PART EIGHT: APPENDICES

8.1 List of community consultations by State/Territory 853

8.1.1 List of community forums held by State/Territory 853

8.1.2 List of consultations 854

8.2 Summary of submissions received by State/Territory 854

8.2.1 Number of submissions received by State/Territory 854

8.3 List of Submissions received by State/Territory 855

8.3.1 List of submissions received - New South Wales 855

8.3.2 List of submissions received - Victoria 856

8.3.4 List of submissions received - South Australia 857

8.3.5 List of submissions received - Western Australia 858

8.3.6 List of submissions received - Australian Capital Territory 859

8.3.7 List of submissions received - Northern Territory 859

8.3.8 List of submissions received - Tasmania 859

8.3.9 List of submissions received - National 860

8.4 Responses from State, Territory and Federal Governments 861

8.4.1 Response from New South Wales Government 861

8.4.2 Response from Victoria Government 866

8.4.3 Response from Queensland Government 882

8.4.4 Response from South Australian Government 893

8.4.5 Response from Western Australian Government 928

8.4.6 Response from Australian Capital Territory Government 946

8.4.7 Response from Northern Territory Government 955

8.4.8 Response from Tasmanian Government 956

8.4.9 Response from Federal Government 958

8.5 Survey – Implementation of community priorities in mental health 964

8.6 Survey – Consumer and carer experiences of care 969

8.7 National Standards for Mental Health Services 980

8.8 Snapshot of media reports regarding crisis in mental health car 1000

8.9 State/Territory funding announcements 1004

8.1 LIST OF COMMUNITY CONSULTATIONS BY STATE / TERRITORY

Table 8.1.1: List of community forums held by State/Territory

State/Territory	Approximate Combined Number of Attendees	Forum Location	Forum Date
Australian Capital Territory	100	Canberra	16 August 2004
New South Wales	163	Sydney Broken Hill Parramatta Parramatta (NESB)*	12 July 2004 15 July 2004 10 September 2004 14 October 2004
Northern Territory	130	Darwin Alice Springs	1 September 2004 2 September 2004
Queensland	110	South Brisbane Rockhampton	12 July 2004 13 July 2004
South Australia	120	Adelaide Murray Bridge	16 July 2004 16 July 2004
Tasmania	80	Hobart	7 September 2004
Victoria	210	Melbourne Morwell Footscray West	6 September 2004 6 September 2004 6 October 2004
Western Australia	280	Bunbury West Perth Geraldton Geraldton (Civic and Local Government Service Leaders)	5 July 2004 6 July 2004 13th September 2004 13th September 2004
Total	**1183**	**19**	

* Focus of forum was on issues for people from a Non-English speaking background

Table 8.1.2: List of consultations

Organisation	Individual(s)	Date
National Disability Advisory Council	Ian Spicer AM, Chair	30 July 2004
Catholic Social Services Victoria	Theresa Lynch, Senior Policy Officer	17 August 2004
CYCLOPS ACT (Connecting Young Carers to Life Opportunities and Personalised Support)	Young carers from CYCLOPS ACT	19 August 2004
South Australian Prison Health Service	Dr Chris Holmwood, Clinical Director	29 September 2004
South Australian Chief Magistrate	Chief Magistrate, Kelvyn John Prescott	29 September 2004
Australian Nursing Federation	Rob Bonner, Senior Industrial Officer	29 September 2004
Victorian Mental Illness Awareness Council (VMIAC)	VMIAC group	6 October 2004
Mental Health Review Board of Victoria	John Lesser, President	12 October 2004
The Australian Capital Territory Community and Health Services Complaints Commissioner	Philip Moss, Community and Health Services Complaints Commissioner	15 October, 2004
Australian Federal Police	Superintendents Quade and Kilfoyle	20 October 2004
Equal Opportunity Commission of South Australia	Linda Matthews, Commissioner for Equal Opportunity	20 October 2004
Forensicare: Victorian Institute of Forensic Mental Health	Michael Burt, CEO Professor Paul Mullen, Clinical Director	15 November 2004

8.2 SUMMARY OF SUBMISSIONS RECEIVED BY STATE / TERRITORY

Table 8.2.1: Number of submissions received by State/Territory

State/Territory	Submissions #
Australian Capital Territory	14
New South Wales	82
Northern Territory	8
Queensland	47
South Australia	31
Tasmania	14
Victoria	94
Western Australia	46
National (including 4 unknown)	15
Total	351

8.3 LIST OF SUBMISSIONS RECEIVED BY STATE / TERRITORY

8.3.1 LIST OF SUBMISSIONS RECEIVED - NEW SOUTH WALES

Anonymous x 19
Bennett, Elizabeth
Beverley, Satu
Butler, Jennifer
Carrington, Ros
Casey, Desley
Chapman, Chris & Gordon
City of Sydney
Comely, Christina
Community Offender Services, Probation and Parole Service. NSW Department of Corrective Services
Comprehensive Area Service Psychiatrists (CASP) Group
Cooke, Cecelia
Council of Social Service of NSW (NCOSS)
Deaf Society
Double, Allison
Drummond, Rita
Eastern Area Interagency NSW
Fisher, Wilma
Flynn, Kate
Glanville, Phil
Goldsmith, John & Bettina
Holt, Gillian & Warren
Gloria
Graham, Rex
Harman, Lyn
Harris, Myree; St Vincent de Paul NSW
Homelessness NSW.ACT
Indigenous Social Justice Association (ISJA) and Justice Action (JA)
Kelly, Warwick & Bronwyn
Leseberg, John
Littley, John
Macqueen, Dr Rod
Makarewicz, Richard
McArthur, Lee
McKenzie, Lindy
Mental Health Coordinating Council
Mental Health Workers Alliance
Morrison, Pat
Neaves, Anna
NSW Association for Adolescent Services
NSW Association for Adolescent Health (NAAH)
NSW Consumer Advisory Group Mental Health Inc
NSW Department of Corrective Services
NSW South Coast Mental Health Community Consultative Committee
Police Association of NSW
Raison, Pauline & John
Reid, Jenni
Rigley, Chris
Rosen, Adjunct Professor Alan

Schofield, Elaine
Scott-Orr, Donald
Snowdon, John
Stevenson, Bob & Shirley
Stuart, Cath
Tamer, Caroline
Taylor, Anna
Van Epen, Lorraine
W, Jacqui
Walgett SAAP Services
Walker, June
Wallace, Michael
Whyte, Denise
Wilkes, Dave
Wright, Ron, St Vincent de Paul, Swansea Conference

8.3.2 LIST OF SUBMISSIONS RECEIVED - VICTORIA

Anonymous x 28
Anex
Association of Relatives and Friends of the Mentally Ill (ARAFEMI) Victoria
Australian & New Zealand College of Mental Health Nurses
Australian Nursing Federation (Vic Branch)
Australian Polish Community Services
Blaikie, John
Bond, Graeme
Brotherhood of St Laurence and Catholic Social Services Victoria
Bryant, Therese
Bush, Gabrielle
Cannard, Gwenda
Carers Victoria
Centre for Psychiatric Nursing Research and Practice
Chamley, Wayne
Clark, Laurel
Cohan, David
Cusworth, Joan
Disability Employment Action Centre (DEAC) Inc.
Delaney, Kath
Di Guglielmo, Mario
Douglas, Lyn
Drummond, Roma
Dwyer, Matthew
Epstein, Merinda
Filando, Frank
Franklin, Majella
Grand, Kathryn
Grieb, Elizabeth
Halloran, John
Health and Community Services Union
Hewitt, Trish
Hyndman, Stephanie
Insane Australia
King, Susan
Kirkham, Judith A

Lewisohn, Penelope
Lillie, Pauline
Lloyd-Thomas, Gina
Lockwood, Peter
Luxford, Pat & Kevin
Lyon, Pat
Margaret
McDonald, Beth & Peter
McGorry, Professor Patrick
Mental Health Legal Centre
Monash, Dr David
Network for Carers
Office of the Public Advocate
Olsen, Anne
Orygen Research Centre
Peninsula Carers Council; Nyorie Lindner
Pinches, Allan
Robinson, Jan
Rose, Peggy
Sayers, Rhonda
Singer, Esther, Youth Participation Worker
Spencer, Reverend Barbara
Steward, Kirsty
Stewart, Carolyn
Storm, Caroline
Thompson, Barry
Tine, Claudio
Vance, Heather
Verdon, Debbie; Grampians disAbility Advocacy Association
Victorian Mental Illness Awareness Council Inc.

8.3.3 LIST OF SUBMISSIONS RECEIVED - QUEENSLAND

Anonymous x 15
Abell, Julie & Joanne
Berrill, Julie
Bird, Gavin
Brain Injury Association of QLD
Burgess, Pat
Campbell, Cathy
Cassar, Simeon
Cesare, Maxine
Cesari-White, Judith
Cook, Brigitte
Cox, Raymond
Daniell, Allan
Down, Judi
Duncan, Jane
Flegg, Dr Bruce, MP; Liberal Party of Queensland
Franklin, Christine
Gunn, Dr Andrew
Kubainski, Peter
Laughton, Ted
Lie, Dr David

McDiarmid, Carolyn
Mental Health Unit, Queensland Health
Miller, Des
Queensland Alliance of Mental Illness and Psychiatric Disability Groups
Quinton, Mal & Elda
Salvage, Rod
Smith, Daryl
Stock, Rhonda
Thomson, Les
Ubaldi, Vera
White Wreath Association
Wyllie, Hazel & Allen

8.3.4 LIST OF SUBMISSIONS RECEIVED - SOUTH AUSTRALIA

Anonymous x 10
beyond...(Kathleen Stacey & Associaties) Pty Ltd
Carers SA, Rosemary Warmington
Cord-Udy, Nigel
Evans, Sheila
Gibbs, Helen
Guther, Pamela
Harding, Stephen
Healey, Maureen
Health and Community Services Network, Murray Mallee Strategic Task Force
Jureidini, Jon
Muir-Cochrane, Eimear
Office of Crime Statistics and Research, Attorney-General’s Department, Government of South Australia
Poole, Dennis & Rosemary
Quick, Pam
Roach, Ronald
Ross, Jayne
Sharon
Smith, Janice
Spurrier, Michael
Taylor, Dawn
Youth Affairs Council of South Australia

8.3.5 LIST OF SUBMISSIONS RECEIVED - WESTERN AUSTRALIA

Anonymous x 22
Bunbury Pathways; Joscelyn Jones
Carers WA
Cook, Margaret
Courtis, Alva
D'Agostino, Rob
Health Consumers’ Council WA
Evans, Peter
Fowke, Tony
Greater Bunbury Division of General Practice
Hindle, John
Jackson, Colin
Loader, Kim, Bunbury Pathways Carer Support Program

Lord, Dr David
Martin, Debbie
McIntosh, Bill
McPherson, Jann
Mitchell, Melva
Mostafanejad, Karola
Prendergast, Margaret
Shanley, Dr Eamon
Sharp, Noel, Senior
St Bartholomew's House; Lyn Evans
Wakely, Carol
Watson, Giz, MLC, Member for North Metropolitan Region, Parliament of Western Australia

8.3.6 LIST OF SUBMISSIONS RECEIVED - AUSTRALIAN CAPITAL TERRITORY

Anonymous x 6
ACT Disability, Aged & Carer Advocacy Service (ADACAS)
Barker, Geoff
Bone, Linette
Egan, Sheelah
McGeechan, Kathleen
Mental Health Community Coalition Consumer and Carer Caucus
Mental Health Foundation ACT Inc
Wylde-Browne, Margy

8.3.7 LIST OF SUBMISSIONS RECEIVED - NORTHERN TERRITORY

Anonymous x 4
Darwin Red Shield Hostel
Davies, Sam
Mental Health Program, Department of Health and Community Services
Support and Equity Services, Charles Darwin University

8.3.8 LIST OF SUBMISSIONS RECEIVED – TASMANIA

Anonymous
Advocacy Tasmania Inc – Mental Health Tribunal Representation Scheme
Anglicare Tasmania (Report by Prue Cameron & Jo Flanagan, Social Action and Research Centre)
ARAFMI Hobart
ARAFMI Tasmania
Australian Family Association Tasmanian Branch
Cadence FM Inc Community Radio
Campbell-Smith, Mollie
Colony 47
Fairbrother, Thea
Graham, James (Migloo)
Konetschnik, Beris
Malaher, Terrence
Napier, Sue, MHA

8.3.9 LIST OF SUBMISSIONS RECEIVED - NATIONAL

Anonymous x 4
Advocates for Seminars of Child Abuse
Australian Infant, Child, Adolescent and Family mental Health Association (AICAFMHA)
BlueVoices
Carers Australia
Constable, Michael
Deafness Forum Australia
Drug Free Australia
Families and Friends for Drug Law Reform
Mental Illness Fellowship of Australia
National Network of Private Psychiatric Sector Consumers and Carers
SANE Australia

8.4 RESPONSES FROM STATE, TERRITORY AND FEDERAL GOVERNMENTS

8.4.1 RESPONSE FROM NEW SOUTH WALES GOVERNMENT

NEW SOUTH WALES

MINISTER FOR HEALTH

H05/ 3214

04 MAY 2012

Mr John Mendoza
Chief Executive Officer
Mental Health Council of Australia
PO Box 174 Deakin West
ACT 2600

Facsimile: 02 6285 2166

Dear Mr Mendoza

Thank you for your letter of 24th March 2005 and the copy of the *Mental Health and Human Rights* Draft Report.

I am enclosing a brief NSW Health Department's response, as invited, for inclusion in the report.

If you would like to have any additional information about the service developments in the response, the person to contact is Dr Michael Paton in the Department's Centre for Mental Health on 02 9391 9309.

Yours sincerely

Morris Iemma MP
Minister for Health

Locked Mail Bag 961 North Sydney NSW 2059 Telephone (02) 9228 4299 Facsimile (02) 9228 4277

NSW Health Response to Mental Health and Human Rights Report

NSW Health welcomes the opportunity to comment on the report of the Mental Health Council of Australia, The Brain and Mind Institute, in association with the Human Rights and Equal Opportunity Commission.

The principal objective of NSW mental health services is to improve the health, wellbeing and social functioning of people with disabling mental disorders and to reduce the incidence of suicide, mental health problems and mental disorders in the community.

To meet those objectives in 2004-05, the NSW Government allocated a $783 million to serve an estimated consumer population of about 100,000, focusing primarily on those people with severe and disabling mental health disorders. NSW mental health services comprised (in 2003-04) 5,573 full-time equivalent clinical staff, who provided 24,642 episodes of acute overnight inpatient care, 261,327 days of non-acute inpatient care and about 2 million community contacts.

In addition, NSW Health continued its telephone survey program to assess population levels of psychological distress in adults and parent-reported problems in children and young people, finding that the levels of both were about the same as in previous years and other countries. In 2003-04 hospitals in NSW admitted 9,500 people after suicide attempts, and the death rate by suicide dropped to 9.6 per 100,000 population, the lowest rate in Australia and the lowest level reached in more than 20 years.

Based on views expressed by those who attended consultations and made submissions, the MHCA report prepared with the assistance of Professor Hickie from the Brain and Mind Research Institute at Sydney University, in association with the Human Rights Commissioner Dr Ozdowski, is critical of mental health services provided by States and Territories.

In the section of the report covering NSW there are about 470 quotations judged to reflect “matters of concern”, including more than 100 citations regarding Standard 9 (service development). More than half of those 100 quotations come from just six submissions, all made by clinicians or clinical groups, each cited between 5 and 15 times. In NSW Health’s view, the report’s methodology places excessive emphasis on the opinions of service development expressed by a very small number of clinicians.

There is an important distinction to be made between what mental health services usually do, and what happens when, on occasion, services do not deliver what consumers and carers expect of them. While it is acknowledged that consumers and carers have reported unacceptable care and treatment, NSW Health does not accept that the report provides convincing evidence of NSW mental health services generally failing in their duty of care.

Mental health is a priority for the NSW Government. The Mental health budget is now at record levels, having increased 121 per cent since 1994-95. Demand for services continues to grow, and many existing services are under pressure. There is no doubt more needs to be done and NSW Health has plans to accelerate this growth in services over the next four years. Details are set out below:

Hospital and Emergency Services

Since June 2001, an additional 257 mental health beds have opened with a further, 40 beds to open by June 2005. These include additions or new units at:

- *Wyong, Tweed Valley, Coffs Harbour, Taree, Kempsey, Tamworth, Wagga Wagga, Albury, Wollongong and Bloomfield Hospital in Orange*
- *child and adolescent beds at Westmead Hospital, Gna Ka Lun at Campbelltown, the Nexus Unit at John Hunter in Newcastle, Sydney Children's Hospital and Westmead Children's Hospital; and*
- *refurbishments and additional beds at Prince of Wales, St George, Sutherland, Westmead, Cumberland and Nepean Hospitals.*

Over the next three years the NSW Government will open 246 more mental health beds. They include:

- Acute units at Lismore, Dubbo, Liverpool and Blue Mountains
- 100 longer stay beds in four 20 bed units at Campbelltown, St George, Shellharbour, Coffs Harbour and the Hunter
- A new child and adolescent unit in Lismore
- An older person's unit in Wollongong
- Additional forensic mental health beds in a new stand alone Forensic Hospital; and
- A brand new 174 bed mental health facility to be built at Concord Hospital replacing the existing facilities at Rozelle. The first phase of this has begun, with the transfer of 40 psycho-geriatric beds from Rozelle Hospital to the new community health facility in Croydon.

Clinical Nurse Consultants have been employed in Emergency Departments to identify, triage and provide specialist care to patients with a mental illness in hospitals at:

- Bankstown, Campbelltown, Gosford, Hornsby, Liverpool, Nepean, Prince of Wales, Royal North Shore, Royal Prince Alfred, St George, Sutherland, St Vincent's, Westmead, Albury-Wodonga, Blue Mountains, Coffs Harbour, Lismore, Maitland, Shellharbour, Tamworth and Taree.

Psychiatric Emergency Care Centres (PECCs) are dedicated services, situated adjacent to the Emergency Department, staffed 24 hours a day, 7 days a week by specialist mental health staff. PECCs have been successfully trialled at Liverpool and Nepean Hospitals and the program is being expanded with PECCs at St Vincent's, St George and Hornsby Hospitals and other centres to follow.

Based on its Mental Health – Clinical Care and Prevention planning model, NSW Health has been building up the less-resourced Areas while maintaining and improving those with higher resource levels. NSW Health has ensured that community as well as inpatient services are being enhanced, with the following developments:

Community Mental Health Services The NSW Government invests 45 per cent of the total mental health budget on community mental health services. In 2004/05, 2,570 mental health staff are working in the community – up from 1,398 in 1994-95.

Housing: A joint initiative between Health, Housing and non-government organisations - the Housing, Accommodation and Support Initiative (HASI) - is providing coordinated disability support, accommodation and health services to over 118 people requiring high-level support to live in the community. HASI Phase 2 is now being implemented with successful tenders awarded to NGOs to provide disability assistance to a further 460 people in public and community housing across NSW.

Court Liaison: In 2003/4 the NSW Government formally established the Statewide Court Liaison Service - a partnership between Health, Police, the Attorney General and Corrective Services. That year it screened 18,902 court attendees, referred 1,945 people for assessment and found 1,413 to have an identifiable mental illness. Of these, 204 were treated in hospital and 702 were provided with treatment by community mental health services. The Court Liaison Service now operates in 19 courts across metropolitan and regional NSW, starting from a two court pilot in 2000.

Human Rights and Legislative Issues

There seems to be a misapprehension in some submissions that NSW Health is over-emphasising the provision of acute inpatient services and adopting a custodial attitude. This is not so. The recent emphasis on adding acute inpatient beds and psychiatric emergency care is driven by the identified need to improve access to acute mental health services in NSW. As noted above, this has not occurred at the expense of community mental health.

NSW Health is not moving to a more custodial mode of service provision in mental health. The NSW Mental Health Act 1990 received favourable mention in the original Burdekin Report of 1993 for its efforts to place key definitions in law, and this requires constant review. The current review of the Mental Health Act sought views on these elements - there was strong endorsement of these definitions and there is no intention to amend them. The discussion papers are available at www.health.nsw.gov.au/pubs/2004/menthealthrev.html.

The formal submission phase of the review concluded in October 2004, but additional input will be sought when an exposure draft Bill is circulated. A further public consultation process on the review of the Mental Health Act has commenced, and NSW Health encourage all to consider the discussion papers and provide comment on to the exposure draft Bill.

Obtaining and responding to consumer and carer feedback

The NSW approach to this area is a direct result of consumer requests in 2001. We have now been working for several years with the NSW Consumer Advisory Group (NSWCAG) on the MH-CoPES (Consumer Perceptions and Experiences of Services) project. MH-CoPES was requested, planned, and managed by consumers. Results are documented at www.mentalhealth.asn.au/members/nswcag under “Projects”.

The aim of MH-COPES is to identify the best way for mental health services across NSW to hear and respond to consumers' views about those services.

The first phase of the project is almost complete, with consultations having been held across NSW in Bega, Yass, Broken Hill, Morisset, Port Macquarie, Tamworth and Griffith in September-December 2004, and Leichhardt, Newcastle and Penrith in February-March 2005. The instrument and process have been developed through a technical working group of twelve (eight of whom are consumers), and via open workshops in which about 130 consumers and service providers have collaborated.

The project team expects to move to Phase 2 of MH-CoPES via large-scale pilot implementation in 2005-06. The MH-CoPES questionnaire should soon be available for inspection, so that readers can verify for themselves what kind of feedback NSW consumers believe NSW Health services should receive and respond to.

The MHCA report notes that state or national authorities with "a genuine commitment to quality improvement" might adopt such mechanisms. NSW Health acknowledges and appreciates this endorsement of its consumer initiative.

Conclusion

If we are to achieve lasting results beyond the headlines, public support for mental health services is essential. The views of mental health consumers and carers are welcomed and their active participation in service provision and planning is essential.

All service improvement starts with open and frank discussion by consumers, carers and staff. To that end NSW Health accepts the report as an expression of legitimate opinion about problems faced in providing appropriate care and treatment of people who live with mental illness.

NSW Health makes many reports and Government responses on mental health issues available in the Publication Section of its website, and we invite readers to view those at http://www.health.nsw.gov.au/pubs/subs/sub_mental.html.

8.4.2 RESPONSE FROM VICTORIA GOVERNMENT

Minister for Health

555 Collins Street
GPO Box 4057
Melbourne Victoria 3001
DX210081
www.dhs.vic.gov.au
Telephone: (03) 9616 8561
Facsimile: (03) 9616 8355

e321723

Mr John Mendoza
Chief Executive Officer
Mental Health Council of Australia
PO Box 174
DEAKIN WEST ACT 2600

Dear Mr Mendoza

Thank you for your letter dated 24 March 2005 inviting States and Territories to provide a formal summary response for inclusion in the Mental Health and Human Rights draft report and detailed comments on the Victorian section.

Attached please find Victoria's response, based on the material that you have provided to date.

I understand that you have recently met with officers from the Victorian Mental Health Branch, who have raised some issues with you regarding the draft report. The key issues were:

- The emotive style of the title page;
- The lack of balancing information – while negative experiences can occur in any system, I believe that these should be considered relative to the number of positive experiences and other supporting information; and
- The absence of a chapter on the Commonwealth jurisdiction's responsibilities to people with mental disorders –including Medicare, Pharmaceutical Benefits Scheme, private psychiatrists, General Practitioners, and vocational rehabilitation. Much of this information is currently contained in the state level sections.

At the meeting you were provided with copies of documents that were produced by the Victorian Department of Human Services to assist you in further developing the report. These documents were:

- Summaries of the 2003/04 surveys of consumer and carer experience of Victorian public mental health services;
- *Victorian strategy for safety and quality in public mental health services*;
- *Annual Report 2003: Office of the Chief Psychiatrist*;

- *Victoria's implementation of the national standards for mental health services; progress report September 2004*; and,
- *Caring Together: an action plan for carer involvement in Victorian public mental health services*.

Exemplar services in Victoria in the forensic and youth early psychosis areas, such as Thomas Embling Hospital and Orygen Youth Health, were also discussed at the meeting. Further, I would like to highlight the innovative service models that have been developed in Victoria in the areas of Psychiatric Disability Rehabilitation and Support, sub acute, primary mental health, and dual diagnosis service delivery. Victoria is recognised as a leader in these areas.

As I mentioned earlier in this letter, Victoria's written response to the draft report is based on the material that you have currently provided. Should you change the report, the response may require adjustment, and I would welcome the opportunity to revise the response.

I look forward to considering the next draft of the report.

Yours sincerely

Hon Bronwyn Pike MP
Minister for Health

Page 2

Victorian Context

There is widespread agreement that Victoria has laid the foundations of a comprehensive age based specialist mental health system, which is now well established and contains most of the elements needed to effectively treat and support people with mental illness. As a specialist system, the bulk of external funding is directed towards the clinical treatment of serious mental illness, supplemented by disability support for consumers to live independently in the community. Victoria, when compared nationally, has proportionally the largest community based system of clinical assessment and treatment and non-clinical support, and the greatest number of people treated in psychiatric wards co-located with general hospitals.

Clinical services treat approximately 56,000 continuing care clients per annum in inpatient and ambulatory settings with up to 12,000 clients also using disability support services with a clinical workforce of over 5000 staff. These services are resourced from a total mental health budget of $652 million in 2004-05.

Victorian Service Developments

In Victoria, the current operating environment is one of sustained demand pressure with an average growth of 7% per annum in clients over the last five years. In response to these pressures and the ongoing need to build on past reforms and improve services access, efficiency and effectiveness the Victorian Government has systematically invested more than $198 million in service improvement strategies since 1999-00. This funding has been directed to strengthening core services, implementing early intervention and relapse prevention initiatives, and creating an environment that enables clinical practice and service models to better align with the changing needs of consumers and their carers. Some major new and innovative initiatives include:

- **Primary Mental Health Teams** that build the capacity of general practitioners and other primary health providers to support people with a mental illness through the provision of specialist consultation.
- **Early Psychosis** programs which provide early intervention for young people with an emerging disorder.
- **Dual Diagnosis** services which provide integrated responses to clients with co-existing mental illness and substance abuse.
- **Sub-acute services** that provide transitional step down support from inpatient care to home.
- **Intensive housing support services** for consumers with complex needs.

Mental Health continues to be high priority for the Victorian Government. It’s social policy action plan *A Fairer Victoria: Creating Opportunity and Addressing Disadvantage* released on 28 April 2005 makes a substantial commitment of **$180 million over the next four years** for mental health service growth and improvement, including $55.5 million for planned capital developments. Mr Jeff Kennett, Chair of Beyondblue stated in the Melbourne Age on 29 April 2005 that this is “the largest contribution to mental health by any state government ever”.

Further improvements will focus on early intervention across the age groups by providing:

- **Intervention and prevention during the early stages** of an emerging disorder (in order to prevent the illness progressing and/or avert escalation and the need for a long period of support).
- A **quicker** service response (to prevent a crisis developing or worsening).
- A **more intensive** service response (to ensure treatment is effective).
- **Better follow-up** after discharge (to prevent relapse of the condition).

Victorian Response to the Report

A formal response for inclusion in the final report was requested in relation to sections of the Mental Health and Human Rights Draft Report forwarded to the Victorian Minister for Health on 24 March 2005. Consequently, the following comments are based on an incomplete draft version of the report.

Whilst information about specific consumer and carer experiences of the mental health system provide a critical contribution to the understanding of its performance, these experiences form part of the picture and do not on their own provide evidence of systemic problems in relation to human rights and national standards. However, Victoria accepts that the views expressed are legitimate and reflect the real experiences of particular individuals and wishes to express regret for the negative experiences described in the Victorian section of the report. Victoria also wishes to assure those people who are concerned with services in this state that any feedback received is taken very seriously and that Victoria will continue to improve its services for consumers and their carers.

Notwithstanding the above statements, Victoria has significant concerns with the report's methodology and findings. These concerns are summarised below.

- **The report lacks balance** as it:
  - Draws heavily on the opinions and perspectives of particular individuals and interest groups.
  - Currently excludes publicly available information about service improvement, expansion and reform available at a state and national level.
  - Shows little evidence of any efforts to elicit or report positive views during the consultation process.
  - Gives no weight to the constraints the states and territories operate under including capped budgets and high levels of non-discretionary expenditure.

- **The report has questionable validity** as it:
  - Draws on the results of two surveys with very low response rates, and in Victoria, four meetings and 97 submissions (primarily from individuals), which is hardly representative of Victoria's large consumer, carer and provider base.
  - Generalises the experiences of a limited number of organisations and often aggrieved individuals to the whole system.

- **The report lacks objective data and evidence to support its findings** and therefore makes an unconvincing and uninformed case regarding these findings. For example, it has disregarded the accreditation system for national standards, assessments made by the accreditation agency and level of compliance by services. In Victoria, 82% of area mental health services have completed the accreditation process.

- **The report draws simplistic conclusions about poor consumer and carer experiences** which cannot always be attributed to specialist mental health system failures but may be:
  - The result of relatively isolated and infrequent events.
  - Linked to the diversity of views about involuntary treatment with it's inherent and complex balancing of rights and protections.
  - Related to events which occurred many years previously.

- **The report employs an emotive and adversarial style** that undermines its credibility and is likely to prove unproductive in an area of health where strong collaboration and partnership has underpinned progress to date.

Ultimately, the report is misleading and may undermine the confidence of the community, consumers and carers in the public mental health system. Available data in Victoria indicates that the system operates reasonably well most of the time despite sustained and increasing pressure. It should also be noted that the system contains high levels of accountability with checks and balances that are enshrined in legislation and practice. Service and clinical standards and guidelines are the subject of continued improvement and review. Recent amendments to the Mental Health Act have further embedded good practice into legislation.

The report also risks setting unrealistic expectations about what can be delivered by a publicly funded specialist system of care. A number of issues raised in the report sit well outside the mandate of the specialist mental health system and will require vigorous and sustained effort by the many different areas and levels of government, including the Commonwealth Government, to address.

Points from HREOC report draft

Standard no	Issues raised in report	Victoria's issues	Victoria's response
1- Rights	• Fear of retribution if person complains • Information not provided to clients and carers • Unclear who should explain rights to service users • Rights are not explained in an understandable manner	• Unable to quantify extent of the problem from the report. • Report findings appear to contradict Victorian 2003/04 consumer and carer participation survey results that show that 67% of consumers of adult mental health services who responded to the survey thought that Victorian services were good to excellent on consumer rights.	• Consumer consultants are employed in all mental health services and carer consultants in many mental health services to assist clients and to represent consumer and carer views to the organisation. • Independent Third Persons and the Office of the Public Advocate are available to provide assistance and support to individuals who have concerns about their treatment. • Apart from internal complaints mechanisms of individual services, the Office of the Chief Psychiatrist and the Health Services Commissioner can investigate consumer and carer complaints about treatment. • The Mental Health Review Board independently reviews the need for the involuntary treatment of individual clients.
2- Safety	• Use of sedation and restraint during bed waits in Emergency Departments • Concerns about client safety in mixed gender units • Lack of supported accommodation • Poor response to carer safety concerns • Staff safety concerns regarding the behaviour of consumers with co morbid mental health and substance misuse issues.	• Unable to quantify extent of problem from the report. • The report implies that waiting in Emergency Departments for a bed is a form of consumer abuse.	• Initiatives are being introduced to improve bed access and increase staffing to reduce waiting times in Emergency Departments. New subacute services should also help ease the demand for mental health acute inpatient beds. In 2004/05, an extra $8.6 million is being used to reduce the need for acute inpatient beds through diversion, early intervention and relapse prevention services. • The need to maximise acute inpatient bed use preclude the creation of gender specific wards except in some specialist services eg mother-baby/eating disorder services, some forensic services • Additional intensive clinical and rehabilitation resources are being provided to improve service responsiveness and the level of support to clients with complex needs to assist relapse prevention eg in 2004/05, an additional $1.4 million has been provided for housing and support, supported accommodation and residential rehabilitation for young people with dual diagnosis. • Dual diagnosis services are being extended and integrated into adult mental health services eg in 2004/05 an additional $0.75 million was provided for dual diagnosis services.

