Queensland
Mental Health
Commission

Annual Report

2014–2015

Queensland
Government

About this report

This annual report provides information about the Queensland Mental Health Commission's financial and non-financial performance for 2014–2015. It records the Commission's achievements in driving ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system.

The Commission's performance is measured against the objectives and targets in the *2014–2018 Strategic Framework* and the *Queensland Health 2014–2015 Service Delivery Statements*.

This report is a key accountability document and the principal way in which the Commission reports on its activities to Parliament and the Queensland community.

Electronic copies of this report are available at **www.qmhc.qld.gov.au** or printed copies of the report are available on request.

Feedback

We value the views of our readers and invite your feedback on this report. Please contact the Queensland Mental Health Commission on telephone **1300 855 945**, fax (07) 3405 9780 or via email at **info@qmhc.qld.gov.au**.

Translation

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

Licence

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Acknowledgement

We pay our respects to Aboriginal and Torres Strait Islander Elders, past and present, and acknowledge the important role of Aboriginal and Torres Strait Islander people, their culture and customs across Queensland.

We also acknowledge the people living with mental health and drug and alcohol problems, their families and carers. We can all contribute to a society that is inclusive and respectful, where everyone is treated with dignity and able to focus on wellness and recovery and have fulfilling lives.

Letter of compliance

Queensland
Mental Health
Commission

ABN 54 163 910 717

The Honourable Cameron Dick MP
Minister for Health and Minister for Ambulance Services
Parliament House
George Street
BRISBANE QLD 4000

7 September 2015

Dear Minister

I am pleased to present the Annual Report 2014–2015 and Financial Statements for the Queensland Mental Health Commission. The Commission was established as a statutory body by the *Queensland Mental Health Commission Act 2013* and has now completed its second year of operation.

I certify that this Annual Report complies with the:

- prescribed requirements of the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2009*,
- and detailed requirements set out in the Annual Reporting Requirements for Queensland Government agencies.

A checklist outlining the annual reporting requirements can be found at Appendix 4 of this report.

Yours sincerely

Dr Lesley van Schoubroeck
Mental Health Commissioner
Queensland Mental Health Commission

Queensland Government

Commissioner's message

In the second full year of the Commission's operation we have reaped the benefits of the establishment work in our foundation year and been able to focus all our energy on improving the mental health and wellbeing of Queenslanders.

In October 2014, after many months of listening to and working with people across Queensland, we published the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019* (Strategic Plan).

The Strategic Plan establishes a new vision for Queensland and sets a platform for innovation and reform for services supporting those experiencing mental health problems and issues relating to alcohol and drug use. It was the touchstone piece of work that has fulfilled one of our major legislative functions. It has also driven and directed the Commission's work program and major initiatives for the year and into the future.

Just as important as the products we deliver is our ability to proactively influence and motivate change across the spectrum of the mental health, drug and alcohol system, whether it is policy settings or service design and delivery, right through to how the community includes people with mental health, drug and alcohol problems.

To do this, we work to raise knowledge and awareness of what individuals, organisations and communities can do for themselves; build the evidence base and provide credible advice to government; use our resources to foster promising practice; and bring people together to share their experiences and develop solutions.

However, as a research and policy agency, we are conscious that influencing systemic change is a long-term prospect, particularly within a health sector that is itself dynamic and challenging. In this context, we carefully consider what initiatives can make a difference to what actually happens day to day. We are very aware that many good policy ideas over the years have not been implemented.

I am pleased to note that our credibility has risen from 68 per cent to 72 per cent on our annual survey and I encourage all interested people to respond to these surveys scheduled for early June each year.

Our agenda, like the interests of our stakeholders, is broad, ranging across matters as diverse as promoting mental health and wellbeing through to rights protection of people who are being treated involuntarily. This demands agility from our staff and stakeholders, but also appreciation that our work is structured to achieve across a wide spectrum of priorities, to a high standard. Our challenge is to ensure that all our stakeholders remain committed and engaged, even if their priorities are not immediately being addressed.

I thank the members of the Queensland Mental Health and Drug Advisory Council for their support and advice.

I pay tribute to the contribution of the staff of the Commission for their enthusiasm and dedication and their team work.

I am very grateful that the Commission has enjoyed the support of the current and previous Ministers for Health and of so many staff in government agencies, professional groups and the non-government sector. Without that support, we would not be able to effect change.

The contribution of individuals and their families with lived experience of suicide, mental health and drug and alcohol problems has been invaluable. Ultimately, we are working together to shape a better future for the many Queenslanders affected by mental health difficulties or issues related to substance use.

I look forward to continuing this journey together.

Dr Lesley van Schoubroeck
Queensland Mental Health Commissioner

About the Queensland Mental Health Commission

The Queensland Mental Health Commission (Commission) was established on 1 July 2013 by the *Queensland Mental Health Commission Act 2013* (the Act).

The Commission's work contributes to the Queensland Government's objectives for the community delivering quality frontline services, creating jobs and a diverse economy and building safe, caring and connected communities with a focus on mental health issues and drug and alcohol problems.

Role and functions

The Commission's role set out under the Act is to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health, drug and alcohol system in Queensland.

The Act also sets out the Commission's functions which include:

- Developing a whole-of-government mental health, drug and alcohol strategic plan, and facilitating and reporting on its implementation
- Monitoring, reviewing and reporting on issues affecting people living with mental health or substance misuse issues, their families, carers and support persons, and people who are vulnerable to, or otherwise at significant risk of, developing mental health or substance use issues
- Supporting and promoting mental health promotion, awareness and early intervention
- Supporting systemic governance including providing support to the Queensland Mental Health and Drug Advisory Council.

The Commission performs its role and functions by working with government and non-government agencies, consumers, families and carers throughout Queensland. The Commission's work extends beyond the health system and acknowledges the many needs and issues faced by those experiencing mental health difficulties and substance use problems.

The Commission's role does not include investigating individual complaints, planning or funding mental health, alcohol and other drug services. These responsibilities rest with other government agencies.

The Commission, based in Brisbane, comprises the Queensland Mental Health Commissioner and its staff. The Queensland Mental Health Commissioner makes recommendations to the Minister for Health.

Our vision

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

Our values

The public service values are fundamental to the Commission's work. These values are: customers first, ideas into action, unleash potential, be courageous, and empower people with the Commission adding an extra value of wellness, linking all that we undertake with our vision.

Our principles

The Commission's work is guided by a set of principles outlined in the Act:

- People with a mental illness or who misuse substances should:
  - Have access to quality mental health or substance misuse services, care and support, wherever they live
  - Be treated with respect and dignity
  - Be supported to participate fully in community life and lead meaningful lives
  - Have the same right to privacy as other members of society.
- Aboriginal and Torres Strait Islander people should be provided with treatment, care and support in a way that recognises and is consistent with Aboriginal tradition or Island custom and is culturally appropriate and respectful.
- Carers, family members and support persons for people with a mental illness or who misuse substances are:
  - Integral to wellbeing, treatment and recovery
  - Respected, valued and supported
  - Engaged, wherever possible, in treatment plans.
- An effective mental health and substance misuse system is the shared responsibility of the government and non-government sectors and requires:
  - A coordinated and integrated approach, across all areas of health, housing, employment, education, justice and policing
  - A commitment to communication and collaboration across public sector and publicly funded agencies, consumers and the community
  - Strategies that foster inclusive, safer and healthier families, workplaces and communities.

Objectives and performance

The Commission's *2014–2018 Strategic Framework* outlines the Commission's objective to achieve better outcomes for people with mental health issues or problematic substance use by:

- Reaching consensus on and making progress towards achieving system wide reforms
- Maximising the collective impact of the available lived experience and professional expertise.

The Commission's strategies for achieving this are arranged under four key result areas that align with its legislated role and functions:

- **Strategic planning –** The Commission is required to develop a whole-of-government strategic plan in consultation with consumers, families, carers, government and non-government stakeholders. The Commission's role is to facilitate, support and report on the implementation of the Strategic Plan.
- **Review, research and report –** Review, research and report are functions of the Commission that enable it to undertake work to inform decision-making or provide recommendations on review of existing activity value or in determining new initiatives.
- **Awareness and promotion –** The Commission has a key role in facilitating and promoting awareness, prevention and early intervention by supporting government and non-government stakeholders in undertaking effective action. Actions are linked to the Strategic Plan's Shared Commitments to Action.
- **Systemic governance –** The Commission is responsible for establishing statewide systemic governance mechanisms which support an approach that is collaborative, representative, transparent and accountable and operates in accordance with the Act.

The Commission's performance is measured against two indicators:

- The extent to which agreed commitments in the Strategic Plan are implemented
- Stakeholder satisfaction with the support and achievements of the Commission, particularly in relation to:
  - Opportunities to provide consumer, support person and provider perspectives on mental health and substance use issues
  - Extent to which consumer, support person and provider perspectives are represented in strategic directions articulated by the Commission to improve the system
  - The range of stakeholders involved in developing and implementing solutions.

In early 2014 the Commission engaged a third party to develop an effectiveness evaluation model. Now in place this model uses a suite of broad and targeted surveys, the responses from which are used to compare trends against a baseline survey. The results are also used to monitor annual performance against the performance indicators and provide focus for improvement. The evaluation will span three years and will inform an independent review of the Commission's performance as required under section 55 of the Act.

Non-financial performance

Overview

The Commission's second year of operation focused on finalising the Strategic Plan and working with consumers, families, carers, government and non-government stakeholders to identify areas of reform and implement actions to improve the mental health and wellbeing of Queenslanders and support those living with mental health difficulties and substance use problems.

The Commission also commenced surveying key stakeholders and members of the community about its effectiveness with a baseline survey and a mini-survey to assess its review, research and report function in 2014–2015.

The Commission's main achievements in 2014–2015 included:

- The finalisation and public release of the Strategic Plan
- The public release of the *Options for reform: Moving towards a more recovery-oriented, least restrictive approach in acute mental health wards including locked wards* report
- Working with consumers, families, carers and service providers to provide two submissions regarding new mental health legislation in Queensland
- The tabling of the Commission's first Ordinary Report, *Social housing: Systemic issues for tenants with complex needs*
- Providing $1.03 million to support 36 locally-led projects and training to improve mental health and wellbeing
- Commencing significant consultation and research to develop whole-of-government actions plans to support the Strategic Plan.

Key result area 1

Strategic planning

The Act requires the Commission to prepare a whole-of-government strategic plan. Once developed, the Commission is responsible for monitoring the plan's implementation and providing reports to the Minister for Health.

Activities undertaken under this key result area include the development of the Strategic Plan and Commission work to support initiatives which support its implementation. It does not include those initiatives which would fall under other Commission functions such as awareness and promotion and systemic governance.

Key actions

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

Following extensive consultation in 2013–2014, the Strategic Plan was publicly released on 9 October 2014 by the former Minister for Health, the Honourable Lawrence Springborg MP. Following the 2015 State Election, the Minister for Health and Minister for Ambulance Services, the Honourable Cameron Dick MP has asked the Queensland Mental Health Commissioner to continue its implementation.

The Strategic Plan sets a shared vision that Queensland is:

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

The Strategic Plan aims to improve the mental health and wellbeing of Queenslanders by working towards six long-term outcomes. Informed by the *National Targets and Indicators for Mental Health Reform* developed by the Council of Australian Governments' Expert Reference Group in 2013 and the *National Drug Strategy 2010–2015*, the six outcomes are:

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

To achieve its vision and outcomes the Strategic Plan sets a platform for innovation and continual improvement under four pillars of reform:

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

Eight Shared Commitments to Action are to be implemented under the Strategic Plan directed towards achieving these outcomes:

1. Engagement and leadership for individuals, families and carers
2. Awareness, prevention and early intervention
3. Targeted responses in priority areas, including suicide prevention; prevention and reduction of the adverse health and wellbeing impacts of alcohol and drugs; and the wellbeing of people living in rural and remote areas, Aboriginal and Torres Strait Islander peoples, people in contact with the criminal justice system and people with disability and other vulnerable groups
4. A responsive and sustainable community sector
5. Integrated and effective government responses
6. More integrated health service delivery
7. Mental health, drug and alcohol services plan
8. Indicators to measure progress towards improving mental health and wellbeing.

Implementation of the Shared Commitments to Action requires whole-of-government and community action. During 2014–2015 the Commission worked with government agencies to identify actions and implement innovative approaches to improve outcomes for people experiencing mental health difficulties and issues related to substance use. The Commission also commenced work to identify indicators to measure progress against achieving the Strategic Plan's outcomes.

This report provides an overview of work in which the Commission has been directly involved to support the Strategic Plan's implementation. A separate report on the whole-of-government implementation of the Strategic Plan will be published in December 2015.

Queensland Alcohol and other Drug Action Plan

In 2014–2015, the Commission worked with stakeholders from the non-government sector, researchers and government agencies to commence work on a Queensland Alcohol and other Drug Action Plan.

The Commission engaged the expertise of Siggins Miller consultants to undertake research and develop a discussion and position paper identifying directions for the Action Plan. As part of this process the Commission hosted a roundtable facilitated by Siggins Miller on 12 May 2015.

The Action Plan's development is being guided by a project reference group which comprises key stakeholders including the Queensland Network of Alcohol and other Drug Agencies (QNADA), Dovetail, Queensland Injectors Health Network, Queensland Indigenous Substance Use Council, Queensland Aboriginal and Torres Strait Islander Health Council, the Gold Coast Hospital and Health Service, the Queensland Police Service, the Public Safety Business Agency, the Department of Justice and Attorney-General and the Department of Communities, Child Safety and Disability Services. Mr Mitchell Giles is a member and represents the Queensland Mental Health and Drug Advisory Council.

The Action Plan will enable Queensland to better coordinate the wide range of services and initiatives that seek to minimise harm relating to alcohol and drug use and will complement the *National Drug Strategy 2010–2015*.

The Action Plan is due to be finalised in 2015–2016 following the public release of a discussion paper and consultations to be jointly led by QNADA and the Commission throughout Queensland with service users and service providers.

Key result area 1

Strategic planning

Rural and remote mental health and wellbeing

Work to support the mental health and wellbeing of people living in rural and remote Queensland has continued during 2014–2015. The Commission's work has focused on:

- Supporting Ministerial Roundtables in rural and remote communities in 2014
- Supporting the development of a community tool kit
- Commencing work to understand consumer experiences of telehealth services
- Commencing work to identify factors that support service integration and referrals.

This work will inform the development of a Rural and Remote Action Plan in 2016.

Ministerial Roundtables

The Commission worked with Queensland Health to support a series of roundtables convened by the then Minister for Health. The roundtables aimed to identify specific actions to support the mental health and wellbeing of rural and remote communities, particularly those facing drought. They were held in Charleville in March 2014, Mount Isa in September 2014 and Stanthorpe in December 2014.

The roundtables identified a number of priority issues including:

- The importance of local ownership
- Improved access to services including the use of telehealth
- Improved access to information about existing services
- Investigation into the barriers to service integration in rural and remote Queensland
- Attraction and retention of the mental health and alcohol and other drug workforce, especially clinical staff
- Suicide prevention.

Communiques summarising outcomes of the roundtables were published on the Commission's website.

Community tool kit and services directory

The Commission, in partnership with the Department of Communities, Child Safety and Disability Services and Queensland Health, funded the development of a community tool kit which was identified at the roundtables as an initiative which could support improved mental health and wellbeing. The community tool kit is being developed by North West Hospital and Health Service and Central Rural Health and seeks to support greater local design and control of services that are funded, especially short to medium term interventions such as those in response to drought.

Communities in Julia Creek, McKinlay, Springsure and Emerald have made a significant contribution to this work.

Following the roundtables, significant progress has been made by Queensland Health towards ensuring that information about mental health services in Queensland is included in the National Health Services Directory.

Consumer experiences of telehealth

Telehealth has the potential to overcome the geographic barriers to service access faced by those living in rural and remote communities. Queensland is leading the way in the use of telehealth nationally.

To ensure that those requiring mental health services in rural and remote Queensland have a good experience of their treatment, on advice from our consultant psychiatrist, the Commission commenced a project to explore consumer experiences of telehealth and telepsychiatry services. The Commission engaged Enlightened Consultants to undertake this work which involved interviewing consumers and mental health service providers in the Darling Downs Hospital and Health Service region. The project will inform the Commission's advice to Queensland Health and Hospital and Health Services in 2015–2016 regarding continuous improvement in consumer experiences of telehealth and telepsychiatry services.

Service integration and referrals

Service integration and client pathways between services can impact significantly on consumer experiences of services, the ability of services to support the holistic needs of consumers, and improved outcomes. This is particularly important in those parts of Queensland where accessing services can be challenging.

In 2014–2015 the Commission engaged CheckUp to map service integration and referral pathways in Queensland's three western Hospital and Health Service regions: North West, Central West and South West. This work not only focused on health services but also considered how other social services such as schools, housing, child protection, domestic violence and sport and recreation services referred clients to mental health and alcohol and drug services and how they worked together to support consumers.

The project involved surveying service providers in the three regions and holding face to face forums in communities including: Mount Isa, Longreach, Roma and Charleville. The project seeks to identify:

- Evidence of the extent of integration between services
- The supports and barriers for agencies in the use of inter-agency referrals
- Identify areas of good practice.

The report is due to be finalised later in 2015.

The criminal justice system

People living with mental health difficulties and alcohol and drug use problems are over-represented in the criminal justice system including as victims. The Strategic Plan commits to implementing actions to improve the wellbeing of people in contact with the criminal justice system with work due to formally commence in 2015–2016.

The Commission is supporting the *Police and Mental Health: improving outcomes at the interface project* that focuses on enhancing the understanding, evidence and development of models for service for the following areas:

- Mental health clinicians in police communications centres
- Mental health services support of siege negotiators
- Police interviews of people with a mental illness.

The Commission provided funding of $151,362 to the Queensland Forensic Mental Health Service to deliver this project during 2015–2016. The findings are intended to be used to drive continuous improvement across the three interrelated areas of activity.

Planning has commenced for a series of strategic conversations during 2015–2016 with relevant government agencies, peak bodies and consumers, families and carers focusing on:

- The interaction between police and people with a mental illness, or people who may be experiencing a mental health related crisis
- The intersection between police and mental health systems and services in the response to, and management of, people with a mental health related issue.

The outcomes from the strategic conversations will support work being undertaken by the Queensland Police Service to review its policies and procedures.

Disability and the National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) is one of the most significant reforms to be undertaken in disability services in decades. It has commenced across Australia with Queensland preparing to commence on 1 July 2016.

In response to requests from stakeholders, planning is underway to facilitate a discussion which aims to influence the way the NDIS is implemented in Queensland to ensure people living with mental illness are able to continue to access services and supports, even if they do not qualify for NDIS.

Key result area 1

Strategic planning

More integrated and effective government services

Integrated government service delivery is essential to supporting the holistic needs of those experiencing mental health difficulties and substance use problems. The Strategic Plan commits to more integration and effective government services to meet the complex and inter-related health and social needs of people living with mental health difficulties and problematic alcohol and drug use.

