assist in providing greater prominence to the issue of mental health generally and within Government.

RECOMMENDATION 9: That the Commission be established as a department of the Queensland Government.

Establishing the Commission as a department provides significant benefits in comparison to an organisational structure of a statutory body. In particular, establishing the Commission as a department allows for the Commission to undertake funding and purchasing activities, a critical lever for driving service delivery reform. The independence of the Commission established as a department, can be provided by legislative safeguards and parliamentary oversight (Recommendation 10).

Whilst a statutory body may be perceived as being more 'independent' than a department, such a model would not allow the Commission to be directly involved in funding and purchasing activities (Recommendation 6), nor would it be most likely to

deliver effectively on the strategic functions of the Commission already determined by the Queensland Government. Further, this organisational form would require a significant number of mental health functions to remain within Queensland Health and/or the Department of Communities, increasing the risk of duplication of effort and increased bureaucracy and creating challenges for information sharing between all parties.

RECOMMENDATION 10: That the Commission should be provided with the necessary authority, via stand-alone legislation, to:

- drive implementation of state reform through the *Queensland Plan for Mental Health 2007-2017,Supporting Recovery: Mental Health Community Services Plan 2011-17* and the *2011 and 2012 Queensland Drug Action Plan*;
- drive national reform by implementing the Fourth National Mental Health Plan: an agenda for *collaborative government action in mental health 2009-14*, the *Ten Year Roadmap for National Mental Health Reform*, and the *National Partnership Agreement on Supporting National Mental Health Reform* and interact with the National Mental Health Commission;
- be able to directly influence cross-sector activity; and
- receive information from any Queensland Government agency relevant to the performance of its functions.

Regular and transparent review of the effectiveness of the Commission, subject to the establishment of the Commission as a department (Recommendation 9) and the inclusion of the statutory role of the DMH (Recommendation 7), will be provided through annual reporting requirements under the *Financial Accountability Act 2009* (Qld) and the *MH Act* respectively.

RECOMMENDATION 11: That, in addition to annual reporting processes, the effectiveness of the Commission be independently reviewed within five years of commencement and at subsequent regular intervals.

10.1. Governance and engagement

RECOMMENDATION 12: That the organisational structure of the Commission include the establishment of an Advisory Council via legislation, which is inclusive of, but not limited to, representation from:

- those with lived experience of mental illness;
- those with a lived experience of alcohol and/or drug misuse;
- a carer or family member of a person with mental illness;
- a carer or family member of a person with alcohol and other drug misuse;
- the Aboriginal and Torres Strait Islander community;
- expertise in service delivery in regional, rural and remote areas;

- Culturally and Linguistically Diverse populations;
- the Gay, Lesbian, Bisexual, Transgender and Inter-sexed sector; and
- the Child ,Youth and Older Persons' sectors.

Existing mental health commissions have been successful in achieving a range of engagement strategies representative of a range of perspectives. The establishment of the Advisory Council should not be the only engagement strategy, but rather the beginning of broad engagement in strategic decision-making.

11. CONSUMERS, CARERS AND FAMILIES

Governments should support and empower the important role that consumers, carer and families play in determining strategic directions and reform of service delivery. Such groups are in the best position to highlight problems, specify their needs, and help find solutions to improving mental health in countries and have a crucial role to play in the design and implementation of policies, plans, laws and services[24].

The Queensland Government has a history of pro-active engagement of consumers, carers and families, being the first jurisdiction to include this membership within the COAG Mental Health Reform Committee, the subsequent Queensland Mental Health Reform Committee and a dedicated Consumer, Carer and Family Team within Queensland Health. Additionally, through the Department of Communities, funding has been allocated to the non-government sector for the establishment of the first three consumer operated services in this country, which is placing consumers at the fore front of service delivery as well. The Committee is keen to see this tradition continue.

RECOMMENDATION 13: That consumers, carers and families are meaningfully engaged in all aspects of the Commission including decision-making forums and processes.

12. INITIAL PRIORITIES OF THE COMMISSION

The Committee has given consideration to potential priorities for the Commission based on current challenges and pressures, acknowledging that one of the first tasks for the Commissioner and Advisory Council will be the development of a 12 month workplan.

The Committee has seen evidence of significant investments in improving the mental health and alcohol and other drug program and services over the last 10 years[25]. The strategic frameworks to continue this work form a solid basis for future reform and investment.