Standard no	Issues raised in report	Victoria's issues	Victoria's response
3 – Consumer & carer participation	• Poor consumer peak representation nationally • Carers ignored • People with Borderline Personality Disorder (BPD) not considered State or nationally	• The quotes are very general and seem to relate more to consumer and carer participation at the national level. • There is a focus on the availability of diagnosis-specific services rather than services for people with severe mental illness regardless of diagnosis • Responses to the 2003/04 Victorian consumer and carer participation survey showed that carers were usually more dissatisfied with services than consumers.	• Victoria focuses on providing public mental health services to people with serious mental illness regardless of diagnosis, although it does have a statewide specialist borderline personality disorder service that provides consultation to broader mental health services • Carer consultants are employed in many Victorian public mental health services to provide assistance to carers and ensure that the carer views are represented in the organisation • Victoria released a new carer policy, *Caring Together*, in 2004. • Consumers and carers are represented on the Ministerial Advisory Committee on mental health and associated subcommittees.
4 – Community acceptance	• Lack of social supports for consumers • National Mental Health Strategy campaigns to reduce stigma have been unsuccessful • Campaigns focus on psychotic illness & depression and do nothing for other disorders such as Borderline Personality Disorder • Discrimination shown by mental health service providers • Unresponsive, unsympathetic services • Family rejection • Housing discrimination • Later service response means greater acuity seen in community. • Therapy seen as less legitimate than medication	• There appears to be a focus on the lack of diagnosis-specific services and a particular type of treatment. • The Commonwealth is also responsible for universal mental health promotion campaigns aimed at reducing stigma.	• Victoria has extensive psychosocial rehabilitation and support services for consumers with mental illness and their carers (receiving $57.7 million in 2004/05). These supplement the personal support that should be available through generic social services. • Paid consumer and carer consultants in area services often participate in in-house staff training to ensure that consumer and carer perspectives are presented to staff. • Public mental health services provide a variety of treatments that include therapeutic as well as medicinal treatments. Limited counselling is available through generic community health services. The Commonwealth is responsible for improving access to private psychologists and counsellors through Medical Benefits Scheme and private health insurance schemes. • Treatment in the least restrictive environment means that people are not admitted to the more restrictive hospital environment unless they cannot be satisfactorily treated in the community. • Additional funding is being provided to Victorian public mental health services to improve service responsiveness and shift the focus from crisis treatment to earlier intervention and relapse prevention (eg an additional $3.2 million funding was provided for early intervention and relapse prevention in 2004/05). • There is redress under legislation for discrimination by businesses based on disability.

Standard no	Issues raised in report	Victoria's issues	Victoria's response
5 – Privacy & confidentiality	• Lack of carer involvement in consumer treatment	• All the issues raised relate to carers. The report ignores the dichotomy between consumer and carer views	• Privacy and confidentiality provisions regarding client treatment are incorporated in the Mental Health Act. While carer involvement is recommended, it is up to the consumer to decide the extent to which this occurs. • Carer consultants are employed in many services to assist carers and ensure that carer views are presented in the organisation. • Carers are incorporated in treatment plans under Mental Health Act amendments.
6 – Prevention & promotion	• Services only respond to crises • Service providers do not listen to carers • Need increased General Practitioner involvement, less stigma and discrimination, and more promotional strategies	• All the comments in the report about early intervention problems are from carers. Only the community promotion concerns appear to have been raised by consumers.	• Victoria is continuing to expand its early psychosis services for young people (an additional $0.96 million funding provided in 2004/05). • Increased resources are being used to shift service system focus more towards early intervention and relapse prevention and away from crisis intervention (eg an additional $3.2 million funding was provided for early intervention and relapse prevention in 2004/05). • Primary Mental Health Teams (PMHT) continue to build relationships and establish service arrangements with primary care providers through shared care, education and consultation services. • Funding for universal mental health promotion is also the responsibility of the Commonwealth government.
7 – Cultural awareness	• Lack of sensitivity to spiritual beliefs • Lack of understanding about recent immigrants	• It is hard to quantify the extent of this problem since the report presents one case and a general statement that did not indicate whether the service response was an issue.	• Victoria funds the *Victorian Transcultural Psychiatry Unit*, *Victorian Foundation for Survivors of Torture* and *Victorian Aboriginal Health Service* for consultation, staff education and training. • Services employ paid consumer consultants to assist consumers and ensure consumer views are represented in the organisation. • Consumers and carers are represented on the Ministerial Advisory Committee on mental health and associated subcommittees.

Standard no	Issues raised in report	Victoria's issues	Victoria's response
8 – Integration 8.1 Service integration	• Non responsiveness of crisis services • Diminished service access & duration • Lack of bulkbilling General Practitioners & private psychiatrists. • Lack of counselling/psychotherapy services • Staff turnover • Lack of communication across treatment settings	• This standard relates to integration of mental health service components and continuity of client care, not integration with other services nor access to services, which are dealt with under other standards.	• Additional staff have been funded to improve service responsiveness, particularly for clients with complex needs such as homelessness and dual diagnosis (eg in 2004/05, an additional $1.6 million funding has been provided for consumers who are homeless and/or has a dual diagnosis). • General Practitioner & private service access (cost & distribution) is a Commonwealth responsibility. • Workforce is flagged as a national issue under the *National Mental Health Plan 2003-2008*. • Communication across treatment setting is covered in Standard 10 - Documentation
8.2 Integration with health system	• Neglect of physical health • Shared care arrangements	• The quotes about physical health problems are from carers. It is unclear if this was an issue for consumers.	• All services except Forensic are mainstreamed with generic health services. • Primary Mental Health Teams (PMHT) continue to build relationships and establish service arrangements with General Practitioners and primary care providers for shared care, education and consultation services. • Discharge planning guidelines provide protocols for General Practitioner and share care arrangements
8.3 Integration with other services	• Difficulties accessing housing • Financial support • Vocational rehabilitation programs needed • Cross-program linkages • Domestic violence • Children of parent with mental illness • Carer support – social, financial • Early intervention for young people • Support services after suicide • Police involvement in transport & restraint • Medicare rebates – rebate delays, psychologists (no rebates), General Practitioner reimbursement • Lack of employment & support	• Specialist mental health services are not core accommodation providers, although they work in partnership with housing services. • Vocation rehabilitation, employment, Centrelink and Medicare are Commonwealth responsibilities. • Suicide is not the sole responsibility of mental health services and requires a whole-of-government approach.	• Additional funding has been provided for supported accommodation and intensive housing support services to assist people with mental illness maintain stable accommodation (in 04/05 an extra $0.86 million). This is apart from the existing partnership with Office of Housing (Housing & Support program), where public housing properties are provided in conjunction with mental health outreach services. • Victoria is currently expanding its early psychosis services for young people (an additional $0.96 million funding provided in 04/05). • A new protocol was recently released between Victorian mental health services and Victoria Police clarifying the role of police in transport and restraint of mental health clients. • Vocational rehabilitation and employment programs are a Commonwealth responsibility. • Medicare and General Practitioner reimbursement are also a Commonwealth responsibility.

Standard no	Issues raised in report	Victoria's issues	Victoria's response
			• Suicide services are broader than mental health services. There has been considerable whole of government effort in responding to the issue of suicide in Victoria since the release of the Victorian Suicide Prevention Taskforce Report in 1997.
9 – Service development	• Cuts to inpatient funding over past 10 years • Culture of blame • Disaggregation of system when mainstreaming occurred • Worse than 12 years ago. • Better than 20 years ago • Deinstitutionalised people now homeless or in jail • Not able to deliver best possible service. • Shortage of acute & short-term beds. • Reliance on carers. • Reform stagnated. • No longer consumer focus. Focus is govt protection. • New institutions created, patchy leadership, poor morale and work practices • The Office of the Chief Psychiatrist not independent of government • Minister out of touch. • Workforce review program late • Auditor-General's concerns correct. • Planning without consultation and inflexible resource distribution. • Service for life • Lack of support services eg after hours, counselling, Psychiatric Disability Residential and Support Services • Dual Diagnosis service • Poorer quality services because service diluted. • Variable quality of care • Unsatisfactory levels of service • Need for more intensive inpatient care.	• This section contains a number of personal opinions that do not appear to be supported by facts. • Many of the issues included in this standard relate to other standards. • Rebates for General Practitioners and private medical services and distribution are Commonwealth responsibilities.	• The Victorian government has consistently increased funding for mental health services. Since 1999, the Government has provided additional funding to the mental health system of over $198 million or 30 per cent. • As standalone institutions were closed, funding was redirected to local, community-based services, where most consumers are treated. Long-term inpatient beds in particular were targeted for redevelopment as community-based services. The *National Mental Health Report 2004* shows that there has been minimal change in the numbers of acute inpatient beds over the last 10 years in Victoria. The 2004 Report also shows that there were more non-acute and community residential beds in June 2002 than in June 1993 (a total of 1,217 non-acute and community residential beds in 1993 compared with a total of 1,353 non-acute and community residential beds in 2002). • Investment in ambulatory services enables greater flexibility in meeting client needs rather than tying up large amounts of resources in bed-based facilities. • Victorian planning for public mental health services focuses on addressing areas of greatest need. It is expected that services use the most efficacious treatment model to improve individual client wellness. • Victorian resource allocation is informed by a weighted population formula, which adjusts for area differences in population characteristics such as socioeconomic status, rurality and availability of private mental health services. • Recent funding initiatives have included funding for additional acute inpatient beds (eg in 2004/05 an additional $2.75 million funding). • Workforce has been identified as a national issue. • Distribution of General Practitioners and private psychiatrists, and Medicare funding are Commonwealth responsibilities. • A Ministerial advisory subcommittee is currently examining service catchments with a view to improving service access.

Standard no	Issues raised in report	Victoria's issues	Victoria's response
	• Staff turnover therefore staff continuity problem • Staff shortage • Heavily accented staff • Inadequate funding level & control • Federal funding increased by $1.2 million but State funding decreased by $1million. • New Zealand provides twice the per capita funding • Progressive inpatient budget cuts. • More funding to primary care via Medicare. • No care in rural areas. • In Melbourne, distribution of public mental health services, private psychiatrists and primary care is direct inverse of need. • Because of catchments, if cannot get care in own area, cannot seek care elsewhere. • Under funding of rural areas. • Planning uses medical model only. • Nurse training • Insensitive staff attitudes • Clinician exposed to negative emotions & burn out		• It is unclear how Victoria is alleged to have reduced its funding for mental health services when it has been progressively increasing funding. Since 1999/2000, the Government has provided additional funding to the mental health system of over $198 million or 30 per cent.
10 – Documentation	• Incomplete documentation • Too much paperwork • Limited or no client engagement by staff • Documentation not accessible across service settings	• Some of the examples seem to relate to issues other than documentation and are covered under other standards.	• Clinical reviews highlighted variability in documentation standards across services but have also noticed improvements over time. • The Office of Chief Psychiatrist is unaware of any complaints from psychiatrists about excessive paperwork associated with Community Treatment Orders and is concerned at the suggestion that a clinician would risk a client's health because of paperwork.

Standard no	Issues raised in report	Victoria's issues	Victoria's response
11 – Delivery of Care 11.1 Access	• Cannot access services even if harming • Carers not heard • Telephone triage – messages not passed on, people rejected • Lack of access to private psychiatrists, General Practitioners, counsellors, Psychiatric Disability Residential and Support Services • People absconding and self-medicating • Short case management • Crisis management means treatment more intrusive & restrictive than if undertaken earlier • Need 24hr clinics • Crisis only service responses • Non-responsive services • Crisis in the community perpetuates stigma • Carers cannot initiate treatment	• Victoria is unable to quantify the extent of the problem from the report. • This section highlights the consumer/carer dichotomy relating to treatment.	• Demand for services has grown faster than growth funding. Additional funding has been earmarked to improve service access and shift service focus more to early intervention and relapse prevention (in 2004/05 an additional $3.2 million was provided for early intervention and relapse prevention). • Victoria has recently released the outcomes of a triage project to standardise access across mental health services.
11.2 Entry	• Entering the system via Emergency Departments – the environment & the wait • Mixed reports about triage	• All the comments reported are from carers. It is unclear if consumers have similar views about Emergency Departments.	• Victoria is aware of increasing wait times in Emergency Departments for mental health treatment and is providing additional resources for more intensive services to people with complex needs who frequently attend Emergency Departments, as well as expanding services to become more responsive earlier in an illness episode (eg in 2004/05 an additional $7.4 million to expand existing service capacity, relapse prevention and early intervention).
11.3 Assessment & review	• telephone assessment • assessments but no obvious treatment	• The comments reported are from carers. It is unclear if consumers have similar views.	• Treatment responses are focused primarily on assessment of consumer needs. There are occasions when consumer and carer views may differ about consumer needs.

Standard no	Issues raised in report	Victoria's issues	Victoria's response
11.4 Treatment & support	• lack of youth services & carer support • lack of dual diagnosis services • rural & regional areas under serviced • lack of personality disorder services • lack of carer involvement	• Availability of private services is a Commonwealth responsibility. • Access to public mental health services (voluntary and involuntary) is based on illness acuity not diagnosis. • Multiple quotes from one or two submissions presented as separate quotes create the illusion of multiple submissions from different people on the same issue. • Victoria focuses on providing public mental health services to people with a serious mental illness regardless of diagnosis.	• Victoria has continued expansion of early psychosis services for young people and dual diagnosis services for people with co morbid mental illness and substance misuse (in 2004/05 an additional $2.6 million for additional early psychosis and dual diagnosis services). Dual diagnosis services are seen as a core part of specialist mental health services. • Victoria has a statewide personality disorder service that provides consultation and liaison to other services. • Carer consultants ensure carer views are represented in many services. • The extent of carer involvement in consumer treatment is dependent on the consumer. • Carers are incorporated in treatment plans under Mental Health Act amendments.
11.4A Community living	• lack of community support services • discharge from community services • lack of leisure, recreation & employment programs • need for self-care programs and supported accommodation	• It is not the responsibility of specialist mental health services to provide all types of services to clients. Under mainstreaming, generic services are funded to provide many services, although this may be done in partnership with mental health services initially.	• Victoria has a well developed Psychiatric Disability Rehabilitation and Support service system (funded for $57.7 million in 2004/05). This is complemented by personal support services available from generic community services. • Generic leisure & recreation programs are funded to provide services to people with mental illness. The provision of these programs is not seen as core business for specialist mental health services. • The Commonwealth government is responsible for employment and vocational rehabilitation. • Victoria has increased funding to and monitoring of services to ensure better post-discharge follow-up of clients (eg an additional $3.56 million funding in 2004/05 to support discharge functions).

Standard no	Issues raised in report	Victoria's issues	Victoria's response
11.4B Supported accommodation	• lack of support accommodation • step up/step down services, especially for dual diagnosis consumers	• Most of the quotes in this section of the report are from clinicians or carers. It is unclear what views consumers have on this issue.	• Victoria has funded intensive supported accommodation services to increase housing stability for complex clients (an additional $0.86 million funding in 2004/05 to expand housing and support and supported accommodation services). This is apart from existing outreach programs that assist clients in maintaining stable accommodation. • The Housing and Support program is the result of a partnership between the Office of Housing and mental health services where public housing is provided in conjunction with mental health services. • Subacute services are being piloted as an alternative to hospitalisation, facilitate earlier intervention and support discharge (an additional 10 places were funded in 2004/05).
11.4C Medication & medical technologies	• Clients unable to get a second opinion	• The example used appears to relate more to the service access standard.	• Victoria is not responsible for the funding or distribution of private services. • Victoria is currently examining its catchment areas to facilitate service access.
11.4D Therapies	• Reliance on medicinal treatment, no behavioural change programs	• Multiple quotes from one submission make it difficult to quantify the extent of this problem.	• Victorian public mental health services provide a variety of therapies. Services are expected to provide the most efficacious treatment for clients.

Standard no	Issues raised in report	Victoria's issues	Victoria's response
11.4E Inpatient care	• death in inpatient care • lack of beds • police transport • restraint • consumers not involved in treatment plans	• Except for the section on restraint, most quotes are from clinicians or carers. It is difficult to assess consumer issues with this standard. • Consumer involvement in treatment plans is covered under other standards eg Standard 1.	• Victoria has recently released a new protocol between public mental health services and Victoria police that clarifies transport arrangements. • Victoria is currently increasing the number of acute beds in under-bedded areas of the state (an additional 26 adult acute beds were funded in 2004/05). • Victoria has increased funding to and monitoring of services to ensure better post-discharge follow-up of clients (eg an additional $3.56 million funding in 2004/05 to support discharge functions). • Apart from consumer consultants, Independent Third Persons and the Office of the Public Advocate are available to provide independent assistance and support to individuals who have concerns about their treatment. • Apart from internal complaints mechanisms of individual services, the Office of the Chief Psychiatrist and the Health Services Commissioner can investigate consumer and carer complaints about treatment. • The Mental Health Review Board independently reviews the need for the involuntary treatment of individual clients.
11.5 Planning for exit	• exit based on access to beds not wellness of client • exit plans not authorised by medical staff	• All the quotes are from carers, so it is difficult to assess consumer issues with this standard.	• See Standard 10 – documentation • Victoria is currently increasing the number of acute beds in under-bedded areas of the state (an additional 26 adult acute beds were funded in 2004/05). • Victoria has increased funding to and monitoring of services to ensure better post-discharge follow-up of clients.
11.6 Exit & re-entry	• carers not consulted when consumers discharged from inpatient units • consumers discharged while ill • no follow-up after inpatient discharge • no review of accommodation arrangements prior to exit	• All the quotes are from carers, so it is difficult to assess consumer issues with this standard.	• Victoria has increased funding to and monitoring of services to ensure better post-discharge follow-up of clients (eg an additional $3.56 million funding in 2004/05 to support discharge functions). • Consumer and carer views do not always align. • Carers are incorporated in treatment plans under Mental Health Act amendments.

Standard no	Issues raised in report	Victoria's issues	Victoria's response
Homicide & suicide	• Homicide – Victorian client in New South Wales • Suicide – after discharge/on leave, carers not heard • need safe place to stay till OK	• Victoria is not responsible for what occurred in New South Wales. • The report is focused on purported performance of services against national standards. Suicide and homicide do not have a separate standard so should not be reported separately.	• Although a Victorian client was involved, the episode occurred interstate, and the client was treated by the interstate services, which are outside Victoria's jurisdiction. • Victoria has increased funding to and monitoring of services to ensure better post-discharge follow-up of clients. • Carers are incorporated in treatment plans under Mental Health Act amendments.

Further supporting information can be found in:

- Summaries of the 2003/04 surveys of consumer and carer experience of Victorian public mental health services;
- *Victorian strategy for safety and quality in public mental health services*;
- *Annual Report 2003: Office of the Chief Psychiatrist*;
- *Victoria's implementation of the national standards for mental health services; progress report September 2004*; and,
- *Caring Together: an action plan for carer involvement in Victorian public mental health services*.

Copies of these documents were provided to Mr John Mendoza, Chief Executive Officer, Mental Health Council of Australia, on Wednesday 13 April 2005 at his meeting with Dr Ruth Vine, Director, Mental Health, Victorian Department of Human Services.

8.4.3 RESPONSE FROM QUEENSLAND GOVERNMENT

Queensland Government

Premier of Queensland
and Minister for Trade

Please quote:MN74598/LR04/Social Policy

27 APR 2005

Mr John Mendoza
Chief Executive Officer
Mental Health Council of Australia
PO Box 174
DEAKIN WEST ACT 2600

Dear Mr Mendoza

Thank you for your letter of 24 March 2005 inviting a Queensland response to the draft report *'Not for Service' Experiences of Injustice and Despair in Mental Health Care in Australia.*

I would like to take this opportunity to commend the work of the Mental Health Council of Australia and the Human Rights and Equal Opportunity Commission in documenting the experiences of those Queensland consumers and community members who participated in community forums and surveys. As invited in your previous letter, the attached Queensland submission takes the opportunity to address issues raised in the draft report. It also provides additional information on the considerable changes to mental health services which have occurred in the past decade in Queensland through implementation of the Ten Year for Mental Health Services (1993) and achievements measured under the National Health Strategy.

Queensland will continue to strive to improve consumer and carer input and linkages with the non-Government sector to deliver responsive mental health services. The enclosed submission also discusses the need for Queensland's services to meet the challenges of a growing and diverse population and the increasing impact of drug and alcohol problems in the community.

Thank you again for contacting me about this important national project.

Yours sincerely

PETER BEATTIE MP
PREMIER AND MINISTER FOR TRADE

Executive Building
100 George Street Brisbane
PO Box 185 Brisbane Albert Street
Queensland 4002 Australia
Telephone +61 7 3224 4500
Facsimile +61 7 3221 3631
Email ThePremier@premiers.qld.gov.au
Website www.thepremier.qld.gov.au

QUEENSLAND HEALTH RESPONSE TO THE HUMAN RIGHTS EQUAL OPPORTUNITIES COMMISSION AND MENTAL HEALTH COUNCIL OF AUSTRALIA REPORT

Executive Summary

In response to the report – *'Not For Service'* by the Mental Health Council of Australia and The Human Rights and Equal Opportunity Commission it is advised:

- A submission was previously completed by Queensland Health in response to a request from the Human Rights and Equal Opportunity Commissioner.
- The submission completed in January 2005 and forwarded to the Commission was not acknowledged in the *'Not For Service'* report, nor were issues raised incorporated into the final report.
- *'Not For Service'* indicates a number of processes occurred to assist in the preparation of the report. The document indicates that:
    - A survey was undertaken to assist in the preparation of the report;
    - Open community forums were conducted and written submissions were received.
- While the report offers some individual insights, it is important that the information it contains is considered in the context of the small sample used.
    - Of the 714 surveys, 95 were for Queensland.
    - This represents a very small proportion of the service contacts for the State (779,527 for 2002/2003) and the projected number of individual community clients (75,300 - 76,240 for 2004/2005).
- In addition, the report should be considered in the context of other data which are used to inform the system of key issues:
    - Mental Health Services in Queensland have changed considerably over the last ten years.
    - Queensland leads other States in terms of the implementation of the National Mental Health Strategy with this exemplified by the Outcomes data system.
    - Queensland Health through their District Services has developed Consumer and Carer consultant roles that are providing significant input into services.
    - District Services have an active complaint management system that is monitored through the mental health service management process in each district.
    - However, services continue to confront rapid changes due to the rapid population growth and the impacts of drug and alcohol use.
    - Recruitment and retention issues are linked to a variety of issues including the rate of graduation of mental health professionals from tertiary education units.
- Notwithstanding the questions about the representative nature of material presented in the report and the limited acknowledgement of positive aspects and progress in Queensland Mental Health Services, Queensland Health will actively work to incorporate suggestions for improvement into its forward planning.
- Queensland Health acknowledges that the continued maturation of services and agencies is required particularly with respect to the links with NGOs and Consumer and Carer groups.
- The response to the report reflects the format adopted in *'Not For Service'*.

SUPPORTING DOCUMENTATION

NMH STANDARD 1: RIGHTS

Queensland Health has implemented training in relation to the Mental Health Act [2000] with this training provided to staff in all District Services. Training in the Mental Health Act [2000] emphasises the rights of those with mental illness and the need to provide treatment that takes into account the importance of the dignity and respect of the individual.

Each person within the mental health system is able to access Complaint's Managers should they perceive their rights have not been addressed. Services have introduced information brochures and signs that provide advice to carers and patients/consumers about rights and responsibilities. Mental Health Services have developed a number of mechanisms for increasing knowledge of rights and responsibilities with one service producing an introductory DVD that is provided to Patients/Consumers and Carers and is used during ward activities as a method of evoking group discussion.

With respect to the criminal justice system, it advised that police are receiving training in relation to mental health matters and that Queensland Health has developed a number of mechanisms that have improved dialogue between Police, Emergency Services and Mental Health Services. The improved communication has assisted in improving the care and treatment of those with mental illness, particularly during the initial phase of contact with Mental Health Services especially in the Emergency Departments.

The Mental Health Review Tribunal has adopted a model that addresses the need to respect the rights of the individual and aims to provide a maximum level of support to individuals. The Tribunal is comprised of a legal person, doctor (usually a psychiatrist) and a community member. Carers and Patients/Consumers attend the hearings and may be legally represented.

In relation to those within the prison service, Queensland Health and Corrective Services have developed a Prison Mental Health Service for those who are identified as having a mental illness. This service seeks to assist those within the Prison setting and, when necessary, facilitate their transfer to an Authorised Mental Health Service.

The Transcultural Mental Health Service has assisted in emphasising the importance of translators and services in Queensland regularly use translators although the cultural and linguistically diverse nature of Queensland impacts on the capacity of services to access some language groups. These rights are linked to those pertaining to all groups, especially to Aboriginal and Torres Strait Islanders.

All District Mental Services via the EQUIP Survey address the rights of individuals.

NMH STANDARD 2: SAFETY

Services in Queensland are confronted with a rapid growth in population and changes in demographics. This growth of between 80-85,000 per year over the last few years has placed stress on services in terms of availability of resources, increases in occasions of service and recruitment and retention of staff. Despite these pressures, services in Queensland have developed new initiatives such as recovery, alternative models of care programs and integrated models of service delivery.

Services now provide extended hours assessment programs. Outside of those hours an assessment can be received through the Emergency Department of a hospital. Queensland Health has developed mobile service teams and single point of entry processes. Services in Queensland are participating in studies that benchmark access issues with many adopting models that reflect priority systems that give specific time frames for patient reviews by Mental Health staff

Queensland Health has developed a policy on restraint to provide guidance for management of individuals who require restraint. Services are now involved in Aggression Management Training which will involve all staff within services.

The development of integrated Risk/Management processes and the Queensland Health Incident Management Policy has occurred on a state wide basis with services now using a standardised mechanism.

Queensland Health has developed a model for residential care that seeks to improve communication with residential care agencies and improve the safety and care of individuals within these services. New Queensland laws have been introduced to improve residential safety, and cross government committees have been developed to assist this process.

NMH STANDARD 3: CONSUMER AND CARER PARTICIPATION

Mental Health Services aim to provide care in the least restrictive manner and with the active involvement of the patient/consumer and carer. The approach for Queensland Health has been the active inclusion of consumers and carers in the delivery of mental health services. The *Action Plan for Consumer and Carer Participation in Queensland Mental Health Services* is currently being implemented. Consumer consultants are employed in 11 districts. Consumer and Carer Advisory Groups operate throughout the state. A new state wide advisory model for consumer and carer participation has been developed and a consultation process will commence in the near future.

Some services have developed consumer/patient and carer discharge surveys that are utilised to evaluate the service and contribute to service improvement with respect to activities such as information on medication, diagnosis and post discharge planning.

A curriculum for clinician education in consumer and carer participation has recently been developed and has been piloted in three District Services. This training is to be evaluated in 2005.

The involvement of consumer/carer groups in the early phase of treatment has commenced in one service with others beginning to explore this in relation to provision of care. Psycho-education programs for patients/consumers and carers have been developed in some services

NMH STANDARD 4: PROMOTING COMMUNITY ACCEPTANCE

Mental health services within Queensland provide education to the community both by way of direct contact, or involvement within community-based programmes such as those associated with Rotary, beyondblue, PPP programs and educational programs for health care professionals, NGOs and other government services. The total funds allocated to NGOs and some research institutions are $6.9 million.

Public Health as part of the promotion of prevention has undertaken activities within Queensland to highlight issues related to mental health including early recognition and de-stigmatisation.

Queensland Health is progressing mental health promotion, prevention and early intervention in this State under the *National Mental Health Plan 2003-2008*. This process includes the mental health promotion, prevention and early intervention initiatives that seek to focus on the needs of priority groups identified in the Queensland Health implementation framework. The program aims at increasing the understanding and knowledge of mental health and the importance of maintaining mental health, and is linked to the recognition of these aspects in all environments and settings.

Mental Health week in Queensland has been actively used to highlight issues pertaining to Mental Health. Rural services are involved with media issues that emphasize the importance of early intervention, the multifactorial nature of mental illness, the importance of carers and the role of therapy in treatment and relapse and prevention.

NMH STANDARD 5: PRIVACY AND CONFIDENTIALITY

The problems raised within the report highlight the difficulties which confront clinicians, patients/consumers, carers and the broader community on a regular basis. Provision of information to family/carers is recognised as an important issue by Queensland Health. However, services are at times confronted with the competing desires of the patient/consumer versus the needs of the family/carers. This clearly, on occasions, causes concern for the community especially family members. However, despite being a difficult matter to overcome, in many cases with appropriate support and counselling communication with the family/carer can be achieved. The document indicates that for person's diagnosed with cancer and other significant illnesses the whole family is involved with this, contrasted with what occurs in mental illness. Unfortunately, this ideal is at times not achieved even when cancer, heart disease and diabetes is diagnosed with some patients refusing to have information divulged to family members.

Services have attempted to deal with this issue by adopting education programs and family focussed groups.

Privacy of patient/consumer and carers is recognised as important but at times is difficult to provide due to building design or the number of individuals presenting to services. The capital works program has resulted in the construction or modification of units with rooms that are single or 2-4 bed units. Units are provided with open space and services have implemented policies that seek to protect privacy and the individual's property.

NMH STANDARD 6 – PREVENTION AND MENTAL HEALTH PROMOTION

It is acknowledged that there are concerns in relation to the provision of rehabilitation programmes. Queensland Health has identified non-government organisations as integral to service delivery and is moving towards the development of programmes that integrate with external agencies and assist in the rehabilitation of people into the community. Mental Health Services are adopting a *Recovery Focus* that promotes maximising the persons and families/carers capacities.

The Mental Health Unit, in partnership with Health Promotion Queensland, is funding a multi-strategy health promotion project which promotes resiliency in children of primary school age in school, family and community settings. The project involves the measuring of elements that promote resiliency in individual children of primary school age.

Early Intervention and Prevention Officers have been appointed to services. At present this program is in its early phase and is still developing its full capacity. The problem of Alcohol and Drugs and its link to mental

illness is well documented. Queensland is continuing to develop strategies to improve assessment and intervention for those with dual diagnosis.

Queensland Health has funded programs for the deaf and has granted further funding for a Centre based in a major teaching hospital. This Centre is widely recognised and from time to time its services are used by bodies from other jurisdictions.

NMH STANDARD 7: CULTURAL AWARENESS

All staff in Queensland Health are required to undergo training in relation to cultural awareness with respect to Aboriginal and Torres Strait Islanders. Queensland Health has developed an active state wide policy which promotes the involvement of the Indigenous mental health workers within services with these staff actively involved in improving the delivery of services to Aboriginal and Torres Strait Islanders within local regions.

Examples of the working relationships forged across the networks include the link established with the Aboriginal and Torres Strait Islander Health Unit and the consultation and input towards the following key activities:

- Queensland Health Aboriginal and Torres Strait Islander Workforce Management Strategy;
- Partnership Framework (Working party for ATODS/MH/Chronic Disease);
- Cultural Respect Framework;
- Outcome measures for Mental Health Services;
- National Aboriginal and Torres Strait Islander Framework for Mental Health and Social and Emotional Wellbeing; and
- Structures have been established on zonal and district levels and these structures/processes contribute to furthering the implementation of the Queensland Health Mental Health Policy – Aboriginal and Torres Strait Islander People 1996. These structures will also play a part in the implementation of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well Being 2004-2009 for Queensland.

Queensland Health perceives Aboriginal and Torres Strait Islander people as a priority target group. The adoption of a holistic definition of health and mental health as defined by Aboriginal and Torres Strait Islander people is part of Mental Health Policy and aims to address Aboriginal and Torres Strait Islander social and emotional well being.

The establishment of Centre for Rural and Remote Mental Health is being explored with Aboriginal and Torres Strait Islander groups intimately involved in the working party. This Centre has attracted support from a variety of groups integral to the development of rural and remote mental health services including Royal Flying Doctor Service, Queensland Health, mining companies, Aboriginal and Torres Strait Islander groups and the Division of General Practice.

NMH STANDARD 8: INTEGRATION

Queensland has adopted an integrated model of care involving inpatient and community mental health services. The integration of services provides continuity of care with a single point of entry across the span of services. This continuity of care also reflects a model care for both the child and youth and older person's mental health services.

In relation to the issue of staff turnover and its impact on integration and care it is evident this reflects, not only the mobility of professional groups involved in mental health services, but problems related to staff resources which reflects decisions made in relation to training in the 1980s. These decisions have had a negative impact in the number of mental health professionals graduating from 1990 to beyond 2005. Governments at every level are attempting to address this issue but it is evident that the resolution of staff shortages will not occur in the short term and, as a consequence, there will continue to be difficulties in terms of the recruitment and retention of staff.

Factors related to the care of individuals within the private sector are not within the direct province of Queensland Health. Strategies seeking to improve communication between the public and private sector have been developed at a service level. The difficulties in accessing appropriate resources within the private sector are also affected by rapid changes in population, the aging of trained professionals, changes in the culture of medical, nursing and allied health professional expectations and, as with the public sector, the impact of decisions made a number of years previously in relation to university numbers in the various disciplines. Despite the development of new medical schools within Queensland, the likelihood of any increase in the number of Australian trained psychiatrists will not occur for approximately 8-10 years due to the need for undergraduate and post-graduate training positions which is linked to the provision of funded, supervised training posts with in the public and private sector.

> *In recognition of the importance of increasing the numbers of trained mental health professionals, Queensland Health has funded scholarships for nurses and allied health staff and is funding the Director of Training (psychiatry). The Director of Training's position has a role in the provision of information to those doctors desirous of entering specialist training in psychiatry and assist in the development of training processes within the State. The state wide position has assisted in the recruitment of registrars within Queensland. Recruitment into training positions has demonstrated growth and is in contrast to other jurisdictions that are experiencing a decline in applicants.*

The Commonwealth Government through the development of innovative general practice programmes has improved the training of General Practitioners. These programmes have improved the capacity to provide integration and increased resources to manage individuals within the community in shared-care arrangements. Services have developed Memorandums of Understanding with Divisions of General Practice that in some cases have permitted General Practitioners to refer patients to services for specific treatment groups while continuing as the 'case manager'.