In 2014–2015 the Commission provided $50,000 to Aftercare to evaluate the West Moreton Adult Integrated Mental Health Services Model. The model aims to improve the coordination and integration of clinical and non-clinical community based services for people living with severe mental illness and complex needs. The evaluation will seek the views of consumers and their experiences of accessing services through the model.

Stronger Community Mental Health and Wellbeing Grants Program

Supporting community inclusion and connectedness and raising awareness about mental health and alcohol and drug issues can make a significant contribution to improving mental health and wellbeing.

To support locally-led projects and initiatives, the Commission provided grants to non-government and local government organisations under the Stronger Community Mental Health and Wellbeing Grants Program in 2014–2015.

In 2014–2015 the grants program comprised three initiatives with a combined budget of $1.03 million (shown right):

- Community Wellbeing Enhancement Initiative
- Community Awareness Initiative
- Capacity Building for Community Wellbeing Initiative.

The majority of activities funded under the Community Wellbeing Enhancement Initiative and Community Awareness Initiative are due for completion by 31 December 2015.

Two rounds for grants were funded this year using resources held over from the Commission's first year of operation pending the launch of the Strategic Plan.

The Commission will highlight the activities funded under these three initiatives as final reports and evaluations are completed. The Commission will also continue its grants funding program in 2015–2016, with a call for submissions in 2015.

Strategic planning effectiveness perceptions

Stakeholder survey results in May 2015 showed that:

- **Close to 50% of respondents had read the Strategic Plan and of these, close to 50% indicated that at least to a large extent it articulated a clear direction for addressing the needs of people with mental health and/or problematic substance use issues in Queensland**
- **The majority of survey respondents agreed that the Strategic Plan identifies priorities that are important to them**
- **Most respondents accepted that it would take 3–5+ years to observe the impact of the Strategic Plan.**

Community Wellbeing Enhancement Initiative

The Community Wellbeing Enhancement Initiative provided grants of up to $50,000 to facilitate the engagement of key community members in wellbeing enhancement activities. Sixteen initiatives were funded over two rounds at a total cost of $759,699. The initiative supports a diverse range of projects designed to meet local community needs, including the needs of people living in rural and remote areas and those who identify as culturally and linguistically diverse, gay, lesbian or transgender.

The Apunipima Cape York Health Council will use funding under this initiative to further develop local community leadership around social and emotional wellbeing in the communities of Mapoon, Aurukun, Kowanyama and Napranum through the roll out of the Family Wellbeing Program.

The initiative is also supporting the Toowoomba Clubhouse's Thrive program, linking clients with community companions to reduce social isolation and promote recovery from mental illness. The Ravenshoe Community Centre will use their funding under this initiative to support the recovery of their local community in the wake of an explosion of a local café in June 2015.

Community Awareness Initiative

The Community Awareness Initiative provided grants of up to $15,000 to improve community awareness and understanding of mental illness and substance use problems. Twenty grants were funded over two rounds at a total cost of $266,608. The initiative is funding the delivery of mental health first aid training across the state, including tailored programs for young people and Aboriginal and Torres Strait Islander peoples. The program is funding training in community settings, social services, workplaces and high schools.

Capacity Building for Community Wellbeing Initiative

The Capacity Building for Community Wellbeing Initiative grants were provided to support non-government organisations and local government staff and volunteers to attend 'Wheel of Wellbeing' training delivered by Tony Coggins from Maudsley International on 28 November 2014. The Commission provided $6,582 to support people from regional and rural Queensland to attend the training.

Training attendees have gone on to use this training to support their local communities. For example, the tools provided as part of this training have been used as a core feature of Aftercare's ongoing support to families and carers of people living with a mental illness in Brisbane.

Bundaberg Impact Community Services have also been using their Wheel of Wellbeing training to give community members tools to improve mental health and address stigma in the Bundaberg and Kingaroy regions. To date, 135 local frontline social services staff, businesses and community members have taken part in interactive education sessions held by Impact Community Services, with further sessions planned for the remainder of 2015.

Key result area 2

Review, research and report

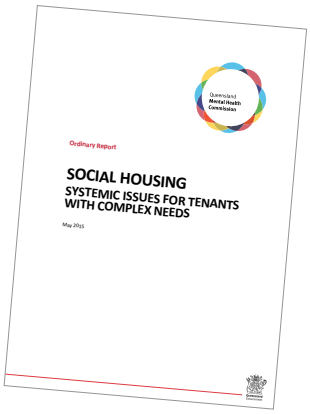
The review, research and report function includes promoting and facilitating knowledge sharing and undertaking or commissioning research regarding mental health and substance use issues. This includes preparing reports on issues which affect those living with mental health difficulties and substance use problems.

The Act enables the Commission to prepare an Ordinary Report which must be tabled in the Queensland Parliament and a Special Report requested by the Minister for Health. The Minister for Health has not requested a Special Report during 2014–2015.

The Commission has developed an Ordinary Report focusing on systemic issues faced by social housing clients with complex needs. The Commission has also prepared discussion papers and an Options for Reform paper on least restrictive recovery-oriented practice in acute mental health wards.

Key actions

Social Housing Ordinary Report



Social housing plays a vital role in providing safe and affordable housing for those who are experiencing mental illness, mental health difficulties and substance use problems (complex needs) in supporting their recovery and participation in the community and the economy.

In June 2015 the Commission delivered its first Ordinary Report, *Social housing: Systemic issues for tenants with complex needs*, to the Minister for Health. The report was prepared by the Commission under section 29 of the Act. It was tabled by the Minister for Health in the Queensland Parliament on 30 June 2015.

The report provides an evidence-based analysis of the social housing needs of people with complex needs, the impact of the Queensland Government's Anti-social Behaviour Management Policy (the ASB Policy) and highlights potential unintended consequences for tenants with mental illness, mental health difficulties or problematic substance use. It examines the impact of the ASB policy and acknowledges that tenants have a responsibility to comply with their tenancy obligations but some with complex needs require support.

The report is based on the *Review of systemic issues for social housing clients with complex needs* research report prepared by the Institute of Social Science Research (ISSR), The University of Queensland on behalf of the Commission. The ISSR research was informed by a policy and literature analysis and a case study analysis of 12 diverse social housing tenants living with mental health and problematic substance use issues who had received at least one strike under the provisions of the ASB Policy. Interviews were conducted with tenants, with their housing workers in the Department of Housing and Public Works, mental health or other support workers and family members. Additionally a review of individual tenancy files was conducted.

The report makes 12 recommendations regarding systemic issues associated with social housing and the ASB Policy and seeks to inform the community housing sector when managing social housing tenancies of people experiencing complex needs. The recommendations aim to work towards more sustainable social housing tenancies through better communication with tenants and more integrated service delivery, the provision of prevention, early intervention and rehabilitation supports and better monitoring of outcomes for social housing tenants who are subject to the ASB 'three strikes' policy.

Pursuant to section 29 of the Act, the Commission consulted the Queensland Mental Health and Drug Advisory Council and agencies that may be significantly affected by the report's recommendations (affected agencies): the Department of Housing and Public Works (DHPW), Queensland Health and the Department of Communities, Child Safety and Disability Services throughout the development of the report. Although not an 'affected agency', the Commission also consulted with the Department of Aboriginal and Torres Strait Islander Partnerships.

As required by the Act, the affected agencies responded to the report's recommendations. The DHPW, as the lead agency for all recommendations, advised that it either accepts or supports the recommendations. This includes two key initiatives: a Mental Health Demonstration Project and a review of social housing policies for fairness.

The Mental Health Demonstration Project will be implemented by DHPW in partnership with Queensland Health and in collaboration with a range of other government and non-government agencies. It involves testing a new integrated housing, health and social welfare support model to improve housing stability outcomes for people living in social housing who are experiencing mental illness or related complex issues.

The review of social housing for fairness initiative will involve reviewing the ASB Policy against a set of fairness principles with a focus on natural justice and will aim to ensure vulnerable social housing tenants are better able to sustain stable housing. As part of the review, it is proposed to withdraw the strike provisions and rename the policy. Queensland Health and the Department of Communities, Child Safety and Disability Services have indicated, as recommended in the report that they will be working with DHPW on these issues. A detailed outline of the DHPW's responses to the report's recommendations is at Appendix 1.

The Commission will monitor and report on actions by government agencies in response to its recommendations.

Key result area 2

Review, research and report

New mental health legislation

Contemporary mental health legislation which promotes recovery, supports least restrictive practices and protects human rights is the cornerstone of a modern and effective mental health system. In 2014–2015, the Commission played an important role in shaping new mental health legislation for Queensland through the 2014 Review of the *Mental Health Act 2000* and providing a submission on the *Mental Health Bill 2015* released by the Queensland Government for public consultation.

To support its work the Commission engaged Dr Penelope Weller, a Senior Lecturer from the Royal Melbourne Institute of Technology who specialises in human rights law, to provide advice on mental health legislation and to facilitate stakeholder forums. The forums sought the views of consumers, families and carers as well as service providers and provided information to support these groups making submissions to the Mental Health Act Review. In total over 150 stakeholders shared their views and experiences.

The Commission's submission to the Mental Health Act Review focused on a number of key issues including the need to:

- Enable consumers to appoint a person of their choice to assist them to express their views
- Ensure the proposed Patient Rights Advisers are and are perceived to be independent from authorised mental health services
- Enable families, carers and supporters to have access to information where appropriate
- Require reviews of involuntary treatment at appropriate intervals
- Reform the way people can be involuntarily examined.

In November 2014, the *Mental Health Bill 2014* was introduced in the Queensland Parliament. The Commission was pleased that many of its recommendations had been adopted, including a role for a nominated support person who, as a person chosen by consumers, will have access to information and will support consumers to express their wishes to treating teams. The Commission was also pleased to support significant changes in how members of the public may be involuntarily examined by replacing Justice Examination Orders with Mental Health Review Tribunal ordered examination authorities informed by clinical advice.

With the State election, the 2014 Bill lapsed and the new State Opposition introduced the Mental Health (Recovery) Bill 2015 as a private members bill into the State Parliament. This Bill has been referred to the Health and Ambulance Services Committee.

The State Government also publicly released a draft Mental Health Bill 2015 for consultation. The Commission has provided a submission on this draft Bill. The Commission's submission indicated it supported the Bill in-principle but noted a number of areas which required further consideration, including the need to ensure the Patient Rights Advisers are independent and are seen to be independent from Hospital and Health Services (HHS). The Commission's submission was informed by previous forums held by the Commission and the views of many members of the public, including consumers, families and their carers through its Facebook page.

The Commission looks forward to the introduction of new and more contemporary mental health legislation in Queensland. The Commission also acknowledges that how this legislation is implemented will determine whether it supports least restrictive practices and recovery.

A more recovery-oriented, least restrictive approach

In December 2014, the Commission published its Options for Reform report: *Moving towards a more recovery-oriented, least restrictive approach to acute mental health wards including locked wards*. It outlined 15 options for HHSs to consider implementing to promote recovery-oriented, least restrictive practices. The report was developed in the context of significant debate following a directive to lock publicly run acute mental health wards in response to concerns regarding the number of people being absent without permission. The report acknowledges that at times, and in certain circumstances, wards may need to be locked. However there is a need to continue to adopt a recovery-oriented, least restrictive approach when these decisions are made.

It focuses on ways a 'whole of ward' approach can be taken to support recovery and least restrictive practices.

Options for reform included:

- Supporting consumers in mental health wards to maintain supportive relationships with families, carers and friends and enhance peer support worker programs
- Reducing absences without leave by developing plans with consumers based on recovery-oriented practice and to address issues leading to their absence
- Reducing the custodial feel and features of wards and providing meaningful activities
- Taking steps to improve consumer safety on wards
- More ongoing training for ward staff in recovery-oriented practice
- Monitoring and reviewing the implementation of the options and outcomes of the decision to lock wards.

The options detailed in the report are based on a research review conducted by The University of Melbourne at the Commission's request, at a cost of $85,877. The options were subsequently refined through a series of five forums with mental health staff and consumers in Logan, Rockhampton and the Gold Coast, and in consultation with the Queensland Mental Health and Drug Advisory Council.

The report was provided to the former Minister for Health, the Director-General of the Department of Health and the Director of Mental Health in November 2014. The Director-General indicated that the reform options are generally consistent with Queensland Health's approach and will inform their ongoing commitment to provide least restrictive, recovery-oriented treatment and care for people with a mental illness.

The Options for Reform report informs the Commission's ongoing engagement with Queensland Health regarding the care of patients in acute mental health wards. The Commission presented the report to Queensland Health's Mental Health Alcohol and Other Drugs Branch Least Restrictive Practices Roundtable in June 2015.

The Options for Reform have also informed the Commission's submissions on new mental health legislation for Queensland.

The Commission will seek responses from all HHSs through Queensland Health on their implementation of the options in late 2015. In 2015–2016, the Commission will continue to highlight and promote best practice in mental health wards across Queensland through its networks and engagement channels.

Key result area 2

Review, research and report

Perinatal and infant mental health community views

In June 2014 the Commission published the *Perinatal and infant mental health service enhancement* discussion paper, which focused on the need to strengthen clinical perinatal and infant mental health services across Queensland.

The discussion paper proposed short, medium and long term initiatives to enhance the perinatal and infant mental health service system in Queensland.

The discussion paper was disseminated for public consultation between August and October 2014. One hundred and one responses were received from the public, almost 70 per cent reporting personal experience of perinatal and/or infant mental health difficulties. In November 2014 the Commission published the consultation results in the *Perinatal and infant mental health service enhancement: community views* report.

The consultation identified perceived gaps in the existing service system for perinatal and infant mental health in Queensland. Respondents provided practical solutions, grouped around three key themes:

- Earlier intervention
- Specialist treatment services
- System-wide capacity building.

Overall, the public consultation process endorsed the model for service enhancement proposed in the discussion paper, which includes:

- The development of specialist parent-infant facilities comparable to those in other states, as a high priority
- Community-based specialist services, including day programs, as the most cost-effective way to provide perinatal and infant mental health treatment close to home
- Resourcing the primary care and non-government sectors to play a major role in mental health promotion, prevention and early intervention across the state, including the use of peer workers
- Recognition of the need to coordinate cross-sectoral workforce development and other capacity-building.

The Commission wrote to Queensland Health regarding these findings and recommendations. Queensland Health advised that the report's findings will inform the Mental Health, Alcohol and Drug Services Plan to be prepared by Queensland Health in 2015 as a commitment under the Strategic Plan.

In addition the Commission will continue to promote the importance of incorporating mental health in general antenatal education and reaffirm the importance of perinatal and infant mental health as an element of broader mental health promotion and early intervention programs.

Review, research and report effectiveness perceptions

Stakeholder survey results in May 2015 showed that:

- Approximately 60% of respondents (5% increase from the baseline) agreed that the review, research and report activities undertaken by the Commission help to identify and respond to current and emerging issues and trends
- During 2014–2015 the Commission led or contributed to the development and release of new research and reports.
- The results of a targeted mini-survey (n=44) regarding this key result area conducted in March 2015 indicated:
  - The majority of respondents felt the Commission's activities were likely to benefit consumers of mental health services and their families and carers and lead to changes in service delivery practices and inform policy
  - Most respondents thought the initiatives provided a catalyst to increase collaboration amongst stakeholders, that the reports were credible and objective and that the initiatives increased awareness of the issues. However, fewer respondents felt positive that the findings of the initiatives had effectively reached their target audiences.

Key result area 3

Promotion and awareness

The Act requires the Commission to support and promote strategies that prevent mental illness and substance misuse and facilitate early intervention for mental illness and substance use problems.

The Commission is also required to support and promote social inclusion and recovery and promote community awareness and understanding about mental health and substance use issues, including reducing stigma and discrimination. Work in this area covered three broad areas in 2014–2015:

- Mental health awareness, prevention and early intervention
- Suicide prevention
- Aboriginal and Torres Strait Islander social and emotional wellbeing.

Mental health awareness, prevention and early intervention

In 2014–2015 the Commission undertook a number of activities that focused on the early years and school years through the Ed-LinQ Cross Sectoral Workforce Development Program, evaluating the Ed-LinQ Program, supporting a perinatal and infant mental health pilot project and providing funding to *beyondblue*. The Commission has also commenced development of a whole-of-government Mental Health Awareness, Prevention and Early Intervention Action Plan.

Ed-LinQ evaluation and cross-sectoral workforce development

The Queensland Ed-LinQ Initiative was established in 2007 to improve linkages and service integration between the education, primary care and mental health sectors for earlier detection and treatment of mental illness affecting school-aged children and young people.

Ed-LinQ Coordinators based in HHSs work across the mental health, education, primary care and community sectors by:

- Facilitating a strategic approach for collaboration and integration between the sectors
- Enabling improved access to mental health consultation, assessment, information and training opportunities.

The Commission supports Ed-LinQ by funding ($235,000) and coordinating the Ed-LinQ Cross Sectoral Workforce Program. This program involves the delivery of evidence-based professional development activities customised for and delivered jointly to key stakeholders in the mental health, education and primary care sectors.

During the year, 15 two-day cross-sectoral workforce development workshops were delivered across Queensland. This comprised:

- Three workshops on the topic of non-suicidal self injury in adolescents
- Five workshops on the topic of assessment and management of anxiety in children and young people
- Seven workshops on the topic of diversity: mental distress and wellbeing in three groups of young people (Aboriginal and Torres Strait Islander young people, same sex attracted young people and young people from culturally and linguistically diverse backgrounds).

Additionally, a new workshop topic was developed for piloting during 2015–2016, titled *Assessment and management of mood disorders in children and young people*. Qualitative data from workshop participants confirms a very high level of satisfaction with the training.

An evaluation has confirmed that the program increases the confidence, knowledge and skills of health and education personnel to identify emerging mental illness in children and young people. Strengthened capacity of the service systems to work collaboratively within and across agencies to improve referral systems, communication and outcomes has been demonstrated. Evaluation data from the Diversity workshop suggests it has assisted participants to provide culturally sensitive and appropriate services to Aboriginal and Torres Strait Islander, same sex attracted and culturally and linguistically diverse young people. This is a significant outcome, especially given that these groups of young people may not only experience elevated mental health risks but also face particular barriers to accessing social, emotional and mental health care and support services.

The future model for early intervention for school-aged children and young people will be developed during 2015–2016 and will be based on an independent evaluation of Ed-LinQ undertaken by ConNetica.

Since receiving the recommendations the Commission has worked with stakeholders from across the health, education and community sectors, including public and independent schools, to plan how to build on the achievements of the Ed-LinQ Initiative and address the areas identified for improvement. This included convening the *Integrating Early Intervention for Children and Young People Workshop* on 24 March 2015 in Brisbane. Around 60 health, education and community participants from across Queensland gathered to discuss effective approaches for schools and health services to work together to better understand, detect and intervene early in mental health problems and disorders affecting children and young people.

The Commission will continue to support the Ed-LinQ Workforce Program in 2015 and 2016 during which time a sustainable model for strengthening health and education sector workforce capability will be developed. The delivery of the program in rural and regional HHSs will also be prioritised during this period.