[24] World Health Organization, *How can the human rights of people with mental disorders be promoted and protected?* (2006)

[25] *Queensland Plan for Mental Health 2007-17: Four Year Report* (October 2011) and *Queensland Drug Strategy 2006-2010 Mid-Point Implementation Report* (2008) and *End-Point Implementation Report* (2010)

RECOMMENDATION 14: That the initial priorities for the Commission be:

- overseeing the implementation of the *Queensland Plan for Mental Health 2007-17, Supporting Recovery: Mental Health Community Services Plan 2011-2017* and the *2011 and 2012 Queensland Drug Action Plan*;
- continuation and expansion of the innovative *Change Our Mind* stigma reduction campaign;
- development of strategic policy and planning to inform the next stage of alcohol and other drug programs and services on expiry of the *2011 and 2012 Queensland Drug Action Plan*;
- driving a cross-sector approach to the *National Partnership Agreement on Supporting National Mental Health Reform* and the *Ten Year Roadmap for Mental Health Reform*;
- undertaking the development of indicators, consistent with national reporting, for providing transparent measures of the performance of mental health clinical services; and
- developing an ongoing reform agenda, sensitive and responsive to emerging priorities and needs.

13. BIBLIOGRAPHY

1. Australian Institute of Health and Welfare (AIHW) 2011. *Alcohol and other drug treatment services in Australia 2009-10: findings from the National Minimum Data Set*. Cat. no. AUS 147. Canberra: AIHW http://www.aihw.gov.au/alcohol-and-other-drugs-publications/

2. Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing: Summary of results. Cat. no. 4326.0. ABS: Canberra; 2008. http://www.abs.gov.au/ausstats/abs@.nsf/mf/4326.0

3. Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez A .,*The burden of disease and injury in Australia 2003, Australian Institute of Health and Welfare* (25 May 2007). http://www.aihw.gov.au/publication-detail/?id=6442467990

4. Collins and Lapsley (2008), *The cost of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05,* National Drug Strategy Monograph Series, No 64; Canberra: Australian Government Department of Health and Ageing. http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/ mono64/$File/mono64.pdf

5. Commonwealth Government, *Delivering National Mental Health Reform Package* (May 2011). http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2011-hmedia02.htm.

6. Council of Australian Governments, National Health Reform Agreement (19 August 2011). http://www.coag.gov.au/

7. *Fourth National Mental Health Plan – An agenda for collaborative government action in 2009-2014.* www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-f-plan09.

8. *Making Tracks: toward closing the gap in health outcomes for Indigenous Queenslanders by 2033 Policy and Accountability Framework*: Queensland Government http://www.health.qld.gov.au/atsihealth/documents/makingtracks/making_tracks_pol.pdf

9. *Mental Health Act 2000* (Qld)

10. *Mental Health Commission Bill 2011* (NSW)

11. *The National Drug Strategy 2010-2015* http://www.nationaldrugstrategy.gov.au/internet/drugstrategy

12. 2011–2012 Queensland Drug Action Plan, Queensland Health, June 2011 http://www.health.qld.gov.au/atod/documents/qld-drug-action-plan.pdf.

13. *Queensland Drug Strategy 2006-2010 Mid-Point Implementation Report* (2008) http://www.health.qld.gov.au/atod/drug_info/drugactionplan.asp.

14. Queensland Drug Strategy 2006-2010 *End-Point Implementation Report* (2010) http://www.health.qld.gov.au/atod/drug_info/drugactionplan.asp.

15. *Queensland Plan for Mental Health 2007-2017* (June 2008) http://www.health.qld.gov.au/mentalhealth/abt_us/qpfmh/08132_qpfmh07.pdf

16. *Queensland Plan for Mental Health 2007-2017: Four Year Report* (October 2011) www.health.qld.gov.au/mentalhealth/abt_us/qpfmh/qpmh-2007-17.pdf

17. Queensland Premier Ministerial Media Statement – *Premier announces new independent Mental Health Commission* (11 October 2011). http://statements.cabinet.qld.gov.au/MMS/StatementDisplaySingle.aspx?id=77039

18. Queensland Premier Ministerial Media Statement –*Queensland Health we need a new beginning* (12 December 2011) http://statements.cabinet.qld.gov.au/MMS/StatementDisplaySingle.aspx?id=78121.

19. Queensland State Budget 2011-12 - Queensland Health and Department of Communities. www.budget.qld.gov.au.

20. *Supporting Recovery: Mental Health Community Services Plan 2011-17*, Queensland Government, Brisbane (October 2011). http://www.communities.qld.gov.au/resources/disability/support-services/our-services/mental-health/documents/mental-health-community-services-plan.pdf

21. Steering Committee for the Review of Government Service Provision 2011, *Report on Government Services 2011, Productivity Commission*, Canberra. (2008-09 data) http://www.pc.gov.au/gsp/reports/rogs/2011

22. Queensland Department of Communities, *Final Evaluation Report of the Queensland Government Housing and Support Program* (November 2010)

http://www.communities.qld.gov.au/resources/disability/support-services/our-services/mental-health/documents/hasp-final-evaluation.pdf

23. Queensland Health, *Queensland Mental Health Inpatient Snapshot Survey 2008 Report* (August 2009).

24. World Health Organization, *How can the human rights of people with mental disorders be promoted and protected?* (2006) http://www.who.int/features/qa/43/en/index.html.