The management of individuals with complex needs is clearly, as indicated in the document, difficult, however, Queensland Health has developed a number of programs that have begun to address the issue of people with mental health disabilities which reflect a whole of Government approach. This process involves linkages with housing, Disability Services Queensland and non-Government Organisations (NGOs). The State Suicide Prevention Strategy is an example of this whole of Government approach and includes representatives from Housing, Police, Education, Premiers, Aboriginal and Torres Strait Islanders and the Commonwealth.

As part of the continued improvement in care, Queensland Health is developing a consultation liaison model of service delivery project that addresses the issues of the physical health of individuals with mental illness in relationship to general hospital inpatient care, outpatient services and primary care positions. This project is due for completion towards the end of 2005 and will have a focus on a broad range of issues related to physical illness and mental health across the state.

The Queensland Government has recently announced the provision of affordable accommodation for homes within Central Brisbane and a number of districts have begun to implement strategies that reflect a whole of Government approach.

As part of this broad strategy, there has been an increase in educational processes related to the care of people with mental illness with the services being provided to Police, Ambulance and other groups within the community.
In relation to the management of people with mental illness and their involvement with the judicial system, Queensland has adopted a model of care and a strategy for managing those with mental illness within the judicial system that is progressive. Those charged with an offence and who have a mental health defence are brought before the Mental Health Court rather than the judicial system. This model is judged by many as reflective of best practice and at the leading edge in terms of the care of those with mental illness who become involved with the legal system. The process allows early intervention for those identified with mental illness and management in a manner that respects their rights and in a less restrictive manner with integration across the prison and mental health systems.

Child and Youth services continue to face problems especially when confronted with the population growth, divorce/separation rates and the rate of child abuse. Following a major review, a new Department of Child Safety has been developed. Queensland Health and the Department of Child Safety, along with other agencies, are developing programmes for children most at risk.

NMH STANDARD 9: SERVICE DEVELOPMENT

The *Queensland Mental Health Plan 1994*, represented the first strategic plan for mental health reform in this State. The plan focussed on integrated systems across regions. The document provided broad based principles that enabled the reform process to commence.

The Plan resulted in the mainstreaming of integrated services to promote continuity of care across service components, the local availability of care through more equitable distribution of mental health resources despite the geographical and demographic complexities of a rapidly growing and developing state, and consumers' and carers' involvement in the planning, operation and evaluation of services.

The Plan has resulted in the progressive reform of psychiatric hospitals, establishment and maintenance of links with Primary Health Care services and implementation of quality management systems including the Minimum Service Standards.

In 1996, this Plan was replaced by a more comprehensive planning document designed to set the framework for the full system of care, and providing the basis for a more equitable distribution of services throughout the State.

The *Ten Year Mental Health Strategy for Queensland* (TYMHSQ) advanced the directions already identified in the *Queensland Mental Health Policy* (1993) and *Queensland Mental Health Plan* (1994).

The TYMHSQ became the key strategic document for mental health reform in this State until 2003. The TYMHSQ assisted in planning and equitable resourcing of services throughout the State.

By 2002/2003, a review of progress of mental health reform found that with the exception of the full complement of community positions, the objectives of the TYMHSQ had generally been reached. The results of

the review did not imply reform was complete but the State was able to progress with the *National Mental Health Plan 2003-2008.* It identified issues related to decentralisation and community positions.

The *Queensland Strategic Plan for Mental Health (2003-2008)* seeks to foster mental health in Queensland for the next five years and beyond. The Strategy aims to promote the mental health of the community, while continuing to build the capacity.

The Strategic Plan aims to address the mental health issues broadly across the community. Specific areas have been identified as a priority. Priority areas include:

- Enhancement of core specialised mental health services.
- Improving service quality and safety.
- Improving service responsiveness.
- Improving the capacity to meet the needs of specific groups within the population.
- Strengthening partnerships across the spectrum of intervention.
- Improving utilisation of data and information in service evaluation and planning.
- Ensuring the availability of a strong and skilled workforce.

Care is seen as a service to be covered across a broad spectrum of providers including primary health care which participates in the continuum of care. Support of primary care providers will be enhanced by technology, the development of consultation/liaison and skills development programs.

Specialised mental health services are secondary and tertiary services are provided by specialist mental health personnel. These services, while focussing on the serious mental health problems, will also provide assessment and care for the high prevalence disorders. It is recognised that the high prevalence disorders negatively impact on quality of life and have the capacity for adverse social consequences.

Services across the state provide continuum of care for individuals. This is assisted by a variety of service activities including:

- Acute Care and Assessment teams
- A continuing care case management approach, which includes the following components:
    - community treatment services
    - outreach services
    - acute inpatient services, with provision for short to medium term treatment, including secure treatment
    - psychiatric crisis response and treatment
    - specialist intensive treatment and support for identified ‘at risk’ individuals (mobile intensive treatment teams)
    - extended inpatient services for treatment and rehabilitation, with services organised around five clinical programmes
    - a recovery focus that has been endorsed by the Queensland Human Services Chief Executive Officers’ Committee.

The Strategy has developed a focus for improvement of Mental Health Services for Rural and Remote Communities and improvement in the Mental Health Services for People Involved in the Criminal Justice System.

The *Queensland Forensic Mental Health Policy 2002* targets adults and young people with mental disorders or severe mental health problems who are also subject to criminal justice processes.

> *Access to secure inpatient treatment has been improved with the opening of a medium and high secure facility in Townsville allowing mentally ill offenders from North Queensland to receive treatment closer to their families and support networks.*
>
> *Specialised community forensic services have developed active outreach processes to provide closer support to mental health services across the State, which assist in local patient management and ensure compliance with formal monitoring requirements. In North Queensland, outreach services extend as far as Papua New Guinea. This care of this group has been enhanced with the development of forensic liaison service positions.*
>
> *A visiting service has been established to the Brisbane Youth Detention Centre integrating both mental health and drug and alcohol workers, and the Child and Youth Forensic Outreach Service facilitates transition from detention to the community.*

The Prison Mental Health Service was established as a joint initiative between the Department of Corrective Services and Queensland Health to provide mental health services to people who have a mental illness and are resident in a correctional centre.

Mental health reform in Queensland has decentralised inpatient beds from the large psychiatric facilities based in Toowoomba, Charters Towers and West Moreton. Inpatient beds have been relocated to regional centres to ensure a more equitable distribution of resources across the State and to facilitate access. Decentralisation of inpatient beds was completed in 2002.

Inpatient programmes have been developed to encompass a range of services including acute inpatient, dual diagnosis, child and youth, psycho-geriatrics, acquired brain injury, medium and high secure services and community care units in suburban settings.

With changes in the inpatient services there has been a progressive expansion of community mental health services throughout the State during the life of the TYMHSQ. Planning targets were established at 30 per 100,000 total population for adult mental health services, 25 per 100,000 for the under 19 population, 10 per 100,000 of the 65+ population, whilst Indigenous workers are set at 5 and 6 per 10,000 for child and youth and adult services respectively.

Community Mental Health provides a range of services including extended hours, Acute Care Teams, Crisis Assessment Teams and Mobile Intensive Treatment Teams. In addition, dual diagnosis projects are being developed. The suicide prevention strategy and aged care strategy have been developed along with specific programs for trans-cultural mental health and those with hearing impairment. The P300 project has assisted in the transition of patients/consumers from hospital to the community.

Queensland Health, as part of the development of Mental Health Services, has fostered research in a variety of settings including the University of Queensland, The Park and in hospital appointments that have both clinical and academic roles

NMH STANDARD 10: DOCUMENTATION

Documentation remains a difficult area for services despite records remaining fundamental to the mechanism of recording clinical information and a significant issue in the medico-legal arena. Poor documentation and lack of access to documents has been demonstrated to contribute to negative outcomes and has been noted by coroners to be a key issue in contributing to patient deaths.

Services in Queensland have been confronted with the difficulty of having separate charts for inpatients, community and other services such as alcohol and drugs. This separation has impacted on patient care. Over the last few years where separate charts existed, the services have moved towards integration of medical records. However, the lack of common record numbers across the State continues to cause some difficulties.

A number of services have introduced comprehensive audit processes that review the comprehensiveness of records, explores adequacy of notes, risk assessment, care plans and discharge planning. The audit mechanism reviews several charts each month in a random fashion with the audit reporting against specific criteria.

NMH STANDARD 11: DELIVERY OF CARE

The Queensland Mental Health Act 2000 is an Act about treating and protecting those with mental illness with this occurring in an environment that seeks to respect the rights of the individual and provide respect for the person's dignity. The Act aims to aid the provision of care in the least restrictive manner.

The broad approach to the management of individuals within Queensland Health Services involves the use of individual care plans, with these care plans developed in consultation with each patient/consumer.

Services are developing pathways of care that involve the recognition of the need for increased consumer involvement, explanation of the nature of the illness and advice on treatment modalities including the pharmacological methods.

Services adopt a broad treatment approach that addresses the psychological, social and pharmacological treatment of mental illness. A number of services provide not only individual but also group therapy and family therapy sessions.

Services are provided, irrespective of an individual's past. Assessment and care are related to the current needs of the person. On accessing a Mental Health Service a comprehensive assessment is undertaken with this reflecting those processes outlined in accreditation guidelines that are required of each district.

8.4.4 RESPONSE FROM SOUTH AUSTRALIAN GOVERNMENT

Hon Lea Stevens MP

Minister for Health
Minister Assisting the
Premier in Social Inclusion

Level 4, ING Building
45 Pirie Street
Adelaide 5000
South Australia

GPO Box 2555
Adelaide 5001
DX 273

Telephone (08) 8207 1855
Facsimile (08) 8207 1950
Email: Minister.Health@health.sa.gov.au

05MHE/1449

9 May 2005

Mr John Mendoza
Chief Executive Officer
Mental Health Council of Australia
PO Box 174
DEAKIN WEST ACT 2600

Dear Mr Mendoza,

Thank you for your letter of 24th March 2005 regarding the Mental Health and Human Rights Draft Report. Thank you for providing South Australia with the opportunity to comment on the relevant sections of the Draft Report.

In acknowledging the significance of the report and in taking this report seriously, I will provide South Australia's detailed response to the Cabinet this week and aim to forward you a copy as soon as possible thereafter.

I appreciate that you require the full report but regrettably the current budget cycle and business of government is such that the report can not be provided within your timeframe.

The importance of the Draft Report is appreciated by the South Australian Government. Over 250,000 South Australians are predicted to have mental health problems/disorders. Of these 38,000 are estimated to have a severe condition. The prevalence of mental health problems/disorders differs across the age ranges[1].

SA acknowledges that mental illness is a whole of government and whole of population matter. Any adequate response to improving services for mentally ill consumers is built on cross-government planning, education, training and review and must involve a number of organisations including health, employment, housing, justice etc. Narrowing mental health focus to the health system will not suffice.

This whole of government commitment is articulated in the South Australian Strategic Plan including a key objective to improve the Health and Wellbeing of South Australians of which mental health is a key factor. Additionally, this state's Social Inclusion agenda specifically targets strategies for people who are the most vulnerable to the co-existence of homelessness, substance abuse, and social

[1] Australian Bureau of Statistics, 2002.

disadvantage, whereby mental illness is a major contributor. Also the government has established a cohesive advocacy sector including the Mental Health Coalition and the Health Consumer Alliance to ensure consumers have a voice in the planning and delivery of mental health services.

National Mental Health Strategy and Plans – achievements to date
SA accepts this framework for reform of mental health services in Australia in accordance with international trends. However, complexities of funding across Australian Government and State/Territory governments lead to patchy and uncertain planning and development of services. For example, enhancement monies from the Australian Government will promote development of specific aspects of a service, sometimes to the detriment of other aspects of the service.

Service models in SA have, to date, predominantly focused on acute care, with hospital services remaining highly significant. For example, SA is criticised as nearly 50% of direct dollars for mental health still goes towards the running of one hospital (Glenside Campus). However, it must be recognised that much has been achieved in collaboration with other departments within the confines of the resources available.

Government commitment
The Labor government came to office with a clear commitment to improve mental health in SA. Immediately funds were injected for a range of services including services for children, young people and Aboriginal people; workforce development, and care packages.

Since coming to government there has been an additional recurrent commitment of $20 million dollars to the reform and delivery of mental health services in this state. Also $80 million dollars was allocated to build better facilities for consumers of mental health services and to enable incremental closure of Glenside Campus, whilst reconfiguring the Mental Health System. In addition, the government funded $56 million dollars to provide support to people residing in marginal accommodation, through the supported residential facility program. This program targets people with a mental illness who require additional services and supports to be able to maintain a level of independence.

As evidenced by the Mental Health and Human Rights Draft Report, SA has significant challenges ahead, in spite of this government's increased investment. However, there has been progress achieved through the commitment and work of many individuals and organisations. Further progress will be made through the government's ongoing pledge to improve not only the resources available, but also the legislation, structures and systems required to support reform.

A population based resource funding approach – the way forward
One of the key outcomes of SA's Generational Health Review was recognition that governance and funding arrangements were required to concentrate the health system 'towards improving the health of the population, enhance capacity to promote population health and meet the equity objectives of the South Australian Government'.

A population approach to mental health provides a framework which can respond to identified problems; unmet need (disorders which could be effectively prevented or treated but which are currently not); and accountability in population terms for improving health and lessening disease prevalence, morbidity, disability and mortality.[2]

The initial focus of the South Australian Reform Agenda is to reorientate the whole health system to a population health planning approach, achieving gains in population health outcomes and improving health status by moving emphasis towards a primary health care focussed system.

Immediate responses

The new regional health structures within SA allow for immediate initiatives to focus on:

- Reducing hospitalisation through extended hours of mobile emergency mental health teams working with ambulance; and a single point of access to mental health care in metropolitan Adelaide;
- Avoiding people entering the hospital system through alternatives to admission with intensive community treatment and support;
- Assisting people to leave hospital earlier through post discharge intensive community follow-up;
- Adequately skilled workforce by developing a single co-ordinated education and training strategy for all disciplines including non-clinical staff.
- Building the capacity of the non-government community based sector to assist in supporting people in their home, out of hospital.

Strategies for sustainability

A number of new initiatives are proposed for SA within the current planning environment. The resources and services required to deliver best practice in mental health care for SA have been assessed and six (6) new strategies have been identified to bridge existing service gaps.

Strategy 1: The specific targeting of prevention and early intervention services where there is a risk of mental health problems and disorders.

Strategy 2: Accessible and responsive community based treatment and care to those for whom the failure to receive it is likely to result in relapse, or social disruption.

Strategy 3: Responsive partnership support to the broader human service sector where the interface has a significant impact.

Strategy 4: Recovery focused support services, which demonstrate outcomes in improved functioning, and reduced demand on high cost specialist services.

Strategy 5: A system of service allocation and monitoring, which facilitates appropriate streaming of consumers into packages of care.

Strategy 6: The development of an available and appropriately skilled workforce that supports the building of a sustainable system of mental health care.

[2] Planning in South Australia is premised on the Mental Health Clinical Care and Prevention Model (MH-CCP) as a mechanism for developing population based estimates of the level of resources required.

I note that you have discussed the draft report and initiatives underway in South Australia in detail with Ms Learne Durrington, Deputy Director, Mental Health Unit, Department of Health. In the mean time, should you require any additional information please contact Ms Durrington directly on (08) 82260777.

Yours sincerely

HON LEA STEVENS MP
Minister for Health
Minister Assisting the Premier in Social Inclusion

Hon Lea Stevens MP

Minister for Health
Minister Assisting the
Premier in Social Inclusion

Level 4, ING Building
45 Pirie Street
Adelaide 5000
South Australia

GPO Box 2555
Adelaide 5001
DX 273

Telephone (08) 8207 1855
Facsimile (08) 8207 1950
Email: Minister.Health@health.sa.gov.au

DH05MHU/0307

12 May 2005

Mr John Mendoza
Chief Executive Officer
Mental Health Council of Australia
PO Box 174
DEAKIN WEST ACT 2600

Dear Mr Mendoza

Thank you for your letter of 24 March 2005, regarding the Mental Health and Human Rights Draft Report. South Australia appreciates the opportunity to comment on the relevant sections of the Draft Report.

Please find attached a response prepared by the Mental Health Unit, Department of Health, South Australia. For your ease, the submission has also been collated under the National Standards for Mental Health Services including both a response and list of significant achievements relating to the concerns raised in the Draft Report.

I note that you have discussed the draft report and initiatives underway in South Australia in detail with Ms Learne Durrington, Deputy Director, Mental Health Unit, Department of Health. Should you require any additional information please contact Learne directly on (08) 82260777.

Yours sincerely

HON LEA STEVENS MP
Minister for Health
Minister Assisting the Premier in Social Inclusion

RESPONSE TO THE MENTAL HEALTH AND HUMAN RIGHTS DRAFT REPORT

EXECUTIVE SUMMARY

This response to the Mental Health and Human Rights Draft Report has been prepared by the Mental Health Unit, Department of Health, South Australia (SA).

Over 250,000 South Australians are predicted to have mental health problems/disorders. Of these 38,000 are estimated to have a severe condition. The prevalence of mental health problems/disorders differs across the age ranges[1].

SA acknowledges that mental illness is a whole of government and whole of population matter. Any adequate response to improving services for mentally ill consumers is built on cross-government planning, education, training and review and must involve a number of organisations including health, employment, housing, justice etc. Narrowing mental health focus to the health system will not suffice.

This whole of government commitment is articulated in South Australia's Strategic Plan including a key objective to improve the Wellbeing of South Australians. The priorities are to focus on quality of life and the wellbeing of the community and individual citizens of which mental health is a key factor. Additionally, this state's Social Inclusion agenda specifically targets strategies for people who are the most vulnerable to the co-existence of homelessness, substance abuse, and social disadvantage, whereby mental illness is a major contributor. Also the government has established a cohesive advocacy sector including the Mental Health Coalition and the Health Consumer Alliance to ensure consumers have a voice in the planning and delivery of mental health services.

National Mental Health Strategy and Plans – achievements to date

SA accepts this framework for reform of mental health services in Australia in accordance with international trends. However, complexities of funding across Australian Government and State/Territory governments lead to patchy and uncertain planning and development of services. For example, enhancement monies from the Australian Government will promote development of specific aspects of a service, sometimes to the detriment of other aspects of the service.

Service models in SA have, to date, predominantly focused on acute care, with hospital services remaining highly significant. For example, SA is criticised as nearly 50% of direct dollars for mental health still goes towards the running of one hospital (Glenside). However, it must be recognised that much has been achieved in collaboration with other departments within the confines of the resources available.

Government commitment

The Labor government came to office with a clear commitment to improve mental health in SA. Immediately funds were injected for a range of services including services for children, young people and Aboriginal people; workforce development, and care packages.

[1] Australian Bureau of Statistics, 2002.

Since coming to government there has been an additional recurrent commitment of $20 million to the reform and delivery of mental health services in this state. Also $80 million was allocated to build better facilities for consumers of mental health services and to enable incremental closure of Glenside Hospital, whilst reconfiguring the Mental Health System. In addition, the government funded $56 million to provide support to people residing in marginal accommodation, through the supported residential facility program. This program targets people with a mental illness who require additional services and supports to be able to maintain a level of independence.

As evidenced by the Mental Health and Human Rights Draft Report, SA has significant challenges ahead, in spite of this government's increased investment. However, there has been progress achieved through the commitment and work of many individuals and organisations. Further progress will be made through the government's ongoing pledge to improve not only the resources available, but also the legislation, structures and systems required to support reform.

A population based resource funding approach – the way forward

One of the key outcomes of SA's Generational Health Review was recognition that governance and funding arrangements were required to concentrate the health system 'towards improving the health of the population, enhance capacity to promote population health and meet the equity objectives of the South Australian Government'. A population approach to mental health provides a framework which can respond to identified problems; unmet need (disorders which could be effectively prevented or treated but which are currently not); and accountability in population terms for improving health and lessening disease prevalence, morbidity, disability and mortality.[2]

The initial focus of the South Australian Reform Agenda is to reorientate the whole health system to a population health planning approach, achieving gains in population health outcomes and improving health status by moving emphasis towards a primary health care focussed system.

Immediate responses

The new regional health structures within SA allow for immediate initiatives to focus on:

- Reducing hospitalisation through extended hours of mobile emergency mental health teams working with ambulance; and a single point of access to mental health care in metropolitan Adelaide;
- Avoiding people entering the hospital system through alternatives to admission with intensive community treatment and support;
- Assisting people to leave hospital earlier through post discharge intensive community follow-up;
- Adequately skilled workforce by developing a single co-ordinated education and training strategy for all disciplines including non-clinical staff;
- Building the capacity of the non-government community based sector to assist in supporting people in their home, out of hospital.

[2] Planning in South Australia is premised on the Mental Health Clinical Care and Prevention Model (MH-CCP) as a mechanism for developing population based estimates of the level of resources required.

Strategies for sustainability

A number of new initiatives are proposed for SA within the current planning environment. The resources and services required to deliver best practice in mental health care for SA have been assessed and six (6) new strategies have been identified to bridge existing service gaps.

Strategy 1: The specific targeting of prevention and early intervention services where there is a risk of mental health problems and disorders.

Strategy 2: Accessible and responsive community based treatment and care to those for whom the failure to receive it is likely to result in relapse, or social disruption.

Strategy 3: Responsive partnership support to the broader human service sector where the interface has a significant impact.

Strategy 4: Recovery focused support services, which demonstrate outcomes in improved functioning, and reduced demand on high cost specialist services.

Strategy 5: A system of service allocation and monitoring, which facilitates appropriate streaming of consumers into packages of care.

Strategy 6: The development of an available and appropriately skilled workforce that supports the building of a sustainable system of mental health care.

Detailed supporting documentation in response to Part Six: South Australia

National Mental Health Standard 1: RIGHTS

ACHIEVEMENTS:

- Comprehensive review of Mental Health Legislation in SA undertaken
- Community Based Information System (CBIS) has been developed and implemented

Human rights legislation, particularly in the form of mental health acts, criminal law acts, ombudsman's acts, public guardianship acts and privacy acts are critical in preventing erosion of fundamental human rights of mental health consumers.

In recognition of this, the Review of Mental Health Legislation in SA was commissioned by the Department of Health last year and involved extensive consultation in metropolitan and country areas with carer and consumer groups, Aboriginal organisations, professional organisations and government agencies from August 2004 to March 2005. The Review Committee received and considered 60 submissions and its report is near completion however, it is yet to be formally received by the SA Government.

In relation to mental health and guardianship the broad themes that have emerged are:

- The rights of carers and consumers should be articulated more clearly in the legislation, as other States have recently done;
- Confidentiality should not be interpreted as a barrier to proper sharing of information in the best interests of consumers;
- The particular needs of Aboriginal people need to be recognised as a matter of principle;
- There must be an emphasis on community care, not just hospital services;
- There should be more flexibility as to who can intervene to assist someone in need of care, or make initial orders for admission and detention;

- Greater flexibility with orders to suit the individual is needed (for example, short-term detention orders to avoid inappropriate transfer of consumers from the country to the city);
- The treatment plan should be a pivotal requirement of involuntary orders;
- The Guardianship Board needs to be humanised from arrival at the door (eg through social work assistance or consumer representation);
- A specialist appeal body should replace the court to ensure appeals and procedural fairness arguments are considered in a therapeutic context.

A Health and Community Services Complaints Commission has been recently established in SA. The government on coming to office has developed and passed legislation and appointed a commissioner. The legislation is the most comprehensive in Australia and includes both public and private health, and the full range of community services. It seeks to resolve complaints whilst developing, implementing and monitoring a Charter of Rights for Consumers. The Complaints Commission also has an educative role regarding rights of consumers and complaints management, coupled with monitoring the overall health system for improvement and quality performance.

The Rights Analysis Instrument recommends that consumers of a mental health service must have a representative whose task it is to advise and protect their rights as long as that person wishes. Consultation in SA also recommends that all consumers subject to involuntary treatment should have comprehensive treatment and discharge plans. Carers and consumers request such plans incorporate their views, goals for recovery and be regularly reviewed.

Advanced directives can be made by a consumer to empower others to make treatment decisions on his/her behalf during temporary and permanent incapacity. However, in SA consumers are not currently empowered by law to express, in writing, their own wishes or treatment preferences in advance for periods of temporary incapacity. Ulysses Agreements are one form of advanced directives that has been used in many countries in various ways. There is strong consumer support for legislative recognition of this concept in SA.

Concern: Information not provided

Mental Health Adverse Event investigations and coronial inquiries in SA have supported this concern by highlighting communication problems in the mental health area, a need for better electronic records and rapid exchange of information.

To achieve this a purpose built Community Based Information System (CBIS) has been developed to enable capture of consistent data to complement in-patient information. When fully operational, the system will provide demographic and contact data, Outcome measures (National Outcome & Casemix Collection – NOCC), risk assessment, triage, Management Plans as well as Crisis and Relapse Prevention Plans.

The intent of CBIS is to collect, analyse and use consistent relevant information to better inform decision-making at both the individual consumer level (eg care planning) and at a regional statewide level (eg resource allocation). Compliance with the National Standards for Mental Health Services and national reporting against minimum data sets are fundamental elements of the system. Access to this system will facilitate information transfer and shared care options and will be particularly helpful in emergency or crisis responses.

CBIS has a primary means of

Capturing consistent client information;
Providing functions to prepare management plans;
Giving security to client information;
Providing access to current and historical client information;
Being accessible from mental health locations across SA; and,
Interfaces to other mental health services' information (eg inpatient).

The National Mental Health Strategy seeks to ensure a jurisdiction's ability to identify "Who receives what services from whom, at what cost, and with what effect?" to support the reporting and management needs of clinical managers and service administrators. CBIS provides the capacity to record this information for Ambulatory and Community Residential services and will eventually link with inpatient systems to provide a comprehensive repository of information that can be retrieved and utilised at the local, regional and statewide levels.

National Mental Health Standard 2: SAFETY

ACHIEVEMENTS:

- *Establishment of quality systems to ensure increased safety and to facilitate the reporting of adverse events*
- Embedding safety and quality systems for mental health services within mainstream quality systems
- *Established a monitoring system for coronial inquiry recommendations to enable system-wide change*
- Incorporation of the National Standards for Mental Health Services into the Service Excellence Framework

Concern: Lack of services for children and youth with behaviour problems

ACHIEVEMENTS:

- Establishment by Child and Adolescent Mental Health Services (CAMHS) partnerships with primary health care providers, the Department of Education, and Family and Youth Services in the provision of programs that focus on resilience and recovery for young people
- Partnership between CAMHS and the Lyell McEwin Health Service for the development of models of care that assist adolescents in successful transition to adult mental health services. This model will be extrapolated to other services
- Additional funds for the provision of mental health services to children and young people outside the metropolitan area
- Provision of funds for a behavioural intervention service to children and young people in the northern metropolitan area
- Increased investment in the provision of a mental health emergency triage service at the Women's and Children's Hospital

The Mental Health Unit have contracted in the NSW Institute of Psychiatry to provide a range of short courses (to December 2005) in the areas of: Introduction to Mental Health; Rehabilitation in Mental Health; Relapse Prevention; Mental Illness and Substance Use; Consumer Advocacy and Carer Advocacy. Some of these courses will include elements of aggression management.

The longer term plan is to develop a systemic approach to training across the sector provided through a single point of co-ordination. With a clear agenda for training to accompany the mental health reform agenda of SA, this will include issues related to recovery, relapse prevention and rehabilitation. Critical to these will be the management of associated behaviours which may arise, including aggression management.

The *Mental Health Act 1993* is not explicit that it applies to children. Since children rarely seek review of or appeal against involuntary orders, it has been recommended that legislation should provide for advocacy to ensure children's legal rights are exercised and protected and that any orders are reviewed on a regular basis. It is accepted best practice that, where possible, treatment for children should be provided in the community.

In calling for legislative clarity around the rights and treatment of children recommendation 27 of the Layton Child Protection Review Report called for the removal of barriers that prevent the appropriate exchange of information about children, young people and families involved with the child protection system and calls for a close working relationship between mental health and child protection services.[3]

The Department of Health has commenced a statewide planning process to ensure that mental health services provided to children and young people are seamless, coordinated with consistent access and entry pathways.

Concern: Requirement for staff to be trained to respond appropriately to aggressive and difficult behaviour

The Mental Health Unit have contracted in the NSW Institute of Psychiatry to provide a range of short courses (to December 2005) in the areas of: Introduction to Mental Health; Rehabilitation in Mental Health; Relapse Prevention; Mental Illness and Substance Use; Consumer Advocacy and Carer Advocacy. Some of these courses will include elements of aggression management. The longer term plan is to develop a systemic approach to training across the sector provided through a single point of coordiation. With a clear agenda for training to accompany the mental health reform agenda of SA, this will include issues related to recovery, relapse prevention and rehabilitation. Critical to these will be the management of associated behaviours which may arise, including aggression management.

National Mental Health Standard 3: CONSUMER AND CARER PARTICIPATION

Concern: Tokenistic approach to consumer and carer involvement

ACHIEVEMENTS:

- Establishment of a memorandum of understanding between the SAn branch of the Royal Australian and New Zealand College of Psychiatrists and the Mental Health Coalition declaring a commitment to the involvement of consumers and carers in all aspects of treatment and care
- *Establishment of Consumer and Carer Advisory Committees within metropolitan and country health units*
- Increased rural consumer and carer representation on government committees and advisory groups including rural areas
- Employment of consumers and carers as peer support workers in a number of health services

Expanding a peer support programme is a priority in SA and would include training for participants. Appropriately trained and funded peer consumer therapists have a significant place in mental health services in other jurisdictions, but require appropriate funding and training. In keeping with overseas experience, consumers could ultimately provide up to 20% of the workforce and reduce, amongst other matters, the current workforce crisis.

[3] Recommendation 27, Layton, R. A. (2003). Our Best Investment: A State Plan to Protect and Advance the Interests of Children, Child Protection Review. South Australia cited by the Review of Mental Health Legislation.

Peer support workers in SA are a developing concept and the northern metropolitan area is leading the way in developing a programme. The vision is to have a paid, skilled and competent peer support workforce working alongside specialist staff at all points of the continuum.

Concern: Lack of funding for consumer and carer participation

ACHIEVEMENTS:

- The Mental Health Unit has provided funding to the Health Consumers' Alliance to implement formal structures and processes to ensure consumers and carers contribute to the planning and delivery of local mental health services
- The Mental Health Unit has also provided 'one off' funds to the Carers Association to enable them to undertake a metropolitan/rural education and support forum for carers
- The Mental Health Unit also provides funding to the Association of Relatives and Friends of the Mentally Ill SA to provide counselling, support services, educational programs and respite care for relatives of friends of people with a mental illness

Future directions in Mental Health in SA include strengthening participation by increasing consumer and carer participation reported through regional Health Service Agreements.

A significant development in SA involved the close working partnership between a Consumer and Carer Steering Committee and Mental Health Unit in developing a *Framework for Developing Partnership Between Consumers and Carers and the Mental Health Sector.* It is intended this document form the major mental health policy and directions in regard to carers and consumers. The Mental Health Unit has worked across the Department of Health to ensure the Framework informs the development of the broader participation mechanisms being developed and to ensure that a focus on mental health consumers and carers is maintained at all levels.

In view of Generational Health Review recommendations, the Department has sought to ensure that there is one consumer peak body supported by the Department and that resources are not dissipated through duplication of participation mechanisms or systems. The Health Consumer Alliance (HCA) has been endorsed as the peak consumer body in SA for the purposes of consumer/carer government interface.
The HCA is as an important mechanism to provide a strong independent and effective voice for consumers, carers and community groups in the SA health system and to ensure that mental health is integrated into broader health reforms at this state.

National Mental Health Standard 4: PROMOTING COMMUNITY ACCEPTANCE

Concern: High levels of stigma and discrimination

ACHIEVEMENTS:

- Collaboration with the Commonwealth Government on programs such as Headroom, MindMatters and beyondblue and the National Suicide Prevention Strategy, with the goals of raising awareness and reducing stigma

SA recognises the following facts:

- Community and population level studies have consistently shown the association between higher levels of self reported discrimination and poorer mental health (Krieger 2000)[4]
- Greater levels of community participation, social support and trust in others in the community have been associated with reduced experience of psychological distress (Berry & Rickwood)[5]
- People who are socially isolated have between two and five times the risk of dying prematurely from all causes compared to those who maintain strong ties with family, friends and community (Berkman & Glass 2000)[6]
- …socially isolated people feel fear, they feel alienated and they lose their sense of belonging, of value and opportunities to contribute in any meaningful way to their community[7]
- "One of the biggest barriers to recovery is discrimination. That is why stopping discrimination and championing respect, rights and equality for people with mental illness is just as important as providing the best treatments and therapies."[8]
- The impact of mental illness, stigma and discrimination and the subsequent burden on the Australian population has been estimated to affect up to one in five people within a 12-month period[9]

Education involving consumers/carers and the community is very important. This will promote health literacy and help to minimise stigma. The work of *beyondblue* (National Depression Initiative) is a good example for this and uptake in SA has been high.