Perinatal Mental Health Awareness Project

The Commission has partnered with Women's Health Queensland Wide to develop a systemic approach to improving the mental health and wellbeing of expectant parents.

The project aims to increase the provision of mental health and mental illness information across all points of the public maternity services system from initial contact through to delivery and aftercare including antenatal classes.

The project also aims to embed actions to promote early access to clinical and non-clinical support and interventions. This includes enhanced linkages to peer-led antenatal support and community based services.

The Perinatal Mental Health Awareness Project will run concurrently with a second project funded by the Statewide Maternity and Neonatal Clinical Network. These two projects will work towards shared outcomes but will be separately governed and managed.

Key result area 3

Promotion and awareness

Supporting community awareness through beyondblue

To raise community awareness of mental health issues the Commission, on behalf of the Queensland Government, supported *beyondblue* with $645,000 in 2014–2015 as part of an ongoing annual commitment.

The Queensland Mental Health Commissioner is an observer on *beyondblue's* Board.

The funding provides Queensland with access to *beyondblue's* suite of activities aimed at:

- Reducing the impact of depression, anxiety and suicide by supporting people to protect their mental health and to recover when they are unwell
- Reducing people's experiences of stigma and discrimination
- Improving people's opportunities to get effective support and services at the right time.

beyondblue indicates that during 2014–2015 more Queenslanders were accessing their websites with over 900,000 visits, representing an increase of 33 per cent from previous years. This included increased visits to the youth *beyondblue* website with over 60,000 visits. There was also a substantial increase in Queenslanders visiting the Heads Up website (31,092 visits).

Queensland Mental Health Awareness, Prevention and Early Intervention Action Plan

The Strategic Plan commits to identifying and implementing actions to improve mental health and wellbeing by reducing the incidence, severity and duration of mental illness and mental health problems.

The Commission is leading the development of the whole-of-government Mental Health Awareness, Prevention and Early Intervention Action Plan that will contribute to:

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

The Commission engaged widely during 2014–2015 to inform the development of the Action Plan. This included a series of stakeholder forums lead by Gregor Henderson in April 2015, involving over 310 government, non-government and community representatives.

The Commission heard that to achieve better mental health and wellbeing, reduce the incidence and impact of mental illness, improve quality of life, and social and economic prosperity it is important to:

- Shift the focus from the 'burden' of mental illness to mental health and wellbeing, illness prevention and early intervention
- Build capacity and embed responsibility for mental wellbeing among individuals, families, schools, services, workplaces and communities
- Foster understanding of, and capability for, 'return to wellness' at every opportunity
- Direct attention to the necessity of addressing the social conditions and factors related to our daily living that foster and support mental health, as well as disrupt and erode it.

The consultations confirmed the solid foundations for mental health and wellbeing that exists in Queensland through a variety of government and non-government services, programs and initiatives. Many opportunities for strengthening and consolidating these services and initiatives were also identified.

A discussion paper to seek the views of government, non-government and community stakeholders on the final Mental Health Awareness, Prevention and Early Intervention Action Plan will be released in July 2015. The Action Plan is expected to be released in late 2015.

Mental Health Week

In April 2015 the Commission approved funding of $50,000 to support Open Minds in facilitating the planning, development and delivery of 2015 Queensland Mental Health Week (4–11 October 2015).

Queensland Mental Health Week is an ideal platform from which a number of the key Commission objectives can be supported. It provides a focused period for promoting ongoing reform in the sector, for improving awareness of mental health, drug and alcohol issues and provides opportunities to utilise sector networks to develop innovative ideas and consider best practice integrated approaches to mental health service delivery.

Suicide prevention

According to the Australian Institute for Suicide Research and Prevention (AISRAP), an estimated 627 people took their own lives in Queensland in 2014. For each suicide, an estimated 30 people have attempted suicide. The impact of these tragic events is immediate, far-reaching and long lasting. Research suggests that for each person who dies by suicide more than six people are directly impacted including families, work colleagues, friends, service providers and first responders.

During 2014–2015 the Commission continued a number of important initiatives, including funding for the Queensland Suicide Register and convening the Queensland Advisory Group on Suicide. The Commission funded and evaluated the HHS Suicide Risk Assessment and Management Project and supported research into farmer suicide. The Commission also commenced development of a whole-of-government Queensland Suicide Prevention Action Plan as part of a commitment in the Strategic Plan.

The Queensland Suicide Register

The Commission provided $275,000 to AISRAP to collect, analyse and report on suicide mortality data for the Queensland Suicide Register (QSR).

The QSR comprises data from suicides that have occurred in Queensland from 1990–2012 and contains a broad range of information regarding these types of deaths including the circumstances of the death, preceding life events and psychiatric history. AISRAP conducts ongoing research based on this data and compiles a tri-annual report on suicide mortality rates.

The QSR is an internationally recognised suicide mortality data collection system. However, there is a need for continued development to expand its capability and ensure greater alignment between differing research, policy and practice needs.

The Commission has been working with AISRAP to identify ways to improve the timeliness and accessibility of suicide mortality data and information, including opportunities for improving preliminary data through the interim Queensland Suicide Register (iQSR). The iQSR is based on information from the initial police report to the Coroner and contains data on suspected suicides that have occurred between 2011 and 2015.

Key result area 3

Promotion and awareness

Suicide Risk Assessment and Management Project

The Commission provided $997,500 to the Hospital and Health Service Suicide Risk Assessment and Management Project (HHS SRAMP) that aimed to enhance the quality and timeliness of suicide risk assessment and management of people presenting with suicidal behaviour in public health settings. During the year the HHS SRAMP operated in seven HHSs across Queensland, specifically Cairns and Hinterland, Central Queensland, Wide Bay, Sunshine Coast, Metro North, Metro South and Gold Coast. Responsibility for the project was transferred from Queensland Health when the Commission was established.

Established in 2010 this project aimed to build the capacity of systems and staff to:

- Better respond to suicidal behaviour
- Improve clinical access and treatment pathways
- Work with key stakeholders to enhance communication, coordination and service integration.

The Commission engaged the Australian Healthcare Associates in late 2014 to conduct an independent evaluation of the HHS SRAMP to measure the effectiveness of the project against its intended aims and objectives, to identify effective models and practice in the detection and management of suicide risk in public health settings and provide advice about potential future directions to improve the detection and management of suicide risk in public health settings.

Funding of $181,300 was provided for this evaluation, with the report due for release in 2015–2016.

Supporting research into farmer suicide

The Commission also supported innovative research projects including as an industry partner on the Australian Research Council (ARC) Linkage *Influences on farmer suicide in Queensland and New South Wales* project. According to AISRAP, in Australia farmer suicide rates have been found to be two times higher than the national average with a recent study finding that suicide rates of farmers in Queensland were 2.1 times higher than in New South Wales. This project aims to determine the individual and environmental risk factors related to suicide in farmers in Queensland and New South Wales. The research also aims to identify the current level of risk and protective factors associated with farmer suicide and attitudes towards suicide and help seeking in farming communities.

Suicide Prevention Action Plan

The Commission is leading development of a Queensland Suicide Prevention Action Plan as part of the implementation of the Strategic Plan.

To identify the Action Plan's priorities and directions the Commission hosted three Strategic Conversations in March and April 2015. The Commission also undertook targeted consultations, including with people who have a lived experience of suicide and broader public consultation through the release of a discussion paper in June 2015.

The Action Plan aims to reduce suicide and its impact on Queenslanders. Developed jointly with stakeholders, this goal extends to supporting those affected by suicide, including families, friends and supporters, service providers and first responders.

Four priority areas for action were identified as part of these consultations, specifically:

1. Stronger community awareness and capacity so that families, workplaces and communities are better equipped to support and respond to people at risk of suicide and those impacted by suicide
2. Improved service system responses and capacity to ensure people at risk, including those who have attempted suicide and service providers impacted by suicide, get the support they need, when and where they need it
3. Focused support for vulnerable groups to address the specific needs of those individuals and groups experiencing higher suicide rates
4. A stronger more accessible evidence base to drive continuous improvement in research, policy and practice.

The Action Plan is due for public release in September 2015.

World Suicide Prevention Day

In 2015 the Commission will be working towards a higher profile, greater awareness and engagement for World Suicide Prevention Day (10 September 2015). To assist with this the Commission is supporting Roses in the Ocean, an organisation of people affected by suicide.

Aboriginal and Torres Strait Islander social and emotional wellbeing

Mental illness is a leading cause of the burden of disease among Aboriginal and Torres Strait Islander peoples in Queensland. Suicide rates among Aboriginal and Torres Strait Islander peoples are 1.5 times greater than that experienced by non-Indigenous Queenslanders. It is particularly high for children and young people at 10 times the rate.

Research indicates that strategies to improve outcomes and close gaps between Indigenous and non-Indigenous mental health and wellbeing must be culturally capable and take a holistic view of life and health with a focus on the individual and also their family and community. The Commission has been working towards improving the social and emotional wellbeing of Aboriginal and Torres Strait Islander Queenslanders by providing support to the National Empowerment Project and identifying indicators to measure social and emotional wellbeing and supporting Indigenous leadership in this area.

Key result area 3

Promotion and awareness

National Empowerment Project

The National Empowerment Project (NEP) is an innovative Aboriginal and Torres Strait Islander led project working directly with communities to address their cultural, social and emotional wellbeing.

It is a national initiative conceptualised by the School of Indigenous Studies at The University of Western Australia. The work of the NEP is underpinned by the principles of human rights and social justice, community ownership and capacity building, resilience-focused, empowerment and partnership, and respect for local knowledge

The Commission supports the two Queensland NEP sites at Cherbourg and Kuranda run in partnership with those communities by Ngoonbi Cooperative Society. To December 2014 the Commission invested $511,000 for support services, community worker training and a healing program in each community.

Formative evaluation undertaken in 2015 indicates that the NEP is making a positive difference in the lives of individuals and families in Cherbourg and Kuranda. In March 2015 the Commission committed a further $160,000 to continuation of support for the NEP.

National Aboriginal and Torres Strait Islander leadership

The National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH) is a core group of senior Aboriginal and Torres Strait Islander people working in the areas of social and emotional wellbeing, mental health and suicide prevention. Most are based in, or associated with, national and state mental health commissions or other national mental health bodies.

NATSILMH's aim is to help restore, maintain and promote the social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander peoples by advocating and providing advice and leadership in these areas. It also aims to reduce the high rates of suicide among Aboriginal and Torres Strait Islander people.

The Commission is represented on NATSILMH and with other Australian mental health commissions provides funding support for its operation. In 2014–2015 the Commission provided $11,000 to support operation of NATSILMH and its work plan, including adaptation of the international Wharerata Declaration to the Australian Indigenous context.

The Wharerata Group of Indigenous mental health leaders from Canada, the United States, Australia, Samoa and New Zealand developed the Wharerata Declaration in 2010. The Declaration is about the importance of Indigenous leadership in addressing the common mental health challenges faced by Indigenous peoples around the world.

In April 2015 the Commission hosted, on behalf of NATSILMH, a consultation on the adaptation of the Declaration with ten Indigenous Queensland leaders and influencers from a variety of backgrounds. Summary feedback and the associated recommendations from the Queensland meeting were then sent to NATSILMH for consideration. Based on this and feedback from other jurisdictions, NATSILMH expect to launch the Gayaa Dhuwi (Proud Spirit) Declaration in August 2015.

Suicide prevention in Aboriginal and Torres Strait Islander communities

Developed at the direct request of the Queensland Mental Health and Drug Advisory Council in April 2015, this project examines the need for a 24 hour primary health care service and will recommend options to improve access to medical, acute mental health and social and emotional wellbeing services for Aboriginal and Torres Strait Islander young people in Townsville.

Respectful consultation with all partners and other stakeholders in Townsville is a critical aspect of this project and has been from the outset. The project will:

- Develop a clear understanding of the issues around access to services for young Indigenous people
- Identify the barriers and opportunities for preventing Indigenous youth suicide
- Make recommendations about options available for access to 24 hour primary health care services, if necessary, by Aboriginal and Torres Strait Islander young people in Townsville.

Measuring Aboriginal and Torres Strait Islander wellbeing

Social and emotional wellbeing is a complex issue and is impacted by a broad range of factors. In 2014–2015 the Commission contracted Edward Tilton Consulting to undertake a project to identify appropriate indicators to measure Aboriginal and Torres Strait islander social and emotional wellbeing. The project was an initiative following a recommendation of the Queensland Mental Health and Drug Advisory Council's Aboriginal and Torres Strait Islander Committee. The Commission has allocated $53,000 for this project.

To help guide the project, the Commission has established a steering group that includes members of the Aboriginal and Torres Strait Islander Committee and other key partners.

The project commenced in June 2015 and is due to conclude with provision of a framework and report in 2015–2016.

National Close the Gap Day

On National Close the Gap Day the Commission partnered with Gallang Place Aboriginal and Torres Strait Islander Corporation to hold a media event at the offices of Gallang Place in Cannon Hill. A member of the Queensland Mental Health and Drug Advisory Council, Professor Gracelyn Smallwood; Mr Charles Passi, Board Chair of the Healing Foundation; and Mrs Noeleen Lopes, Chief Executive of Gallang Place, presented to an audience of stakeholders and alongside varied media representatives. The Queensland Mental Health Commissioner announced Commission grants made to recipients undertaking work with Aboriginal and Torres Strait Islander peoples around the state, including the Healing Centre (ATSICHS) and Apunipima Cape York Health Council.

Awareness and promotion effectiveness perceptions

Stakeholder survey results in May 2015 showed that:

- Stakeholder perception has improved in the last year with 56% of respondents (11% increase from the baseline) agreeing that the promotion and awareness work undertaken is increasing community awareness and decreasing stigma and discrimination.

This key result area will be subject to a mini-survey in 2015–2016.

Key result area 4

Systemic governance

Queensland Mental Health and Drug Advisory Council

The Queensland Mental Health and Drug Advisory Council (Council) was established by the Act on 1 July 2013. Its functions outlined in the Act are to:

- Provide advice to the Commission on mental health or substance misuse issues, either on its own initiative or at the Commission's request
- Make recommendations to the Commission regarding the Commission's functions.

During 2014–2015 the Council held six meetings. Table 1 provides an overview of Council members and attendance at these meetings.

Council members act as a champion for people living with mental health issues and/or substance use issues, including their families, carers and support people.

The membership of the Council reflects the diversity of the Queensland community stakeholders and is chaired by Professor Harvey Whiteford. The Council currently has 10 members including the Chair and Deputy Chair.

During 2014–2015 the Council farewelled three outgoing members: Ms Ailsa Rayner, Dr Christian Rowan and Mr Ben Tune, who resigned for personal reasons. The Commission thanks the outgoing members for their valuable contributions to the work of the Commission.

Recruitment of new members of the Council is planned to commence in late 2015.

Table 1 – Council members and meeting attendance

Council member	Date of term expiry	Meetings eligible to attend	Meetings attended
Prof Harvey Whiteford (Chair)	25 September 2016	6	5
Ms Jan Kealton (Deputy Chair)	23 February 2017	6	6
Mr Kingsley Bedwell	23 February 2017	6	6
Ms Amelia Callaghan	23 February 2016	6	5
Mr Mitchell Giles	23 February 2017	6	5
Prof Brenda Happell	23 February 2016	6	5
Ms Ailsa Rayner	Resigned	5	4
Mr Etienne Roux	23 February 2017	6	5
Dr Christian Rowan	Resigned	2	1
Prof Gracelyn Smallwood	23 February 2016	6	5
Ms Debbie Spink	23 February 2016	6	6
Mr Luke Terry	23 February 2016	6	6
Mr Ben Tune	Resigned	4	1

Council remuneration

Council remuneration payments are based on the *Remuneration Procedures for part-time Chairs and Members of Queensland Government Bodies* E2 category.

The Council chair and members are remunerated for their attendance at meetings. The remuneration rate for the Council chair to attend a full day meeting (more than four hours in duration) is $392 and $196 for a meeting of four hours or less in duration. The remuneration rate for Council members to attend a full day meeting is $314 and $157 for a meeting of four hours or less in duration.

Council meetings and special assignments

Support was provided to the six Council meetings in 2014–2015 and to a special joint teleconference with the Western Australia Mental Health Advisory Council held in June 2015. Regular meetings of the Chair, Deputy Chair and Queensland Mental Health Commissioner were also held.

The Council did not make any formal recommendations to the Commission during 2014–2015.

The Council, however, requested that the Commission undertake a number of actions including:

- Addressing a number of specific issues in its submission on the Mental Health Act Review
- Consider how it might review the extent that the options for reform in the *Moving towards a more recovery-oriented least restrictive approach in acute mental health wards including locked wards* report are implemented by Queensland Health
- Continue discussions with Queensland Health to explore opportunities to support consumers leaving inpatient facilities to maintain their commitment to cease smoking
- Prioritise research to identify and collate the benefits of consumer and carer input into service planning and delivery in its 2015–2016 Operational Plan
- Promote support for the principles of the Wharerata Declaration at all levels of policy, planning and service delivery relevant to Aboriginal and Torres Strait Islander peoples and establish a mechanism for Aboriginal and Torres Strait Islander input at the highest level of policy.

The Commission has progressed all requests made by the Council (see Appendix 2).

Council Committees

In 2014–2015 the Council established two committees: the Consumer, Family and Carer Committee (CFC Committee) and the Aboriginal and Torres Strait Islander Committee. The Commission provided secretariat support to each Committee.

The CFC Committee was chaired by Ms Jan Kealton and comprised consumers and service providers. Its work program informed the Commission's work in consumer, family and carer engagement and leadership.

The Aboriginal and Torres Strait Islander Committee was chaired by Professor Gracelyn Smallwood. Its main role was to provide advice to the Council on practical changes to improve the lives of Aboriginal and Torres Strait Islander consumers, carers, families and communities of Queensland. Its request regarding the need for social and emotional wellbeing indicators is being implemented by the Commission.

The Terms of Reference for both Committees expired on 30 June 2015 and the Council has agreed that the Committees will meet as and when required. Committee members continue to be engaged in the Commission's work and on steering committees for specific projects.

Report from the Queensland Mental Health and Drug Advisory Council

The role of the Council is to provide advice to the Commission that will help improve the mental health and wellbeing of all Queenslanders and minimise the impact of substance misuse in our communities. The Council met on six occasions in 2014–2015 and the communiqué released after each meeting is available on the Commission website.

Five important pieces of work in 2014–2015 included the Council's input into the *Queensland Mental Health Drug and Alcohol Strategic Plan 2014–2019* which was launched in October 2014; the Commission's response to the draft Mental Health Bill released in May 2015; the Ordinary Report *Social housing: Systemic issues for tenants with complex needs* tabled in Parliament on 30 June; the development of the Alcohol and Other Drug Action Plan and the Consumer Involvement in Mental Health Nursing Education Issues Paper and Roundtable.