Jorm, Christensen and Griffiths[10], in evaluating the impact of *beyondblue* found that awareness of *beyondblue* in states that funded the program was approximately twice as high as in those that did not. The high-exposure states had a greater change in beliefs about some treatments including counselling and medication and help-seeking.

The continued operation of an ageing and outdated Glenside Campus contributes to discriminatory perceptions of mental illness, and barriers to people accessing mental health care. The realisation of the government's mental health capital works program ($80 million) will result in modern integrated facilities over the next 5-7 years.

Concern: Discrimination directed towards children of parents with mental illness

The Children of Parents with Mental Illness (COPMI) organisation is proudly supported by SA and many initiatives have been driven from this state. For example, COPMI have produced a document titled *"Principles and Actions for Services and People with Children of Parents with a Mental Illness"* which has been published as a National Mental Health Strategy document and has set a framework for Australian agencies working with children of parents with mental illness.

---

[4] Krieger N 2000, "Discrimination and Health", In: Berkman L, Kawachi I, eds. *Social epidemiology.* Oxford: Oxford University Press, 36-75

[5] Berry HL, Rickwood DJ 2000, "Measuring social capital at the individual level: personal social capital, values and psychological distress". *International Journal of Mental Health Promotion* 2(3); 35-44.

[6] Berkman LF & Glass T 2000, "Social integration, social networks, social support and health", In: *Social epidemiology, eds ,* Berkman L, Kawachi I. *Social epidemiology.* Oxford: Oxford University Press.

[7] Connections Directions –ideas for taking action. Together We Do Better. VicHealth, 2003.

[8] Blueprint for Mental Health Services in New Zealand, November 1998

[9] McLennan A 1997, "Mental Health and Wellbeing: Profile of Adults: Australia". Canberra: Australian Bureau of Statistics. 1998.

[10] Jorm, A. F., Christensen, H. and Griffiths, K. M. (2000, p. 1).

Another publication is "*The Best for Me and My Baby*" which is a booklet for women with mental health problems and their partners who are thinking about having a baby. In addition, *"Family Talk"* is information for families where a parent has a mental health problem or disorder. In addition, these publications are underscored by the COPMI website www.copmi.net.au. COPMI has worked with various jurisdictions to determine how to implement the published guides. COPMI has worked with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) to develop a position statement for Psychiatrists regarding the need to work with a whole family as more of a holistic systems view.

The Perinatal and Infant Mental Health in the Community project is a 2-year project, funded under the Department of Health Innovative Initiative Grants program. It is a partnership between Helen Mayo House, the South Australian Divisions of General Practice and Community Mental Health Services, Royal Adelaide Hospital. This project is ground breaking in terms of identifying and implementing training and workforce needs in relation to children of parents with a mental illness.

National Mental Health Standard 5: PRIVACY AND CONFIDENTIALITY

Concern: Negative consequences to relationships when carers are not involved

ACHIEVEMENTS:

- The Review of Mental Health Legislation has recommended that:
- Barriers to proper disclosure of information should be removed as a matter of urgency by legislative change
- There should also be professional development of mental health staff on mental health law, and duties of care and confidentiality

There are approximately 250,000 carers in SA and it is estimated that the value of family carers in this State alone is in excess of $2 billion per annum.

Carers have a recognised need for educational assistance, not only in relation to aspects of assistance for their relative/friend with a disability, but also in techniques of personal resilience. The Department of Health has made available funding for 12 carer forums in 2005 across SA to assist family carers of mental health consumers to link with one another and to provide opportunities to meet and network. The forums aim to make local service providers more accessible and provide carers with opportunities to hear about new initiatives.

The National Privacy Principles[11] have clarified issues of privacy and confidentiality. In response a – Code of Fair Information Practice was developed by Government and the Department runs training sessions including training for regional mental health services. Additionally, a document called "Achieving the Balance" targeted at mental health workers to explain ways in which privacy / confidentiality can be balanced with duty of care, will be incorporated into a training manual / module for mental health workers to be delivered as part of training for code of fair information practice.

Work will also be undertaken to convert this "Achieving the Balance" document into a format for consumers and carers including training through the Health Consumer Alliance to ensure consumers understand their rights.

[11] The National Privacy Principles in the Privacy Amendment (Privacy Sector) Act 2000 cited by the Review of Mental Health Legislation (2005, p. 22).

National Mental Health Standard 6: PREVENTION AND MENTAL HEALTH PROMOTION

Concern: Prevention not a focus of mental health services

ACHIEVEMENTS:
- Development of the next phase of activity with beyondblue is currently underway
- Increased funding for suicide prevention activities
- Support workforce development regarding mental health promotion, illness prevention and early intervention in partnership with national workforce development initiatives (additional funds provided to establish statewide over 1.5 years)
- Development of a SA Mental Health First Aid training program that will aim to increase the mental health literacy

Advancing mental health promotion, illness prevention and early intervention is a key priority for government. This direction will lead to improving community awareness and knowledge about mental illness in order to reduce stigma and discrimination that is unfortunately associated with having mental health problems or illness.

The State Government, through the Department of Health, has established several partnerships that complement the directions contained within the National Mental Health Plan 2003-2008. These focus on the promotion of mental health and prevention of mental illness. For example, the State Government currently funds and supports the coordination of regular public education programs and activities that include Mental Health Week, the Dr Margaret Tobin Awards, Rotary Forums and Mental Health First Aid Training programs that contribute to increasing the mental health literacy of the community.

Concern: Lack of services to provide early intervention for youth is a critical problem

ACHIEVEMENTS:
- SA participation in beyondblue-Schools Research Initiative projects across 16 high schools
- Distribution of thousands of copies of the *Mental Health First Aid* booklet to government agencies and service providers
- Continued development and support to SA media and communication outlets using national resource packages that include the national media initiative *Mindframe* that promotes respectful and responsible reporting
- Supporting rural communities in the prevention of suicide and deliberate self harming practices through a range of community led projects and programs with a focus on young men and indigenous communities

The State Government, through the Departments of Health and Education, are working collaboratively in promoting the mental health and well-being of SA children and young people in areas of service provision (including service pathways) reducing depression (through the beyondblue School Research Initiative) and developing the skills and knowledge of the workforce (mental health and education and early childcare).

The State Government has developed a range of collaborative partnerships with key organisations and initiatives that include *beyondblue* (the national depression initiative), *Auseinet* (the Australian Network for Promotion, Prevention and Early Intervention for Mental Health) and MindMatters (national secondary schools mental health promotion initiative).

National Mental Health Standard 7: CULTURAL AWARENESS

Concern: Lack of culturally appropriate practices for Indigenous people

'Aboriginal culture has a different, broader concept of mental illness. In essence, health is seen not just as the well-being of the individual, but also involves the extended family, and indeed, the social, emotional, spiritual, and cultural well-being of the whole community. Kinship ties, responsibilities and obligations place a strong emphasis on sharing and mutual support. Dispossession and racism have had a profound effect on families. Drug and alcohol abuse, depression and other forms of mental illness have followed. [12]*'*

In March 2005, a coronial inquest into the deaths of four Aboriginal men in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands between May 2003 and March 2004 commented on future policy formulation including:

- A need for high quality interpreting services and video-conferencing facilities;
- A fast-tracked training program / supported employment of Aboriginal workers;
- A longer-term and innovative program for the selection, support and training of Aboriginal Medical Officers and ultimately psychiatrists;
- Further consideration of the role of Adelaide-based mental health services because of disincentives for patients to come to an Adelaide-based facility.

ACHIEVEMENTS:

- Investment in the provision of specialist Aboriginal mental health services in the Pitjantjatjara Lands
- Appointment of Aboriginal workers within the Aboriginal Youth Mental Health Partnership Project and Cavan and Magill Youth Training Centres to work with young people who are part of the juvenile justice system
- Development of strategies in the western suburbs for mental health promotion and prevention, early intervention and illness recovery within the Aboriginal community
- Additional funds for the development of a culturally appropriate mental health service for Aboriginal people in the metropolitan area to link to mainstream services
- Funds for the provision of specialist Aboriginal mental health workers across the state including services to children and young people
- Funding to assist with liaison between rural and remote inpatient services and country services for people from Aboriginal communities
- Funding for a project for enhancement of primary health care for Aboriginal people in the western metropolitan area
- Funding for Aboriginal Mental Health Liaison Services at the Noarlunga Health Services

The Commonwealth Government has made a commitment to invest in the construction of a Substance Misuse Facility on the APY Lands in the far northwest of SA. Additional facilities that are designed and operated to provide improved care for Aboriginal sufferers of mental illness and respite for their carers would be beneficial as would be the facilitation of Aboriginal self-management and community-controlled governance structures.

[12] See for example, Aboriginal Health – Everybody's Business, Social and Emotional Well-Being, A South Australian Strategy for Aboriginal and Torres Strait Islander People 2005-2010, South Australian Aboriginal Health Partnership.

National Mental Health Standard 8: SERVICE INTEGRATION

Mental Health Services as they are currently configured in SA do not comprise an integrated system. The current mental health system is made up of a number of component services. The performance of each service component is contingent upon the effectiveness of other related service components.

However, the SA mental health reform is consistent with international and national directions, and has as a fundamental principle, that the hub of service delivery is the community mental health team. As far as practicable, people with mental health disorder should be treated within their community, and therefore within each region, specialist inpatient facilities and a range of community rehabilitation programs should be made available. Specialist statewide services, such as forensic mental health services, focus on specific target populations and should support and augment adult community mental health services.

Concern: Problems with continuity between adolescent and adult mental health services

A transitional program has commenced between Child and Adolescent Mental Health Services and Eastern Community Mental Health Services to cater for 16-18 year old young people who will require adult mental health care in the future.

The Department of Health has commenced statewide planning into mental health services for children and young people which will feature a specialised service for people with first episode of mental illness. The target age range will be 15-24 years.

Concern: Link between mental health services and general practitioners

ACHIEVEMENTS:

- Establishment of the Metro GP Access program which, in partnership with GPs, provides a range of flexible psychiatric disability support services to people experiencing disability as a result of a mental illness
- Implementation of standardised referrals between GPs through a partnership between the South Australian Divisions of General Practice and Mental Health Services and Programs
- Establishment of partnerships between community mental health teams and local GPs, including mental health staff consultancy and advice via telephone or face-to-face

However in SA, primary health care is a central focus for health system reform and a Primary Health Care Policy has been released to inform the implementation of this focus.

However, despite significant development of GP services eg Better Outcomes in Mental Health (BOIMH), delivery of services through general practices is sub-optimal. A lack of first class electronic communication between general practice and the public sector leads to safety and quality concerns.

Parallel with this policy direction are ongoing changes to the health system in SA in moving to a regional model with mental health as a priority concern. Primary health care networks are being formed at a regional level with the main focus being on the management of chronic diseases. Mental health and in particular depression is a major co-morbidity for all leading chronic diseases and is a concern for health professionals and consumers. A range of models are also being considered in line with the National Chronic Disease Strategies.

Work with the Divisions of General Practice has commenced in SA developing shared care models including the role of mental health nurse practitioners within the general practice to provide improved mental health services to clients. These models seek to ensure the effective integration of care across service boundaries and to enhance the overall knowledge and capacity of general practice to identify and manage mental health complaints.
Concern: Problems with integration with NGO services

ACHIEVEMENTS:
- Incorporation of the National Standards for Mental Health Services into the DHS Service Excellence Framework to assist in standardisation of service provision for non-government organisations
- Provision of in-home support assisting people with a psychiatric disability to manage everyday living tasks through the Community Support Inc Scheme and the Metro Access Program
- Establishment of partnerships between the government and non-government sectors in the delivery of programs for young people such as Primetime, a vocational rehabilitation program for young people with mental health problems

Integration between NGOs and specialist mental health services is a recognised priority of the Department of Health and strategies for capacity building and integration across human services has commenced.

The Mental Health Coalition is the newly established peak body for mental health non-government organisations. The Integration Project is funded as a one off grant to the Mental Health Coalition of SA (MHCSA). The aim of the project is to increase the viability of the smaller agencies by building their capacity via integrated management and administration.

Funding allocation has also been given to urgently address the lack of service integration across the mental health NGO sector and to modernise service delivery in accord with contemporary policy agendas.

Key Deliverables include:
- Increased service viability and integration of services;
- Established links between the NGO sector and key partners in service provision including primary care, education, disability, housing, welfare, aged care and other services;
- A coherent service mix and model of service across the non government sector;
- Services reshaped to better reflect contemporary models of care and support;
- Sector capacity to function as a partner in delivering proposed rehabilitation packages;
- Protocols and procedures to co-ordinate service delivery to consumers;
- Meet required national quality standards.

Concern: Lack of access to services to meet physical health needs

The Mental Health Emergency Demand Management Policy and Procedure series developed by the Mental Health Unit seeks to ensure appropriate medical assessment is undertaken when necessary. Additionally the recent National Institute of Clinical Studies (NICS) Mental Health Emergency Care Interface Project ensures that mental health services within the Emergency Department are mainstreamed and efficient.

The shared care models between mental health services and general practitioners provide greater access to mainstream medical care when required.

Concern: Housing

ACHIEVEMENTS:

- Initiation of a national research project on the support of people with a mental illness who have been provided with emergency accommodation through the Supported Accommodation Assistance Program
- Implementation of the SRF Reform Strategy which aims to provide better outcomes for people, many of whom have psychiatric disabilities, who are residents within Supported Residential Facilities or are affected by the closure of an SRF
- Integrated care and support of homeless people with a mental illness into the Inner City Homelessness Strategy
- Significant expansion of access to supported accommodation facilities
- Homelessness initiatives:
  - Transfer Liaison Officer positions,
  - Boarding house outreach service,
  - Best practice program for homeless persons with complex needs,
  - Integrated services for homeless persons with dual mental health and drug and alcohol problems

There is currently a draft Memorandum of Understanding, developed by the SAHT, between the Minister for Housing (South Australian Housing Trust, Aboriginal Housing Authority and Australian Community Housing Authority) and the Minister for Health (South Australian Mental Health Services).

The MOU has been developed as a broad inclusive strategy to guide the coordinated delivery of mental health services and housing support services. The aim of the MOU is for the parties to the agreement to work collaboratively, to improve the well being and housing outcomes for people with mental health disorder.

Concern: Health and Community Care (HACC)

It is an objective of the Department of Health to increase the proportion of HACC funding allocated to psychiatric disability and to build HACC agencies' capacity around mental health. An increasing proportion of HACC funding is allocated for disability services.

Mental Health Services for Older People have been contracted to provide mental health training to HACC agencies and build sustainable local networks to give support and assistance to both workers, coordinators and managers of HACC programs as required.

Country — Ageing & Community Care have committed to the provision of funding for an additional suitably qualified person to join the Country team so that the Country team now has the capacity to expand their training program across all seven country regions and develop sustainable networks with local HACC agencies.

Metro — Ageing & Community Care have committed to the provision of funding for Metro Mental Health Services for Older People to expand their existing mental health training programs and support to all metro HACC agencies.

Concern: Police

ACHIEVEMENTS:
- MOU developed between SA Police, Mental Health, SA Ambulance Service and the Royal Flying Doctors Service.

A Memorandum of Understanding (MOU) has been developed between SA Police, Mental Health, SA Ambulance and Royal Flying Doctor Services. This has been signed off by all parties and the final publication will be coordinated by SA Police.

The Memorandum seeks to clearly define the roles and responsibilities of each of the service providers and provides an endorsed strategy for implementation at an operational level.

The implementation strategy seeks to ensure that there is a consistent and coordinated state-wide response, provided by the parties to this agreement, to ensure that people with known and suspected mental disorder are provided with access to available mental health services.

Concern: Education

ACHIEVEMENTS:
- Specific strategies for recruitment, retention and maintenance of a specialist mental health workforce ($1 million)
- Support workforce development for mental health and related workforce regarding mental health promotion, illness prevention and early intervention (in partnership with national workforce development initiatives) establishment phase over 1.5 years
- Funding provided for training and development for the non-government sector
- 30 scholarships to support staff undertaking post graduate studies in mental health nursing (20 metropolitan, 10 country
- Two additional positions (one within each metropolitan region) to facilitate practice development within the mental health nursing
- Additional funding to support the education of appropriate staff as supervisors, and to encourage the implementation of clinical supervision
- Provision of a wide range of training programs, for example:
  - Training of direct care workers through TAFE
  - Education and training for police officers
  - Training for staff in emergency departments and Assessment and Crisis Intervention Services
  - Clinical training in emergency mental health and drug and alcohol misuse for general clinical staff, including country health workers, the South Australian Ambulance Association and the Royal Flying Doctor Service

Development of mental health system workforce strategy has commenced. This integrates with regional health units and health system-wide workforce strategies and creates collaborative arrangements with relevant national committees, industrial bodies, academic institutions and peak bodies which support:

- The development of new models of care;
- Improved workforce utilisation (i.e., nurse practitioners);
- Appropriate workforce mix and distribution;
- A sustainable and competent workforce.

Establishment and funding for a training consortium has commenced in order to provide ongoing education and staff development programs for the workforce across the spectrum of service provision (including non-government service providers). Targeted recruitment and training for Aboriginal and Torres Strait Islander, and culturally and linguistically diverse mental health workers has taken place. Support for the existing workforce to transition to the provision of new models of care has commenced.

Concern: Centrelink

Centrelink and the lack of access to welfare and employment systems of centrelink for Mental Health consumers is a recognised issue in SA. The state recommends that the issue be addressed at the national level at the National Mental Health Policy interface with Welfare Policy.

Concern: Transport

SA Health Commission Guidelines for Patient Transport were developed in 1997 and are currently under review and the Mental Health Unit of the Department of Health is ensuring that they reflect best practice for mental health consumers.

Additionally, the Department of Health published a policy as part of the Mental Health Emergency Demand Management Strategy on *'Emergency Transport of Mental Health Consumers from Country Locations*', which includes principles of care, legal and professional issues and specific procedures relating to transport. This policy promotes transport by the least restrictive means possible, in a manner that ensures the safety of the person and others with regard for the rights, dignity and privacy and with the with the involvement of consumers and carers in choices. A collaborative approach between health professionals, consumers, family members and emergency services, encourages good communication and agreed values, which will ensure timely access to metropolitan hospitals, including Emergency Departments and inpatient units.

Additionally, a Memorandum of Understanding (MOU) has been developed between SA Police, Mental Health, SA Ambulance and Royal Flying Doctor Services.

Concern: Wards of the State – Need for a whole-of-government approach

Research shows a number of underlying and interrelated factors contribute to environments where children are harmed which also includes mental illness and substance misuse. There has been an overall 35% increase in notifications in the last 3 years.

The South Australian Government's child protection reform program 'Keeping Them Safe' commenced in May 2004. Child protection cannot be separated from policies that benefit children in many areas. The government is injecting significant resources to match our policy commitment to the wellbeing of children.

This child protection strategy seeks to provide the levels of safety, opportunity and choice that will enable children, families and communities to flourish.

The role of the Department of Health is to promote greater awareness and understanding amongst health services and health workers in relation to their responsibilities in the area of child protection and to aid in the integration of this work across health service policy and direction. In essence, to provide a well connected child centred approach, across the continuum of care, from promotion and prevention to acute assessment and therapeutic intervention.

'Keeping Them Safe' identifies 5 key directions for reform, all directly related to Health:

1. Support to children and families
2. Effective, appropriate intervention
3. Reforming work practices and culture
4. Collaborative partnerships
5. Improved accountability

Health already has a significant role in the promotion of the health of families and children, including, target strategies for children of parents with a mental illness. The Department has provided Child and Adolescent Mental Health Services (CAMHS) with specific funds in order to prioritise referrals from this vulnerable group.

Concern: Health in rural and remote areas - Collaboration between state and federal governments to improve services in rural and remote areas.

ACHIEVEMENTS:

- Investment for improved availability of inpatient country mental health services
- Recurrent funding provided to Whyalla, Port Augusta, Port Lincoln and Wallaroo hospitals and Port Lincoln Aboriginal Health Services to improve mental health inpatient services

Approximately 28% of South Australians live in rural or remote areas. The dispersed nature of the population and service distribution, as well as fewer mental health clinicians per capita than metropolitan services, results in significantly reduced access to mental health care for country people. Of the young people waiting for service from Child and Adolescent Mental Health Service (CAMHS) nearly half are living in country regions. The Department of Health also recognises a need for psychogeriatric services to country regions.

Country SA is unique as there are no major rural bases and tertiary care is mostly provided by metropolitan Adelaide. Therefore, there is a requirement to build clinical networks that capitalise on the use of technology due to this reliance on Adelaide based services.

Significant funds from the Social Inclusion Board to develop suicide prevention programs in each rural region that are based upon collaborative care arrangements specifically designed to join up state and federal initiatives. Additionally, increase in access to both non-government organisations and primary health care services are key priorities for the Department of Health especially for Aboriginal people. This will be linked with the Commonwealth Aboriginal Primary Health Care Access Program (APHCAP).

Commitment has been made by the Department of Health in the form of Strategic Directions for Country Health 2005-2010. These state that the objectives for mental health will be met by cooperation and collaboration with other agencies on integrated mental health; ensuring consumer and community participation; provision of supportive environments for the safe and effective delivery of mental health care; ensure a highly skilled, well-supported, confident and sustainable health workforce.

Concern: Criminal Justice System - Collaboration with the Adelaide Magistrates Court to provide services to, and reduce offending by, people with mental illness.

ACHIEVEMENTS:
- Establishment of the Mental Impairment Implementation Reference Committee (MIIRC) to address coordination of services across portfolios and to improve mental health outcomes for prisoners and offenders
- Provision through the Magistrates Court Diversion Program of alternatives to incarceration for criminal offenders

Recent reviews[13] have recommended the expansion of current capacity of Forensic Mental Health Services and Department of Correctional Services (DCS) professional staff to meet specialist inpatient, consultative and treatment needs of DCS clients and licensees who are in prison or in the community.

Diversion programme operations within the judicial system in the Magistrates / Children's Courts, are a cost-effective way of avoiding institutionalisation and the problems caused by institutionalisation.

It should be possible for a court to dismiss a charge and/or refer an offender for mental health services to prevent increasing use of the section 269 Mental Impairment Provisions (1995) of the Criminal Law Consolidation Act (1935) which results in clogging up of the courts and acute forensic mental health facilities. This issue is being addressed in the current review of the Mental Health Act and the con-current review of the Criminal Law Consolidation Act specifically section 269.

Planning for a new 40-bed forensic facility and a new secure 30-bed secure rehabilitation facility has commenced. Planning for the forensic facility will include a capacity to expand to a possible total of 50-beds. Consultants are to be engaged by mid-2005 and construction is due to commence in mid-2006 with completion expected by early 2008.

National Mental Health Standard 9: SERVICE DEVELOPMENT

Concern: Lack of resources and services and the impact of this on clinicians

Services models in SA have traditionally focused on acute care, with hospital services remaining highly significant. The initial focus of the SAn Reform Agenda is to reorientate the health system to a population health approach, achieving gains in population health outcomes and improving health status by moving emphasis towards a primary health care focussed system.

In acknowledging and proactively addressing criticisms, the South Australia Government has committed approximately eighty million dollars to a mental health capital program from 2002 to 2007.

[13] Joint Stakeholder Survey (2005, p. 95).

Concern: Distribution of services – lack of services in rural and regional areas

ACHIEVEMENTS:
- Investment for improved availability of inpatient country mental health services
- Increased funding for country mental health services and linkages with the rural and remote mental health service
- Expanded telepsychiatry, leading to better access for consumers in rural areas to specialist resources
- An increase in the number of psychiatrists visiting rural areas to undertake shared care and provide support to GPs via a partnership between the Commonwealth Medical Specialist Outreach Assistance Program and the Rural Doctors Workforce Agency
- Development of a Health and Community Services Complaints Commission in SA

In country regions, the focus is on increasing the availability of consultation and liaison services provided by community mental health services, distance consultation services and visiting specialist services to better support GPs and other local services. Then the priority will be to get the services to work as a single system of mental health care.

Concern: Model of mental health care needs to change – inappropriate focus on inpatient and crisis care

A Transition plan for consumers from Glenside has commenced entitled: – Returning Home Project.

Ongoing community support services will be provided by a non-government organisation to up to twenty people who will be assisted to transfer their care to the northern metropolitan area from residential rehabilitation on Glenside Hospital. This represents the post assessment phases of the Returning Home Project (transfer planning and preparation).

The Department has provided funding to assist with establishment of households, purchase of furniture and appliances, and recruitment of staff. Further discussions are being held regarding assisting other groups transfer their care from Glenside to the community, in light of the information generated by the assessments.

Concern: Lack of consultation with consumers, carers and staff

There has recently been extensive and detailed consultation in SA with carers, consumers and other stakeholders in relation to mental health.

The Review of Mental Health Legislation in SA was commissioned by the Department of Health in mid-2004 and involved extensive consultation in metropolitan and country areas with carer and consumer groups, Aboriginal organisations, professional organisations and government agencies from August 2004 to March 2005. The Review Committee received and considered 60 submissions.

At the same time, on behalf of the Departments of Health, Justice and the Attorney-General's Department, Ms Margaret Bonesmo carried out a Joint Stakeholder Survey and for this she interviewed more than 60 stakeholders to gauge understanding and awareness of the principles and operation of the 1995 mental impairment provisions of the Criminal Law Consolidation Act 1935 and the Magistrates Court Diversion Program. Another review, the SA Review of Health Services and Programs for Prisoners and Young People in Custody was carried out by consultants Jocelyn Auer and Belinda Chapman.

Concern: Lack of mechanisms to improve service delivery and accountability

The Guardianship and Administration Act includes as a function of the Public Advocate ‘to give support to and promote the interests of carers of mentally incapacitated persons’. The Public Advocate therefore has an important information role in supporting carers through systems advocacy and the provision of information about requirements.

The SA mental health legislation is seen as taking a minimalist approach when compared with statements of objectives and principles in the Model Mental Health Legislation. In particular, the Mental Health Act 1993 does not reflect principles of care in the community, consumer and carer rights, the concepts of early intervention and recovery, service standards, treatment plans, services to children and the particular needs of Aboriginal people.

In addressing this, the Mental Health Unit of the Department of Health carried out a review of mental health legislation from August 2004 to March 2003. The report which is being finalised contains specific recommendations for legislative change. For example, it has been recommended that in order to ensure continuity of care from acute to community services, community treatment orders (CTOs) should be specific about who is responsible for monitoring and follow up.

A Health and Community Services Complaints Commission has been recently established in SA. The government on coming to office has developed and passed legislation and appointed a commissioner. The legislation is the most comprehensive in Australia and includes both public and private health, and the full range of community services. It seeks to resolve complaints whilst developing, implementing and monitoring a Charter of Rights for Consumers. The Complaints Commission also has an educative role regarding rights of consumers and complaints management, coupled with monitoring the overall health system for improvement and quality performance.

Concern: Training of GPs

ACHIEVEMENTS:
- Establishment of training programs in emergency psychiatry for mental health services and GPs in country and metropolitan regions

The training of GP’s is predominantly a Commonwealth policy agenda and is largely enacted via the Better Outcomes in Mental Health Care initiative which seeks to overcome barriers to GP involvement in the management of mental health disorders by providing financial and other supports, particularly training.

The Department continues to fund shared care programs which seek to develop clear pathways between specialist mental health and general practice. These programs provide a model of care which enables GPs to access consultancy support from specialist mental health workers. As such, these programs seek to enhance GP’s knowledge and confidence in managing mental health consumers.

Concern: Lack of funding

Current expenditure on Mental Health Services (2004/2005) in SA is $158 million and future expenditure is dependant upon pending budget processes. However, as highlighted through this document, significant achievements have been made in SA through provision of additional targeted funding.

Concern: Affordability of care: Public vs Private

Services provided by private consultant psychiatrists are not optimised. Current Health Insurance Commission funding encourages specialised treatment services, rather than consultation services.

National Mental Health Standard 10: DOCUMENTATION

Concern: Documentation systems not being utilised

Adverse event investigations and coronial inquiries in SA have highlighted communication problems in the mental health area, a need for better electronic records and rapid exchange of information. It is also well-recognised that communication and information exchange between correctional services, prison health services forensic mental health services and community mental health services should be improved.

As part of the *2nd National Mental Health Plan 1998-2003*, all Health Ministers agreed to the mandatory implementation of routine consumer outcome measurement across mental health services. In SA, the Mental Health – Consumer Information, Assessment and Outcomes (MH-CIAO) initiative captures the state's commitment to improving data collection, outcome measures and quality control for monitoring and evaluating mental health services. To achieve this commitment, a purpose built Community Based Information System (CBIS) has been developed to enable capture of consistent data to complement in-patient information. When fully operational, the system will provide demographic and contact data, Outcome measures (National Outcome and Casemix Collection – NOCC), risk assessment, triage, Care Plans as well as Crisis and Relapse Plans.

The intent of the initiative is to collect, analyse and use consistent, relevant information to better inform decision-making at both the individual consumer level (eg care planning) and at a regional and statewide level (eg resource allocation). Compliance with the NSMHS and national reporting against minimum data sets are fundamental elements of the MH-CIAO initiative.

Concern: Carers' plea for access with request to be corroborated with documentation ignored

The Emergency Demand Management Policy & Procedure Series which was introduced in 2003 has resulted in the mandatory use of a detailed risk assessment tool across SA. All consumers are also expected to have a relapse prevention plan and a crisis management plan.

It has been recommended that, like legislation in other Australian jurisdictions, the SA Mental Health Act should emphasise an individual and comprehensive treatment plan as crucial to continuity of treatment and services. It should also be the cornerstone of compulsory orders for detention or community treatment. It is further recommended that legislation should provide that carers should be consulted in the development of treatment and discharge plans for a consumer, where practical and appropriate.

In particular, recent reviews have recommended that Aboriginal people need support and advocacy from family when they are receiving involuntary treatment and that children need support from family and/or advocates to ensure their rights are upheld.

National Mental Health Standard 11: DELIVERY OF CARE

Concern: No choice, no continuous care, no individual care

As stated at '*Carer's plea for access with request to be corroborated with documentation ignored'* (see page 24), SA legislation should emphasise individual and comprehensive treatment plans as crucial to continuity of treatment and services. Recommendations that are currently being considered include that treatment plans, including Community Treatment Orders (CTOs) should be broader than medication and should be regularly reviewed/revised to note progress and provide for:

- The wishes of the person and carers to be indicated
- Beneficial alternative treatments to be indicated including options such as counselling, training/education, therapeutic/rehabilitation programmes
- Treatment agencies or providers to be specified
- Where a person should reside if necessary for the treatment and
- Goals for recovery

Concern: Difficulties being experienced by Indigenous people

See Standard 7, page 12.

Concern: Operational policies are limiting access (opening hours and mode of contact)

ACHIEVEMENTS:

- Establishment of hospital at home programs in two metropolitan regions resulting in decreased mental health presentation to emergency departments

In February 2005, SA announced an Australian-first pilot programme between mental health services and ambulance services which will see specially trained crews of mental health staff and ambulance paramedics available (initially only in the northern and southern metropolitan areas) to attend call-outs to crisis situations throughout the night. The move effectively expands the existing Assessment and Crisis Intervention Service (ACIS), which currently operates from 8am to 10pm.

Concern: Crisis required before access is permitted

Consumers and carers in SA have indicated that early intervention should be legislated for and that treatment in the community is a desirable first option in preference to detention in hospital.

The Review of Mental Health Legislation has recommended that it should be possible for a range of approved health professionals to make a Community Treatment Order (CTO) or an order for assessment and admission (with appropriate review) to facilitate early intervention and access to services. It is proposed that legislation should provide for intervention to prevent imminent harm or serious deterioration in a person's mental or physical condition rather than on the basis of health or safety.

The Department of Health is finalising a cabinet submission to facilitate the drafting of regulations to enable the planned treatment and transfer of mental health consumers in other jurisdictions. This would be of particular benefit to Aboriginal consumers in the APY Lands who would be able to access treatment in Alice Springs.

The increasing availability of audio-visual facilities continues to assist South Australian country consumers in accessing appropriate specialist services.

Concern: Carers not heard

Carers have a recognised need for educational assistance, not only in relation to aspects of assistance for their relative/friend with a disability, but also in techniques of personal resilience. The Department of Health has made available funding for 12 carer forums in 2005 across SA to assist family carers of mental health consumers to link with one another and to provide opportunities to meet and network.

The forums aim to make local service providers more accessible and provide carers with opportunities to hear about new initiatives. For service providers the forums are an opportunity to build relationships with carers, collect feedback from carers on services and to be informed of needs and priorities.

Concern: Long wait lists or no clinicians available

ACHIEVEMENTS:

- Improved emergency mental health care through greater consistency of access to acute and emergency services demonstrated through reduction in waiting times
- Establishment of hospital at home programs in four metropolitan health services resulting in decreased mental health presentation to emergency departments

Key future priorities for implementation over the next five years are increased community based treatment and care services with caseload or clinical load ratios that permit relapse prevention and recovery focussed service delivery.

Concern: Lack of services for people with mental illness and complex needs

ACHIEVEMENTS:

- Establishment of the Exceptional Needs Unit, which enables people who would have once remained in institutional care to be supported in the community

SA is having to respond to the growing number of people with long term complex and multiple needs.

The Exceptional Needs Unit (ENU) is a collaborative between the Department of Health and Department of Families and Community Services. The ENU looks for solutions through enhanced relationships between government departments in providing holistic care planning and delivery to assist people to function in the community in the best possible way.

People with mental illness represented 80% of their client group requiring special funding packages.

Concern: Lack of services for people with personality disorders

In addition, it is proposed to retain a broad definition of mental illness as including 'any illness or disorder of the mind' in order to ensure that people in need of help are not excluded from short-term assistance. This would continue to assist with short-term intervention to stabilise a person suffering from a drug or alcohol induced psychosis where there are no other services available eg country locations.

Funding has been provided for extensive education and training package for mental health workers in evidence based assessment and treatment for people with personality disorders currently being rolled out across all services.

Concern: Concerns about the quality of the assessment and review process

See Standard 11, pages 24-25.

Concern: Restrictive and intrusive practices

See Standard 1, page 3.

Concern: Lack of involvement of carers

See Standard 3, page 7.

Concern: Services for refugees and newly arrived immigrants

ACHIEVEMENTS

- Ongoing allocation of significant funding to the significant allocation of funds to the Survivors of Torture and Trauma Rehabilitation Service (STTARS) to provide counselling and resettlement support services for clients with refugee backgrounds who suffer from post traumatic stress disorder
- Mental Health Unit provides a STTARS is a member of the National Forum of Services to Survivors of Torture and Trauma

Approximately 20% of South Australians were born overseas, and significantly higher numbers are of culturally and linguistically diverse backgrounds[14]. There is a lower level of access to hospital and community based mental health services[15] among many people from these backgrounds.

SA has an increasing number of asylum seekers, refugees and Temporary Protection Visa holders entering the State. Many people are traumatised and require the delivery of clinically relevant integrated mental health services in order to build resilience and capacity. Culturally appropriate Interventions to promote mental health and reduce the impact of mental health and mental health problems must be developed.

Various strategies are in place to progress support for clients with refugee backgrounds including, the establishment of a Central Northern Adelaide Health Region in improving mainstream health services access to:

- Members of emerging communities eg in the northern suburbs
- People residing here 20 years or more but not part of strongly established communities
- Refugees who go straight to their sponsor and miss some links into the service system
- Refugees who have received settlement services but for whom problems emerge subsequently.

A steering group with wide membership has been meeting since November 2004 to address key areas of concern including the development of transition programs to enable people to move confidently to locally based programs by people from culturally & linguistically diverse backgrounds.

---

[14] South Australian Multicultural and Ethnic Affairs Commission, An Overview of South Australia's Multicultural Population, 2001

[15] McDonald, B.& Steel, Z., Immigrants and mental health, An epidemiological analysis, Transcultural Mental Health Centre, Sydney, 1997.

It is intended that a raft of ongoing and proposed activities across sector planning, training and mental health promotion will enable mental health services and mainstream agencies to respond effectively to the special needs of migrants, refugees and other people from non-English speaking backgrounds, aided by interpreters and culturally trained staff. It is intended measures across these activities facilitate access to language and culture specific services and support.

Regarding immigration detainees, a Memorandum of Understanding between the Commonwealth of Australia and the State Government of SA (represented by the Department of Health) in relation to the provision of health services to immigration detainees is being finalised and detailed protocols have been developed to describe the process by which immigration detainees held within Baxter Immigration Detention Facility and Port Augusta Housing Project will access specialist mental health services in SA.

Concern: Lack of services for people with mental illness and drug and alcohol problems

Preliminary work has commenced to develop a jointly agreed policy as well as protocols and pathways to improve the responsiveness of both alcohol and other drug services and mental health services to people with co-occurring mental health and substance misuse issues.

A reference group has been formed to provide advice to the Department of Health on the development of protocols, and to aid the process of improving the service response for this client group.

One specific project is auspiced by Catherine House, a non-government organisation run by the Catholic Church. This is a Social Inclusion Project which involves Drug and Alcohol Services together with Mental Health. This project is a collaborative aimed at developing best practice responses for homeless women suffering from mental health and drug and alcohol issues.

Concern: Lack of services for people with physical disability and mental illness

It is a priority for government to ensure a pathway exists for the joint assessment and management for people with dual diagnosis including physical disability and mental illness.

Promoting Independence: Disability Action Plans for SA have resulted from a whole of government strategy to ensure systems are in place for the development and delivery of non-discriminatory services which promote access to vulnerable groups. All Department Chief Executives must report annually against 5 key outcome areas.

Also within Supported Residential Facility (SRF) projects, many of the residents have both physical disability and mental illness. The mental health reform strategy is ensuring that both the health needs psycho-social support needs are being adequately met.

Concern: Lack of mental health services for the aged

Addressing lack of Mental health services for the aged, including information about aged care forum was held 19th April 2005.

The principle of "aging in place" should underpin reform of mental health services for older people. Aim is to engage mainstream aged care providers in delivering services to older people with mental illness.

The objective is to develop "integrated" models of care that wrap services around older people with mental illness based on individual need. Shared care between aged care provider, mental health of older people, and GPs etc. based on comprehensive assessment of need across all life domains is a priority.

A forum was held for aged care providers to begin to talk to mental health services re development of new integrated models of care. The forum attracted a large number of NGO aged care providers.

Discussion also commenced with Commonwealth Aged and Community Care Section of the Department of Health and Aged Care re how the topic of mainstreaming of aged care services for older people with mental illness might be progressed.

Collaborative work is proceeding with mainstream aged care providers to work with mental health services for older people to develop alternative models of care which are more in keeping with philosophy of ageing. This will occur either within aged care residential settings or for supporting older people with packages in their own home. Work has commenced to provide education and training to all Health and Community Care (HACC) workers to better recognise and respond to older people with mental heath needs.

Acute aged mental health care beds are moving from Glenside Hospital to a modern purpose built facility at Repatriation General Hospital (RGH) and residents within the Aged Extended Care beds will be moved to more appropriate mainstream aged care services with support from mental health services for older people. Also work is occurring with aged care providers to encourage the provision of more appropriate and specialised services for older people with mental illness.

Concern: Lack of services for people with eating disorders

The Department of Health via the Mental Health Unit provides annual funding to the Eating Disorder Association of SA Inc. EDASA provide services to people with eating disorders, their families and other interested community members. They provide individual support, support groups, referrals, information and education resources.

It is intended that a review take place of this service in the wider context of mental health policy in SA.

Concern: Lack of family-centred approaches and support services

The Perinatal and Infant Mental Health in the Community project is a 2-year project, funded under the Department of Health Innovative Initiative Grants program. It is a partnership between Helen Mayo House, the South Australian Divisions of General Practice and Community Mental Health Services, Royal Adelaide Hospital.

The project's goal is to improve the diagnosis and management of perinatal and maternal infant mental health problems in the community, primarily by increasing the skills and knowledge of GP's and community mental health workers in perinatal and infant mental health, improving communication and collaboration among providers involved in providing care to mothers and babies, and developing a framework for co-ordinated service delivery of perinatal and infant mental health services in the community.

The project has an exciting focus in bringing together a diverse spectrum of health and community service providers who work with these population groups.

Concern: Lack of self care and living skills programs

See *Concern: Discharge used as a threat, inappropriate discharge and lack of follow-up*, page 32.

Concern: Lack of community support services to maximise opportunities to live independently

See *Concern: Discharge used as a threat, inappropriate discharge and lack of follow-up*, page 32.

Concern: Lack of available supported accommodation including providers and options for young people

ACHIEVEMENTS:
- Introduction of the Supported Accommodation Program, which has established 16 projects across metropolitan and country regions ($3.4 million)
- Development of Supported Accommodation projects across 16 metropolitan and country locations to provide integrated services, such as housing, clinical and non-clinical support, to people at risk of homelessness because of complex needs, including psychiatric disability
- Implementation of the Supported Residential Facilities (SRF) Reform Strategy ($57million over 5 years) which aims to provide better outcomes for people, many of whom have psychiatric disabilities, who are residents within Supported Residential Facilites or are affected by the closure of an SRF.

It is widely recognised that there is a need for community accommodation options to accommodate flexible and staged levels of supervision and support to free up demand for treatment of acute forensic and mental health patients in hospitals.

One such project for women exiting Glenside Hospital is auspiced by Catherine House, a non-government organisation run by the Catholic Church. This is a supported accommodation model to enable these women to be able to move back to the community to live independently with appropriate supports. It is a model of integrated service provision between Glenside Hospital, community mental health, Catherine house and social housing providers.

Efficient and effective use of acute inpatient beds is highly dependent on improving the availability and responsiveness of non-acute services (including sub-acute, rehabilitation care, intensive supported accommodation and psycho-social rehabilitation support) and strengthening assessment processes in all parts of the service system, with common thresholds for entry/exit and detention.

Currently, SA offers in-home supports through the:

- Community Support Inc Scheme under the Home and Community Care (HACC) program, funded by the State and Commonwealth governments;
- A variety of programs funded through NGOs which provide psycho-social rehabilitation for people in independent housing across metropolitan and country regions.

The SRF Reform Strategy provides a subsidy to all residents living in licensed SRFs. Additional supports are provided for those residents with high and complex needs. In addition dental, optical and allied health services are provided to residents. A quality management project (Service Excellence Framework) is being implemented to assist the sector to improve standards and quality of service to residents.

South Australia's mental health system is currently out of balance. Over 50% of its resources are tied up in acute hospital care. Most of it in Glenside Hospital. Beds on Glenside will not be closed until new beds are in place, which will be modern hospital units placed with general hospitals. These new hospital units will be closer to where people live and more accessible when needed. This is part of the state government's $80 million plus capital works program to rebuild the state's mental health facilities.

For people with a longer-term illness, three Community Recovery Centres, with a total of 60 places will be located within metropolitan Adelaide. The three facilities will provide intensive rehabilitation services to people with mental health disorders from country and metropolitan regions.

Consumers with a complex needs will have an option of care in a secure rehabilitation facility (30 beds), which will open early in 2008.

Concern: Medication the only treatment option

As stated at *'No choice, no continuous care, no individual care'* (see page24), it has been documented in SA that legislation should emphasise individual and comprehensive treatment plans as crucial to continuity of treatment and services. Recommendations that are currently being considered include that treatment plans, including Community Treatment Orders (CTOs) should be broader than medication and should be regularly reviewed/revised to note progress and provide for:

- The wishes of the person and carers to be indicated
- Beneficial alternative treatments to be indicated including options such as counselling, training/education, therapeutic/rehabilitation programmes
- Treatment agencies or providers to be specified
- Where a person should reside if necessary for the treatment and
- Goals for recovery

Concern: Concerns about the use of antidepressants for children

Recent reviews of the published and unpublished literature have established that a number of Serotonin Specific Reuptake Inhibitors (SSRIs) have been insufficiently researched to demonstrate their effectiveness or otherwise in young people under 18 years of age. This also applies to SSRIs with adequate research data available where the cost/benefit ratio (when patient safety is taken into account) is at best marginal or in some cases inadequate in the treatment of mild and moderately severe adolescent depression[16],[17],[18],[19]. It is the expectation of the Department is that all prescriptions will meet with current practice guidelines which are evidence based.

[16] Jureidini et al 2004, Whittington et al 2004, March et al, 2004.
[17] Jureidini J, Doecke C, Mansfield P, Haby M, Menkes D, Tonkin A (2004), Efficacy and safety of antidepressants for children and adolescents, BMJ 328:879-83
[18] Whittington CJ, Kendall T, Fonagy P, Cottrell D, Cotgrove A, Boddington E (2004), Selective serotonin reuptake inhibitors in childhood depression: systematic review of published versus unpublished data, The Lancet, 2004; 363 (9418) 1341-1345).
[19] March, J et al (2004), Fluoxetine, cognitive behaviour therapy and their combination for adolescents with depression. Journal of the American Medical Association, 292, 7, 807-820

Concern: Excessive use of restraint and seclusion

Detention/seclusion are practices to be avoided if possible. Neither is compatible with the central dictum of mental health best practice guidelines, specifically that treatment must occur in the least restrictive setting in individual circumstances.

Whilst there will be very occasional need to seclude a consumer such action should be highly controlled with clear indicators for seclusion, mandated observation/review and specified periods of seclusion. Seclusion should only be considered where the consumer is causing immediate danger to him/herself and/or others.

To this end, policy on restraint and seclusion in health units (including mental health situations) which incorporates minimum standards and reporting requirements has been developed and promulgated by the Department of Health.

Concern: Consumers and carers not informed or involved in treatment plan

Please refer to responses at *'Medication the only treatment option'* (see page 30) and *'No choice, no continuous care, no individual care'* (see page 24).

It is well-known that carers nationally contribute significantly to the care of mental health consumers and have felt frustrated at, what is perceived to be, a lack of recognition and involvement with service providers. Carers have said that consumer rights and the importance of family and carers in the care and treatment of people with mental illness should be acknowledged in legislation, a view that is consistent with the National Mental Health Plan ie that 'the rights of consumers and their families and carers must shape reform' and 'a recovery orientation should drive service delivery'.[20] These issues are being systematically addressed in SA.

Concern: Inadequate planning

Again, refer to responses at *'Medication the only treatment option'* (see page 30) and *'No choice, no continuous care, no individual care'* (see page 24). The challenges in relation to continuum of care that have been highlighted through coronial inquests and adverse events are being systematically addressed.

Communication in the interest of providing streamlined care in SA is being enhanced by:

Community Based Information System (CBIS)

- CBIS allows Assessment Crisis Intervention Service (ACIS) staff in hospital Emergency Departments to view historical information and clients' movements. If the client has been seen in the community and has some alerts recorded, these will be visible which will be a significant improvement on the current situation.
- Because of privacy and confidentiality safeguards, not all staff will have this level of access, only those who need the information in order to provide appropriate care to the individual.

[20] National Mental Health Plan 2003-2008, Australian Health Ministers, July 2003, at pp. 10-11.

Open Architecture Clinical Information Service (OACIS)

- OACIS is a clinical information system within the major metropolitan hospitals.
- OACIS links the clinical data across the hospitals into a single cohesive patient record which makes available to the treating clinician a comprehensive view of recent activity.
- If a patient then attends another participating site and has a unit record number the summaries are available to the treating clinicians.

Concern: Discharge used as a threat, inappropriate discharge and lack of follow-up

This Government has committed $3.5 million urgently to provide comprehensive support to consumers in the community. A preferred provider panel has been established with a range of local and interstate providers. The panel process will enable a transparent and time effective approach to allocate funds associated with packages of care. To date 12 organisations have been approved to provide these services to support recovery.

A typical care package will consist of a range of services including support services to assist the person to achieve optimal function and independence in self care, house hold management and other daily activities that facilitate community living skills, encompassing:

- Support and case management services to assist the consumer to manage self and health care, including personal hygiene and nutrition.
- Social support including social skills, communication and self esteem.
- Home management including assistance to establish and care for a home, managing finances and shopping.
- Behaviour support including motivation, healthy living skills and personal safety.
- Community engagement including vocation, recreation and other community living skills.
- Support for the consumer in the development of goals, individual case plan and provision of housing.

HOMICIDE AND SUICIDE

The Minister for Health has established a Ministerial Advisory Council on the Prevention of Suicide and Deliberate Self Harm (SuiMAC) under Section 18 of the *South Australian Health Commission Act 1976*, in consultation with the Minister for Families and Communities.

- Information systems required in SA to ensure that suicide and self-harm patterns are carefully monitored and that service responses are meeting the needs of vulnerable groups and individuals.
- Effective links with a range of committees, including Aboriginal Advisory Committees and the Aboriginal Health Council to ensure that strategies are culturally relevant for Aboriginal people.
- Existing research and best practice initiatives, and, where necessary, on new projects to inform future prevention strategies.

In February 2005, the Social Inclusion Board, through SuiMAC provided $680,000 over two years for suicide prevention initiatives in country SA, in particular initiatives focusing on young men.

8.4.5 RESPONSE FROM WESTERN AUSTRALIAN GOVERNMENT

Author's Note: The Western Australian Government's response was received on 3 June 2005, well after the deadline of 22 April 2005. As a result, the author's were unable to incorporate their feedback into the report.

MINISTER FOR HEALTH

ATTORNEY GENERAL; ELECTORAL AFFAIRS

FOR WESTERN AUSTRALIA

Our Ref: 4-31688

Mr John Mendoza
Chief Executive Officer
Mental Health Council of Australia
PO Box 174
DEAKIN WEST ACT 2600

Dear Mr Mendoza

Thank you for your letter dated 24 March 2005 concerning the Mental Health and Human Rights Draft Report and the opportunity to comment on the sections of the report relevant to my jurisdiction.

Please find attached the Government of Western Australia's written submission to be included in the final report to be released in July 2005. Please note that this submission has also been lodged electronically as requested.

I look forward to receiving a copy of the final report once completed.

Yours sincerely

JIM McGINTY MLA
MINISTER FOR HEALTH

3 JUN 2005

30th Floor Allendale Square
77 St George's Terrace Perth WA 6000
Tel: +61 8 9220 5000 Fax: +61 8 9221 2068
ABN: 61313082730

WESTERN AUSTRALIAN RESPONSE

Executive Summary

Our State's mental health system has been under significant pressure for many years and improving mental health services for all Western Australians is one of the Gallop Government's top health priorities.

In recognition of the need in this area, the State Government has allocated $173.4 million in additional funding over the next three years for the implementation of a comprehensive package of mental health reform initiatives.

Next year, total annual funding from the State Government for mental health will be more than $300 million, over nine per cent of the total health budget, making Western Australia the first state to achieve this level of funding.

It will also mean that total spending on mental health will have increased by 50 per cent from the $208 million annual expenditure when the Gallop Government came to office in 2001[21].

This strong commitment to funding a range of new initiatives and the expansion of existing mental health services will have significant benefits for many individuals, carers and families in Western Australia who need support.

The *Mental Health Strategy 2004-07* outlines the key reforms, which will address the most pressing areas of need within our current mental health system. The aim is to meet demand for services, improve access to appropriate inpatient services, increase intermediate care options, provide more community support services and improve safety for consumers, staff and the community.

The *Mental Health Strategy 2004-2007* is the culmination of an extensive consultation process and reflects the significant consideration the mental health sector has given to developing better services for mental health consumers.

The reforms will see the provision of 19 new observation beds in Emergency Departments for people with mental illness, 113 additional acute inpatient and intermediate care beds and the creation of 420 community beds statewide.

In addition community mental health services will be expanded through new post natal depression services, expanded community adult, child and adolescent services, day treatment programs, services for children of parents with a mental illness, multisystemic therapy services and a new community based eating disorders service.

In total these initiatives will see the recruitment of more than 475 new mental health staff into the Western Australian Health System, representing the greatest commitment to mental health by a Western Australian Government.

These key strategies form part of the first phase of the innovative longer term plans for public health system reform outlined in the Health Reform Committee's final report *A Healthy Future for Western Australians – Report of the Heath Reform Committee 2004*.

Dr Neale Fong, Director General, Department of Health, Western Australia and Executive Chairman of the Health Reform Implementation Taskforce, is leading the implementation of mental health reform, in partnership with the Department of Health's Division of Mental Health.

Implementation of mental health reform and the provision of significant funding for new mental health initiatives provide a comprehensive approach by this Government to better meet community need for mental health services in Western Australia.

[21] Department of Health and Ageing (2003) *National Mental Health Report 2004: Eighth Report-Summary of changes in Australia's Mental Health Services under the National Mental Health Strategy 1993-2002.* Commonwealth of Australia, Canberra.

There is a recognition that more needs to be done in mental health to achieve our aim of a high quality, effective and efficient mental health system in Western Australia. To achieve this, the Government is committed to a process of ongoing mental health service reform.

The Government has recently undertaken a number of community consultations to further gauge the community's priorities for mental health service development. These consultations have provided us with a detailed picture that will enable us to move forward with mental health reform over the next five years.

PART 1: GENERAL REMARKS

The Western Australian Government welcomes the opportunity to provide comment on the Human Rights and Equal Opportunity Commission (HREOC), Mental Health Council of Australia and the Brain and Mind Institute draft report Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia, draft dated the 9th March 2005, henceforth referred to as the Report.

The Government recognises that there are shortcomings in the mental health system in Western Australia. The Government is committed to ongoing processes of reform and quality improvement and is pursing a number of mechanisms to promote this.

The Department of Health (DoH) has gathered a large amount of information regarding the performance of the mental health system, information on gaps in current service delivery, needs of mental health service consumers and community priorities for mental health reform that may provide another source of information for your report. Some of the recent key mechanisms are:

- Statewide consultations undertaken to inform the Mental Health Strategy 2004-2007;
- Statewide consultations undertaken to inform the development of the draft Mental Health Action Plan 2005-2010;
- Snapshot surveys of treatment and accommodation needs of mental health inpatients undertaken in 2002, 2003 and 2004;
- Consumer and carer consultations held to inform consumer/carer participation structures;
- Feedback from Consumer Advisory Groups and consumer satisfaction surveys;
- 2004 Survey of People in Perth with Serious and Persistent Mental Illness who are Homeless;
- The reports of in depth reviews of mental health services by the Australian Council of Healthcare Standards (ACHS) against the National Standards for Mental Health Services;
- The Chief Psychiatrist's Reviews of Mental Health Services;
- The National Survey of Mental Health Services; and
- WA mental health information systems, notably the Mental Health Information System and PSOLIS (the mental health clinical information system).

This broad base informs the Government about the status of the people who access the mental health service system in Western Australia. This submission draws on these and other sources of information to inform the authors of the Report of recent initiatives that may not have been revealed during the community consultations.

This submission will not respond to each issue discussed in the Report, but will concentrate on some of the key areas raised.

Part 2: Mental Health Reform in Western Australia – an overview

The latest per capita figures for 2002-2003 show that Western Australia had the highest per capita gross recurrent expenditure for mental health of $119 per person[22]. This figure does not include funds for the recently announced mental health initiatives under the Mental Health Strategy 2004-2007 (The Strategy). The total funding for this Strategy, including the Department of Housing and Works contribution of $42 million, is $173.4 million. This Strategy will boost expenditure on mental health services to more than 9 per cent of the total health budget in Western Australia. In 2001, expenditure on mental health totalled $204 million (current prices). By 2006, more than $300 million will be spent on mental health, an increase of 50 per cent since 2001.

The Report on Government Services 2005 also showed that Western Australia had the highest national number of direct care staff per 100,000 people in specialist mental health services (104.2)[22].

Mental health consumers are the highest bed day users in the Western Australian health sector. Hospital demand modelling undertaken by the Department of Health indicates that inpatient demand by people with mental illness will continue to grow rapidly during the period 2004 to 2016.

Overall, Western Australia ranks fifth nationally in the number of acute and non-acute general psychiatric beds that it provides per 100,000 population. There continues to be unprecedented and protracted demands on inpatient beds in the acute mental health sector. In addition, there is an unprecedented demand for services within Emergency Departments with a notable increase in presentations of psychiatric illness and drug overdose. Access block to inpatient services is exacerbated where mental health units are not authorised and therefore cannot accommodate involuntary patients.

The Western Australian Government supports the National Mental Health Strategy, which proposes the development of a comprehensive mental health system consisting of a wide range of services that both promote mental health and provide treatment services for those who do develop mental illness. This includes a range of services across the continuum of mental health care, from inpatient and community based specialist services, to primary health care services as well as mental health promotion and prevention initiatives. The Government also supports a system of care that includes responses from a range of sectors and across government partnerships and collaborations.

Improving mental health is a high priority in Western Australia and the Government has introduced a number of initiatives over the past year, as part of the Strategy, aimed at increasing the responsiveness of mental health services to the demands on services and is continuing to assess new ways to improve mental health.

The Western Australian Government has recently announced a range of reforms to build the capacity of the mental health sector to respond to the needs of people with mental illness, through Western Australia's Mental Health Strategy 2004-07.

The Mental Health Strategy 2004-2007 consists of 5 key initiatives:

- Key Initiative 1 - Mental Health Emergency Services
- Key Initiative 2 - Adult Inpatient Services
- Key Initiative 3 - Community Mental Health
- Key Initiative 4 - Supported Community Accommodation
- Key Initiative 5 - Workforce and Safety Initiatives

[22] SCRGSP (Steering Committee for the Review of Government Service Provision) 2005 *Report on Government Services 2005*, Productivity Commission, Canberra

Table 1: Western Australia's Mental Health Strategy 2004-07 funding

Source of Funds	*value*
Department of Health	*$131,265,000*
Operating	*$ 93,115,000*
Capital	*$ 15,700,000*
Land value for Housing	*$ 22,450,000*
Department of Housing and Works	*$ 42,140,000*
TOTAL	*$173,405,000*

Further details of the Mental Health Strategy 2004-2007 can be found at Appendix 1.
This package of initiatives represents the greatest single commitment by any Western Australian Government to mental health care in this state. It is important to note that these reforms are a major step on the path to better mental health care for Western Australians. These strategies will be of benefit to the more than 35,000 people who use public mental health services in Western Australia each year. These strategies form the first part of an ongoing plan to deliver better patient care, help ease pressure on public hospitals and deliver much needed community support including supported accommodation.

The Government recognises that there will need to be a continuous process of health sector reform that responds to the predicted growth in mental illness and disability in our society. Western Australia is currently undertaking continued planning for mental health service reform. The Government is in the process of developing a five year Action Plan for Mental Health that will outline the Government's continued commitment to providing mental health services that are alongside the best in this country. Initial consultations have been held in Western Australia to inform the development of the Action Plan.

Over 300 people from around WA participated in these consultations through attendance at community forums or through written feedback. Feedback was received from consumers, carers, government and non-government mental health service providers, and other interested parties. Initial feedback has indicated priorities for further reform include increasing the level mental health services in the community and mental health promotion, prevention and early intervention initiatives. Work is also progressing on enhancing the service interface between primary, secondary and tertiary mental health care.

The Government recognises that a comprehensive mental health service requires activities beyond the health sector. Promoting mental health and well being and reducing the impact of mental illness is a concern for, and the responsibility of, our whole community. The Government will continue to build on existing whole of government and community wide partnerships to enhance our capacity to promote mental health and respond to mental illness. Key partners include the Disability Services Commission, the Department of Education and Training, Department of Justice, Department of Community Development, consumers and carers, non-government organisations, general practitioners and other private health providers.

PART 3: National Standards Mental Health Services

As a general comment, the reviews of all public mental health services conducted by the ACHS, which specifically assess compliance against the National Standards for Mental Health Services, provide an excellent source of information for measurement against the Standards.

Services are required to provide evidence of meeting these standards and are progressively introducing mechanisms to be in a better position to do so. For example, in Western Australia, services are increasingly introducing mechanisms to gauge consumer satisfaction with the services they provide. Services are obliged to follow recommendations made by the ACHS and this has encouraged a continuous process of quality improvement.

A number of activities have recently been undertaken in relation to mental health service reform and the following section will briefly highlight some of the developments that have been put into place during the past year.

3.1 National Mental Health Standard 1: Rights

There are a number of mechanisms in place to assess whether rights of consumers are being upheld. Legislation is a key mechanism for this as is the former Mental Health Review Board, which has been subsumed within the State Administrative Tribunal.

Mental health services themselves also have systems in place to promote rights of mental health service consumers and to investigate instances where these may not have been upheld.

The Council of Official Visitors plays a key role in upholding rights of people with a mental illness through visits to health services and complaints management process. The Council would be an excellent source of independent advice on the extent to which public mental health services in Western Australia uphold the rights of people with a mental illness.

Consumers Rights are supported through access to free legal services through the Mental Health Law Centre.

The Chief Psychiatrist of WA has legislative responsibilities to ensure standards of care and protect the rights of people who have mental illness.

On 28 October 2004 the Minister for Health laid before Parliament the Report on the Review of the Mental Health Act*. In his speech the Minister noted that the vast majority of the recommendations of the review have been accepted. The recommendations advance the rights of people with mental illness while further supporting the responsibilities of mental health clinicians to provide quality care.*
The Minister accepted the recommendation of a new Mental Health Act, which will include:

- Revising the definition of mental illness in accord with internationally accepted standards.
- Expanding the objects of the Act to include principles related to Aboriginal and Torres Strait Islanders and carers.
- Providing more information to consumers related to their care, including a mandatory discharge plan.
- Prohibiting the use of Electroconvulsive Therapy as an emergency treatment or in relation to children under 12 years of age.
- Expanding the role of the Council of Official Visitors and the Chief Psychiatrist to offer a more comprehensive advocacy and monitoring service.
- Conducting mandatory reviews by the Mental Health Review Board significantly earlier than in the present Act; and
- Introducing a part of the legislation that will deal with children and adolescents, and have a new part of the Act to deal with complaints.

3.2 National Mental Health Standard 2: Safety

WA public mental health services have legislative requirements and a philosophy of ‘least restrictive care’ that guides clinical practice in this state. Staff and patient safety are taken seriously and are of paramount concern.

The state and local infrastructure that ensures a systematic and integrated approach to assuring healthy outcomes for Western Australian mental health consumers includes:

- WA Clinical Governance Framework and the more specific mental health clinical governance framework. The Office of the Chief Psychiatrist makes reviews of mental health services against the mental health clinical governance framework;
- The National Standards for Mental Health Services are reviewed by the Australian Council of Healthcare Standards;
- Safety and health in Western Australian workplaces is regulated by the Occupational Safety and Health Act 1984 and the Occupational Safety and Health Regulations 1996 supported by codes of practice and guidance notes.

WA mental health services have Occupational Safety and Health officers who establish and monitor safe systems of work in the workplace that ensures the safety of staff, consumers and their carers; and

- Reviews of safety of workplaces conducted by WorkSafe.

The DoH meets with a number of organisations to address broader safety issues. These collaborations include the Western Australian Police Service, St John Ambulance and the Royal Flying Doctor Service to review safety issues, specifically around safe transportation of people with a mental illness.

Recent work has focused on reviewing models for community to hospital transfer of patients as well as hospital-to-hospital transfers and the need to broaden the training for police officers in mental health issues and mental illness. Further, a review of the existing protocol between the WA Police Service and the Division of Mental Health, which provides a framework for outlining the relationships between the Police and Mental Health Services, is being undertaken.

The WA Mental Health Safety Working Group, established under the Mental Health Strategy 2004-2007 began meeting in 2004 to address many of the complex outstanding WorkSafe notices that had statewide implications. The group's key priorities for implementation included; conducting risk assessments, duress alarm systems, safe design of mental health facilities, safe transportation of patients, core competency training, safety considerations for home and community visiting, and safe and sustainable communication in the field. The working group have developed draft Safety Guidelines with the aim of providing sensible, practical suggestions on how clinicians and managers can work toward ensuring a safe environment for consumers, carers, families, staff and the community.

The Prevention of Workplace Aggression and Violence, Policy and Guidelines produced by the DoH makes it mandatory for all staff to complete training in this area. Although all mental health services currently have in place training programs for the management of aggression and violence in the workplace, the DoH is developing a state standardised training program applicable across all age specialties and service settings.

The WA Guideline Development Group for Short-term Management of Disturbed/Violent Behaviour in In-Patient Psychiatric Settings is preparing clinical guidelines for Western Australian public mental health services for the short-term management of disturbed (violent) behaviour in inpatient psychiatric settings, including consideration of pharmacological, physical (including seclusion and restraint), preventative and psychosocial interventions. This is aimed at establishing best practice for these difficult situations were there is often marked variability of standards.

The DoH provides an education program that includes sessions on the rights of patients as provided for under the Mental Health Act 1996. Further to this a newsletter is published four times per year that includes information about patient or consumer 'rights' when appropriate to highlight this and other such important issues.

3.3 National Mental Health Standard 3: Consumer and Carer Participation

The WA Government has a strong commitment to consumer and carer participation. There are a number of mechanisms in place to promote this, and the Government is currently looking at ways to enhance consumer and carer participation. For instance

- Consumers and carers provide input to state mental health planning, implementation and service evaluation through consultations, advocacy and committee memberships.
- Consumers and carers are members of a range of mental health service management and operational committees. Consumers and carers are also consulted about and sit on committees developing state mental health policies.
- Consumers and carers sit on committees progressing the current Western Australian *Mental Health Strategy 2004-2007*. The consumers and carers participating on these committees have recently formed a consumer and carer communication group, to provide support and increase awareness and progress of projects.
- Consumers and carers have also provided feedback to the draft *Mental Health Action Plan 2005-2010* through the community consultation process.

As recognised in the Report, the DoH previously funded the Health Consumers Council for mental health consumer participation and training.

The DoH has now established a separate process whereby authorised payment of consumers and carers for participation in mental health service activities such as attendance on committees and other formal meetings is ensured. A revised Consumer Participation Payments Policy was released on 1 January 2005.