In the 2015 calendar year the Council is focussing on four priority areas: improving outcomes for people with alcohol and other drug problems; Aboriginal and Torres Strait Islander social and emotional wellbeing, improving partnerships with areas such as employment and criminal justice; and promoting awareness and early intervention. At the time of this report, the first two of these have been addressed by Council.

In the alcohol and other drug area, the Council worked with the Commission to facilitate delivery of an expert roundtable as a precursor to a final position paper in 2015–2016 on preventing and reducing the adverse impact of alcohol and other drugs being prepared for public consideration.

With respect to Aboriginal and Torres Strait Islander issues, the Council requested the Commission adopt the principles of the Wharerata Declaration at all levels of policy, planning and service delivery as relevant to Aboriginal and Torres Strait Islander peoples, promote the establishment of a mechanism for Indigenous input at the highest level of health and social services policy, planning and service delivery and seek that urgent attention be given to addressing the rates of suicide and attempted suicide in Indigenous populations.

The Council also responded to numerous emergent issues during the year. In response to the shootings of six individuals with mental illness by police in 2014, the Council strongly supported the Commission's engagement with the Commissioner for Police and senior officers of the Department of Health in establishing an independent review of the shootings, incorporating the views of a wider group of stakeholders, including families.

At the request of Council, the Commissioner raised with the Director General, Department of Health, the need to ensure funding for community-managed mental health services not be adversely impacted by the roll out of the National Disability Insurance Scheme.

The Council responded to the need to reduce restrictive practices in acute inpatient units, the mental health issues facing Indigenous populations and the need for increased input from consumers and families in the activities of the Commission. Council members were involved in a range of community activities, such as the CEO Sleepout to raise awareness of homelessness, and the planning of Mental Health Week activities.

The Council has also considered feedback on its role, received directly by members and also as part of the independent evaluation of the Commission's functions. In response the Council will renew its efforts to address strategic priority areas, especially those affecting regional and remote Queensland. In 2016, Council members will meet at least once outside south-east Queensland, to engage with consumers, carers, health professionals and members of the community, to better understand and promote action on the mental health, drug and alcohol issues most relevant to regional and remote Queenslanders.

I wish to thank all Council members for their commitment to the work of the Commission. A special thanks to Jan Kealton who chaired Council meetings in my absence and also to Ailsa Rayner, Christian Rowan and Ben Tune for whom a change in personal circumstances led to their stepping down from the Council. On behalf of the Council, I would like to thank the Queensland Mental Health Commissioner, Dr Lesley van Schoubroeck, the Council secretariat Mandy Beaumont and all the Commission staff for their support of the Council. We look forward to continuing to support the work of the Commission and improving the mental health and wellbeing of Queenslanders.

Prof Harvey Whiteford
Chair, Queensland Mental Health and Drug Advisory Council

Consistent with the Act (s51c) the Council has requested that an overview of its performance is included in this Annual Report.

Consumers, families and carers

The engagement of mental health consumers and alcohol and drug service users, their families, carers and support people is essential to effective mental health and drug and alcohol service planning and delivery. The Commission is committed to working in partnership with people with a lived experience of mental illness, suicide or problematic substance use to influence change and drive ongoing reform. This includes promoting and facilitating the active engagement and contribution of individuals, families and carers across all levels of policy, legislation, planning and program design, service delivery and evaluation.

In 2014–2015 the Commission, as part of a commitment under the Strategic Plan, commenced a number of projects focused on enhancing consumer, family and carer engagement and leadership including:

- Mapping engagement
- Developing best practice principles
- Consumer involvement in nurse education.

Mapping engagement and leadership

This project was identified by the CFC Committee as important to understanding the breadth and depth of consumer, family and carer engagement and leadership in Queensland's mental health and alcohol and other drug service system.

The Mapping of Engagement Project will build a comprehensive understanding of the current state of service user, consumer, family and carer engagement in Queensland through a statewide survey of private, public and non-government services providers.

The project will help set priorities for reform and be a baseline against which changes in engagement can be measured in the future. The project is being delivered in conjunction with the social consulting research firm Urbis at a cost of $104,700. A total of $68,050 was spent in 2014–2015 on the development of the survey tool. It is anticipated that the project will be completed late 2015.

Key result area 4

Systemic governance

Best practice principles

In 2014–2015 the Commission engaged Queensland Alliance for Mental Health to develop best practice principles for consumer, family and carer engagement across the mental health and alcohol and other drugs service sectors.

The Best Practice Principles Project will develop and document a comprehensive understanding of best practice principles for including service users, consumers, families and carers in service development, service delivery, evaluation and governance processes. It will help develop workable solutions for improving engagement across the mental health and alcohol and other drug sectors. The project will be consumer-led and will involve consultation with service users, families and carers.

The Commission has allocated $188,674 for this project with draft best practice principles to be finalised by mid-2016.

The National Mental Health Consumer and Carer Forum

The Commission has continued to support Queensland's representation on the National Mental Health Consumer and Carer Forum, at a cost $21,400 in 2014–2015.

Queensland is represented by Mr Noel Muller (consumer representative appointed in 2007) and Mr Peter Dillon (carer representative appointed in 2014).

The forum is auspiced by Mental Health Australia and provides a mechanism for mental health consumers and carers to influence mental health policy and service reform, particularly at the national level. The National Mental Health Consumer and Carer Forum meet in person twice a year, supplemented by regular teleconferences. In addition to financial support, the Commission offers assistance to Queensland's representatives in the form of information sharing activities. It is anticipated that state representatives liaise with other relevant Queenslanders.

Nurse education and training

In 2014–2015, the Commission engaged Professor Brenda Happell to develop an issues paper to highlight the importance and value of consumer involvement in the education of mental health nurses. A roundtable, hosted by the Commission and facilitated by Professor Happell, was held to identify ways to increase the participation of consumers in the design and delivery of mental health nursing education and training. The Commission allocated $20,000 to this project. A summary of the roundtable is available on the Commission website.

The Commission is liaising with Professor Happell, Dr Louise Byrne and the Australian College of Mental Health Nurses to consider how to further promote consumer participation in the education and training of the mental health workforce. Nurses play a major role in the provision of mental health care and have significant potential to influence change toward more recovery-oriented models of care.

Consumers, families and carers effectiveness perceptions

Stakeholder survey results in May 2015 showed that:

- **Similar to 2013–2014 survey results, 60% of respondents agree the Commission is utilising the views of people with lived experience, their families, carers and support people to inform planning and decision-making. A stronger focus will be made in 2015–2016 with the engagement of a consultant with lived experience.**

Partnerships

Consultation, engagement and development of formal and informal partnerships are essential to the success of the Commission. The Commission has sought to work collaboratively across the sector with both government and non-government organisations in all the work it has undertaken.

In February 2014, the Commission convened a meeting of all Mental Health Commissions in Australia, and also invited South Australia in recognition of the Government's commitment to establishing a commission there in the coming year. Participants issued a communiqué affirming ongoing collaboration and highlighting issues of common concern. A formal Memorandum of Understanding exists between commissions.

Partnerships with Queensland Health were maintained through regular meetings with the Deputy Director-General, the Director of Mental Health and the Chief Psychiatrist. The Queensland Mental Health Commissioner met with the Chair of the Hospital and Health Board Chairs' Forum a number of times. The Townsville Hospital and Health Service Chief Executive was allocated the mental health portfolio on behalf of the Health Service Chief Executives' Forum and the key point of liaison for the Commission. The Commission has also worked in partnership with three Clinical Networks: the Mental Health, Alcohol and Other Drugs Network, the Maternity and Neonatal Network, and through the Chair of the Statewide Rural and Remote Clinical Network.

Queensland Voice for Mental Health, Queensland Alliance for Mental Health, the Queensland Network of Alcohol and other Drug Agencies and the Queensland Aboriginal and Islander Health Council are key partners of the Commission on systemic issues.

Throughout the year the Commission also worked to strengthen its partnerships with government departments on specific projects referred to elsewhere in this report.

Partnership and collaborative effectiveness perceptions

Stakeholder survey results in May 2015 showed that:

- **The proportion of respondents agreeing that the Commission is improving collaboration across sectors rose from 42% to 49%, with 29% still unable to comment. The largest improvements observed were for the sectors of health (16%) and employment (13%).**

Key result area 4

Systemic governance

Communications

The Queensland Mental Health Commissioner has the lead role in representing the Commission and communicating with its stakeholders. Appendix 3 provides a summary of major forums and events the Commissioner participated in during 2014–2015.

The Commission has undertaken a program of continuous improvement to its communication and engagement function by implementing new tools such as Facebook, and extending the quality and use of existing tools such as the website, QMHC eNews and Twitter.

As part of the ongoing development of the communication capacity, and in response to the annual effectiveness survey, the Commission has focused on making its existing communication channels more relevant, engaging and audience-centric, extending audience reach and delivering a consistent, in-depth narrative about its work and issues relevant to consumers, clients, family, carers and supporters, and the mental health and drug sector.

The Commission's written reports are continually reviewed to increase their relevance and readability for both professional and lay audiences.

eNews

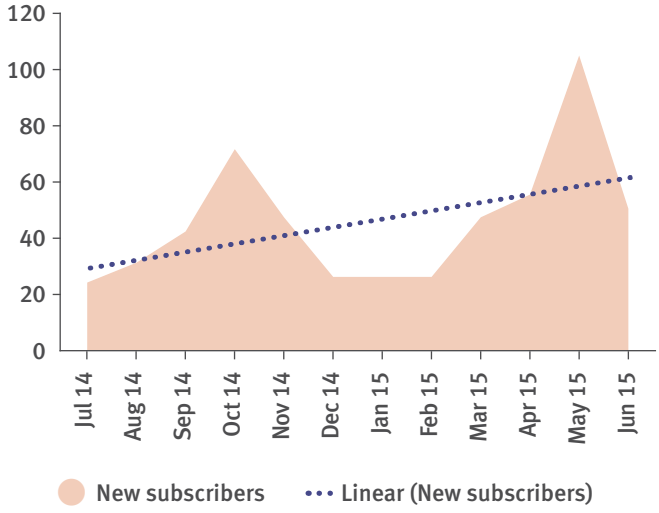
QMHC eNews is one of the Commission's principal communication tools.

At 30 June 2015 the Commission had 1,347 active eNews subscribers, achieving a total of 549 new subscribers in the period. This resulted in a net increase of 458 subscribers after taking into account unsubscribes (27) and bounces from out of date email addresses.

Ten issues of eNews were distributed during the year. The best readership was achieved for Issue 18 in May 2015, tipping over 55 per cent open rate, with the average open rate across all editions sitting over 46 per cent. This compares to an average open rate for government/defence of 47 per cent and 38 per cent for all industry categories (Vision 6, Email Marketing Metrics Report for Australia (February–July 2015).

"Just wanting to commend you on the great work compiling the eNews... is one of only a few newsletters that I have read cover to cover! It is fantastic, I have opened 10 links to read more, it is an insightful newsletter and is certainly helping to share the great work that is being done in mental health across Queensland."

Figure 1 – New eNews subscribers



Website

The Commission's other fundamental communication tool, its website, has been undergoing gradual refinement throughout 2014–2015, including upgrading content, focusing on improved engagement, clickability and visual amenity, with a significant overhaul to be completed in 2015–2016. Website metrics show over 100 per cent increase in sessions and visitors over 2013–2014, with 29,700 sessions and 18,800 visitors respectively. Page views increased by 14 per cent to 81,700.

Mainstream media

The Commission recognises the media as a key partner in the process of communicating the work of the Commission, sparking awareness, promoting prevention and conversations around topics that reach at the heart of our communities. In 2014–2015 the Commission increased its media engagement and number of media releases issued, and correspondingly increased the exposure of mental health issues to the general community.

Social media

Twitter

Further effort has been made to expand the Commission's Twitter presence by developing full campaigns on key topics and delivering more engaging content through imagery and graphics.

The Commission's Twitter account was established on 1 May 2014, and as at 30 June 2014 the Commission had tweeted 79 times and had 69 followers. As at 30 June 2015, the Commission's twitter following had grown to 292 with 52,500 impressions (number of times users saw the tweet). This activity generated 5,642 visits to the Commission's profile, 113 mentions and 223 new followers – notably after a number of concentrated campaigns in the final quarter of the year.

The Queensland Mental Health Commissioner also commenced her own Twitter account on 11 May 2015, achieving 95 followers by the end of June, 128 tweets, 2369 profile visits and 28,145 impressions.

Facebook

The Commission's Facebook page was launched on 11 May 2015 as a means to expand consultation and engagement, particularly with consumers, service users, families, carers and supporters, and mental health workers. As at 30 June 2015 the Commission Facebook page had 442 page likes and achieved an organic reach of 5,875 and 6,807 impressions (or views) of its posts.

The Commission's initial Facebook campaign focused on the exposure (consultation) draft Mental Health Bill 2015 generating reach and feedback to contribute to the Commission's submission on the Bill to Queensland Health.

The Commission's use of Facebook as a discussion and consultation tool is still in its infancy, but holds great potential to broaden the conversation around the issues that matter most to the Commission's constituency. It has added a valuable new tool to the Commission's communications and a means to reach audiences beyond those with a specific interest in mental health, alcohol and drugs.

Emerging issues

The Commission's work to drive reform continues in a changing policy and service delivery environment. Many of the issues identified in 2014–2015 continue into 2015–2016, and will influence the Commission's reform agenda.

These include:

- New mental health legislation in Queensland with the anticipated introduction of the Mental Health Bill 2015 and debate of legislative reforms due in the Queensland Parliament in 2015–2016
- Continued preparation for the roll out of the NDIS due to commence on 1 July 2016.

National programs and services play a significant role in improving the mental health and wellbeing of Queenslanders including preventing suicide. In 2014 the National Mental Health Commission publicly released its *National Review of Mental Health Services and Programmes 2014* (the National Review). The National Review made 25 recommendations which called for increased focus on awareness, prevention and early intervention and better service coordination. Its recommendations included that the Australian Government develop, agree and implement a *National Mental Health and Suicide Prevention Plan* with States and Territories, in collaboration with people with lived experience, their families and support people.

The Australian Government's response may lead to significant reforms in the mental health sector and in suicide prevention.

The *National Drug Strategy 2010–2015* is also currently under review with a new strategy based largely on current directions expected to be released later in 2015.

An independent review of the performance of the Commission's functions is to be undertaken within three years of the Act's commencement (s55). A review of the effectiveness of the Act will also be undertaken as soon as practicable after three years of the Act's commencement (s56).

Financial performance

Overview

Revenue

The Commission's second year operating budget was $8.504 million, administered as a grant through the health portfolio. This included $1.2 million in funding deferred from the previous financial year. The remaining sources of income resulted from a cash at bank position for the previous year result, a small amount of interest payable against cash at bank and small contributions of funding from other agencies towards specific initiatives.

Expenditure

Employee expenses relate directly to maintaining a full time equivalent (FTE) staffing of 15.

Of the $2.12 million expended in general supplies and services, approximately $1.04 million was expended on consultancy and contractor activities (Table 3 and 4) which informed and supported the Commission's key result areas. A further $227,000 was expended for corporate services support provided to the Commission by an outsourced third party and $420,000 was expended on accommodation costs.

The Commission's grant expenses relate to existing grant commitments originally novated from the Department of Health $2.14 million on establishment of the Commission, a Stronger Communities Grants program of $1.03 million, and the remainder $560,000 relating to activity that supports key result areas.

Financial performance

Cash at bank

The cash at bank at the end of the financial year was $1.63 million, reflecting approximately 16.5 per cent of the total revenue for the year. Approximately one third of this relates to outstanding 2014–2015 contract commitments. Much of the remainder is already committed or allocated to key result area work to be undertaken during 2015–2016.

With a full staffing complement and business processes now in place, it is anticipated the full budget will be acquitted in 2015–2016.

A summary of the Commission's financial performance for the year is shown in Table 2.

Table 2 – Commission financial performance summary

Revenue	$,000
Cash at bank	664
Grants	8604
Interest	164
GST collected from customers	(1)
GST Input tax	446
Total Revenue	**9877**
Expenditure	**$,000**
Employee expenses	1955
Supplies and services	2116
Grants	3703
GST paid	472
GST Remitted	(1)
Total Expenditure	**8245**
Operating result	**1632**

Consultancies

As a small policy organisation the Commission often engages external third party subject matter experts to provide advice, research and prepare reports. This practice both enhances the credibility of the result and increases opportunity for sectoral collaboration.

Table 3 lists the key consultancies (over $20,000) engaged during 2014–2015. The consultancies where some deliverables, and consequently expenditure, will not be finalised until next financial year show a carry forward for 2015–2016. Also included are consultancies that commenced in 2013–2014 however delivered the majority of work in 2014–2015.

Table 3 – Key consultancies engaged during 2014–2015

Description	Organisation	Total Value	Acquitted 13/14	Acquitted FY 14/15	Committed FY 15/16
Ed-LinQ Evaluation	ConNetica Consulting	**$103,600**	$54,360	$49,240	–
Mental Health Act Review	RMIT University	**$33,868**	$8,250	$24,750	–
Review of systematic issues for social housing clients with complex needs	The University of Queensland	**$114,811**	$28,703	$86,108	–
Review of restrictive practices	The University of Melbourne	**$85,877**	–	$85,877	–
Commission effectiveness – Paxton Partners	Paxton Partners	**$398,215**	$90,566	$149,450	$158,199
Evaluation of the Suicide Risk Assessment and Management Project	Australian Health Care Associates	**$181,373**	–	$137,572	$43,801
Consumer consultations relating to the use of Telehealth/Telepsychiatry services	Enlightened Consultants	**$41,051**	–	$10,263	$30,788
Service integration and referral mapping analysis for mental health, alcohol and other drugs	CheckUP	**$50,000**	–	$25,000	$25,000
Identify actions to inform the development of a statewide alcohol and other drug action plan	Siggins Miller Consultants	**$79,604**	–	$79,604	–
Undertake a comprehensive state-wide survey of consumer, family and carer engagement	Urbis Pty Ltd	**$104,694**	–	$68,051	$36,643
Aboriginal and Torres Strait Islander social and emotional wellbeing, mental health, alcohol and other drugs services – indicators	Edward Tilton Consulting	**$48,336**	–	$12,084	$36,252
Development of best practice principles for consumer, family and carer engagement	Queensland Alliance for Mental Health	**$171,522**	–	$42,881	$128,642
Design a strengths based, community model for suicide prevention	KBC Australia	**$97,130**	–	–	$97,130
Alcohol and other drug action planning front line service providers, service users, their families and support persons consultation	Queensland Network of Alcohol and Other Drug Agencies Ltd (QNADA)	**$38,250**	–	$11,475	$26,775

Contractors

Table 4 lists key contractors (over $20,000) who were engaged during the reporting period to assist and/or provide subject expert advice where specific expertise was considered essential.