A consumer has been employed as a consultant by the Division of Mental Health to assist with the implementation of the policy, assist with problem solving with consumers about participation issues and advise on the process to develop long-term consumer participation structures.

Although the Division of Mental Health continues to pay consumers for their participation it is recognised that a dedicated service is needed to coordinate and support mental health consumer participation, advocacy, training, information exchange and support.

To address this, the Division of Mental Health hosted two consumer and carer workshops in November 2004 and January 2005. These workshops sought consumer and carer input on potential structures for participation in mental health services. The workshops were attended by a total of 66 consumers and carers (33 people attended both workshops).

The outcomes from these workshops highlighted the agreed need for good support, including training and education, and effective structures for mental health consumer and carer participation in Western Australia. At the workshops consumers indicated that some key areas need to be progressed in WA are:

- support structures which coordinate consumer participation;
- guaranteed funding to support consumer and carer participation;
- education and training for consumers; and
- greater commitment of mental health services to involvement of consumers.

The process to develop the statewide mental health consumer and carer participation framework is ongoing. A steering group has been established to guide the development of participation structures. The framework will incorporate a range of services including consumer coordination, advocacy, training and research.

WA is the first State to have legislation aimed at recognising the role of carers, reflecting the prominence that the Western Australian Government gives to supporting carers. A key part of the Act requires service providers to comply with the Western Australian Carers Charter. The Charter provides clear direction on how carers are to be treated and how carers are to be involved in the delivery of services. The Act:

- formally recognises carers as key partners in the delivery of care;
- provides a mechanism for the involvement of carers in the assessment, planning and delivery of services that impact on them and their caring role; and
- allows carers to make a complaint about non-compliance with the Carers Charter and if necessary to seek remedies through the Office of Health Review.

Carers WA is the dedicated peak body for carers in Western Australia. It provides specialised mental health carer advocacy and support. Carers have expressed their satisfaction with this arrangement.

3.4 National Mental Health Standard 4: Promoting Community Acceptance

The WA Government recognises that more needs to be done to address community acceptance of people with a mental illness. Recent community consultations have identified increasing community acceptance and decreasing stigma and discrimination as central issues in which Western Australia needs to be more proactive.

Actions to address community acceptance to date include: Mental Health Week, radio and print media attention to issues and contributions by mental health professionals to the Health and Medicine lift-out of the West Australian newspaper. Workforce discrimination towards people with mental health issues is being addressed through the Family Partnerships training program.

The Healthway Scoping Project tested the Victorian "Together We Do Better" campaign for its applicability in Western Australia. This campaign aimed to determine current beliefs and concepts of mental health, social connection, valuing diversity and physical and emotional health and wellbeing in the Western Australian community. The project sought to promote community acceptance and understanding of mental health issues and the socio-behavioural factors contributing to 'mental healthiness'.

In addition, Western Australia joined beyondblue, the national depression initiative, in November 2004. Beyondblue is a national, independent, not-for-profit organisation working to increase awareness and understanding of depression, anxiety and related disorders throughout Australia.

Finally, two Western Australian mental health services have formed a partnership with the Social Inclusion Project run by the UK NHS as part of developing shared learning across different countries and cultures to minimise the social exclusion of people suffering from serious mental illness.

3.5 National Mental Health Standard 5: Privacy and Confidentiality

Upholding rights to privacy and confidentiality are of extreme importance. There are a number of mechanisms in place to ensure that this occurs. There are also a number of initiatives underway to further enhance the systems capacity to uphold these rights.

The Confidentiality in Mental Health Settings Guidelines were developed by the Division of Mental Health and are available in all mental health services.
The Guidelines are aimed at ensuring people with mental health problems have their confidentiality respected while receiving the best possible care. It outlines the legal and ethical obligations faced by mental health professionals in order to assist them in making informed decisions concerning confidentiality. These guidelines can be made available on request.

The guiding principles of the Guidelines are:

- that the establishment of trust, based on a mutual understanding about confidentiality, is an important part of the therapeutic relationship;
- good patient management generally requires that information is obtained from, and shared between, professional staff, patients families and other caregivers; and
- confidentiality issues should, at the commencement of care, be discussed by clinicians with their patients.

The balance between confidentiality and communication with families and carers is of paramount importance in achieving better health outcomes for patients. In practice factors such as increasing specialisation, multidisciplinary team management and the need to involve the family and other carers can result in conflict between a persons wish for absolute confidentially and their desire to receive the best possible care. In view of this, the DoH is working with carers of people with mental illness to more specifically define the confidentiality issues that arise between carers and general practitioners in the treatment process.

3.6 National Mental Health Standard 6: Prevention and Mental Health Promotion

The Government acknowledges the need for growth of mental health promotion and illness prevention (MHP&IP) programs. This was recognised in A Healthy Future for Western Australians, the Health Administrative Review Committee Report (HARC), the WA Mental Health Strategic Plan and the Statewide Audit of Mental Health Promotion and Illness Prevention.

There are a range of MHP&IP services currently operating in WA. These include FRIENDS (anxiety prevention): The Resourceful Adolescent Promotion Program, the Positive Parenting Program (social behavioural problems prevention and early intervention) and Aussie Optimism (anxiety and depression prevention program/resilience enhancement). These initiatives are provided across the range of community health services, in collaboration with other sectors (eg Department of Education and Training, Department for Community Development).

The DoH also supports a range of specific suicide prevention and intervention services and projects. This funding is provided for public sector services, public funded services in non-government organisations and private organisations. Work in progress includes the development of a comprehensive suicide prevention strategy, through a collaborative and coordinated approach involving all Government Departments. This involvement includes a broad range of non-government and community organisations.

Many of the above programs have a statewide focus and are offered in both metropolitan and rural regions.

The Statewide Perinatal Reference Group is organising the implementation of statewide services expansion through funding allocated under the Mental Health Strategy 2004-2007. The service expansion will have a particular focus on people from culturally and linguistically diverse backgrounds and Aboriginal people.
Promotion, prevention and early intervention activities are also undertaken at a service level, with services offering early intervention as an option for referral and some having dedicated promotion prevention and early intervention positions. First episode psychosis programs are also in place. The expansion of community mental health services under the Mental Health Strategy 2004-2007 will expand the scope for services to further undertake prevention, promotion and early intervention programs.

3.7 National Mental Health Standard 7: Cultural awareness

Three programs will be developed and implemented to increase the cultural competency of the mental health workforce. Firstly, a training package entitled Managing Cultural Diversity in Mental Health (a Culturally and Linguistically Diverse (CALD) program) will be adapted and delivered to WA clinicians. Secondly, a Cultural Competency Audit Tool will be piloted and implemented in services.

In keeping with the National Practice Standards for the Mental Health Workforce, the cultural competency for staff working with indigenous clients will be improved through the development of training programs. Cultural education can promote a clearer understanding of the processes involved in establishing and maintaining links with social and cultural community groups and how to access these resources. Training programs aim to target staff awareness of other cultural beliefs, values and practices and encourage broader consideration when planning and delivering appropriate care.

The WA Multicultural Forum for Mental Health Practitioners promotes and facilitates culturally sensitive management practices for culturally and linguistically diverse clients with mental health issues through education, quality assurance and input into policy development.

3.8 National Mental Health Standard 8: Integration

Developing mechanisms that support integration between and within services is a key target for the Western Australian Government.

At a whole of Government and whole of community level, the Government has established a number of mechanisms to promote integration of services for people with mental health concerns. The key partners in promoting integration include the Department of Health, Department of Justice, Department of Premier and Cabinet (including the Social Policy Unit and the Office of Crime Prevention), West Australian Police Service, Department of Housing and Works, Disability Services Commission, Department of Education, Department for Community Development, Divisions of General Practice, local government, non-government organisations, public mental health services and consumer and carer representatives.

The key mechanisms that promote integration include:

- The Children First Strategy, which includes numerous activities for children and youth across a number of portfolio areas. Of particular mention is the Early Years Strategy aimed at improving the well being of children under the age of 8 years.
- The Children of Parents with a Mental Illness Interagency Advisory Committee, established to improve service coordination and delivery for children where they have a parent with a mental illness. These children face a range of social, emotional, behavioural and physical disadvantages.
- Collaborations to address the interrelationship of mental illness and crime. These include the Crime Prevention Strategy, the Interagency Access to Justice Committee and the Offender Health Council.
- Collaborations between the Department of Health and the Department of Housing and Works to support people with serious and persistent mental illness to live in the community;
- Ministerial Council Of Suicide Prevention;
- State Government Homelessness Strategy Monitoring Committee;
- State Perinatal Reference Group, which is representative of key stakeholder groups and oversees perinatal service development across WA;
- Disability Services Commission/Department of Health, Mental Health Quarterly Interagency Meeting; and
- Supported Accommodation Assistance Program State Advisory Committee.

Agreements to clarify roles and service responsibilities and promote integration between services include:

- The Protocol between the Disability Services Commission and the Department of Health People with Intellectual Disabilities and Mental Disorders: Guidelines for Service Providers;
- WA SAAP Protocols between the Health Department of Western Australia and Family and Children's Services to improve linkages between mental health services and Supported Accommodation Assistance Program (SAAP) services;
- The draft Children of Parents with a Mental Illness Interagency Protocol, which define roles and responsibilities of a range of the eight partners party to the Protocol and outlines good practice in interagency collaboration;
- Protocol between the Western Australia Police Service and the Mental Health Division of the Department of Health, Western Australia;
- Memorandum of Understanding between the Department of Health and Department of Education and Training to support implementation of the Aussie Optimism Program;
- Department of Health and Department of Housing and Works Mental Health Housing Strategy 2004-07 Memorandum of Understanding; and
- The Ministerial Council for Suicide Prevention.

At a program level, there are also a number of interagency initiatives underway these include:

- MulitSystemic Therapy Program;
- Triple P (Positive Parenting) Program;
- Aussie Optimism Program;
- Independent Living Program;
- Children of parents with a Mental Illness Project;
- Intensive Community Youth Service and Youthlink; and
- Early Psychosis Program.

Within the health sector there are also a variety of activities occurring to promote continuity of care for people with a mental illness across the health sector. These include:

- Collaborations to improve the interface between specialist mental health services and primary health care;
- Collaborations to improve the interface between inpatient and community services;
- Collaborations to promote integration between mental health and drug and alcohol services. This is guided by the Statewide Strategic Dual Diagnosis Planning Group;

- Development of the draft Aboriginal Social and Emotional Wellbeing and Mental Health Strategy;
- Assertive case management (which will be expanded through resources available to community mental health services under the Mental Health Strategy 2004-2007)
- The Child and Adolescent Mental Health Services Advisory Committee Cohesion Group (looking at the interface between community mental health services and inpatient services for children and adolescents); and
- Rural and remote communication strategy (seeking to enhance integration between rural and remote and metropolitan mental health services).

3.9 National Mental Health Standard 9: Service Development

In Western Australia there is an ongoing process of quality improvement and education and training to promote the quality of services provided. The following areas will be addressed commencing in 2005 with emphasis on working to achieve the National Practice Standards for the Mental Health Workforce.

- Orientation Program. With over 470 new positions to be established under the Mental Health Strategy 2004-2007. The expectations of the new staff coming into the WA mental health system from interstate and overseas will be met with a standardised, efficient and thorough orientation program that is currently being developed.
- Clinical Supervision: At present there is no agreed framework for clinical supervision for all disciplines in WA mental health services. Consultation with health services will occur to develop a framework for clinical supervision for all disciplines across mental health services. Clinical supervision enables clinicians to develop and reflect on their practice in a peer or individual relationship.
- Leadership and Management Program for Mental Health Professionals. A program for approximately 45 mental health senior staff is being developed. This program will include leadership development, strategic planning, managing and implementing change and managing performance. This program is aimed at ensuring senior managers are well equipped to implement the National Standards for Mental Health Services.
- Core Competency Training. Statewide training packages will be developed and implemented in core areas of clinical practice. A central warehouse of training courses available throughout mental health services will be created enabling clinicians throughout the state to access courses specific to their needs.

A coordinated graduate programme for nurses specifically in mental health began in February 2005. This programme provided 6 weeks of intensive theoretical and practical experience for newly graduated comprehensive nurses at the start of their 12-month graduate programme, hence making it a 58 week programme

Service quality is measured through the use of customer satisfaction surveys and other customer satisfaction measurements (such as the provision of feedback forms, establishing community advisory bodies and surveys of specific areas of concern).

Some of the findings that the investigators should note include:

- Psychiatric Emergency Team conducts annual Consumer Stakeholder Perception Survey. The 2004 Consumer and Stakeholder Perception Survey of the Psychiatric Emergency Team surveyed 76 randomly sampled consumer and cares. The results of the survey showed that the majority of participants were satisfied to very satisfied with the services. The majority of the negative feedback was associated with involuntary admission under the Mental Health Act 1996. Staff management and knowledge impressed the majority of stakeholders.
- The South Metropolitan Area Mental Health Service conducted a Child and Adolescent Mental Health Service Customers Satisfaction Survey. 700 survey forms were distributed. Results showed that nearly 1 in 2 carers reported the service they received as excellent, with only 13% of carers reporting the service to be fair or poor. The majority of young people (80.7%) gave the service a grade of either A or B. This demonstrates a high satisfaction with CAMHS services from both carers/parents and consumers.

Non-government organisations also measure customer satisfaction with the services they provide. NGOs provide this information to the DoH as a part of their contractual requirements or as evidence of quality service provision. For instance;

- Southern Cross Care Consumer Satisfaction Survey of June 2004 found that 99% of consumers felt that they were getting the services they required and that staff show open communications skills and explain things clearly.

The Chief Psychiatrist has been conducting clinical reviews of mental health services since 1999. These reviews are a key element in the quality improvement cycle for mental health services. Eleven clinical reviews have been conducted with two of the eleven being the pilots for the mental health clinical governance framework. This new framework includes consumers and carers in the review process who are trained and participate as team members alongside clinicians.
The reviews enable the Chief Psychiatrist to assess mental health services' attention to the continuous quality improvement processes that ensure the provision of optimal mental health care. A specific process facilitates collection of data on consumer and carer concerns directly from those individuals by consumer and carer reviewers. The data collected as part of the review process also enables the staff, consumers and carers to acknowledge those areas, which mental health services excel in and those that require further attention.

The Government believes that this approach to an independent comprehensive assessment of Mental Health Services against a specific mental health clinical governance framework to be the most progressive in Australia and places this State in a position to further ensure the quality of care to mental health consumers into the future.

The DoH has developed and implemented a statewide policy on complaints management. Some individuals may have indicated that they had problems with the complaint procedures because they did not agree with the outcome of their complaint investigation.

There are also a number of complaint agencies external to health services available for patients/clients including:

- the Office of Health Review,
- professional registration boards; and
- the Ombudsman's Office.

All public Mental Health Services have implemented the routine collection of consumer outcome measures. Clinicians and key administrative staff have received training in the use of nationally agreed consumer outcome measures; including a consumer self report tool, and the National Outcome and Casemix Collection (NOCC) protocols. Managers and clinicians in public Mental Health Services receive monthly reports on the NOCC data. This information is currently being used to inform quality improvements in clinical practice. Projects are underway to ensure that training is provided in the interpretation of the data and use of the information in everyday clinical practice. Consumer outcome measurement assists in the assessment of service effectiveness and the establishment of benchmarks.

3.10 National Mental Health Standard 10: Documentation

PSOLIS is the mental health clinical information system that has been developed for use by all government mental health staff throughout Western Australia. It allows for information sharing, within the bounds of confidentiality, across inpatient and community services. PSOLIS is built using leading edge technology and aims to provide mental health services with the ability to share, analyse and retrieve information about clients in an efficient and effective manner.

PSOLIS, has been implemented in all public Mental Health Services (inpatient and community-based) throughout Western Australia. PSOLIS is a centrally based clinical information system that is used by medical, nursing, allied health, management and clerical staff and it is linked to the core health application TOPAS. Information related to patient demographics, referrals, admissions, discharges, transfers, diagnoses and service events related to staff and client activity is collected and stored in PSOLIS. Functionality includes:

- enhanced search functions which allows a client to be tracked across community-based and inpatient service settings;
- alerts, incidents and investigations to inform clinicians of potential risks and assist client-specific management strategies and treatment plans;

- client reviews to support the clinician and clinical team in the client review process;
- on-line management and crisis plans to improve communication within and between clinical teams at each service as well as with external services; and
- the collection and reporting of mandatory data collections, for example, the National Outcome and Casemix Collection (NOCC)and the National Minimum Data Sets for Mental Health Care.

The Government believes that PSOLIS is the only complete integrated electronic mental health information system in Australia that collects all information required for all National Minimum Datasets, NOCC, essential clinical information as well as have a unique patient identifier and an episode of care identifier.

3.11 National Mental Health Standard 11: Delivery of Care

The delivery of care by mental health services is guided by quality improvement mechanisms as outlined above in response to Standard 9: Service Development.
In regards to the particular issues of access, entry, assessment and review, treatment and support, medication, therapies and planing for exit and re-entry; these are measured and quality improvement supported through these mechanisms outlined above.

In regards to the level of access to community and inpatient services, as opposed to the quality of those services, the implementation of the Mental Health Strategy 2004-07 is a major step in increasing capacity of the mental health system.

The Department of Health has supported the development of quality improvement initiatives such as the Service Standards for Non-government Providers of Community Mental Health Services and the Agency Self-Assessment Guide and Supporting Resources Kit.

Current support to non-government organisations included $19.3 million in 2004-05 in funding for statewide services. This includes:

- 570 Independent Living Program places statewide. This service grows at 60 places per year;
- support to 560 residents living in private psychiatric hostels; and
- community support services including psychosocial support, recreation, advocacy, carer support and respite, mental illness prevention, suicide prevention.

Appendix 1: Mental Health Strategy 2004-2007

The mental health reform initiatives outlined in the *Mental Health Strategy 2004-2007* aim to increase the capacity of mental health services to meet the increase in demand.

The focus will be on relieving pressures in the mental health system, especially where this impacts on other parts of the health system such as Emergency Departments, increasing access to appropriate inpatient services and addressing the lack of intermediate care treatment options and community support services.

During the past few years a number of reports have been generated to plan for the delivery of mental health care in Western Australia. These include:

- *Western Australia's Mental Plan* (previously the Draft State Mental Health Strategic Plan);
- *A Healthy Future for Western Australians – Report of the Health Reform Committee*; and
- *Enhancing the Capacity of Mental Health Services*.

Specifically, the *Mental Health Strategy 2004-2007* addresses five main areas in the health system where targeted interventions have the capacity to immediately and significantly increase access to mental health services and reduce demand on acute hospital beds. The five strategy areas are:

- Mental health emergency services
- Adult inpatient services
- Community mental health services (Adult & Young people)
- Supported community accommodation
- Workforce and safety initiatives

These strategies are aligned with the innovative and longer term plans outlined in the Health Reform Committee's final report, which is being rolled out by the Health Reform Implementation Taskforce.

The development of these individual strategies is the culmination of a significant amount of consultation involving consumers, carers, mental health professionals, government and non-government mental health bodies and peak industry organisations.

To assist with the implementation of major reforms to mental health services in Western Australia, a Mental Health Advisory Group has been established. The Advisory Group of mental health specialists will oversee implementation of the *Mental Health Strategy 2004-2007* and play an integral role in the development and monitoring of activities. The Advisory Group will also be involved in engaging consumers, carers, community bodies and other stakeholders in the provision of advice and feedback and assist with communicating information out to the community.

Key Initiative 1 - Mental Health Emergency Services

Objective

To expand statewide mental health emergency services to meet the demand for services within Emergency departments.

Actions

1. Increasing the number of specialist mental health nurses within hospital emergency departments. The service ill provide 24-hour coverage for people presenting with mental health problems. An additional 42 (FTE) mental health nurses will be employed to provide specialised mental health triaging and clinical support within emergency departments across the metropolitan area.
2. Expansion of the Psychiatric Emergency Team (PET) to ensure comprehensive cover across the metropolitan area. This service will provide dedicated emergency coverage north and south of the river.
3. Increasing the number of On Duty Psychiatric Registrars for after hours cover across the metropolitan area, to provide psychiatric assessment, treatment and support for mental health patients in the Emergency Department.
4. Establishing 19 new mental health beds consisting of five-bed admission holding units at Sir Charles Gairdner Hospital, Fremantle Hospital and Royal Perth Hospital and a four-bed admissions unit at Graylands Hospital. These units will provide a safe and secure environment for both patients and staff.

Key Initiative 2: Adult Inpatient services

Objective

To increase access to adult inpatient beds for people with severe mental illness.

Actions

1. Provision of an additional 113 beds in the following locations:
    a. *Graylands Hospital* – conversion of an existing facility (the Fitzroy Administration complex) to provide 12 new acute secure beds.
    b. *Armadale Hospital* – creation of 8 new beds within the current facility.
    c. *Bentley Hospital* – provision of an additional 20 beds through the reconfiguration of inpatient services.
    d. *Mother and Baby Unit* – the mother and baby unit at Graylands Hospital will be transferred to King Edward Memorial Hospital for the establishment of an 8 bed authorised unit.
    e. *Bunbury Regional Hospital* – expansion of the acute psychiatric unit to provide an additional 18 beds.
    f. *Intermediate Care* – establishment of 47 new intermediate care beds, 22 beds in the north and 25 beds in the south metropolitan areas, to provide rehabilitation, disability and clinical support services.
2. Provision of additional psychiatrist cover in Albany, Bunbury and Geraldton to ensure inpatient services in these rural areas are maintained.

Key Initiative 3 Community Mental Health Services

a) ADULTS

Objective

To improve clinical outcomes for people with a mental illness through provision of accessible community services which encourage early identification, intervention and recovery.

Actions

1. Expansion of community mental health clinical services, through an assertive case management approach. These services will be undertaken by multidisciplinary community teams.
2. Establishment of day therapy services to individuals with a major mental illness. The services will provide structured individual and group based clinical programs. Therapy services may include intensive rehabilitation and be provided in the person's own home or in a community facility.
3. Extension of the statewide Post Natal Depression (PND) services for mothers with babies through the statewide expansion of non-government community services, particularly in areas with a high number and projected growth of young families. Research will also be undertaken to inform the development PND services for Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds.

b) YOUNG PEOPLE

Objective

To enhance service coverage and accessibility and provide a whole of service/government approach to ensure that young people with a mental health problem are given the best opportunities for early intervention.

Actions

1. Development of two Multi Systemic Therapy (MST) teams for young people aged 12-16 years at risk of developing mental illness in the south and the north metropolitan areas.

2. Establishment of the Intensive Community Youth Service to provide intensive counselling, access to stable accommodation, education and employment access for homeless youth at risk of mental illness, with little family or guardian support, in the south metropolitan area.
3. Expansion of the Bentley Child and Adolescent Mental Health Service's transition unit for its Day Treatment Program, to support 10 extra children and treat others at home to prevent unnecessary hospital admission.
4. Recruitment of additional clinical staff to expand existing Child and Adolescent Mental Health Services into areas of rapid youth population growth to provide services to young people with severe and complex mental disorders.
5. Development of a service to assess and treat people with an eating disorder, particularly young adults. The service will have strong links with regional and rural services.

Key Initiative 4 Supported Community Accommodation

Objective

To expand community supported accommodation services for people with severe mental illness.

Action

1. Creation of 420 community beds statewide through the following programs:
    a. *Supported Community Residential Units* – provision of 200 beds in cluster accommodation for up to 25 people with 24 hour on-site staff support in locations including the metropolitan area, Albany, Bunbury and Geraldton.
    b. *Licensed Psychiatric Hostels* – increase in the personal care subsidy to improve service quality to hostel residents.
    c. *Specialist Residential Services* – development and construction of an extended care service at Graylands Hospital to provide rehabilitation and a home-like environment for 20 people with chronic mental illness and severe disability, currently in acute inpatient beds.
    d. *Community Options 100* – transition of 30 people with long-term support needs from Graylands Hospital to community living with associated support services in the metropolitan area.
    e. *Psychosocial Support Services* – expansion of statewide non-clinical psychosocial/disability support services to assist people to live in their own homes. This includes the construction of 120 housing units for the Independent Living Program.
    f. *Supported Accommodation* – establishment of non-government services in Perth inner city, Fremantle and Armadale to support 50 homeless people with a mental illness. The services will provide 24 hour support, ‘drop in’ services and community outreach.

Key Initiative 5 Workforce And Safety Initiatives

Objective

To ensure services are adequately staffed with the appropriate skills and discipline mix and that Mental Health Services are safe places where innovative clinical practice is fostered.

Actions

1. Recruitment and retention of 425 staff through the following:
    a. A major recruitment drive in Australia and overseas. Mental health staff including psychiatrists, nurses, social workers and occupational therapists will be recruited.
    b. Provision of incentives to practice in areas of greatest need and workforce shortage to ensure adequate staff coverage in rural and remote areas.
    c. Improvement of workforce re-entry processes for staff that have left the workforce. Education and training will be tailored to address the projected workforce requirements. Innovative education and training models will equip the workforce with the skills, knowledge and attitudes to competently do their work.

d. Improvement of workplace safety through convening a statewide safety working group that will make recommendations for many current complex safety issues. The safety working group will address issues such as the use and availability of duress alarms, communication (including mobile phones), the safe transportation of patients and safe, flexible working environments. Mental health staff will be provided with improved education and training in key areas of practice such as assessment, risk assessment and dealing with aggression.
e. Expansion of the electronic mental health clinical information system PSOLIS to provide intermediate information to all clinicians to assist them with day to day clinical decision making.

8.4.6 RESPONSE FROM AUSTRALIAN CAPITAL TERRITORY GOVERNMENT

Simon Corbell MLA

MINISTER FOR HEALTH MINISTER FOR PLANNING

MEMBER FOR MOLONGLO

Mr John Mendoza
Chief Executive Officer
Mental Health Council of Australia
PO Box 174
DEAKIN WEST ACT 2600

Dear Mr Mendoza

Thank you for your letter of 24 March 2005 presenting the draft Human Rights and *Mental Health* report for comment.

As reported to you in my previous correspondence (28 March 2005), the ACT Government welcomes any review that provides representative and meaningful information and guidance regarding the protection of human rights, particularly of those individuals living with mental illness, and their carers.

The ACT Government and ACT Health, through Mental Health ACT, are committed to providing accessible, safe, responsive and quality mental health care for the ACT community. Since election in 2001, the Stanhope Government has increased funding for mental health in each of its three budgets as a clear demonstration of its commitment to improving mental health in the ACT.

This Government has overseen an extensive community consultation and collaboration process to develop the ACT Mental Health Strategy and Action Plan 2003-2008 (the Plan). This Plan reflects the identification of mental health as a key priority area within the ACT Health Action Plan and the reform agenda of the National Mental Health Plan 2003-2008.

We have worked to build partnerships with other government agencies and community organisations to improve mental health services in the ACT. Much has already been achieved and significant additional work is still in progress.

I am therefore disappointed in the draft of this report as it currently stands. The current draft presents a collection of anecdotal observations and inference drawn from those anecdotes. There is no evidence of any attempt at strategic analysis, which greatly detracts from the criticisms raised.

This is not to say that I wish to dismiss the issues raised. The size of the cohort does not invalidate the level of concern expressed in relation to these perceptions of care. These findings tell us that, twelve years into a national mental health strategy, we may have achieved some significant reform but there is still much to be done to ensure that mental health care meets the needs and expectations of the community.

One of the problems with a report such as this is that there is a risk that our mental health professionals, the majority of whom work extremely hard in often difficult circumstances, might bare the brunt of the criticism about the level and quality of care provided within complex mental health care systems.

It will be important for the final report to be clear that the issues raised are about systems and processes in place to plan and monitor quality mental health care and not about individual clinicians or the work that they do in the field. .

ACT Specific Comments:

NMH STANDARD 1: RIGHTS

As stated in my letter of 28 March 2005, the ACT is the first jurisdiction in Australia to have a Bill of Rights with the enactment of the ACT Human Rights Act in 2004. In 2004 ACT Health engaged the Castan Centre for Human Rights Law at Monash University to conduct an audit of all legislation for which ACT Health has responsibility, for consistency with the HRA. This included components of the *Mental Health (Treatment and Care) Act 1994*. The ACT Government has committed to a full review of the ACT *Mental Health, (Treatment & Care) Act 1994* to commence later in 2005. A component of this review will be to test the Act in its entirety against the Human Rights Act.

Consumers and carers are also provided with information about the Mental Health (Treatment and Care) Act 1994 as well as advice about their rights under that Act and the National Standards for Mental Health Services. Mandatory training is provided to all Mental Health ACT staff to provide them with skills to treat all consumers and carers with dignity and respect.

NMH STANDARD 2: SAFETY

The ACT Government has commissioned a number of significant reviews in response to concerns about the safety of mental health care in the ACT, particularly in the inpatient facilities.

The internal quality review of ACT Mental Health Services in 2002 resulted in a number of recommendations about improving the quality and safety of systems to provide mental health care.

*The ACT Health Complaints Commissioner "*Investigation into Risk of Harm to Clients of Mental Health Services November 2002 *(Patterson Report) was tabled in the ACT Legislative Assembly in December 2003. This review provided 58 recommendations for improving consumer safety in mental health care, all of which have been implemented. The Patterson Report supported the majority of the findings of the Quality Review.*

*The Mann/La Roche report on "*The review of the design and operation of the Psychiatry Services Unit (PSU), Canberra Hospital December 2002 - January 2003*" was commissioned as a direct response to one of the recommendations of the Patterson Report. The Government has allocated $1.35 million dollars for the recommended refurbishments to the PSU following this review. The recommended work is almost completed. In response to ongoing consumer, carer and staff concerns about the safety of the PSU, even with the recommended refurbishments, the Government has committed a further $10 million dollars for a replacement unit in the longer term.*

The Australian Protective Services Review of Mental Health ACT was completed late in 2003. This Review has provided a range of recommendations in relation to infrastructure and systems to improve safety for consumers, staff and visitors to Mental Health ACT facilities. Mental Health ACT is progressing through the workplan developed to implement the recommendations of this review.

The Australian Incident Monitoring System (AIMS) is being utilised across ACT Health to monitor adverse events and inform a systems response to such events.

NMH STANDARD 3: CONSUMER AND CARER PARTICIPATION

The ACT Government and Mental Health ACT have committed significant resources to support and facilitate consumer and carer participation in the planning of mental health care in the ACT. The ACT has two paid consumer consultants, has both a consumer and carer representative sitting on its executive management group and a range of other consultative and advisory committees. The Mental Health ACT Carers Committee is supported by the organisation and actively contributes to organisational policies. MHACT provides carer peer support workers to assist carers of people admitted to the acute inpatient unit. ACT Health also funds separate consumer and carer organisations in addition to a mental health "Peak Body".

ACT Health has undertaken significant work in developing a standardised consumer/carer feedback/complaints procedure and policies. Timeframes for managing complaints are set in policy and compliance with this process is monitored by the Executive. I am advised that information about the feedback process is made widely available in all areas of the service and consumers and carers are encouraged, and even assisted if required, to use the system as necessary. In the past eighteen months, approximately 240 consumers/ carers have availed themselves of the opportunity to use the consumer/carer feedback process. Of the total number 164 have raised issues of concern and 76 have provided compliments on the level of service they have received. The most common issues of concern are (i) attitude; (ii) medication issues and (iii) treatment coordination. MHACT acknowledges these concerns and will be seeking to address these and other issues in planning services in the future.

There has been a significant emphasis in recent years on improving the level of information provided to carers about services and supports available to assist them in caring for their loved ones. The Minister for Disability, Housing and Community Services launched the ACT Caring for Carers Policy in 2004. This policy was developed after extensive consultation with the community and provides an agreed framework for working with carers, respecting their rights and supporting their role in the community. The ACT Caring for Carers Policy has wide support within the Territory and implementation of the policy is being closely monitored by a multi-agency implementation committee.

Mental Health ACT acknowledges the significant expertise and contribution provided by carers and consumers through their representatives on the Mental Health ACT Executive group and the range of other committees and structures within the organisation. Mental Health ACT also funds or supports a range of specific programs for carer and consumer support including the Mental Health Carers' Committee, the Canberra Schizophrenia Fellowship, the Mental Health Foundation, The ACT Mental Health Consumer Network, the ACT Mental Health Community Coalition and the Children of Parents with a Mental Illness (COPMI) project.

Carers' groups have also worked with MHACT staff to develop a flip chart for carers to keep on the fridge with a range of contact details including who to contact and where to go in an emergency and other important information to assist in the care of people with a mental illness. I will be launching this new aid for carers in the near future.

NMH STANDARD 4: PROMOTING COMMUNITY ACCEPTANCE

The issue of raising community awareness and acceptance of mental illness is one that engages the minds of all who work in the area of mental health and it is clear that we all need to be doing more in this area. As identified in some of the comments in the report, the stigma associated with mental illness can be particularly problematic in seeking to access a range of other services, including safe, appropriate and affordable housing and employment.

The ACT Government has supported a number of programs aimed at raising awareness, understanding and acceptance of mental illness in our community.

The ACT Government funds Mental Illness Education ACT (MIEACT) to provide mental health programs in secondary schools. This program utilises consumers and carers who share their stories and has been very effective in generating more informed discussion and understanding of mental health issues in the schools where it has been presented.

In addition, the Government provides funding to a community organisation, OzHelp, to provide suicide prevention and other mental health programs for the building industry. This program is well-recognised and highly regarded locally and nationally. The success of this model in the difficult environment of the building industry has generated considerable interest from other jurisdictions.

I am advised that the MHACT Community Education Officer provides sessions for Government agencies, community organisations, sporting clubs and other businesses to try to raise the level of awareness and support for people with a mental illness more broadly.

The ACT also funds the Canberra Schizophrenia Fellowship to provide vocational rehabilitation programs for mental health consumers to help transition them into the mainstream workforce. The ACT Mental Health Strategy and Action Plan 2003-2008 acknowledges that vocational rehabilitation is an area of mental health that still requires significant reform. The need to work with businesses to raise their awareness and understanding of mental illness is a key to facilitating access for people with a history of mental illness back into the workplace.

MHACT staff and a range of key stakeholders have recently developed a brochure "Helping a friend with mental illness" which also includes a section for workplaces and supervisors with advice about how work colleagues can assist in supporting a worker who might be experiencing a level of mental illness. I will be launching this publication in the near future.

The issue of the perpetuation of stigma and stereotypes in the media is an ongoing one. As one of your respondents also indicates, the Government and MHACT frequently seek to remind relevant media outlets in the ACT of the "*Reporting suicide prevention and mental illness – a resource for media professionals*" guidelines for reporting mental health issues. We will continue to try to work with the media to try to encourage them to moderate their reporting of these important issues.

NMH STANDARD 5: PRIVACY AND CONFIDENTIALITY

The balance of protecting consumers' rights to confidentiality and the need for carers to be informed to enable them to care for their loved ones is an ongoing dilemma for mental health clinicians.

MHACT clinicians are bound by the Health Records (Privacy & Access) Act 1997. This can at times hinder family involvement in the care of their loved ones. It is very difficult for staff in such situations to decide what information to provide to family. There is no doubt that at these times carers and family members can be left feeling quite frustrated and uninformed

It is important to note that the ACT Health Records & Privacy Act 1997 is being reviewed in detail to clarify the role of caregivers and any restrictions placed on their by the Act. This was one of the recommendations of the Investigation into Risk of Harm to Clients of Mental Health Services.

MHACT, in collaboration with the Australian National University is currently trialling advanced agreements where consumers, clinicians, carers and others involved in care sign an agreement when the consumer is well that enables an agreed plan to be followed if the consumer becomes unwell. The project is in the early stages and will be evaluated after 12 months.

NMH STANDARD 6: PREVENTION AND MENTAL HEALTH PROMOTION

The ACT Mental Health Strategy and Action Plan 2003-2008 (the Plan) proposes a shift in culture towards a mental health promotion and early intervention model for mental health care in the ACT. The Plan supports the development of an ACT Mental Health Promotion, Prevention and Early Intervention Strategy which promotes a whole of population approach to promoting and maintaining good mental health across the Territory.

It is clear that the promotion of mental health and the prevention of mental illness cannot be achieved without whole of government cooperation. Provision of specialist clinical mental health care is only a small component of what is needed to achieve and maintain good mental health. The ACT Mental Health Strategy and Action Plan promotes a whole of government approach to mental health through strong partnerships with agencies for housing, education, welfare support, employment, drug and alcohol programs, policing and corrections.

The ACT Mental Health Promotion, Prevention and Early Intervention Strategy is being developed in consultation with all these groups and other key stakeholders to try to improve our capacity to identify those at risk of developing a mental illness and intervene early with the aim or reducing that risk.

I am advised that MHACT is also participating in a Collaborative Therapy project in collaboration with the Australian National University. This project aims to work with consumers, their carers, clinical managers, GPs and others involved in their care to develop an agreed management plan while providing consumers with enhanced skills to enable them to be able to identify signs of relapse and when they may need to seek additional support or other care to reduce the risk of relapse. The project is in the early stages and will be evaluated after 12 months.

NMH STANDARD 7: CULTURAL AWARENESS

ACT Health is currently developing a Cultural Respect Implementation Plan for all staff to raise awareness of cultural issues in the workforce and provide training to enhance staff capacity to work effectively with people from Aboriginal and Torres Strait Islander descent.

NMH STANDARD 8: INTEGRATION

Mental Health ACT is committed to providing quality, integrated services that are timely and responsive. The comments in the draft report highlight that some consumers and carers feel frustration that services are not as integrated as they should be to ensure a seamless continuum of care.

The ACT Government has acknowledged these concerns and has provided funding for discharge planners for the inpatient units to facilitate planning for transition from the acute inpatient unit back into the community. I am advised that MHACT is monitoring re-admission rates and follow-up within 7 days of discharge to further improve the integration of the services provided and ensure that consumers are discharged with appropriate care plans and support.

Mental Health ACT is also part of a broad ACT Health portfolio wide project, in collaboration with the ACT Division of General Practice, to develop and implement agreed and consistent discharge planning systems and documentation.

The Chief Executive of ACT Health has recently signed-off on a revised structure for MHACT which sees the management of both community and inpatient services come under the one director which should also assist in the development of more integrated services across the care continuum.

MHACT has Memorandums of Understanding (MOUs) with a range of other Government agencies including ACT Housing, the Australian Federal Police, Drug and Alcohol Program, etc. These formal MOUs and other less formal mechanisms seek to ensure a collaborative and integrated approach to managing people with a mental illness. Two very successful programs are the Dual Disability Program and the work of the Dual Diagnosis worker. Both these programs have assisted in improving collaboration and integration across services to achieve better health outcomes for consumers.

Apart from the discharge planning project, MHACT is also working with the ACT Division of General Practice on a project to improve the physical health of people with a mental illness. My Government and Department are fully aware of the poor physical health of people with a mental illness and the difficulties encountered by a number of disadvantaged groups seeking primary health care, including those with mental illness. This is in part due to the undersupply of GPs in the ACT as a result of Australian Government Policy and the fact that there are now very few GPs who provide bulk billing services.

The joint project with ACTDGP provides a primary care nurse to work within a community mental health team to facilitate and coordinate access to GP practices for participating consumers. Participating GPs and mental health clinicians will develop collaborative care plans that address the physical and the mental health need of consumers. The project will be evaluated at the completion of the 12 month trial.

MHACT works closely with the Australian Federal Police (AFP) within the terms of their MOU to facilitate appropriate management by the police of people with a mental illness. The MHACT Community Education Officer also provides information and education sessions for the AFP to develop their skills in dealing with people with a mental illness who come in contact with the police.

The Minister for Disability, Housing and Community Services launched "*Breaking the Cycle - the ACT Homelessness Strategy"* in 2004. This Strategy identifies a number of target groups who are at particular risk of becoming homeless, including those with an enduring mental illness. The Government has committed significant funding ($13.3 million) to implement this strategy aimed at improving housing options for the most vulnerable in our community.

Developing and coordinating appropriate funding models across government to support clients who are homeless or at risk of homelessness are key initiatives under the strategy and the actions include:

- *Action 1.1.3:* Assess and develop current funding models to ensure they adequately support service viability and sustainability in providing outcomes for clients.
- *Action 3.1.2:* Develop an investment strategy for social housing in the ACT.

Theme 3 of *Breaking the Cycle* recognises that access to appropriate housing is a keystone to health and well being for the community. In addition to housing, access to a range of social and community support services assist people with mental health issues to participate in the broader community and provide opportunities for management of mental health issues

The existing MOU between Housing ACT and MHACT provides a good framework for the two agencies to work together in trying to provide safe, appropriate and affordable housing for people with a mental illness, including an agreement that ensures that ACT Housing tenants who have to be admitted to a mental health facility for any length of time will not lose their tenancy. There is a clear recognition of the importance of appropriate accommodation in achieving and maintaining good mental health.

As with a number of other comments in the report, the need for additional accommodation options for people with a mental illness has been identified as an area for action in the ACT Mental Health Strategy and Action Plan. In the interim, in the 2003-04 budget, the Government provided an additional $240,000 for supported accommodation and respite places. A further $200,000 was made available for mental health respite as part of a broader respite care package in the same funding period. This brings the total amount of funding for supported accommodation for people with a mental illness to $1.2 million.

NMH STANDARD 9: SERVICE DEVELOPMENT

The ACT Government and MHACT have made significant changes to the way in which mental health services are organised and provided within the ACT. It is clear that there is still much to be done and we continue to work proactively to implement a range of initiatives to provide better mental health outcomes for the ACT community.

The ACT Government has demonstrated its on going commitment to mental health by increasing funding for mental health initiatives in the last three budgets. The National Mental Health Report of 2002 noted the ACT Government's expenditure on Mental Health services was lagging behind the national average with a per capita expenditure of $67 in 1999-2000 compared to the national average of $81 per capita. Under the present ACT Government, this level of funding has increased significantly and in the ACT 2004 – 2005 budget handed down on 4 May 2004 an estimated target per capita expenditure of $131 was announced. This records a substantial growth in mental health funding and will be validated in future *National Mental Health Reports*.

In May 2004 I launched the *ACT Mental Health Strategy & Action Plan 2003-2008 (the Plan)* which is the principal document guiding the ACT's mental health service delivery. The Plan was developed after an extensive consultation period and represents a genuine collaborative agreement on mental health priorities and actions for the people of the ACT. Many of the issues round effective involvement of consumers, their families and carers in all areas of the mental health system, access to appropriate coordinated and quality treatment services including supported accommodation for mental health consumers, raised in the HREOC *Report,* have already been identified as priorities for action in the *ACT Mental Health Strategy & Action Plan 2003-2008*.

Priority 5 of the plan focuses on system or organisational level issues with the following objectives:

- To establish transparent and accountable quality systems that promote and support innovation in the mental health care sector and complies with the National Standards for Mental Health Services;
- To develop an appropriate skilled workforce that provides quality service delivery;
- To develop a comprehensive epidemiological base for the planning and long-term evaluation of mental health services in the ACT;
- To facilitate data collection and reporting that is meaningful to the operation and outcomes of the ACT mental health system;
- To develop and apply a funding model that ensures effective and accountable allocation of resources; and
- To promote and facilitate a whole of government and whole of Territory approach to mental health service provision in the ACT.
-

There is an emphasis on strategies to recruit and retain appropriately skilled staff and to develop a robust education and training program to support them in their work and professional development,
Work to undertake a systemic analysis of current and future needs for mental health services is in progress to enable the appropriate allocation of human and financial resources to meet these identified needs and improve mental health outcomes.

In response to concerns about access to forensic mental health services expressed by some member of the ACT community, including the Chief Magistrate, the ACT Chief Minister established an Interdepartmental Committee (IDC) to undertake a full review of forensic mental health issues within the ACT in 2004. One of the recommendations of the IDC was to undertake a feasibility study into high secure mental health care for the ACT. The feasibility study has been completed and the recommendations from the study, together with all the recommendations from the IDC, are currently being considered by Government. The expected outcome of this work is that the ACT will have a quality forensic mental health service that provides care across the care continuum as required. This will include linkages in the community and in-reach into the proposed new ACT prison.

In the 2004-2005 budget the ACT Government also allocated a total of $230,000 to undertake a comprehensive services planning project and feasibility studies for acute adult mental health services, child and adolescent mental health services, crisis assessment and treatment services. The consultation process of this project is in progress. The consultant is due to report to ACT Health before the end of the 2004-2005 financial year. It is intended that this work will guide the provision of mental health services for the ACT projected needs to the year 2014.

MHACT is in the process for preparing for accreditation through the Australian Council of Healthcare Services EQuIP program. This will be the first time that MHACT has been through accreditation as a stand-alone organisation and will provide an independent evaluation of our services against the EQuIP quality improvement framework and the National Standards for Mental Health Services. .

In addition to this, substantial funds have been provided to specific suicide prevention, early intervention and mental health promotion projects.

One of the criticisms directed at mental health services is that there has been too little commitment to evaluating reforms and new initiatives to determine their effectiveness in improving mental health outcomes. I am advised that, as a apart of the revised clinical and corporate governance arrangements for MHACT, the Executive is developing a key set of corporate and performance measures that will enable transparent and accountable operation of the service and clinical care delivery.

NMH STANDARD 10: DOCUMENTATION

Mental Health ACT has developed its clinical information management system – MHAGIC - *Mental Health Assessment Generation & Information Collection System* which is aligned with mental health legislation, meets local and national data requirement, links Outcome Measurement to Care Planning and has recently been externally assessed (as part of the ACHS EQuIP pre-accreditation survey) as meeting these requirements, as well as providing information that supports safety and other *National Standards for Mental Health Service*. There is also an established clinical governance committee that regularly reviews, monitors and advises of all matters relating to MHAGIC

NMH STANDARD 11: DELIVERY OF CARE

Mental Health ACT as a division of ACT Health aims to collaborate with their community partners to provide quality mental health care across the lifespan and the care continuum. The organisation operates within the core values of professionalism, respect and integrity; collaboration and teamwork, commitment to quality and recovery, performance accountability, innovation and sustainability.

Underpinning principles for mental health care provision are consumer and carer focus, empowerment and participation for consumers, equitable and timely access and mutual respect.

It is acknowledged that, even with these values and principles as our guide, there is still much work to be done to ensure that our service meets the care needs of our community more comprehensively.

As identified in other areas of this response, this Government and MHACT have identified a number of gaps in the range of services required to achieve and maintain good mental health for the ACT community and has funded a number of initiatives to address these gaps.

In the last three budgets the ACT Government has provided significant additional funding to enhance services to support people in the community, including;

$400,000 per annum for additional regional outreach programs
$400,000 for a 7 Day extended service for Community Mental Health Teams
$80,000 for a dedicated Drug and Alcohol/Mental Health Worker
$240,000 for additional Supported Accommodation
$80,000 for a Discharge Planner Service for inpatient services
$35,000 for Carer Support.
$300,000 for Forensic Mental Health Community Team

The Government, has also increased funding to Child and Adolescent and Older Persons Mental Health Services, to enable them to provide earlier intervention and more comprehensive treatment and support services for these two identified at risk groups .The planned 20 bed acute psychogeriatric inpatient unit is expected to be commissioned in the 2006-2007 financial year and will form an integral part of the overall older personals mental health care continuum.

Programs funded to improve the delivery of specialist mental health care include:

- Child and adolescent mental health services
- Older persons mental health services
- Enhanced community mental health teams including outreach teams for new suburbs
- Mobile intensive treatment teams
- Dual disability and dual diagnosis teams
- Discharge planning
- Forensic community mental health team

Programs funded to enhance the level of support for people with a mental illness in the community include:

- Consumer and carer support
- Community education
- Psychosocial and vocational rehabilitation programs
- Suicide prevention programs
- Supported accommodation and respite services

The National Mental Health Plan 2003-2008 provides us with a clear direction for ongoing mental health reform. The ACT Mental Health Strategy and Action Plan 2003-2008 reflects the principles and is underpinned by our ongoing commitment to ensure that the National Standards for Mental Health Services are fully implemented and that this is reflected in how consumers and carers perceive our care into the future.

Thank you for the opportunity to comment on the draft report. I trust that the report will be used to generate a renewed enthusiasm for mental health reform and will not simply be seen as a vehicle for criticising those working in the system without trying to determine an agreed way forward.

Yours sincerely

Simon Corbell MLA

8.4.7 RESPONSE FROM NORTHERN TERRITORY GOVERNMENT

During preparation of this report, all jurisdictions including the Northern Territory were formally offered the opportunity to comment on the draft sections of the report pertaining to that jurisdiction as well as other relevant sections of the draft report.

No response was received from the Northern Territory Government, as represented by The Honourable Peter Toyne, MLA, Minister for Health.

8.4.8 RESPONSE FROM TASMANIAN GOVERNMENT

Tasmania

MINISTER *for*
HEALTH *and* HUMAN SERVICES

9 May 2005

Mr John Mendoza
Chief Executive Officer
Mental Health Council of Australia
PO Box 174
DEAKIN WEST ACT 2600

Dear Mr Mendoza

Thank you for the opportunity to review the draft report on your recent consultations. Unfortunately the timeframes you provide do not allow for a considered response to each individual item collected during your consultations.

You may be aware that the Department of Health and Human Services also conducted broad consultation with service providers, non-government organisations, consumers, carers and community representatives during 2004. A number of the issues identified in your report were raised during those consultations.

In November 2004 I released '*The Bridging The Gap Report.*' I commend this report to you. The report identifies key priority areas for attention and makes a set of relevant recommendations.

The Government has committed $47M to address the recommendations over a four year period. This represents the largest ever funding increase for service expansion in the 170 year history of Tasmania's Mental Health Services. The funding addresses the following initiatives:

- $4.36 million to create a total of 62 additional packages of care to support options for clients to live in the community, ranging from independent living to support in provided accommodation;
- $7.45 million to establish a 12-bed high support community facility in Northern Tasmania;
- $3.7 million to establish a 12-bed Cluster House for 24 hour seven day a week supported accommodation in the North West;
- $3.7 million to establish a 12-bed Cluster House for 24 hour seven day a week supported accommodation in the South;
- $7.32 million for an additional 26 full time equivalent clinical positions in Child and Adolescent Mental Health Services – more than double the current establishment of 21.5 FTEs;
- $5.85 million for an additional 16 FTE clinical positions in adult mental health services – an increase of more than 21 %;

-2-

- $2.55 million for an additional 6 FTE clinical positions to work with elderly mental health clients – an increase of one third on current numbers;
- $3.78 million to drive quality and safety improvements; assist with implementation of the Mental Health Act; and develop a mother and baby service, including:
  - Three additional quality positions – one Senior Quality Office statewide; one in the North and one in the North West to focus on quality and safety issues;
  - Establishment of four consumer and carer/family representative positions – two in the South and two in the North – to work with Mental Health Services to improve service quality and safety;
  - Appointment of a Senior Consultant Psychiatrist and additional support positions to support administration of the Mental Health Act and ensure the rights of consumers and advocates are protected in the delivery of all mental health services; and
  - Provision of a specialised mother and baby inpatient service to accommodate women with young children, experiencing mental health problems;
- $3.74 million to establish Recovery Programs in each region to provide activity, social and vocational skills-based programs to support recovery alongside community clinical and supported accommodation services; and
- $4.52 million to upgrade existing facilities, places and services to bring them into line with current specifications in the supported accommodation framework.

In addition, the Government funded an additional 18 mental health clinical positions in the community as part of the 2004/2005 budget.

2004 also saw the commencement of the Kids In Mind Tasmania strategy to provide support to children, young people, parents and carers and service reform and improvement in the mental health area. The Department of Premier and Cabinet has provided $1.05 million over two years for this strategy.

I am confident that these investments represents an important first step in recognising the need and continuing a planned, systematic approach to improving mental health services in Tasmania.

Thank you for writing to me on this matter.

Yours sincerely,

David Llewellyn, MHA
DEPUTY PREMIER

8.4.9 RESPONSE FROM FEDERAL GOVERNMENT

THE HON CHRISTOPHER PYNE MP

Parliamentary Secretary to the Minister for Health and Ageing

Mr John Mendoza
Chief Executive Officer
Mental Health Council of Australia
PO Box 174
DEAKIN WEST ACT 2600

Dear Mr Mendoza John

Thank you for your letter of 5 April 2005 to the Minister for Health and Ageing, the Hon Tony Abbott MP, regarding the invitation to the Australian Government to provide a written response to the Mental Health Council of Australia's report on experiences of care entitled *Not for Service*. As Parliamentary Secretary with executive responsibility for this matter, I am responding on behalf of the Australian Government.

It is clear that the Mental Health Council of Australia and the Brain and Mind Research Institute, together with the Human Rights and Equal Opportunities Commission, have invested considerable time and effort in consulting with mental health consumers, carers and service providers, and gathering the data to produce such a report, which comes at a critical time in our consideration of the state of mental health services in Australia.

We supported the development of an independent Mental Health Council of Australia to provide us with direct community perspective on issues in mental health and related policies.

The report clearly highlights that there are concerns about the mental health system in Australia and the delivery of services to those experiencing mental illness. The Australian Government recognises that there is more to be done.

New areas of Australian Government program support include innovations in relevant areas of education, employment and training, with a specific emphasis on enhanced youth mental health. We maintain and reinforce our commitment to reducing the exposure of our young people to illegal drugs, alcohol and other forms of substance abuse.

The Report has bought us back to an essential aspect of monitoring health care. It is necessary to talk openly with those who use the systems, those who have had poor experiences and those local providers of services who are frustrated by current approaches. Australia's National Mental Health Strategy has been applauded as world-leading. We need to respond constructively to critical incidents, especially when they highlight major system failures.

Since 1996, the Australian Government has emerged as a leader in critical aspects such as the development of a national suicide prevention strategy, the first ever conduct of a national household survey of mental health problems, redevelopment of primary mental health care services and support for community education, schools-based programs and destigmatisation. While our emphasis has been on modes of prevention or early intervention, there is more to be done in the area of increased access to everyday mental health services.

Parliament House Canberra ACT 2600 • Telephone: (02) 6277 4842 Facsimile: (02) 6277 8581

2

The instigation and recent funding of major new programs such as Better Outcomes in Mental Health and *beyondblue: the national depression initiative* are clear evidence of our ongoing commitment. For the first time, we are supporting access to non-medical specialists such as clinical psychologists, mental health nurses and social workers to work in partnership with general practitioners. These programs are now being expanded to increase that access to treatments other than medication.

Under the National Mental Health Strategy, the Australian Government has a strong and proud record in mental health reform since 1992, beginning with the development of the National Mental Health Policy. It has not only provided substantial funding directly to States and Territories, through Medicare and the Pharmaceutical Benefits Scheme and more indirectly through the income and disability support it provides, but has acted as leader in progressing significant national mental health initiatives.

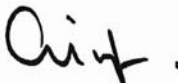
Through the Australian Health Care Agreements 2003-2008 funding for mental health services is provided to all States and Territories. Over the five years of the Agreements, the Australian Government will provide $42 billion for public hospital funding. Of this, up to $331 million is being provided to States and Territories for improving the delivery of mental health services, including community-based services. Over the period 1993 to 2002 Australian Government funding on mental health has increased by 128% or $643 million.

The increased funding described above is in accordance with the aims articulated in the *National Mental Health Plan 2003 -2008* and is further evidence of the commitment of the Australian Government towards building a sustainable evidenced based mental health reform sector and building upon initiatives that have shown positive results.

I believe there are some inaccuracies in the report you may like to consider. In that regard, I have attached a summary of suggested amendments.

The Australian Government is supportive of any activity aimed at improving the efficiency and effectiveness of mental health services in Australia and remains committed to continue this work with jurisdictions and other key stakeholders.

Yours sincerely



Christopher Pyne MP

1 1 MAY 2005

Attachment

Australian Government comments on the Mental Health Council of Australia's *Not for Service* report

> *"The National Mental Health Strategy was developed over a decade ago to respond to obvious service failures and human rights abuses. An analysis of the current manifestations of that strategy, namely the 2004 National Mental Health Report and the 2003-2008 National Third Plan, make it clear that we do not yet have a national process for translating the policy rhetoric into real increases in resources, enhanced service access, accepted service standards or service accountability" (Section 2.2.1 p8)*
>
> *"Within the National Report (2004) many of the key indicators of the failure of all governments to live up to their commitments under the National Mental Health Strategy over the last decade are evident" (Section 2.5, p14)*

Comment: The *National Mental Health Report 2004* provides substantial evidence of significant service change and resource growth. The National Report states "Many of the major structural reforms proposed at the outset of the Strategy ten years ago have been followed through by all jurisdictions, and are near completion in some cases" (p30). It is not accurate to suggest that 'we do not yet have a national process for translating the policy rhetoric into real … (change)". It should be noted that the Mental Health Council of Australia is in fact a component of this national process.

> *"Most importantly, the growth in government mental health spending (64.9%) has only just outpaced the growth in overall health expenditure (61.1%) indicating no real change in the overall pattern of health expenditure" (Section 2.5, p14)*

Comment: There would seem to be a misunderstanding of the expenditure agreement that underpinned the First and Second National Mental Health Plans (and AHCAs). Maintenance, was the agreement made by all parties and indeed all jurisdictions have met this commitment. It also does not acknowledge that the Strategy was driven by a need to stop the 'bleeding' of funds perceived to have occurred in the decade prior to the Strategy, and that this has been achieved.

> *"Actual total public sector inpatient beds per 100,000 fell from 45.5 to 30.4 from June 1993 to June 2002, a staggering 33% decrease during a period of increased demand for services" (Section 2.5, p14)*

Comment: This statement ignores the growth in community residential beds presented in the *National Mental Health Report 2004* and promotes the false view that bed reduction is a result of the National Mental Health Strategy. The vast majority of beds were closed before the Strategy and the rate of closure actually decreased under the Strategy.

1

Attachment

> *"No appreciable increase in resources has been allocated for ... patients cared for within the community" (Section 2.1A, p1)*
>
> *"There have been no significant proportional increases in resources for mental health care" (Section 2.1A, p1):*

Comment: The *National Mental Health Report 2004* indicates a 65% increase (in real terms) in government spending on mental health since 1993. It also highlights 109% growth in clinical staff working in public sector community services.

> *" ... the report highlights, much of the change is accounted for largely by radical changes within one state, namely Victoria" (Section 2.5, p14) –*

Comment: The *National Mental Health Report 2004* highlights that the early dominance of Victoria is being moderated by more recent changes in other jurisdictions. It states the following: "National trends in the first five years were largely dominated by ... Victoria, but as noted in the National Report 2002, the restructuring of other jurisdictions became more prominent in the first two years of the *Second National Mental Health Plan*." (p19)

There would seem to be a misapprehension of various past initiatives, and the report ignores a number of current and planned initiatives being taken under the *National Mental Health Plan 2003-2008*. Those initiatives are specifically designed to address issues raised in the report and that has been considered by the AHMAC National Mental Health Working Group.

> *"Mental health promotion has been supported in Australia, but the reach and intensity of programs is extremely limited in reach and duration. Little has been done to tackle stigma... while increased mental health literacy programs are now promoted to some schools and in some workplaces, actual access to care is not mandatory" (Section 2.6, p17)*

Comment: This statement ignores that there has been an internationally recognised and successful national community education campaign supported by the Australian Government to reduce stigma and improve mental health literacy. There is no acknowledgement of the substantial other initiatives to combat stigma, such as *MindFrame* national media guidelines and support for SANE's *StigmaWatch*. The recognition given to Australia's mental health promotion and prevention efforts, as documented in the *International Review of the Second National Mental Health Plan* (2001, Thornicroft & Betts), has been ignored as has the uptake of *MindMatters*, which is now in over 80% of secondary schools.

2

Attachment

"Current proposed Key Performance Indicators for Public Mental Health Services ... not only do not include regular measures of consumer or carer outcome, or safety, but also do not propose such innovative measures of experiences of care" (Section 2.4, p13))

Comment: This does not give any recognition to the intensive and extensive work being undertaken to implement routine consumer outcome measures, and that Australia leads the international field in this area. The Key Performance Indicator Framework – outcome measures, perceptions of care and safety- are identified as highest priorities for the next stage of development and implementation, and are not part of the originally agreed indicators solely because work is first being undertaken on developing the necessary measures to collect this information. No recognition is given to the extensive initiatives in these areas to be undertaken through the *National Mental Health Information Priorities 2nd Edition.*

"The Mental Health Council is committed to continuation of this process of active review of individual experiences of care. It is not yet at all clear that the responsible governments in Australia, or any of those other bodies who share responsibility for the provision of services, are also committed to this goal. (Section 2.4, p13)

Comment: Development of a measure of perceptions of care (consumer and carer) identified as a priority national project to be undertaken over next years, via the *National Mental Health Information Priorities 2nd Edition.* This has been available since October 2004 and the Mental Health Council of Australia participated in the national workshop that produced the original drafts.

"Currently, services provided by psychiatrists in the private sector are in decline (Section 2.6, p17)

Comment: This overlooks evidence presented in the *National Mental Health Report 2004* that the decline in private psychiatry is a corollary of growth in the medical workforce employed in the public sector. The report states: "It is important to note that in parallel with the reducing levels of private sector activity, medical staffing in the public mental health sector has increased by 36% since 1994, with most growth occurring in the psychiatric registrar and consultant psychiatrist categories." (*National Mental Health Report 2004*, p37)

"... our mental health care services provide only short-term and limited care despite the fact that many people have recurrent or chronically-disabling disorders" (Section 2.1A, p2)

Comment: It is apparent that in the public sector mental health services, the 'typical' consumer is an individual who has been under care for several years. The report also does not recognise that a key contributor to access problems faced by new clients presenting is the fact that the majority of public resources are directed to long term clients.

3

Attachment

" ... mental health is not resourced appropriately relative to its disease burden" (Section 2.6, p17)

Comment: This statement is based on a discredited argument concerning health system funding. No health system in the world is funded in proportion to its disease burden. To do so, without taking into account the cost of reducing the burden and other social and economic factors, can lead to pronounced inequities in resource allocation.

"..changes in the attitudes of health professionals [are needed].. little evidence now of a systematic response" (Section 4.7, p13)

Comment: This statement ignores the development of the *National Mental Health Practice Standards* (2003), which identifies the attitudes, knowledge and skills needed by all mental health professionals which have been agreed with each clinical disciplines professional organization, endorsed by the Australian and all State and Territory Governments, and currently being implemented.

8.5 SURVEY – IMPLEMENTATION OF COMMUNITY PRIORITIES IN MENTAL HEALTH

REVIEW OF MENTAL HEALTH SERVICES IN AUSTRALIA FOR 2003-2008.

Introduction: Community review of services

In April 2003, the Mental Health Council of Australia launched its national review of mental health services in Australia: "Out of Hospital, Out of Mind!". The report highlighted the obvious deficiencies in care but also presented community priorities for further action. A key proposal was increased accountability. To date, we have insufficient data from government agencies about what really happens in mental health at local, regional and state/ territory levels. Consequently, the Mental Health Council of Australia, with academic support from the Brain & Mind Research Institute, is undertaking a state-by-state review of services in 2003. Our goal is to produce a report in each state/ territory to underpin urgent reform in your local area.

The study is being conducted by Professor Ian Hickie, Professor of Psychiatry and Executive Director, Brain & Mind Research Institute, The University of Sydney; and, Dr Grace Groom, Chief Executive Officer, Mental Health Council of Australia.

If you agree to participate in this study, you will be asked to complete the following questionnaire. It is not expected that you will experience any discomfort from this process. It should take you no more than 15-20 minutes to complete.

All aspects of the study, including results, will be strictly confidential and only the investigators named above and research staff will have access to information on participants except as required by law. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Participation in this study is entirely voluntary: you are not obliged to participate and - if you do participate - you can withdraw at any time. Whatever your decision, it will not affect your relationship with the investigators, The University of Sydney, or the Mental Health Council of Australia.

If you would like to know more at any stage, please feel free to contact Professor Ian Hickie on 02 9556 9418. This information sheet is for you to keep.

Any person with concerns or complaints about the conduct of a research study can contact the Manager for Ethics Administration, The University of Sydney on 02 9351 4811 or at gbriody@mail.usyd.edu.au.

Instructions for completing the survey

Our intention is to evaluate the extent to which national and community priorities have been supported and are being implemented at both the local and state level. We believe that this is a unique opportunity for genuine and broad mental health sector input to priorities for the next five years.

This survey is divided into three sections:

- The first asks some demographic information about you or your service.
- The second asks you to rate how the priorities have been supported or implemented within your **LOCAL** area.
- The third asks you to rate how the priorities have been supported or implemented at the **STATE** level.

Please return the completed survey in the **reply paid** envelope enclosed or **fax to 02 9556 9171**. For any further queries, our contact details are:

Brain & Mind Research Institute
Top Floor, Broughton Hall
PO Box 1
ROZELLE NSW 2039
PH: (02) 9556 9113
Fax: (02) 9556 9171

SECTION ONE: Your details.

As part of the survey, we would like to ask you some details about yourself and the area of the mental health sector you represent. Your name (or organisation) will not be reported in connection with your responses to the remainder of the survey, so your opinions and comments remain confidential.

Are you completing this survey as an individual or on behalf of an organisation?

❑ Individual ❑ Organisation

Name of organisation (optional): ______________________________

Please tick ONE of the following descriptions which BEST describes your position or role in the mental health sector, or the position or role of your organisation:

- ❑ Consumer of mental health services
- ❑ Carer of a person with a mental illness
- ❑ Consumer or carer advocacy group
- ❑ Public provider of specialist treatment
- ❑ Private provider of specialist treatment
- ❑ Provider of early intervention services
- ❑ General practitioner
- ❑ Divisions of General Practice
- ❑ Non-government community service provider
- ❑ Mental health promotion or education
- ❑ Mental health research or evaluation
- ❑ Health policy maker or advisor
- ❑ Human services agency other than health
- ❑ Other (please specify):

What is your postcode/ the postcode of your organisation: ☐☐☐☐

Today's date: ☐☐ – ☐☐ – 2 0 0 ☐

day month year

SECTION TWO: Local area.