Table 4 – Key contractors engaged during 2014–2015

Contractor's name	Description of work	Value	Comment
Thirteen Digital	Commission web maintenance and development	$26,100	–
Emma Sutton	Communications Officer	$36,400	Has since become a public service position
Associate Professor Jagmohan Singh Gilhotra	Consultant Psychiatrist	$183,315	Continues and now replaced by Associate Professor Neeraj Singh Gill
McArthur Recruitment	Rural and Remote Contractor	$31,704	Has since become a public service position with a broader focus
KG Medical Pty Ltd	Consultant Psychiatrist	$26,440	Associate Professor Neeraj Singh Gill
The Prism Partnership Pty Ltd	Provision of professional media services	$31,284	–

Overseas travel

There has been no staff overseas travel undertaken during 2014–2015.

Agency governance

Overview

The Commission is a statutory body within the health portfolio and as such has close links with Queensland Health while retaining its independent role. Its legislative functions and obligations are defined in the Act.

Legislative obligation

In addition to the legislative functions and obligations defined in the Act, the Commission must comply with a range of public administration legislation including:

- *Financial Accountability Act 2009*
- *Public Records Act 2002*
- *Public Interest Disclosure Act 2010*
- *Auditor General Act 2009*
- *Public Sector Ethics Act 1994*
- *Right to Information Act 2009*
- *Information Privacy Act 2009*
- *Workers Compensation and Rehabilitation Act 2003*
- *Work Health and Safety Act 2011.*

Agency governance

Table 5 – Executive Management Team membership

Position	Name
Mental Health Commissioner	Dr Lesley van Schoubroeck
Executive Director, Strategy Policy and Research	Carmel Ybarlucea
Director, Engagement and Reporting	Cassandra Gillies (on 12 months leave from May 2015)
Business Manager	Michael Corne

Management

The Queensland Mental Health Commissioner is the Chief Executive and accountable officer, appointed by the Governor in Council and reporting directly to the Minister for Health. The Commissioner is responsible for the management and performance of the Commission's functions in accordance with its legislative obligation, outlined in the Act.

The Commission does not have a board of management, rather its leadership is provided through an Executive Management Team (EMT) which is responsible for delivering the Commission's legislative requirements within a compliant corporate governance framework. Advice is sought from the Council on matters relevant to the Council's role.

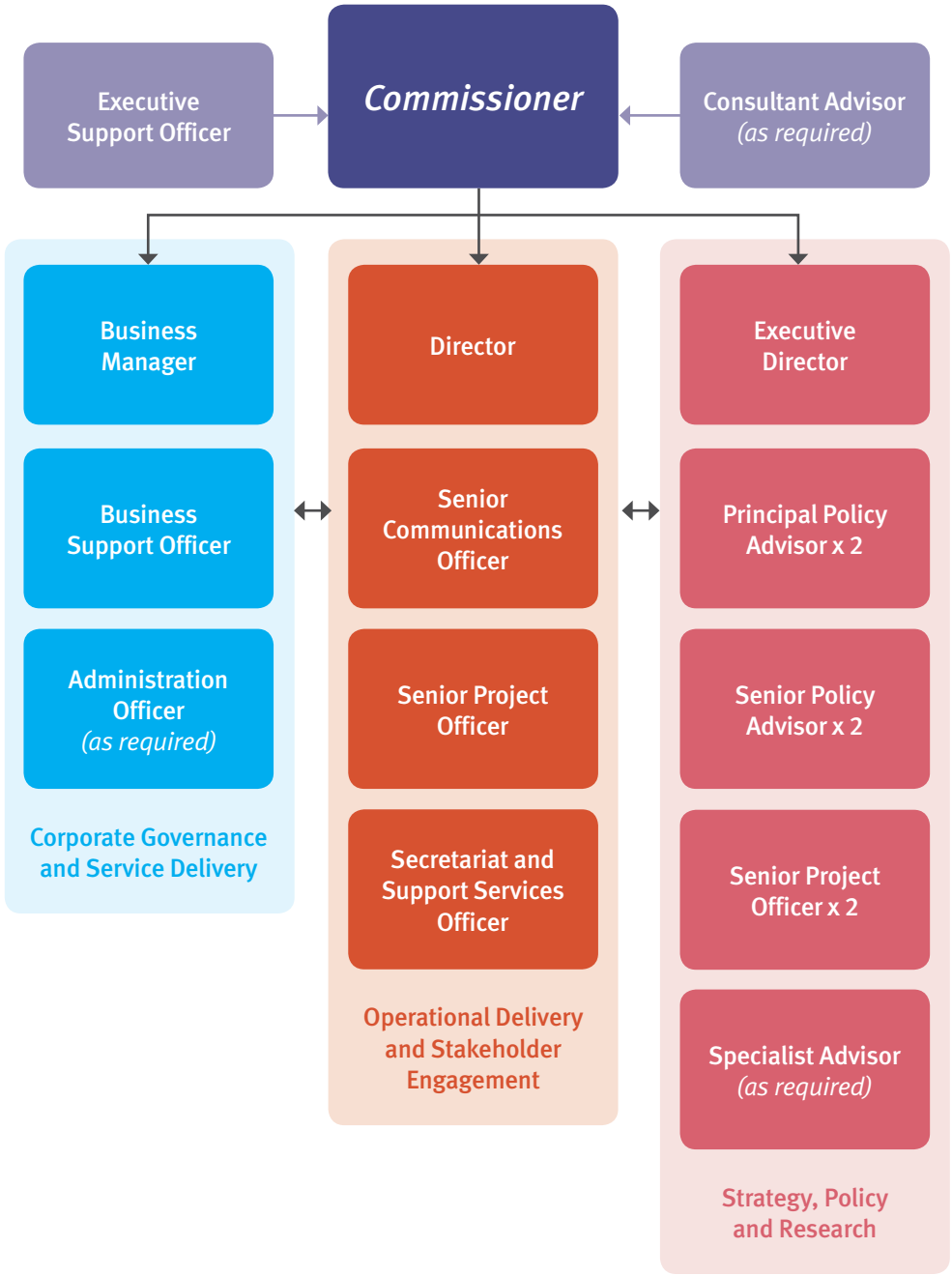
Organisational structure

In 2014–2015 the Commission's staffing establishment was 15 FTE.

The structure remains intentionally lean and is designed to work collaboratively with other government bodies, industry and community groups.

The Commission continues to outsource corporate service delivery to the Corporate Administration Agency which includes access to advice in meeting its statutory body compliance obligations. It also engages consultancies and contractors when considered necessary, providing flexibility to respond to emerging priorities and opportunities and to engage subject matter expertise to address specific requirements.

The Commission's structure is shown below:



Agency effectiveness

The Commission engaged an independent organisation to develop a model to evaluate its effectiveness. This was undertaken as part of good business practice and to contribute to a review of the Commission's performance, legislatively required after three years of the commencement of the Act.

The model finalised in early 2014–2015, considered two important aspects:

- The collective effort of all agencies, government and otherwise to making a difference to the mental health and wellbeing of Queenslanders
- The contribution of the Commission to making a difference to the mental health and wellbeing of Queenslanders.

The model reflects a theory of change to making a difference, focusing on matters over which the Commission has direct and indirect control and influence. The Commission has:

- Direct control over allocation of its resources, who it works with and the advice it gives
- Direct influence over better services, better awareness, prevention and early intervention initiatives, better engagement and collaboration, and better transparency and accountability
- Indirect influence over outcomes for people including:
  - A population with good mental health and wellbeing
  - Reduced stigma and discrimination
  - Reduced avoidable harm
  - Lives with purpose
  - Better physical and oral health
  - Positive experiences of support, care and treatment.

The model is developed around five key elements:

- The collective impact focusing on higher level indicators related to consumer outcomes
- Key result areas which consider performance against each of the Commission's stated functions
- Partnerships, focusing on the Commission's ability to develop appropriate, effective and sustainable partnerships
- Profile, focusing on assessing the Commission's communication and engagement effectiveness
- Organisational enablers that explore the effectiveness our supporting systems, processes and infrastructure.

Methodology

The evaluation focuses on observation and assessment of operational and business practices and a suite of surveys, both broad and targeted, to determine key stakeholder perceptions.

The first area reviews business, planning and communications processes and also explores what the Commission does with the survey results. The second consolidates and compares survey results against a baseline survey of stakeholders and progressive surveys to track progress.

Progress to date

The baseline survey was conducted in September 2014 and achieved 581 responses with a response rate of 35 per cent of targeted participants. The first annual survey, conducted in June 2015, had 590 responses with a response rate of 25 per cent of targeted participants.

Survey respondents represented a variety of roles in the community. The largest proportion of respondents identified as service providers, while a similarly high proportion were family members of a person with lived experience. The most significant difference between the 2015 survey and baseline was an approximate 5 per cent increase in respondents identifying as government employees.

A mini-survey was also undertaken against the Commission's research, review and report key result area and specific evaluations are conducted of the Commission's events and product releases.

Progress relating to specific areas of the evaluation model is mentioned in relevant areas throughout this report. The key focus of the evaluation however is the Commission's government agreed service standards:

- The perceived benefit of the Strategic Plan to: consumers, collaboration between sectors and decision-making at government level
- Stakeholder satisfaction with:
  - Opportunities to provide consumer, support person and provider perspectives
  - Extent to which consumer, support person and provider perspectives are represented in planning
  - The range of stakeholders involved in developing and implementing solutions.

The results in Table 6 and Figure 2 reflect responses from the annual survey.

Strategic Plan

The annual survey results indicate that 93 per cent of respondents think more than three years is required for the Strategic Plan to make a difference and 37 per cent of respondents think at least five years. One quarter of respondents believe it is too early to tell if the Strategic Plan will make a difference.

Perceived benefit of the Strategic Plan is shown in Table 6.

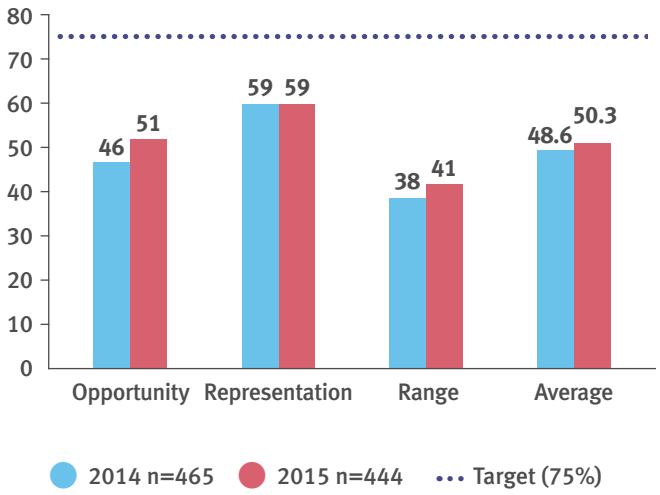
Table 6 – Perceived benefit of the Strategic Plan (n=444)

Already perceived benefit to	May change in future	Very likely / Already changed
Mental health consumers, families and carers	44%	20%
Alcohol and other drug service users, families and carers	45%	17%
Collaboration between sectors	42%	22%
Decision making at Government level	44%	16%

Stakeholder satisfaction

The results in Figure 2 indicate there has been an incremental improvement in all areas of stakeholder satisfaction. While positive, this reflects the medium to long-term challenges for the Commission to make a perceived difference. A target of 75 per cent within five years has been set for stakeholder satisfaction.

Figure 2 – Stakeholder satisfaction from annual survey results



Public sector ethics

The Queensland Public Service Code of Conduct applies to the Commission. The Commission has included the Code of Conduct in its induction processes, provided training to staff and incorporated its requirements, principles and values into staff performance management plans.

Risk management

The Commission adopts a risk management philosophy that incorporates risk assessment as a standard business practice in all that is undertaken. Risk is managed through identifying, analysing, assessing and controlling the exposures that are likely to impact on the Commission's strategic and operational performance.

Due to the Commission's size, a specific risk management committee has not been established, rather the responsibility has been included as part of the EMT's charter, which includes a review of key risks on a quarterly basis. The top four areas of risk and the actions undertaken to mitigate are:

- **Expectations** – High and varied expectations of the Commission are held by stakeholders including consumers, families, carers and supporters, non-government agencies, the public and private sectors, academia and professional bodies. This is managed through promoting the Commission's role, working collaboratively and regular communication.
- **Reputation** – Perceptions of the Commission as an independent body are essential to its credibility, reputation and capacity to affect change. This will be influenced by the quality of the Commission communication processes, particularly timely and transparent reporting of progress across all sectors. Perceptions of independence are monitored in the annual survey.
- **Governance** – The capacity of the Commission to perform effectively and efficiently in a complex environment with finite resources requires robust governance and management systems. This is managed through well-established systems and processes and a suitably structured and skilled organisation.
- **Reform influence** – The Commission's ability to facilitate reform across government links closely with the first two risks, expectations and reputation, and requires it to effectively monitor changing government priorities and maintain sound relationships with central agencies.

Audit committee and internal audit

A separate audit committee has not been established, rather responsibility is included as part of the EMT's charter. The Commission has recently engaged its corporate services provider to establish and undertake an audit program that targets Commission governance compliance, the results of which will be reported to and actioned where necessary by the EMT.

A separate internal audit function is not required unless directed by the Minister.

Information management and record keeping

Records management

Sound records management practices are an essential element of good corporate governance. The Commission's information and records are corporate assets, vital both for ongoing operations and also in providing valuable evidence of business decisions, activities and transactions.

The Commission has invested in an electronic document and record management system and is committed to training staff to ensure its records management practices are consistent, accurate, fit for purpose and are undertaken in accordance with the requirements of the *Public Records Act 2002*.

Stakeholder management

A stakeholder management system is now well established, which records and profiles the stakeholders with whom the Commission engages. This tool is proving invaluable in focusing both its collaborative and consultative efforts and currently contains approximately 2,000 individual and organisation stakeholder profiles.

Internal communication and governance

During the year the Commission developed and implemented an intranet to enhance internal information sharing, efficiency and accessibility of corporate documents, data sets and news updates.

Policies, guidelines and registers were also established to improve governance.

Open data

The Commission has opted to be included with Queensland Health's *Open Data Strategy 2013–2016* which is available to view on the Queensland Government data website.

The Commission also has official use of the Queensland Health Clinical Knowledge Network which provides access to both virtual and hard copy information resources. This has improved the Commission's online access to research material.

Human resources

During 2014–2015 the Commission recruited to the approved staffing level of 15. Key roles filled include a Senior Communications Officer, a Senior Policy Advisor and Senior Project Officers. These positions will improve the Commission's capacity in policy development and in media and communications.

The Commission's separation rate for permanent staff during the reporting period was zero. One permanent staff member has taken 12 months leave without pay to undertake a related non-government professional role.

During the year the Commission undertook a staff climate and wellness review and a review of its values. The findings from both have prompted an action plan developed by staff and management to guide how business is undertaken within the Commission. A key outcome of the values review was the addition of an extra value (wellness) to the existing suite of public service values.

Financial statements

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General information

These financial statements cover the Commission. It has no controlled entities.

The Commission is controlled by the State of Queensland which is the ultimate parent.

The head office and principal place of business of the Commission is:

Level 30, 400 George Street
BRISBANE QLD 4000

A description of the nature of the Commission's operations and its principal activities is included in the notes to the financial statements.

For information in relation to the Commission's financial report please email **info@qmhc.qld.gov.au** or visit the Commission's internet site **www.qmhc.qld.gov.au.**

Amounts shown in these financial statements may not add to the correct sub-totals or total due to rounding.

Statement of comprehensive income
for the year ended 30 June 2015

	Notes	2015 $'000	2014 $'000
Income from Continuing Operations			
Revenue			
Grants and other contributions	**2**	8,604	7,147
Interest		164	107
Other revenue		-	35
Total Income from Continuing Operations		8,768	7,289
Expenses from Continuing Operations			
Employee expenses	**3**	2,000	1,566
Supplies and services	**5**	2,135	1,727
Grants and subsidies	**6**	3,703	2,356
Depreciation		4	3
Other expenses	**7**	26	1,209
Total Expenses from Continuing Operations		7,868	6,861
Operating Result from Continuing Operations		900	428
Total Comprehensive Income		900	428

The accompanying notes form part of these statements.

Statement of financial position
for the year ended 30 June 2015

	Notes	2015 $'000	2014 $'000
Current Assets			
Cash and cash equivalents	**8**	1,632	664
Receivables	**9**	81	60
Prepayments		20	18
Total Current Assets		1,733	742
Non Current Assets			
Plant and equipment	**10**	5	9
Total Non Current Assets		5	9
Total Assets		1,738	751
Current Liabilities			
Payables	**11**	208	123
Accrued employee benefits	**12**	62	22
Other liabilities	**13**	55	38
Total Current Liabilities		325	183
Non Current Liabilities			
Other liabilities	**13**	85	140
Total Non Current Liabilities		85	140
Total Liabilities		410	323
Net Assets		1,328	428
Equity			
Accumulated surplus		1,328	428
Total Equity		1,328	428

The accompanying notes form part of these statements.

Statement of changes in equity
for the year ended 30 June 2015

	Accumulated Surplus $'000	TOTAL $'000
Balance as at 1st July 2013	-	-
Operating Result from Continuing Operations	428	428
Balance as at 30 June 2014	428	428
Balance as at 1st July 2014	428	428
Operating Result from Continuing Operations	900	900
Balance as at 30 June 2015	1,328	1,328

The accompanying notes form part of these statements.

Statement of cash flows
for the year ended 30 June 2015

	Notes	2015 $'000	2014 $'000
Cash flows from operating activities			
Inflows:			
Grants and other contributions		8,604	7,147
GST collected from customers		1	4
GST input tax credits from ATO		446	264
Interest receipts		164	-
Other		-	142
Outflows:			
Employee expenses		(1,955)	(1,570)
Supplies and services		(2,116)	(2,653)
GST paid to suppliers		(472)	(298)
GST remitted to ATO		(1)	(4)
Grants and subsidies		(3,703)	(2,356)
Net cash provided by operating activities	**14**	968	676
Cash flows from investing activities			
Outflows:			
Payments for plant and equipment		-	(12)
Net cash provided by (used in) investing activities		-	(12)
Net increase in cash held		968	664
Cash at beginning of financial year		664	-
Cash at end of financial year	**8**	1,632	664

The accompanying notes form part of these statements.

Notes to and forming part of the Financial statements
for the year ended 30 June 2015

	Objectives and Principal Activities of the Agency
Note 1:	Summary of Significant Accounting Policies
Note 2:	Grants and Other Contributions
Note 3:	Employee Expenses
Note 4:	Key Management Personnel and Remuneration Expenses
Note 5:	Supplies and Services
Note 6:	Grants and subsidies
Note 7:	Other Expenses
Note 8:	Cash and Cash Equivalents
Note 9:	Receivables
Note 10:	Plant and Equipment
Note 11:	Payables
Note 12:	Accrued Employee Benefits
Note 13:	Other Liabilities
Note 14:	Reconciliation of Operating Result to Net Cash from Operating Activities
Note 15:	Commitments for Expenditure
Note 16:	Contingencies
Note 17:	Financial Instruments
Note 18:	Budget vs Actual Comparison

Objectives and Principal Activities of the Queensland Mental Health Commission

The QMHC seeks to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health, drug and alcohol system within Queensland.

1. Summary of Significant Accounting Policies

(a) Statement of Compliance

The Queensland Mental Health Commission has prepared these financial statements in compliance with section 43 of the Financial and Performance Management Standard 2009.

These financial statements are general purpose financial statements, and have been prepared on an accrual basis in accordance with Australian Accounting Standards and Interpretations. In addition, the financial statements comply with Queensland Treasury's Minimum Reporting Requirements for the year ending 30 June 2015, and other authoritative pronouncements.

With respect to compliance with Australian Accounting Standards and Interpretations, the Queensland Mental Health Commission has applied those requirements applicable to not-for-profit entities, as the Queensland Mental Health Commission is a not-for-profit entity. Except where stated, the historical cost convention is used.

(b) The Reporting Entity

The financial statements include the value of all income, expenses, assets, liabilities and equity of the Commission. The Commission does not have any controlled entities.

(c) Grants and Other Contributions

Grants and contributions that are non-reciprocal in nature are recognised as revenue in the year in which the Commission obtains control over them (control is generally obtained at the time of receipt).

(d) Cash and Cash Equivalents

For the purposes of the Statement of Financial Position and the Statement of Cash Flows, cash assets include all cash and cheques receipted but not banked at 30 June as well as deposits at call with financial institutions.

(e) Receivables

Trade debtors are recognised at the amounts due at the time of sale or service delivery i.e. the agreed purchase/contract price. Settlement of these amounts is required within 30 days from invoice date.

The collectability of receivables is assessed periodically. There is no allowance for impairment at 30 June 2015. No bad debts were written off at 30 June.

(f) Acquisitions of Assets

Actual cost is used for the initial recording of all non-current physical asset acquisitions. Cost is determined as the value given as consideration plus costs incidental to the acquisition, including all other costs incurred in getting the assets ready for use. However, any training costs are expensed as incurred.

(g) Plant and Equipment

Items of plant and equipment with a cost or other value equal to or in excess of $5,000 are recognised for financial reporting purposes in the year of acquisition. Items with a lesser value are expensed in the year of acquisition.

1. Summary of Significant Accounting Policies (contd)

(h) Depreciation of Plant and Equipment

Plant and equipment is depreciated on a straight-line basis so as to allocate to the Commission the net cost or revalued amount of each asset, less its estimated residual value, progressively over its estimated useful life.

For each class of depreciable asset, where held, the following depreciation rates are used:

Class	***Rate%***
Plant and Equipment:	
Office Equipment	33.33%

(i) Impairment of Non-Current Assets

All non-current physical assets are assessed for indicators of impairment on an annual basis. If an indicator of possible impairment exists, the Commission determines the asset's recoverable amount. Any amount by which the asset's carrying amount exceeds the recoverable amount is recorded as an impairment loss.

(j) Leases

A distinction is made in the financial statements between finance leases that effectively transfer from the lessor to the lessee substantially all risks and benefits incidental to ownership, and operating leases, under which the lessor retains substantially all risks and benefits.

Where a non-current physical asset is acquired by means of a finance lease, the asset is recognised at the lower of the fair value of the leased property and the present value of the minimum lease payments. The lease liability is recognised at the same amount. There were no finance leases during the year.

Operating lease payments are representative of the pattern of benefits derived from the leased assets and are expensed in the periods in which they are incurred.

Incentives received on entering into operating leases are recognised as liabilities. Lease payments are allocated between rental expense and reduction of the liability.

(k) Payables

Trade creditors are recognised upon receipt of the goods or services ordered and are measured at the agreed purchase/contract price, gross of applicable trade and other discounts. Amounts owing are unsecured and are generally settled on 30 day terms.

(l) Financial Instruments

Recognition

Financial assets and financial liabilities are recognised in the Statement of Financial Position when the Commission becomes party to the contractual provisions of the financial instrument.

Classification

Financial instruments are classified and measured as follows:

- Receivables - held at amortised value
- Payables - held at amortised value

The Commission does not enter into transactions for speculative purposes, nor for hedging. The Commission also holds no financial assets classified at fair value through profit or loss.

All other disclosures relating to the measurement and financial risk management of financial instruments held by the Commission are included in Note 17.

1. Summary of Significant Accounting Policies (contd)

(m) Employee Benefits

Employer superannuation contributions, annual leave levies and long service leave levies are regarded as employee benefits.

Payroll tax and workers' compensation insurance are a consequence of employing employees, but are not counted in an employee's total remuneration package. They are not employee benefits and are recognised separately as employee related expenses.

Wages, Salaries and Sick leave

Wages and salaries due but unpaid at reporting date are recognised in the Statement of Financial Position at the current salary rates.

As the Commission expects such liabilities to be wholly settled within 12 months of reporting date, the liabilities are recognised at undiscounted amounts.

Prior history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised.

As sick leave is non-vesting, an expense is recognised for this leave as it is taken.

Annual Leave

Under the Queensland Government's Annual Leave Central Scheme (ALCS), a levy is made on the Commission to cover the cost of employees' annual leave (including leave loading and on-costs). The levies are expensed in the period in which they are payable. Amounts paid to employees for annual leave are claimed from the scheme quarterly in arrears.

No provision for annual leave is recognised in the Commission's financial statements as the liability is held on a whole-of-government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting*.

Long Service Leave

Under the Queensland Government's long service leave scheme, a levy is made on the Commission to cover the cost of employees' long service leave. The levies are expensed in the period in which they are payable. Amounts paid to employees for long service leave are claimed from the scheme quarterly in arrears.

No provision for long service leave is recognised in the Commission's financial statements, the liability being held on a whole-of-Government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting.*

Superannuation

Employer superannuation contributions are paid to QSuper, the superannuation scheme for Queensland Government employees, at rates determined by the Treasurer on the advice of the State Actuary. Contributions are expensed in the period in which they are paid or payable. The Commission's obligation is limited to its contribution to QSuper.

The QSuper scheme has defined benefit and defined contribution categories. The liability for defined benefits is held on a whole-of-Government basis and reported in those financial statements pursuant to AASB 1049 *Whole of Government and General Government Sector Financial Reporting.*

1. Summary of Significant Accounting Policies (contd)

(m) Employee Benefits (contd)

Key Management Personnel and Remuneration

Key management personnel and remuneration disclosures are made in accordance with section 5 of the Financial Reporting Requirements for Queensland Government Agencies issued by Queensland Treasury. Refer to Note 4 for the disclosures on key management personnel and remuneration.

(n) Insurance

The Commission's non-current physical assets and other risks are insured through the Queensland Government Insurance Fund, premiums being paid on a risk assessment basis. In addition, the Commission pays premiums to WorkCover Queensland in respect of its obligations for employee compensation.

(o) Taxation

The Commission is a State body as defined under the *Income Tax Assessment Act 1936* and is exempt from Commonwealth taxation with the exception of Fringe Benefits Tax (FBT) and Goods and Services Tax (GST). FBT and GST are the only taxes accounted for by the Commission. GST credits receivable from, and GST payable to the ATO, are recognised (refer to Note 9).

(p) Issuance of Financial Statements

The financial statements are authorised for issue by the Commissioner and the Executive Director at the date of signing the management certificate.

(q) Judgements

The preparation of financial statements necessarily requires the determination and use of certain critical accounting estimates, assumptions, and management judgements that have the potential to cause a material adjustment to the carrying amounts of assets and liabilities within the next financial year. Such estimates, judgements and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised and in future periods as relevant. No judgements or estimates were required in the preparation of the current year's financial statements.

(r) Currency, Rounding and Comparatives

Amounts included in the financial statements are in Australian dollars and have been rounded to the nearest $1,000 or, where that amount is $500 or less, to zero, unless disclosure of the full amount is specifically required.

Comparative information has been restated where necessary to be consistent with disclosures in the current reporting period.

(s) Implementation of the Shared Services Initiative

The Corporate Administration Agency (CAA) provides Queensland Mental Health Commission with corporate services under the "Shared Services Provider" model. The fees and terms of the services are agreed through a Service Level Agreement, negotiated annually and include:

- Financial services
- Human resources recruitment and payroll
- Information systems and support

1. Summary of Significant Accounting Policies (contd)

(t) New and Revised Accounting Standards

The Commission did not voluntarily change any of its accounting policies during 2014-15. The Australian Accounting Standard applicable for the first time as from 2014-15 that had the most significant impact on the Queensland Mental Health Commission's financial statements is AASB 1055 Budgetary Reporting.

AASB 1055 became effective from reporting periods beginning on or after 1 July 2014. In response to this new standard, the Commission has included in these financial statements a comprehensive new note 'Budget vs Actual Comparison' (Note 18). This note discloses the Commission's original published budgeted figures for 2014-15 compared to actual results, with explanations of major variances, in respect of the Commission's Statement of Comprehensive Income, Statement of Financial Position and Statement of Cash Flows. Note 18 also includes a comparison between the original published budgeted figures for 2014-15 compared to actual results, and explanations of major variances, in respect of the Commission's major classes of income, expenses, assets and liabilities.

There were no other new or revised standards commencing from reporting periods beginning on or after 1 January 2014 that impacted on the Queensland Mental Health Commission.

The Commission is not permitted to early adopt a new or amended accounting standard ahead of the specified commencement date unless approval is obtained from Queensland Treasury. Consequently, the Commission has not applied any Australian Accounting Standards and Interpretations that have been issued but are not yet effective. The Commission applies standards and interpretations in accordance with their respective commencement dates.

At the date of authorisation of the financial report, the expected impacts of new or amended Australian Accounting Standards with future commencement dates are as set out below.

From reporting periods beginning on or after 1 July 2016, the Commission will need to comply with the requirements of AASB 124 Related Party Disclosures . That accounting standard requires a range of disclosures about the remuneration of key management personnel, transactions with related parties/entities, and relationships between parent and controlled entities. The Commission already discloses information about the remuneration expenses for key management personnel (refer to Note 4) in compliance with requirements from Queensland Treasury. Therefore, the most significant implications of AASB 124 for the Commission's financial statements will be the disclosures to be made about transactions with related parties, including transactions with key management personnel or close members of their families.

All other Australian accounting standards and interpretations with future commencement dates are either not applicable to the Commission's activities, or have no material impact on the Commission.

		2015 $'000	2014 $'000
2.	**Grants and Other Contributions**		
	Contributions from Government	8,604	7,147
	Total	8,604	7,147
3.	**Employee Expenses**		
	Employee Benefits		
	Wages and salaries	1,475	1,069
	Employer superannuation contributions	189	127
	Annual leave levy/expense	170	132
	Long service leave levy/expense	34	2
	Employee Related Expenses		
	Workers' compensation premium	13	9
	Payroll tax and fringe benefits tax	92	64
	Other employee related expenses	27	163
	Total	2,000	1,566

The number of employees as at 30 June, including both full-time and part-time employees measured on a full-time equivalent basis reflecting Minimum Obligatory Human Resource Information (MOHRI)) is:

	2015	2014
Number of employees:	15	11

4. Key Management Personnel and Remuneration Expenses

(a) Key Management Personnel

The following details for key management personnel include those positions that had authority and responsibility for planning, directing and controlling the activities of the Commission during 2014-15. Further information on these positions can be found in the body of the Annual Report under the section relating to Executive Management.

Position	Responsibilities	Current Incumbents	
		Contract classification and appointment authority	Date appointed to position (Date resigned from position)
Mental Health Commissioner	Chief Executive Officer for the Commission.	HSES 3.5; *Public Service Act 2008* (s24 of the *Queensland Mental Health Commission Act 2013*).	Appointed 01 July 2013
Executive Director	Provides strategic leadership for the Commission's policy and program and research functions.	HSES 2.1 (low); *Public Service Act 2008* (s24 of the *Queensland Mental Health Commission Act 2013*).	Appointed 22 April 2014

(b) Remuneration Expenses

Remuneration policy for the Commission's key management personnel is set by the Queensland Public Service Commission as provided for under the *Public Service Act 2008*, and the *Queensland Mental Health Act 2013* for the Commissioner. The remuneration and other terms of employment for the key management personnel are specified in employment contracts. The contracts provide for other benefits including motor vehicles.

For the 2014-15 year, remuneration packages of key management personnel increased by 2.2 % in accordance with government policy.

The following disclosures focus on the expenses incurred by the Commission during the 2014-15 reporting period, that is attributable to key management positions. Therefore, the amounts disclosed reflects expenses recognised in the Statement of Comprehensive Income.

Remuneration expenses for key management personnel comprises the following components:-

- Short term employee expenses which include:

  -salaries, allowances and leave entitlements earned and expensed for the entire year or for that part of the year during which the employee occupied the specified position.

  -non-monetary benefits - consisting of provision of vehicle together with fringe benefits tax applicable to the benefit.

4. Key Management Personnel and Remuneration (contd)

(b) Remuneration Expenses (contd)

- Long term employee expenses include amounts expensed in respect of long service leave entitlements earned.
- Post-employment expenses include amounts expensed in respect of employer superannuation obligations.
- Termination benefits are not provided for within individual contracts of employment. Contracts of employment provide only for notice periods or payment in lieu of notice on termination, regardless of the reason for termination.

1 July 2014 – 30 June 2015

Position (date resigned if applicable)	Short Term Employee Expenses		Long Term Employee Expenses	Post-Employment Expenses	Termination Benefits	Total Expenses
	Monetary Expenses $'000	Non-Monetary Benefits $'000	$'000	$'000	$'000	$'000
Mental Health Commissioner	227	-	5	24	-	256
Executive Director	165	-	3	17	-	185

1 July 2013 - 30 June 2014

Position (date resigned if applicable)	Short Term Employee Benefits		Long Term Employee Expenses	Post Employment Expenses	Termination Benefits	Total Expenses
	Monetary Expenses $'000	Non-Monetary Benefits $'000	$'000	$'000	$'000	$'000
Mental Health Commissioner	210	-	4	22	-	236
Executive Director	32	-	1	3	-	36

(c) Performance Payments

No performance payments were made to the key management personnel of the Commission.

			2015 $'000	2014 $'000
5.	**Supplies and Services**			
	Corporate service charges		229	231
	Consultants and contractors		1,152	796
	Travel		55	69
	Building Maintenance and Services		436	465
	Information technology		12	21
	Motor vehicle		8	12
	Catering		11	22
	Communications		21	26
	Advertising and promotion		85	39
	Administration costs		126	46
	Total		2,135	1,727
6.	**Grants and subsidies**			
	Grants to Industry - New		1,402	216
	Grants to Industry - Recurrent		1,085	1,072
	Grants to Qld Govt Depts - New		45	70
	Grants to Qld Govt Depts - Recurrent		1,004	998
	Grants - Other		167	-
	Total		3,703	2,356
7.	**Other Expenses**			
	External audit fees	*	26	9
	Return of funds to Department of Health		-	1,200
	Total		26	1,209

* Total audit fees payable to the Queensland Audit Office relating to the 2014-15 financial statements are quoted to be $17,200. (2014 $18,000). There are no non-audit services included in this amount.

		2015 $'000	2014 $'000
8.	**Cash and Cash Equivalents**		
	Cash at bank	1,632	664
	Total	1,632	664
9.	**Receivables**		
	GST receivable	60	34
		60	34
	Long service leave reimbursements	-	1
	Annual leave reimbursements	21	25
	Total	81	60
10.	**Plant and Equipment**		
	At cost	12	12
	Less: Accumulated depreciation	(7)	(3)
	Total	5	9
11.	**Payables**		
	Trade creditors	45	48
	Accrued expenses	156	69
	Payroll tax	7	6
	Total	208	123

	2015 $'000	2014 $'000
12. Accrued Employee Benefits		
Current		
Salary and wage related	11	4
Annual leave levy payable	39	10
Long service leave levy payable	8	7
Superannuation	1	1
Other Employee Entitlements	3	-
Total	62	22
13. Other Liabilities		
Current		
Lease incentive	55	38
Total	55	38
Non-current		
Lease incentive	85	140
Total	140	178
14. Reconciliation of Operating Result to Net Cash from Operating Activities		
Operating surplus/(deficit)	900	428
Depreciation expense	4	3
Changes in assets and liabilities:		
(Increase)/decrease in GST receivable	(26)	(34)
(Increase)/decrease in LSL reimbursement receivables	1	(1)
(Increase)/decrease in annual leave reimbursement receivable	4	(25)
(Increase)/decrease in prepayments	(2)	(18)
Increase/(decrease) in payables	85	301
Increase/(decrease) in accrued employee benefits	40	22
Increase/(decrease) in other current liabilities	17	-
Increase/(decrease) in other non-current liabilities	(55)	-
Net cash provided by operating activities	968	676

15. Commitments for Expenditure

(i) Non-cancellable Operating Leases

Commitments under operating leases at reporting date are inclusive of anticipated GST and are payable as follows:

	2015 $'000	2014 $'000
Not later than one year	508	463
Later than one year and not later than five years	616	1,062
Total	**1,124**	**1,525**

Operating leases are entered into as a means of acquiring access to office accommodation. Lease payments are generally fixed, both with inflation escalation clauses on which contingent rentals are determined.

(ii) Grants and Subsidies

Grants and subsidies commitments inclusive of anticipated GST, committed to provide at reporting date, but not recognised in the accounts are payable as follows:

	2015 $'000	2014 $'000
Payable:		
Not later than one year	1,809	2,475
Later than one year and not later than five years	826	275
Total	**2,635**	**2,750**

(iii) Other Expenditure Commitments

Other expenditure committed at the end of the period but not recognised in the accounts are as follows:

	2015 $'000	2014 $'000
Payable:		
Not later than one year	962	755
Later than one year and not later than five years	-	150
Total	**962**	**905**

16. Contingencies

There are no legal or any other contingencies that are known to the Commission at 30 June 2015.

17. Financial Instruments

(a) Categorisation of Financial Instruments

The Commission has the following categories of financial assets and financial liabilities as reflected in the Statement of Financial Position - cash and cash equivalents, Receivables and Payables.

(b) Financial Risk Management

The Commission's activities expose it to a variety of financial risks - interest rate risk, credit risk, liquidity risk and market risk.

Financial risk management is implemented pursuant to Government and Commission policy. These policies focus on the unpredictability of financial markets and seek to minimise potential adverse effects on the financial performance of the Commission.

All financial risk is managed by Executive Management under policies approved by the Commission. The Commission provides written principles for overall risk management, as well as policies covering specific areas.

The Commission measures risk exposure using a variety of methods as follows -

Risk Exposure	Measurement method
Credit Risk	Ageing analysis, earnings at risk
Liquidity Risk	Sensitivity analysis
Market Risk	Interest rate sensitivity analysis

(c) Credit Risk Exposure

Credit risk exposure refers to the situation where the Commission may incur financial loss as a result of another party to a financial instrument failing to discharge their obligation.

The maximum exposure to credit risk at balance date in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any provisions for impairment.

Financial Assets

The carrying amount of receivables represents the maximum exposure to credit risk.

No financial assets and financial liabilities have been offset and presented net in the Statement of Financial Position.

As at 30 June there were no receivables past due.

(d) Liquidity Risk

The liquidity risk of the financial liabilities held by the Commission is limited to obligations relating to its payables as outlined in Note 11.

17. Financial Instruments (contd)

(e) Market Risk

The Commission does not trade in foreign currency and is not materially exposed to commodity price changes. The Commission is exposed to interest rate risk through its cash deposits in interest bearing accounts. The Commission does not undertake any hedging in relation to interest risk and manages its risk as per the liquidity risk management strategy as articulated in the Commission's Financial Management Practice Manual.

(f) Interest Rate Sensitivity Analysis

The Commission is not sensitive to interest rate movements.

(g) Fair Value

The fair value of trade receivables and payables is assumed to approximate the value of the original transaction, less any allowance for impairment.

The Commission has not offset any assets and liabilities.

18. Budget vs Actual Comparison

NB. A budget vs actual comparison, and explanations for major variances, has not been included for the Statement of Changes in Equity, as major variances relating to that statement have been addressed in explanations of major variances for other statements.

Statement of Comprehensive Income

	Variance Notes	Orginal Budget 2015 $'000	Actual 2015 $'000	Variance $'000	Variance % of Budget
Income from Continuing Operations					
Revenue					
Grants and other contributions		8504	8,604	100	1%
Interest		-	164	164	100%
Total Income from Continuing Operations		**8,504**	**8,768**	264	3%
Expenses from Continuing Operations					
Employee expenses		2,062	2,000	62	3%
Supplies and services	1	2,476	2,135	341	14%
Grants and subsidies	2	3,938	3,703	235	6%
Depreciation		-	4	(4)	100%
Other expenses		28	26	2	8%
Total Expenses from Continuing Operations		**8,504**	**7,868**	**636**	**7%**
Operating Result from Continuing Operations		-	**900**	900	100%
Total Comprehensive Income		**-**	**900**	900	100%

The accompanying notes form part of these statements.

18. Budget vs Actual Comparison (contd)

Statement of Financial Position

	Variance Notes	Original Budget 2015 $'000	Actual 2015 $'000	Variance $'000	Variance % of Budget
Current Assets					
Cash and cash equivalents		-	1,632	1,632	100%
Receivables		-	81	81	100%
Prepayments		-	20	20	100
Total Current Assets		**-**	**1,733**	1,733	100
Non Current Assets					
Plant and equipment		-	5	5	100%
Total Non Current Assets		**-**	**5**	5	100%
Total Assets		**-**	**1,738**	1,738	100%
Current Liabilities					
Payables		-	208	(208)	100%
Accrued employee benefits		-	62	(62)	100%
Other liabilities		-	55	(55)	100%
Total Current Liabilities		**-**	**325**	325	100%
Non Current Liabilities					
Other liabilities		-	85	(85)	100%
Total Non Current Liabilities		**-**	**85**	(85)	100%
Total Liabilities		**-**	**410**	(410)	100%
Net Assets		**-**	**1,328**	1,328	100%
Equity					
Accumulated surplus		-	1,328	1,328	100%
Total Equity		**-**	**1,328**	1,328	100%

The accompanying notes form part of these statements.

18. Budget vs Actual Comparison (contd)

Statement of Cash Flows

	Variance Notes	Original Budget 2015 $'000	Actual 2015 $'000	Variance $'000	Variance % of Budget
Cash flows from operating activities					
Inflows:					
Grants and other contributions		8,504	8,604	100	1%
GST collected from customers		-	1	1	100%
GST input tax credits from ATO		-	446	446	100%
Interest receipts		-	164	164	100%
Outflows:					
Employee expenses		(2,134)	(1,955)	179	-8%
Grants and subsidies		(3,938)	(3,703)	235	-6%
Supplies and services	1	(2,476)	(2,116)	360	-15%
GST paid to suppliers		-	(472)	(472)	100%
GST remitted to ATO		-	(1)	(1)	100%
Other		(28)	-	28	-100%
Net cash provided by operating activities		**(72)**	**968**	**1,040**	-1444%
Net increase in cash held		(72)	968	1,040	-1444%
Cash and cash equivalents at beginning of financial year		72	664	592	822%
Cash and cash equivalents at end of financial year		**-**	**1,632**	**1,632**	100%

The accompanying notes form part of these statements.

18. Budget vs Actual Comparison (contd)

Explanations of Major Variances

Statement of Comprehensive Income

1. Supplies and services - The underspend is due to a number of consultancy contract deliverables not being achieved in the current year. It is expected that these will be completed in early 2015/16. Systemic Governance ($141K) and Suicide Prevention ($106K) are the two largest areas of work still being finalised.

2. Grants and Subsidies - The underspend reflects a minor delay in grant deliverables not being achieved in the current year. It is expected that these will be completed in early 2015/16. A promotion and awareness initiative is the largest area of work to be finalised ($200K)

Statement of Financial Position

In budget preparation a zero budget was assumed, as full delivery of all activities was anticipated. The variance resulted from delays in delivery relating to Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019 (not released until October 2014) followed by the Government caretaker period. The equity position has been included in 2015/16 operational budget planning.

Management Certificate
for the Queensland Mental Health Commission

These general purpose financial statements have been prepared pursuant to section 62(1) of the *Financial Accountability Act 2009* (the Act), section 43 of the *Financial and Performance Management Standard 2009* and other prescribed requirements. In accordance with section 62(1)(b) of the Act we certify that in our opinion:

(a) the prescribed requirements for establishing and keeping the accounts have been complied with in all material respects; and

(b) the financial statements have been drawn up to present a true and fair view, in accordance with prescribed accounting standards, of the transactions of the Queensland Mental Health Commission for the financial year ended 30 June 2015 and of the financial position of the Commission at the end of that year; and

(c) these assertions are based on an appropriate system of internal controls and risk management processes being effective, in all material respects, with respect to financial reporting throughout the reporting period.

Name Dr Lesley van Schoubroeck
Title Mental Health Commissioner
Queensland Mental Health Commission
Date: 26.8.15

Name Michael Corne
Title Business Manager
Queensland Mental Health Commission
Date: 24/8/15

Independent Auditor's Report

To the Commissioner of Queensland Mental Health Commission

Report on the Financial Report

I have audited the accompanying financial report of Queensland Mental Health Commission, which comprises the statement of financial position as at 30 June 2015, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and certificates given by the Mental Health Commissioner and the Business Manager.

The Commissioner's Responsibility for the Financial Report

The Commissioner is responsible for the preparation of the financial report that gives a true and fair view in accordance with prescribed accounting requirements identified in the *Financial Accountability Act 2009* and the *Financial and Performance Management Standard 2009*, including compliance with Australian Accounting Standards. The Commissioner's responsibility also includes such internal control as the Commissioner determines is necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial report based on the audit. The audit was conducted in accordance with the *Auditor-General of Queensland Auditing Standards*, which incorporate the Australian Auditing Standards. Those standards require compliance with relevant ethical requirements relating to audit engagements and that the audit is planned and performed to obtain reasonable assurance about whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation of the financial report that gives a true and fair view in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control, other than in expressing an opinion on compliance with prescribed requirements. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Commissioner, as well as evaluating the overall presentation of the financial report including any mandatory financial reporting requirements approved by the Treasurer for application in Queensland.

I believe that the audit evidence obtained is sufficient and appropriate to provide a basis for my audit opinion.

Independence

The *Auditor-General Act 2009* promotes the independence of the Auditor-General and all authorised auditors. The Auditor-General is the auditor of all Queensland public sector entities and can be removed only by Parliament.

The Auditor-General may conduct an audit in any way considered appropriate and is not subject to direction by any person about the way in which audit powers are to be exercised. The Auditor-General has for the purposes of conducting an audit, access to all documents and property and can report to Parliament matters which in the Auditor-General's opinion are significant.

Opinion

In accordance with s.40 of the *Auditor-General Act 2009* –

(a) I have received all the information and explanations which I have required; and

(b) in my opinion –

(i) the prescribed requirements in relation to the establishment and keeping of accounts have been complied with in all material respects; and

(ii) the financial report presents a true and fair view, in accordance with the prescribed accounting standards, of the transactions of the Queensland Mental Health Commission for the financial year 1 July 2014 to 30 June 2015 and of the financial position as at the end of that year; and

Other Matters - Electronic Presentation of the Audited Financial Report

Those viewing an electronic presentation of these financial statements should note that audit does not provide assurance on the integrity of the information presented electronically and does not provide an opinion on any information which may be hyperlinked to or from the financial statements. If users of the financial statements are concerned with the inherent risks arising from electronic presentation of information, they are advised to refer to the printed copy of the audited financial statements to confirm the accuracy of this electronically presented information.

D J Olive CPA
(as Delegate of the Auditor-General of Queensland)

Queensland Audit Office
Brisbane

Appendices

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Appendix 1
DHPW response to Social Housing Ordinary Report recommendations

Planning to meet social housing needs

Recommendation 1.

The Department of Housing and Public Works (DHPW) reviews data collection mechanisms to identify the number of current social housing tenants, including those on the State Housing Register, with complex needs, to support future planning and current service delivery.

Position: **Accepted**

Current activities:

Current DHPW practice is to consider people with complex needs in future planning and current service delivery activities at local, regional and whole-of-state levels.

Reliability of data collected and held by DHPW on social housing tenants and people on the State Housing Register relating to their complex needs is dependent on accuracy of self-disclosure.

Processes to improve data collection and management to improve service delivery are being considered as part of the development of a new IT platform (Reside) currently underway.

Future activities:

DHPW is considering opportunities for developing a case management approach for supporting social housing tenants, including the development of a new Housing Strategy.

Access to suitable affordable housing

Recommendation 2.

The DHPW examines how social housing stock may be adjusted to meet the needs of tenants with complex needs, including earmarking social housing stock for people experiencing mental illness.

Position: **Supported**

Current activities:

DHPW currently modifies social housing stock to meet the reasonable needs of people with a disability.

Under the National Partnership Agreement Supporting National Mental Health Reform (NPA), $26.226 million has been allocated to DHPW over five years (2011–12 to 2015–16) to expand the overall capacity of the social housing portfolio to provide housing options for clients of two mental health programs; the Housing and Support Program (HASP) and Transitional Recovery (TR) services. This enables the department to prioritise access to available social housing stock for eligible Queenslanders with mental illness under these initiatives.

Strategies will be considered around improving social housing stock allocation processes to more appropriately take into account the needs of people with mental illness or related complex needs, where possible, as part of the two year Mental Health Demonstration Project.

The Demonstration Project is testing a new integrated housing, health and social welfare support model to improve housing stability outcomes for people living in social housing who are experiencing mental illness or related complex needs.

Future activities:

Work will continue at Australian and State Government levels to resolve policy issues relating to impacts of the NDIS on social housing tenants with a disability, including those experiencing mental illness.

Monitoring outcomes for social housing tenants with complex needs

Recommendation 3.

The DHPW develops and implements, in collaboration with relevant agencies, a system to monitor and report on strikes issued and tenancies terminated under the Anti-social Behaviour (ASB) policy. The system should:

- record the end outcome for social housing tenants
- enable an assessment of supports being provided for social housing tenants with complex needs
- monitor the impact on other government priorities including reducing homelessness, reducing demand for acute mental health care inpatient services and reducing child protection issues.

Position: **Supported**

Current activities:

DHPW is currently undertaking a number of initiatives which will contribute to addressing this recommendation, including: the two year Mental Health Demonstration Project which is testing a new integrated housing, health and social welfare support model which aims to improve housing stability outcomes for people living in social housing who are experiencing mental illness or related complex needs. Evaluation of this Project will consider the supports provided to social housing tenants with mental illness or related complex needs, as well as consideration of impacts of tenancy terminations on other government priorities and systems.

DHPW is currently undertaking a review of all of its housing policies, including the ASB Policy, to ensure that they are fair. Policies will be tested against a set of fairness principles with a focus on natural justice and ensuring a human element is a key priority in how policies are implemented. The objective is to ensure vulnerable social housing tenants are better able to sustain stable housing. The current ASB policy will be reframed to focus on early intervention, referral and support; and mutual obligation of tenants and the Department to develop the skills and capacity to sustain tenancies.

The Project's evaluation will provide valuable information to inform future policies around systems for improving supports for people with mental illness or related complex needs to better enable them to sustain stable housing.

Cross-agency collaboration will be necessary to identify possibilities for further addressing this recommendation, including information privacy and technology issues related to tracking tenants' housing status.

Future activities:

DHPW is exploring opportunities for developing a case management approach for assessing the supports needed and provided to social housing tenants and people seeking housing assistance, which would also include partnerships with relevant agencies and services across the system.

Appendix 1

DHPW response to Social Housing Ordinary Report recommendations

Impacts on at risk groups

Recommendation 4.

The DHPW examines and analyses the impact of the ASB policy on Aboriginal and Torres Strait Islander and sole parent family households, including whether these groups are subject to systemic discrimination and require additional supports to sustain their social housing tenancies.

Position: **Supported**

Current activities:

DHPW continues to monitor all of the Aboriginal and Torres Strait Islander households whose tenancy is at risk due to anti-social behaviour. The Indigenous Support Team assists housing service centres (HSCs) by developing and implementing best practice approaches, including resources, to improve housing service responses to Aboriginal and Torres Strait Islander clients.

A two-year Mental Health Demonstration Project currently being implemented is testing a new integrated housing, health and social welfare support model to improve housing stability outcomes for people living in social housing who are experiencing mental illness or related complex needs. This Project will be culturally capable and include consideration of specific supports that may be needed by Aboriginal and Torres Strait Islander participants to sustain their social housing tenancies. Evaluation of the Project will provide valuable information to inform future policies around systems for improving supports for people with mental illness or related complex needs, including Aboriginal and Torres Strait Islander peoples, to better enable them to sustain stable housing.

Future activities:

DHPW will continue to explore options for new initiatives to improve the capability of vulnerable social housing tenants to sustain their tenancies.

Recommendation 5.

The DHPW:

- Reviews the ASB Policy's communication requirements to ensure social housing tenants receive the right type of information, at the right time and in the right way, based on their unique circumstances and needs.
- Considers additional steps that could be taken to reduce confusion between strike and breach processes.
- Provides information regarding a strike or warning to support agencies and/or local mental health services, where a social housing tenant with complex needs is involved with those agencies and agrees to information being shared.

Position: **Accepted**

Current activities:

DHPW is currently undertaking a review of all of its housing policies, including the ASB Policy, to ensure that they are fair. As part of this project, strategies will be identified to improve communication with tenants and the community about DHPW policies, to ensure messages are clear, able to be understood and are transparent, to promote fairness.

This work will include consideration of the issues raised by the Commission.

Options are being considered for improving cross-agency sharing of information of participants in order to achieve more effective collaborative service delivery outcomes, as part of the two year Mental Health Demonstration Project currently underway.

The Demonstration Project is testing a new integrated housing, health and social welfare support model to improve housing stability outcomes for people living in social housing who are experiencing mental illness or related complex needs.

Impacts on at risk groups

Recommendation 6.

The DHPW reconsiders the name of the ASB policy to reflect that it includes a range of behaviours that would not ordinarily be described as 'anti-social'.

Position: **Accepted**

Current activities:

DHPW will implement this recommendation under the current review of all housing policies for fairness.

Recommendation 7.

The DHPW works in partnership with the Department of Health and other relevant agencies to:

- ensure HSC staff are provided with support and training to identify relevant support services and negotiate supports for social housing tenants where needed
- provide training and workforce development opportunities to housing HSC to enable them to identify and better work with people living with mental illness, mental health difficulties and substance use problems.

Position: **Accepted**

Current activities:

A two-year Mental Health Demonstration Project currently being implemented by DHPW in partnership with Queensland Health and in collaboration with a range of other government and non-government agencies, is testing a new integrated housing, health and social welfare support model to improve housing stability outcomes for people living in social housing who are experiencing mental illness or related complex needs.

Key deliverables from this Project which will be available for broader application across the state, include:

- the development of local support network collaboration protocols and professional development to improve HSC staff capability in identifying and coordinating relevant support services
- the development of training and workforce development opportunities to enable HSC staff to identify and better work with people living with mental illness, mental health difficulties and substance use problems.

Recommendation 8.

The DHPW considers the creation of a specialist unit or specialist positions to provide expert advice to HSC staff on dealing with complex anti-social behaviour.

Position: **Supported**

Current activities:

DHPW currently provides a range of practice improvement, procedural, and professional development supports to HSC staff to assist them in responding to clients with complex needs and/or challenging behaviour, delivered by a specialised service delivery support training team.

The two-year Mental Health Demonstration Project currently underway is trialling various additional strategies for better enabling HSC staff to deal with complex behaviours of people with mental illness or related complex needs. The Project evaluation will be available to inform improved practices in HSCs across the state in effectively dealing with complex behaviours.

Appendix 1

DHPW response to Social Housing Ordinary Report recommendations

Impacts on at risk groups

Recommendation 9.

The DHPW works in partnership with Queensland Health and other relevant agencies to implement an integrated approach at the local level to provide support to tenants to maintain their social housing tenancy, which may include developing an interagency protocol.

Position: **Accepted**

Current activities:

As part of its everyday business operations, DHPW regional offices utilise individual consent authorities and actively engage with clients to ensure appropriate links and referrals are developed and maintained to support successful tenancies. Regular information exchanges occur at a local level between agencies to share and learn from each other's processes and protocols, and these complement regular more formal interactions at the client level.

The development of interagency protocols to facilitate effective collaboration of local housing, health and welfare service delivery agencies will be undertaken as part of a two-year Mental Health Demonstration Project currently being led by DHPW in partnership with Queensland Health and in collaboration with a range of government and non-government agencies.

The Demonstration Project is testing a new integrated housing, health and social welfare support model to improve housing stability outcomes for people living in social housing who are experiencing mental illness or related complex needs.

Part of the Project will involve establishing joint processes and protocols for sharing client information between agencies, where we have the appropriate client consent, so people do not have to tell their story multiple times and services have a holistic understanding of a person's needs.

The Project's evaluation will provide valuable information to inform future government policy around most effective approaches at the local level for supporting people with mental illness or related complex needs to sustain stable housing.

Future activities:

DHPW will continue to explore options for new initiatives to improve the capability of vulnerable social housing tenants to sustain their tenancies.

Impacts on at risk groups

Recommendation 10.

The DHPW considers complementing the ASB policy with preventative, supportive and rehabilitative strategies at critical points of a person's engagement with social housing services. For example:

- preventative measures that may include mediation between social housing tenants and those making complaints, and incentive schemes
- support strategies that may include working with other agencies, staff training and expanding current supportive housing options such as HASP
- rehabilitation strategies that may include post-eviction support.

Position: **Accepted**

Current activities:

DHPW is currently undertaking a review of all of its housing policies, including policies related to anti-social behaviour, to ensure that they are fair. Policies will be tested against a set of fairness principles with a focus on natural justice and ensuring a human element is a key priority in how policies dealing with anti-social behaviour are implemented. The objective is to ensure vulnerable social housing tenants are better able to sustain stable housing.

DHPW is currently rolling out a new training and development program for HSC staff to improve their capability in early intervention complaints management responses to tenants displaying disruptive behaviour, to achieve improved sustaining tenancy outcomes.

DHPW is currently developing a tenancy management plan to better assist people living in social housing through the life of their tenancy. This will include strategies to build people's capability to achieve greater independence.

DHPW is currently undertaking development of a new IT platform (Reside) which has the potential to incorporate a client case management tool to assist in improving interactions at critical points of a person's engagement with social housing services.

Future activities:

DHPW is exploring opportunities for developing a case management approach for supporting social housing tenants and people seeking housing assistance, which would also include partnerships with relevant agencies and services across the system.

DHPW will continue to explore options for new initiatives to improve the capability of vulnerable social housing tenants to sustain their tenancies.

DHPW will review the operational procedures relating to the HASP program for people living in social housing with mental illness to ensure stronger relationships between applicants/tenants, DHPW, support agencies and Queensland Health.

Appendix 1

DHPW response to Social Housing Ordinary Report recommendations

Impacts on at risk groups

Recommendation 11.

The DHPW considers amending the ASB policy to require that:

- warnings are issued prior to the first strike for social housing tenants with complex needs
- social housing tenants are engaged in developing Acceptable Behaviour Agreements.

Position: **Accepted**

Current activities:

DHPW is currently undertaking a review of all of its housing policies, including the ASB Policy, to ensure that they are fair. Policies will be tested against a set of fairness principles with a focus on natural justice and ensuring a human element is a key priority in how policies are implemented. The objective is to ensure vulnerable social housing tenants are better able to sustain stable housing.

A part of the review, it is proposed to withdraw strike provisions in policy and retain the escalation of breach provisions so that termination of tenancies can occur when tenants or the household and guests persistently demonstrate poor behaviour. Any new policy development resulting from this review will incorporate earlier provision of support to stabilise the tenancy, including how Acceptable Behaviour Agreements will be used.

As part of this project, strategies will also be identified to improve communication with tenants and the community about DHPW policies to ensure messages are clear, able to be understood, and transparent, to promote fairness.

DHPW is currently developing a tenancy management plan to better assist people living in social housing through the life of their tenancies.

Future activities:

DHPW is exploring opportunities for developing a case management approach for supporting social housing tenants and people seeking housing assistance, which would also include partnerships with relevant agencies and services across the system.

Recommendation 12.

The DHPW considers including provisions in the ASB policy that:

- acknowledge that tenants with complex needs may be more likely than the general population to be victims of anti-social behaviour
- provide a mechanism to identify where complaints have been made against social housing tenants on the basis of discrimination and when complaints may be considered vexatious.

Position: **Accepted**

Current activities:

DHPW is currently undertaking a review of all of its housing policies, including the ASB Policy, to ensure that they are fair. Policies will be tested against a set of fairness principles with a focus on natural justice and ensuring a human element is a key priority in how policies are implemented. The objective is to ensure vulnerable social housing tenants are better able to sustain stable housing.

A new policy for managing disruptive behaviour in social housing sets out the expectations of reasonable behaviours and establishes a framework for managing breaches, including focus on early intervention, referral and support; and mutual obligation of tenants and the department to develop the skills and capacity to sustain tenancies.

A guide to supportive tenancy management called 'Living in Social Housing' will clearly establish tenants and clearly explains tenancy rights and responsibilities and will help support successful tenancies.

This review will include examination of complaints management practice processes undertaken by HSCs relating to complaints of anti-social behaviour of tenants.

Future activities:

DHPW will consider options around housing allocations and tenancy management of people with high and complex needs, especially where behavioural issues are putting tenancies at risk.

Appendix 2
Requests made by Council

Meeting date: **21 July 2014**

Issue: **Mental Health Act Review**

Commission's submission to the Department of Health regarding the proposals for legislative change.

Council request/s:

1. Council requested the Commission address the following key issues in preparing its submission to the Mental Health Act Review:
   - Embedding a consumer-centred and recovery-orientated approach and the importance of families and carers in the objects, principles and throughout legislation.
   - Maintenance of the role of the Allied Person as a right not a requirement and ensuring independence of the proposed independent patient companion.
   - Ensuring implementation is appropriately resourced and an early process for external review is established.
   - Review times for the Mental Health Review Tribunal should be shortened, commensurate with best practice in other jurisdictions; with specific consideration given to shorter review times for children.
   - The importance of maintaining an approach that this legislation is about treating people with mental illness, whether or not they are in the civil or forensic system.
   - To the extent that mental health legislation is not an appropriate tool to ensure physical health and patient safety, action is taken through alternative mechanisms to address these critical issues.

Commission actions:

The Commission provided a submission on the draft Bill incorporating the key issues raised by the Council.

The submission indicated that although the Commission supported the Bill in-principle it noted a number of areas which required further consideration including the need to ensure the Patient Rights Advisers are independent and are seen to be independent from Hospital and Health Services.

Meeting date: **14 October 2014**

Issue: **Least restrictive practice and locked wards**

Commission recommendations for implementing least restrictive practices in acute mental health wards including locked wards.

Council request/s:

1. Council requested the Commission to consider how it might review the extent to which these recommendations will be implemented in 12 months' time.

Commission actions:

The Commission is currently working with the Department of Health to monitor and support implementation.

The Mental Health, Alcohol and Drug Clinical Network advised the options for reform will be included in the agenda for an upcoming workshop.

The Commission also supported the options for reform through a variety of forums, including ensuring that the Mental Health Bill enables their implementation.

Meeting date: **2 December 2014**

Issue: **Cessation of smoking**

Support post discharge from in-patient facilities.

Council request/s:

1. Council requested the Commission to continue their discussions with Queensland Health to explore opportunities to support consumers leaving in-patient facilities to maintain their commitment to giving up smoking when leaving hospital.

Commission actions:

Commission is continuing their discussions with Queensland Health.

Appendix 2
Requests made by Council

Meeting date: **20 April 2015**

Issue: **Consumer and carer input into service design and delivery**

Concern regarding lack of acceptance for the importance of consumer and carer input into service design and delivery.

Council request/s:	*Commission actions:*
1. Commission prioritise research to identify and collate the benefits of consumer and care input in improving service planning and delivery in its 2015–2016 operational plan. This should include primary, community and public mental health services.	The Commission has engaged Urbis to undertake a project to map the extent and nature of consumer, family and carer leadership and engagement in the public, private and non-government mental health and alcohol and drug sectors. This work has commenced and is due to be completed towards the end of 2015.

Meeting date: **20 April 2015**

Issue: **Lack of Indigenous leadership in health services**

Lack of opportunity for Indigenous leadership in the planning and oversight of the Hospital and Health Services as well as primary health services.

Council request/s:	*Commission actions:*
1. Commissioner write to the Director-General, Department of Health seeking support to: • Adopt the principles of the Wharerata Declaration at all levels of policy, planning and service delivery relevant to Aboriginal and Torres Strait Islander peoples. • Establish a mechanism for Aboriginal and Torres Strait Islander input at the highest level in policy, planning and service delivery across social services, including physical and mental health.	Correspondence was sent from the Commissioner to the Acting Director-General, Department of Health. The Acting Director-General advised that he had raised the issue with the Chairs of Hospital and Health Boards.

Meeting date: **20 April 2015**

Issue: **Response to Indigenous suicides**

Townsville Indigenous Suicide.

Council request/s:	*Commission actions:*
1. Commissioner to write to the Director-General, Department of Health seeking support to give urgent consideration to increasing access to 24 hour services in areas where there are relatively high levels of suicide and attempted suicide. 2. Commissioner to urgently investigate the options for funding and evaluating a trial 24 hour primary health service in Townsville that focusses on suicide prevention.	The Commission has engaged Professor Barbara Schmidt to scope the issues around a 24 hour response to suicides in Townsville.

Meeting date: **20 April 2015**

Issue: **Mental Health Act Review**

Concern over the use of medication as a form of chemical restraint rather than as a therapeutic treatment and lack of guidance in current legislation.

Council request/s:	*Commission actions:*
1. Commission to raise the issue of medication being used specifically to restrain behaviour in its forthcoming comment on the draft Mental Health Bill. 2. If not an appropriate lever, Council requested information on current and any proposed forms of oversight and guidelines, and the extent of consumer, family and carer input to the development and review of those guidelines.	The Commission welcomed in their recent submission the inclusion of provisions making it an offence to give medication to an involuntary patient unless the medication is clinically necessary.

Meeting date: **20 April 2015**

Issue: **NDIS implementation**

Concerns regarding the implementation of NDIS for people with psychosocial (psychiatric) disability.

Council request/s:	*Commission actions:*
1. Commissioner was requested to write to the Queensland Health to: • Seek assurance that funding for community-managed mental health services will not be impacted by the introduction of the NDIS in Queensland. • Clarify related issues of the potential impact of NDIS implementation in Queensland on people with mental illness.	Commissioner wrote to the Acting Director-General regarding the issues raised by Council at 20 April 2015 meeting. The Commission will convene a workshop for sector leaders in September 2015 to identify any specific actions that might complement existing activity. In June the Commissioner wrote to the Disability Services Minister to raise the issue of mental health representation on the Queensland Transition Implementation Advisory Group (QTAG). Inclusion of a mental health service provider was suggested as a possible improvement. The Minister advised that additional representative panels will be convened as locations and cohorts are phased in from July 2016.

Meeting date: **20 April 2015**

Issue: **Social Services Legislation Amendment Bill 2015 (Disability Support Pensions for forensic patients)**

Concern regarding the proposal by the Commonwealth Government to remove eligibility of certain forensic mental health patients for disability support pension.

Council request/s	
1. Commission to provide an update from the correspondence to the Director-General, Department of Health in relation to funding to meet the gap should the change be implemented.	Commission wrote to the Acting Director-General, Department of Health seeking assurance that mental health funding will not be affected as a result of disability support payments to inpatients on a Forensic Order. Queensland Health prepared a comprehensive submission to the Commonwealth arguing against this amendment.

Appendix 3
Forums and events attended by the Commissioner

July

2	Mental Health Act Review facilitated forums
	Premiers Office, presentation to Child Protection Reform Leaders Group
12	Opening address at Branch Conference of the Royal Australian and New Zealand College of Psychiatrists
15	Estimates Hearing, Parliament House
18	Queensland Police Service, presentation by Queensland Fixated Threat Assessment Centre
21	Queensland Mental Health and Drug Advisory Council meeting
30	Mount Isa Centre for Rural and Remote Health

August

15	Medicare Local – West Moreton/Oxley
28	The MHS Conference, Perth
29	The MHS Conference, Perth

September

2	Violence Research and Prevention Program Policy Breakfast *(guest speaker)*
3	Statewide Maternity and Neonatal Clinical Network Forum *(guest speaker)*
4	Community Visitors Forum *(guest speaker)*
10	World Suicide Prevention Day *(guest speaker)*
	Homelessness and Mental Health Conference, Broadbeach *(guest speaker)*
17	Department of Premier and Cabinet, Social Policy Speakers Corner
23	Department of Communities, Child Safety and Disability Services Executive Management Team Meeting
24	Assistant Minister for Multicultural Affairs, Mr Robert Cavallucci MP, Queensland Cultural Diversity Roundtable
30	Ministerial Roundtable for Rural and Remote Mental Health

October

2	Australian Association for Infant Mental Health National Conference *(guest speaker)*
8	Queensland Mental Health Week Launch Q&A
10	Launch of School of Hard Knocks
	Queensland Mental Health Week Achievement Awards
12	Mental Awareness Foundation Walk for Awareness
14	Queensland Mental Health and Drug Advisory Council meeting
17	Local Buy Procurement Forum
22	ARAFMI Annual General Meeting
30	Queensland Mind and Neuroscience Institute Forum – University of Sunshine Coast *(guest speaker)*
31	GROW Annual Branch Conference *(guest speaker)*

November

5	Drought Community Mental Health Tool Kit Steering Committee
7	Queensland Alliance for Mental Health and the Strategic Adviser to the National Disability Insurance Agency
10	QPASTT Annual General Meeting
26	Mental Illness Fellowship Queensland staff conference *(guest speaker)*
	NDIS Qld Business Leaders Forum

December

1	CheckUP Forum with Professor Linda Aiken
2	Queensland Mental Health and Drug Advisory Council Christmas Event with Minister for Health and invited guests
3	Queensland Nurses' Union symposium *(guest speaker)*
5	Gay and Lesbian Welfare Association AGM *(guest speaker)*
8	Mental Health Alcohol and Other Drugs Branch staff meeting *(guest speaker)*
11	Stanthorpe Rural and Remote Ministerial Roundtable
12	South Australian Mental Health (Adelaide) *(guest speaker)*
19	School of Hard Knocks Choir

February

10	Royal Australian and New Zealand College of Psychiatrists Queensland Branch Committee Meeting
13	Queensland Mental Health and Drug Advisory Council meeting
16	Mental Health Commissioners Australia and New Zealand
25	Scenic Rim Community Forum *(guest speaker)*
26	Gold Coast Hospital and Health Board meeting (guest participant)
27	LIFE Think Tank Workshop series *(guest speaker)*

March

6	Suicide prevention action plan workshop
18	Queensland Brain Institute Autism Seminar
19	Partners in Recovery Community Forum, *(guest speaker)*
	Gallang Place, Closing the Gap event *(guest speaker)*
24	Ed-LinQ Planning Workshop
25	Isis The Eating Issues Centre
26	Hearing Voices Workshop, Metro North Mental Health Services
27	Alcohol and Other Drug Reference Group, hosted by the Commission

April

2	Out of the Box Conference, Wide Bay Hospital and Health Service *(guest speaker)*
13	Mental Health and Wellbeing 'Start Well' Consultation Forum
14	Mental Health and Wellbeing 'Live Well' Statewide Consultation Forum
	Mental Health and Wellbeing 'Work Well' Consultation Forum
15	Mental Health and Wellbeing 'Age Well' Consultation Forum
16	Senior Executives, Queensland Government Departments on mental health and wellbeing
	Wharerata consultation meeting
17	Mental Health and Wellbeing 'Live Well' Statewide Consultation Forum Townsville
24	Wesley LifeForce Mission *(guest speaker)*

May

4	Royal Australian and New Zealand College of Psychiatrists Annual College Ceremony
7	Justice in Focus Series *(panel discussion)*
8	Queensland Fire and Emergency Services Breakfast Forum
11	Pre-launch 24th Annual Art Exhibition, Mental Illness Fellowship Queensland
12	Alcohol and Other Drug Roundtable, hosted by the Commission
13	24th Annual Art Exhibition opening, Mental Illness Fellowship Queensland
26	Roundtable on consumers and mental health nursing education, hosted by the Commission
29	Brisbane Mental Health and Wellbeing of Young People seminar *(guest speaker)*

June

2	North Brisbane Partners in Recovery
4	Mental Health Nursing & Perinatal & Infant Mental Health Conference *(guest speaker)*
15	Queensland Mental Health and Drug Advisory Council meeting
16	Health Community Leaders Roundtable on Domestic and Family Violence, Gold Coast
17	MATES in Construction Breakfast Forum for Kokoda Trek
	Queensland Mental Health Week Corporate Workplace Achievement Awards
24	Suicide & Self-harm Prevention Conference, Cairns *(guest speaker)*
25	Suicide & Self-harm Prevention Conference, Cairns
26	Indigenous Knowledge Conference
30	Minister for Health lunch with Queensland mental health and drug sector

Appendix 4
Compliance checklist

Summary of requirement		Basis for requirement	Annual Report reference
Letter of compliance	A letter of compliance from the accountable officer or statutory body to the relevant Minister/s	ARRs – section 8	3
Accessibility	Table of contents	ARRs – section 10.1	1
	Glossary		94
	Public availability	ARRs – section 10.2	Imprint page
	Interpreter service statement	*Queensland Government Language Services Policy* ARRs – section 10.3	Imprint page
	Copyright notice	*Copyright Act 1968* ARRs – section 10.4	Imprint page
	Information Licensing	*QGEA – Information Licensing* ARRs – section 10.5	Imprint page
General information	Introductory Information	ARRs – section 11.1	6
	Agency role and main functions	ARRs – section 11.2	6
	Operating environment	ARRs – section 11.3	43
	Machinery of government changes	ARRs – section 11.4	N/A
Non-financial performance	Government's objectives for the community	ARRs – section 12.1	6
	Other whole-of-government plans / specific initiatives	ARRs – section 12.2	10
	Agency objectives and performance indicators	ARRs – section 12.3	8, 46
	Agency service areas and service standards	ARRs – section 12.4	46
Financial performance	Summary of financial performance	ARRs – section 13.1	39
Governance – management and structure	Organisational structure	ARRs – section 14.1	45
	Executive management	ARRs – section 14.2	44
	Government bodies (statutory bodies and other entities)	ARRs – section 14.3	N/A
	Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* ARRs – section 14.4	48

Summary of requirement		Basis for requirement	Annual Report reference
Governance – risk management and accountability	Risk management	ARRs – section 15.1	48
	External scrutiny	ARRs – section 15.2	N/A
	Audit committee	ARRs – section 15.3	49
	Internal audit	ARRs – section 15.4	49
	Information systems and recordkeeping	ARRs – section 15.5	49
Governance – human resources	Workforce planning and performance	ARRs – section 16.1	49
	Early retirement, redundancy and retrenchment	Directive No.11/12 *Early Retirement, Redundancy and Retrenchment* ARRs – section 16.2	N/A
Open Data	Consultancies	ARRs – section 17 ARRs – section 34.1	40
	Overseas travel	ARRs – section 17 ARRs – section 34.2	42
	Queensland Language Services Policy	ARRs – section 17 ARRs – section 34.3	N/A
	Government bodies	ARRs – section 17 ARRs – section 34.4	N/A
Financial statements	Certification of financial statements	FAA – section 62 FPMS – sections 42, 43 and 50 ARRs – section 18.1	76
	Independent Auditors Report	FAA – section 62 FPMS – section 50 ARRs – section 18.2	77
	Remuneration disclosures	Financial Reporting Requirements for Queensland Government Agencies ARRs – section 18.3	64

Appendix 5
Glossary

Term	Meaning
Act	*Queensland Mental Health Commission Act 2013*
AISRAP	Australian Institute of Suicide Research and Prevention
ARC	Australian Research Council
ASB Policy	Anti-social Behaviour Management Policy
CFC Committee	Consumer, Family and Carer Committee
Commission	Queensland Mental Health Commission
Council	Queensland Mental Health and Drug Advisory Council
DHPW	Department of Housing and Public Works
EMT	Executive Management Team
FTE	Full time equivalent
HASP	Housing and Support Program
HHS	Hospital and Health Service
HHS SRAMP	Hospital and Health Service Suicide Risk Assessment and Management Project
HSC	Housing Service Centre
iQSR	Interim Queensland Suicide Register
ISSR	Institute of Social Science Research
NATSILMH	National Aboriginal and Torres Strait Islander Leadership in Mental Health
NEP	National Empowerment Project
QNADA	Queensland Network of Alcohol and other Drug Agencies
QSR	Queensland Suicide Register

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