This section asks you to rate the extent to which each of the following priorities have been implemented or supported IN YOUR LOCAL AREA. Please mark the appropriate box with a cross.

		No action taken OR no support	Discussion and planning OR low level support	Implemen-tation begun OR moderate support	Nearly complete OR high level support	Fully implemen-ted OR full support
1.	Implementation of early intervention services	☐	☐	☐	☐	☐
2.	Development of innovative services for people with mental health and alcohol or substance abuse disorders	☐	☐	☐	☐	☐
3.	Development of a wider spectrum of acute and community-based care settings	☐	☐	☐	☐	☐
4.	Implementation of the national standards for mental health services	☐	☐	☐	☐	☐
5.	Programs that promote attitudinal change among mental health workers	☐	☐	☐	☐	☐
6.	Increased support for stigma reduction campaigns	☐	☐	☐	☐	☐
7.	Development of specific inter-governmental service agreements (eg. between health, education, housing, employment, and social security)	☐	☐	☐	☐	☐
8.	More genuine consumer participation	☐	☐	☐	☐	☐
9.	Direct support for 'innovation', 'research' and 'service evaluation' in mental health	☐	☐	☐	☐	☐
	Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR LOCAL AREA.	No action taken OR no support	Discussion and planning OR low level support	Implemen-tation begun OR moderate support	Nearly complete OR high level support	Fully implemen-ted OR full support
10.	Introduction of specific schemes to enhance access to mental health specialists	☐	☐	☐	☐	☐
11.	More genuine carer participation	☐	☐	☐	☐	(
12.	Support for enhanced role of non-government organisations in all aspects of care	(	(	(	(	(
13.	Clear accountability for expenditure of mental health strategy funds	(	(	(	(	(
14.	Specification of clear primary care and specialist workforce roles	(	(	(	(	(

SECTION THREE: State level.

This section asks you to rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE. Please mark the appropriate box with a cross:

		No action taken OR no support	Discussion and planning OR low level support	Implemen-tation begun OR moderate support	Nearly complete OR high level support	Fully implemen-ted OR full support
1.	Development of specific inter-governmental service agreements (eg. between health, education, housing, employment, and social security)	(	(	(	(	(
2.	Direct support for ‘innovation’, ‘research’ and ‘service evaluation’ in mental health	(	(	(	(	(
3.	Introduction of specific schemes to enhance access to mental health specialists	(	(	(	(	(
4.	Support for specific disease prevention initiatives (eg. in anxiety, depression, alcohol or substance abuse)	(	(	(	(	(
5.	Support for general mental health promotion	(	(	☐	☐	☐
6.	Support for enhanced role of non-government organisations in all aspects of care	☐	☐	☐	☐	☐
7.	Clear accountability for expenditure of mental health strategy funds	☐	☐	☐	☐	☐
8.	Ongoing support for suicide prevention campaigns	☐	☐	☐	☐	☐
9.	Development of datasets for monitoring the quality of local services	☐	☐	☐	☐	☐

	Please rate the extent to which each of the following priorities have been implemented or supported IN YOUR STATE.	No action taken OR no support	Discussion and planning OR low level support	Implemen-tation begun OR moderate support	Nearly complete OR high level support	Fully implemen-ted OR full support
10.	Service development for those in forensic (i.e. prison-based) services	☐	☐	☐	☐	☐
11.	Specification of clear primary care and specialist workforces	☐	☐	☐	☐	☐
12.	Service enhancement for persons from culturally- and linguistically-diverse backgrounds	☐	☐	☐	☐	☐
13.	Support for community leadership in mental health	☐	(	(	(	(
14.	Support for professional leadership in mental health	(	(	(	(	(
15.	Development of specific procedures for reporting Human Rights abuses or neglect	(	(	(	(	(
16.	Increased support for stigma reduction campaigns	(	(	(	(	(
	If you are in a regional or rural area of Australia, please answer the following question.					
17.	IN YOUR STATE, what is the level of support for service development in rural and regional areas?	(	(	(	(	(
	If you are in a poorly resourced area of Australia, please answer the following question.					
18.	IN YOUR STATE, what is the level of support for service development in poorly resourced areas?	(	(	(	(	(

Other comments:

Thank you for completing this survey.
Please return it in the reply paid envelope.

8.6 SURVEY – CONSUMER AND CARER EXPERIENCES OF CARE

REVIEW OF MENTAL HEALTH SERVICES IN AUSTRALIA FOR 2003-2008:

PART II: CONSUMERS & CARERS Direct Experiences of Care

Introduction: community review of services

In April 2003, the Mental Health Council of Australia launched its national review of mental health services in Australia: "Out of Hospital, Out of Mind!". We continue to have insufficient data about what really happens in our mental health services. Consequently, the Mental Health Council of Australia, with academic support from the Brain & Mind Research Institute, is committed to ongoing review of these services. The study is being conducted by Professor Ian Hickie, Executive Director, Brain & Mind Research Institute, The University of Sydney; and, Dr Grace Groom, Chief Executive Officer, Mental Health Council of Australia.

If you agree to participate in this study, you will be asked to complete the following questionnaire. It is not expected that you will experience any discomfort from this process. It should take you no more than 15-20 minutes to complete.

All aspects of the study, including results, will be strictly confidential and only the investigators named above and research staff will have access to information on participants except as required by law. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Participation in this study is entirely voluntary: you are not obliged to participate and - if you do participate - you can withdraw at any time. Whatever your decision, it will not affect your relationship with the investigators, The University of Sydney, or the Mental Health Council of Australia.

If you would like to know more at any stage, please feel free to contact Professor Ian Hickie on 02 9556 9418. This information sheet is for you to keep. If you wish to add any details of your ongoing care, or any other detailed comments, please forward them directly to Professor Ian Hickie at: ianh@med.usyd.edu.au

Any person with concerns or complaints about the conduct of a research study can contact the Manager for Ethics Administration, The University of Sydney on 02 9351 4811 or at gbriody@mail.usyd.edu.au.

Instructions for completing the survey

Our intention in this second survey is to evaluate the direct experience of mental health care by consumers, carers and family members. This is the second survey. The first survey, which you can also complete (http://www.mhca.com.au/Survey/default.html), asks about your knowledge of service developments at your local and state level. These surveys provide a unique opportunity for genuine and broad community input to priorities for the next five years.

This survey is divided into two sections:

- The first asks consumers, carers and family members about their experiences with mental health services as well as some demographic information. It basic domains are drawn from those identified by the Picker Institute Europe as critical elements of quality health care.
- The second asks consumers only more specific questions about their experiences with mental health services. It is based on a current survey being undertaken also in the United Kingdom to evaluate consumer's direct experiences of care.

Please return the completed survey in the reply paid envelope enclosed or fax to 02 9556 9171. For any further queries, our contact details are:

Brain & Mind Research Institute
Top Floor, Broughton Hall
PO Box 1
ROZELLE NSW 2039

Phone: (02) 9556 9418
Fax: (02) 9556 9171

SECTION 1: TO BE COMPLETED BY CONSUMERS, CARERS OR FAMILY MEMBERS

BACKGROUND INFORMATION:

i. Have you, or someone else very close to you, received treatment for a mental health problem in the last 12 months?

- o Yes
- o No [STOP HERE]

ii. Who provided this treatment?

- o Public health services (eg. emergency department, public hospital, community health centre)
- o Private health services (eg. general practitioner, private psychiatrist, private hospital)
- o Public and private health services

iii. Was the main provider a…

- o A general practitioner
- o ***A clinical psychologist/ counsellor***
- o A specialist psychiatrist
- o Hospital/ emergency service
- o Community mental health service
- o Other non-government organisation

iv. Have you, or someone else very close to you, been admitted to a hospital as a mental health inpatient in the last 12 months?

- o No
- o ***Yes, once***
- o Yes, two or three times
- o Yes, more than three times

A. IF YOU, OR SOMEONE ELSE VERY CLOSE TO YOU, DID RECEIVE TREATMENT FOR A MENTAL HEALTH PROBLEM IN THE LAST 12 MONTHS:

1. To what extent were you/ they treated with respect and dignity by health professionals?

- o ***Always***
- o Nearly always
- o Sometimes
- o Not often
- o Never

2. How much information about your/ their condition or treatment was given to <u>you</u>?

- o Too much
- o Right amount
- o Some
- o Not enough
- o None

3. To what extent were you able to access adequate services for your/ their mental health problems?

- o *Always*
- o Nearly always
- o Sometimes
- o Not often
- o Never

4. Did you find a health professional to talk to about your concerns?

- o Yes, definitely
- o Yes, to some extent
- o Yes, a little
- o No
- o I had no concerns

5. If your family or someone else close to you wanted to talk to a health professional, did they have enough opportunity to do so?

- o Yes, definitely
- o Yes, to some extent
- o No
- o No family or friends were involved
- o My family didn't want or need information
- o I didn't want my family or friends to talk to a health professional

6. How much information about your condition or treatment was given to your family or someone else close to you?

- o Not enough
- o Right amount
- o Too much
- o No family or friends were involved
- o My family didn't want or need information
- o I didn't want my family or friends to have any information

7. If you/ they were prescribed any medication for a mental health problem, was its purpose, benefits and/or side-effects fully explained?

- o Yes, definitely
- o Yes, to some extent
- o Yes, a little
- o No
- o I was not prescribed any medications

8. If you/ they were admitted as a hospital inpatient for treatment of a mental health problem, did staff attend to your/ their physical health needs (eg. assistance eating, or getting to a bathroom) in a timely manner?

- o Yes, definitely
- o Yes, to some extent
- o Yes, a little
- o No
- o I did not require assistance with any physical health needs

9. Sometimes, one health professional will say one thing and another health professional will say something quite different. Did this happen to you?
- o Always
- o Nearly always
- o Sometimes
- o Not often
- o Never

B. OVERALL

1. Did you have enough say in decisions about your/ their care and treatment?
- o Yes, definitely
- o Yes, to some extent
- o No

2. Has your/ their diagnosis been discussed with you?
- o Yes, definitely
- o Yes, to some extent
- o No

C. ABOUT YOU

1. Gender?
- o Male
- o Female

2. Age? ☐☐

3. Postcode? ☐☐☐☐

4. What is the geographical nature of the area you live in?
- o Rural/ district (less than 10,000 people)
- o Regional centre (greater than 10,000 people)
- o Major urban area (greater than 100,000 people)

5. In which country were you born?
- o Australia
- o Overseas (please specify)____________________

6. Are you an Aboriginal or Torres Strait Islander?
- o *Yes*
- o No

7. What language do you most commonly speak?
- o English
- o Other (please specify)________________

8. What language do you most commonly speak *at home*?
- o English
- o Other (please specify)________________

9. Who else, if anybody, do you live with?
- o No-one, I live alone
- o Partner
- o Child/ children under 18
- o Child/ children over 18
- o A parent or guardian
- o With other family members
- o With people other than family members

10. Are you a:
- o Consumer (i.e. receive care yourself)
- o Carer
- o Family member or close friend

11. During the past four weeks how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable?)
- o Not at all
- o Slightly
- o Moderately
- o Quite a lot
- o Extremely

12. In general, how is your mental health right now?
- o Excellent
- o Very good
- o Good
- o Fair
- o Poor
- o Very poor

You can finish this survey here [SUBMIT] or, if you are a consumer (that is, directly receive mental heath care yourself) you can go onto complete a series of more specific questions about the mental health services you have received in the last 12 months. These questions are based on a survey from the National Health Service in the United Kingdom. For more information please visit http://www.nhssurveys.org. [CONTINUE]

SECTION 2: TO BE COMPLETED BY CONSUMERS ONLY

D. YOUR CARE AND TREATMENT

1. How long have you been in contact with mental health services?
- o One year or less
- o One to five years
- o More than five years
- o Don’t know/ Can’t remember
- o I have never been in contact with mental health services [STOP HERE]

2. Overall, how would you rate the health care you have received for your mental health problem in the last 12 months?
- o Excellent
- o Very good
- o Good
- o Fair
- o Poor
- o Very poor

E. HEALTH PROFESSIONALS

Psychiatrists

1. Have you seen a psychiatrist in the last 12 months?
- o Yes
- o No GO TO Q7, SECTION E

The LAST time you saw a psychiatrist…

2. Did the psychiatrist listen carefully to you?
- o Yes, definitely
- o Yes, to some extent
- o No

3. Did you have trust and confidence in the psychiatrist you saw?
- o Yes, definitely
- o Yes, to some extent
- o No

4. Did the psychiatrist treat you with respect and dignity?
- o Yes, definitely
- o Yes, to some extent
- o No

Still thinking about the LAST time you saw a psychiatrist…

5. Were you given enough time to discuss your condition and treatment?
- o Yes, definitely
- o Yes, to some extent
- o No

6. The last two times you had an appointment with a psychiatrist, was it…?
- o With the **same** psychiatrist both times
- o With two **different** psychiatrists

Community psychiatric nurse (CPN)

7. Have you seen a CPN in the last 12 months?
- o Yes
- o No GO TO Q11, SECTION E

The LAST time you saw a CPN…

8. Did the CPN listen carefully to you?
- o Yes, definitely
- o Yes, to some extent
- o No

9. Did you have trust and confidence in the CPN?
- o Yes, definitely
- o Yes, to some extent
- o No

10. Did the CPN treat you with respect and dignity?
- o Yes, definitely
- o Yes, to some extent
- o No

Other health professionals

11. Have you seen anyone else in mental health services in the last 12 months?
- o Yes
- o No GO TO Q1, SECTION F

12. The last time you saw someone, other than a psychiatrist or CPN, who did you see?
- o A social worker
- o An occupational therapist
- o A psychologist
- o Someone else

The LAST time you saw this person…

13. Did they listen carefully to you?
- o Yes, definitely
- o Yes, to some extent
- o No

14. Did you have trust and confidence in the person that you saw?
- o Yes, definitely
- o Yes, to some extent
- o No

15. Did the person treat you with respect and dignity?
- o Yes, definitely
- o Yes, to some extent
- o No

F. MEDICATIONS

1. In the last 12 months have you taken any medications for your mental health problems?
- o Yes
- o No GO TO Q1, SECTION G

2. Do you have a say in decisions about the medication you take?
- o Yes, definitely
- o Yes, to some extent
- o No

3. In the last 12 months, have any **new** medications (eg. tablets, injections, liquid medicines) been prescribed for you by a psychiatrist?
- o Yes
- o No
- o Can't remember

The LAST time you had a new medication prescribed for you…

4. Were the purposes of the medications explained to you?
o *Yes, definitely*
o Yes, to some extent
o No

5. Were you told about possible side-effects of the medications?
o Yes, definitely
o *Yes, to some extent*
o No

G. TALKING THERAPIES

1. In the last 12 months have you had any talking therapy (eg. counselling) from mental health services?
o Yes
o No

2. In the last 12 months, did you want talking therapy?
o *Yes*
o *No*

H. YOUR CARE PLAN (CPA)

A care plan shows your mental health needs and who will provide services to you. It might be a document given to you by one of the mental health team, or it might be a letter, explaining how your care has been planned.

1. Have you been given (or offered) a written or printed copy of your care plan?
o Yes
o No GO TO Q4, SECTION H
o Don't know/ Not sure

2. Do you understand what is in your care plan?
o Yes, definitely
o Yes, to some extent
o No
o Don't know
o I do not have a care plan

3. Do you agree with what is in your care plan?
o Yes, definitely
o Yes, to some extent
o No
o Don't know

Your care review
A care review is a meeting with you and the people involved in your care in which you discuss how your care plan is working.

4. In the last 12 months have you had a care review?
o *Yes, I have had more than one*
o Yes, I have had one
o No, I have not had a care review in the last 12 months GO TO Q8, SECTION H

5. Were you told that you could bring a friend or relative to your care review meetings?
- o Yes
- o No
- o Don't know/ Can't remember

The LAST time you had a care review meeting…

6. Were you given a chance to express your views at the meeting?
- o Yes, definitely
- o Yes, to some extent
- o *No*

7. Did you find the care review helpful?
- o Yes, definitely
- o Yes, to some extent
- o *No*

Your care co-ordinator

A <u>care co-ordinator</u> (or keyworker) is someone from mental health services who keeps in regular contact with you. For example, this person could be a community psychiatric nurse (CPN) or a social worker.

8. Have you been told who your care co-ordinator is?
- o Yes
- o No GO TO Q1, SECTION I
- o Not sure/ Don't know

9. How long is it since you last saw your care co-ordinator?
- o Less than one month
- o One to three months
- o Three to six months
- o More than six months

10. Can you contact your care co-ordinator if you have a problem?
- o Yes, always
- o Yes, sometimes
- o No

I. SUPPORT IN THE COMMUNITY

Day centres or day hospitals

Some mental health service users go to a <u>day centre</u> where staff are available to help with problems, and activities are arranged.

1. In the last two months, how often have you visited a day centre?
- o Most days
- o Once or twice a week
- o Once or twice a month
- o I have not visited a day centre in the last two months GO TO Q3, SECTION I

2. Were the activities provided by the centre helpful?
- o Yes, definitely
- o Yes, to some extent
- o No

Where you live

3. In the last 12 months, have you received any help with accommodation?
- o Yes
- o No, but I would have liked help
- o I did not need any help

Other support in the community

4. In the last 12 months have you received help with finding work?
- o Yes
- o No, but I would have liked help
- o I did not need any help
- o I am unable to work because of my mental health problems

5. Are you currently in paid work?
- o Yes
- o No
- o No, but I work on a casual or voluntary basis
- o No, but I am a full-time student

6. In the last 12 months have you received help with getting benefits?
- o Yes
- o No, but I would have liked help
- o I did not need any help

7. In the last 12 months have you received any information about local support groups for mental health service users?
- o Yes
- o No, but I would have liked information
- o I did not need any information

8. When was the last time you saw someone about your mental health problem?
- o Less than one month ago
- o One to three months ago
- o Three to six months ago
- o More than six months ago

9. In the last 12 months, have any appointments been cancelled or changed by mental health services?
- o No
- o Yes, one appointment was cancelled or changed
- o Yes, two or three appointments have been cancelled or changed
- o Yes, four or more appointments have been cancelled or changed

J. CRISIS CARE

1. Do you have the number of someone in mental health services that you can call out of office hours?
- o Yes
- o No GO TO Q1, SECTION K
- o Not sure/ Don't know

2. In the last 12 months, have you called this number?
- o Yes
- o No

3. The last time you called the number, how long did it take you to get through to someone?
- o I got through immediately
- o I got through in one hour or less
- o A few hours
- o A day or more
- o A could not get through to anyone

K. STANDARDS

Mental Health Act

1. In the last 12 months, have you been detained (sectioned or scheduled) under the Mental Health Act?
- o Yes
- o No GO TO SECTION L

2. When you were detained, were your rights explained to you?
- o Yes
- o No

L. OTHER COMMENTS

If there is anything else you would like to tell us about your experiences of mental health care in the last 12 months, please do so here.

Is there anything particularly good about your care?

Is there anything that could be improved?

Any other comments?

THANK YOU VERY MUCH FOR YOUR HELP.
Please check that you answered all the questions that apply to you. [SUBMIT]

8.7 NATIONAL STANDARDS FOR MENTAL HEALTH SERVICES

The Standards can be downloaded at:

www.health.gov.au/internet/wcms/publishing.nsf/Content/mentalhealth-mhinfo-standards-nsmhs.htm/

Standard 1 - Rights

The rights of people affected by mental disorders and/or mental health problems are upheld by the MHS.

Criteria

1.1 Staff of the MHS comply with relevant legislation, regulations and instruments protecting the rights of people affected by mental disorders and/or mental health problems.

1.2 Consumers and their carers are provided with a written and verbal statement of their rights and responsibilities as soon as possible after entering the MHS.

1.3 The written and verbal statement of rights and responsibilities is provided in a way that is understandable to the consumer and their carers.

1.4 The statement of rights includes the principles contained in the Australian Health Ministers Mental Health Statement of Rights and Responsibilities (1991) and the United Nations General Assembly Resolution on the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1992).

1.5 The right of the consumer not to have others involved in their care is recognised and upheld to the extent that it does not impose imminent serious risk to the consumer or other person(s).

1.6 Independent advocacy services and support persons are actively promoted by the MHS and consumers are made aware of their right to have an independent advocate or support person with them at any time during their involvement with the MHS.

1.7 The MHS upholds the right of the consumer and their carers to have access to accredited interpreters.

1.8 The MHS provides consumers and their carers with information about available mental health services, mental disorders, mental health problems and available treatments and support services.

1.9 The MHS recognises the rights of people with mental disorders and/or mental health problems in their service goals and staff job descriptions.

1.10 The MHS has an easily accessed, responsive and fair complaints procedure for consumers and carers and the MHS informs consumers and carers about this procedure.

1.11 Documented policies and procedures exist and are used to achieve the above criteria.

1.12 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 2 - Safety

The activities and environment of the MHS are safe for consumers, carers, families, staff and the community.

Criteria

2.1 The MHS and its staff comply with relevant legislation, regulations and other instruments.

2.2 Treatment and support offered by the MHS ensure that the consumer is protected from abuse and exploitation.

2.3 Policies, procedures and resources are available to promote the safety of consumers, carers, staff and the community.

2.4 Staff are regularly trained to understand and appropriately and safely respond to aggressive and other difficult behaviours.

2.5 A staff member working alone / solo has the opportunity to access another staff member at all times in their work settings.

2.6 A consumer has the opportunity to access a staff member of their own gender.

2.7 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 3 - Consumer and Carer Participation

Consumers and carers are involved in the planning, implementation and evaluation of the MHS.

Criteria

3.1 The MHS has policies and procedures related to consumer and carer participation which are used to maximise their roles and involvement in the MHS.

3.2 The MHS undertakes and supports a range of activities which maximise both consumer and carer participation in the service.

3.3 The MHS assists with training and support for consumers, carers and staff which maximise consumer and carer participation in the service.

3.4 A process and methods exist for consumers and carers to be reimbursed for expenses and/or paid for their time and expertise where appropriate.

3.5 The MHS has a written statement of roles and responsibilities (code of conduct) for consumers and carers participating in the service which is developed and reviewed with consumers and carers.

3.6 Consumer and carers are supported to independently and individually determine who will represent the views of each group to the MHS.

3.7 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 4 - Promoting Community Acceptance

The MHS promotes community acceptance and the reduction of stigma for people affected by mental disorders and/or mental health problems.

Criteria

4.1 The MHS works collaboratively with the defined community to initiate and participate in a range of activities designed to promote acceptance of people with mental disorders and/or mental health problems by reducing stigma in the community.

4.2 The MHS provides understandable information to mainstream workers and the defined community about mental disorders and mental health problems.

4.3 Documented policies and procedures exist and are used to achieve the above criteria.

4.4 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 5 - Privacy and Confidentiality

The MHS ensures the privacy and confidentiality of consumers and carers.

Criteria

5.1 Staff of the MHS comply with relevant legislation, regulations and instruments in relation to the privacy and confidentiality of consumers and carers.

5.2 The MHS has documented policies and procedures which ensure the protection of confidentiality and privacy for consumers and carers and these are available to consumers and carers in an understandable language and format.

5.3 The MHS encourages, and provides opportunities for, the consumer to involve others in their care.

5.4 Consumers give informed consent before their personal information is communicated to health professionals outside the MHS, to carers or other agencies or people.

5.5 Consumers have the opportunity to communicate with others in privacy unless contraindicated on safety or clinical grounds.

5.6 The location used for the delivery of mental health care provides an opportunity for sight and sound privacy.

5.7 Consumers have adequate personal space in regard to indoor and outdoor physical care environments.

5.8 Consumers are supported in exercising control over their personal space and personal effects in residential and inpatient settings.

5.9 Confidential processes exist by which consumers and carers can regularly feedback their perception of the care environment to the MHS.

5.10 Consumers have appropriate space and privacy in order to practice their cultural, religious and spiritual beliefs.

5.11 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 6 - Prevention and Mental Health Promotion

The MHS works with the defined community in prevention, early detection, early intervention and mental health promotion.

Criteria

6.1 The MHS has policy, resources and plans that support mental health promotion, prevention of mental disorders and mental health problems, early detection and intervention.

Promotion of Mental Health

6.2 The MHS works collaboratively with health promotion units and other organisations to conduct and manage activities which promote mental health and prevent the onset of mental disorders and/or mental health problems across the lifespan.

6.3 The MHS provides information to mainstream workers and the defined community about mental disorders and mental health problems as well as information about factors that prevent mental disorders and/or mental heath problems.

Prevention of Mental Disorders and Psychiatric Disability

6.4 The MHS has the capacity to identify and appropriately respond to the most vulnerable consumers and carers in the defined community.

6.5 The MHS has the capacity to identify and respond to people with mental disorders and/or mental health problems as early as possible.

6.6 Treatment and support offered by the MHS occur in a community setting in preference to an institutional setting unless there is a justifiable reason consistent with the best outcome for the consumer.

6.7 Each consumer receives assistance to develop a plan which identifies early warning signs of relapse and appropriate action.

6.8 The MHS ensures that the consumer has access to rehabilitation programs which aim to minimise psychiatric disability and prevent relapse.

6.9 Wherever possible and appropriate, vocational and social needs are met through the use of mainstream agencies with support from the MHS.

6.10 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 7 - Cultural Awareness

The MHS delivers non-discriminatory treatment and support which are sensitive to the social and cultural values of the consumer and the consumer's family and community.

Criteria

7.1 Staff of the MHS have knowledge of the social and cultural groups represented in the defined community and an understanding of those social and historical factors relevant to their current circumstances.

7.2 The MHS considers the needs and unique factors of social and cultural groups represented in the defined community and involves these groups in the planning and implementation of services.

7.3 The MHS delivers treatment and support in a manner which is sensitive to the social and cultural beliefs, values and cultural practices of the consumer and their carers.

7.4 The MHS employs staff or develops links with other service providers/organisations with relevant experience in the provision of treatment and support to the specific social and cultural groups represented in the defined community.

7.5 The MHS monitors and addresses issues associated with social and cultural prejudice in regard to its own staff.

7.6 Documented policies and procedures exist and are used to achieve the above criteria.

7.7 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 8 - Integration

Standard 8.1 - Service Integration

The MHS is integrated and coordinated to provide a balanced mix of services which ensure continuity of care for the consumer.

Criteria

8.1.1 There is an integrated MHS available to serve each defined community.

8.1.2 The consumer's transition between components of the MHS is facilitated by a designated staff member and a single individual care plan known to all involved.

8.1.3 There are regular meetings between staff of each of the MHS programs and sites in order to promote integration and continuity.

8.1.4 Opportunity exists for the rotation of staff between settings and programs within the MHS, and which maintains continuity of care for the consumer.

8.1.5 The MHS has documented policies and procedures which are used to promote continuity of care across programs, sites, other services and lifespan.

8.1.6 The MHS has specified procedures to facilitate and review internal and external referral processes within the programs of the MHS.

8.1.7 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

8.1.8

Standard 8.2 - Integration within the Health System

The MHS develops and maintains links with other health service providers at local, state and national levels to ensure specialised coordinated care and promote community integration for people with mental disorders and/or mental health problems.

Criteria

8.2.1 The MHS is part of the general health care system and promotes comprehensive health care for consumers, including access to specialist medical resources.

8.2.2 Mental health staff know about the range of other health resources available to the consumer and can provide information on how to access other relevant services.

8.2.3 The MHS supports the staff, consumers and carers in their involvement with other health service providers.

8.2.4 The MHS has formal processes to promote inter-agency collaboration.

8.2.5 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 8.3 - Integration with Other Sectors

The MHS develops and maintains links with other sectors at local, state and national levels to ensure specialised coordinated care and promote community integration for people with mental disorders and/or mental health problems.

Criteria

8.3.1 Mental health staff know about the range of other agencies available to the consumer and carers.

8.3.2 The MHS supports its staff, consumers and carers in their involvement with other agencies wherever possible and appropriate.

8.3.3 The MHS has formal processes to develop intersectoral links and collaboration.

8.3.4 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 9 - Service Development

The MHS is managed effectively and efficiently to facilitate the delivery of coordinated and integrated services.

Criteria

Organisational Structure

9.1 The MHS is managed by an appropriately qualified and experienced person with authority over, and accountability for, mental health service resources and planning.

9.2 There is single point accountability for the MHS across all settings, programs and age groups.

9.3 The MHS has an organisational structure which identifies it as a discrete entity within the larger organisation.

9.4 The organisational structure of the MHS ensures continuity of care for consumers across all settings, programs and age groups.

9.5 The organisational structure of the MHS reflects a multidisciplinary approach to planning, implementing and evaluating care.

9.6 A system exists which ensures that staff are aware of their roles and responsibilities within the MHS.

Planning

9.7 The MHS produces and regularly reviews a strategic plan which is made available to the defined community.

9.8 The strategic plan is developed and reviewed through a process of consultation with staff, consumers, carers, other appropriate service providers and the defined community.

9.9 The strategic plan includes:
- consumer and community needs analysis
- quality improvement plan
- service evaluation plan including the measurement of health outcomes for individual consumers
- plan for maximising consumer and carer participation in the MHS
- plan for improving the skills of staff, and
- relevant financial information.

9.10 The strategic plan is consistent with national mental health policies and legislative requirements.

9.11 The MHS has operational plans based on the strategic plan, which establish time frames, responsibilities of organisations and/or individuals and targets for implementation.

Funding

9.12 The MHS manages a dedicated budget using nationally accepted accounting practices.

9.13 The MHS allocates a portion of its budget for the provision of staff development and, in the public sector, for the promotion of consumer and family / carer participation in the MHS.

Resource allocation

9.14 Resources are allocated according to the documented priorities of the MHS and reflect national mental health policies.

9.15 Resources are allocated in a manner which follow the consumer' and allows the MHS to respond promptly to the changing needs of the defined community.

9.16 Where the MHS has redeployed staff according to demand, it ensures that staff are a dequately trained for new and/or changing roles and ensures that continuity of care for consumers is maintained.

Staff training and development

9.17 The MHS regularly identifies training and development needs of its staff.

9.18 The MHS ensures that staff participate in education and professional development programs.

9.19 New staff are provided with an orientation program to the MHS.

9.20 The MHS ensures that staff have access to formal and informal supervision.

9.21 The MHS has a system for supporting staff during and after critical incidents.

Information systems

9.22 The MHS collects and aggregates data which promote effective care for consumers and their family/carer, assist with the management and evaluation of the MHS, and promote staff training and research.

9.23 Data are collected in a manner which ensures reliability, validity and timeliness of reporting.

9.24 Data collected are analysed and used to promote continuous quality improvement within the MHS.

9.25 Information is made available to funders, staff and the defined community in an understandable format within the bounds of confidentiality requirements.

9.26 Data collection is consistent with statutory requirements and State/Territory/ National requirements for mental health services.

9.27 Data collected are stored and reported in a manner which ensures confidentiality and complies with relevant legislation.

Service evaluation, outcome measurement, research and quality improvement

9.28 There is documented accountability and responsibility for the evaluation of the MHS.

9.29 The MHS has a service evaluation strategy which promotes participation by staff, consumers, carers, other service providers and the defined community.

9.30 The MHS routinely monitors health outcomes for individual consumers using a combination of accepted quantitative and qualitative methods.

9.31 The MHS conducts or participates in appropriate research activities.

9.32 Research proposals are reviewed by an ethics committee constituted and functioning in accordance with the National Health and Research Medical Council Statement on Human Experimentation and Explanatory Notes.

9.33 The MHS is able to demonstrate a process of continuous quality improvement.

9.34 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 10 - Documentation

Clinical activities and service development activities are documented to assist in the delivery of care and in the management of services.

Criteria

10.1 The MHS complies with relevant legislation and regulations protecting consumer confidentiality and ensures that documentation processes are such that confidentiality is protected.

10.2 Treatment and support provided by the MHS are recorded in an individual clinical record which is accessible throughout the components of the MHS.

10.3 Documentation in the individual clinical record is dated, signed (with designation), shows the time of each intervention and is legible.

10.4 A system exists by which the MHS uses the individual clinical record to promote continuity of care across settings, programs and time.

10.5 Documentation is a comprehensive, factual and sequential record of the consumer's condition and the treatment and support offered.

10.6 Each consumer has an individual care plan within their individual clinical record which documents the consumer's relevant history, assessment, investigations, diagnosis, treatment and support services required, other service providers, progress, follow-up details and outcomes.

10.7 The MHS ensures that only authorised persons have access to information about the consumer.

10.8 Documented policies and procedures exist and are used to achieve the above criteria.

10.9 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 11 - Delivery of Care

Principles guiding the delivery of care

The care, treatment and support delivered by the mental health service is guided by:

Choice: Access to a range of specialised mental health treatment and support options and information to assist in the selection of the most appropriate option(s) in the setting most empowering for the consumer.

Social, cultural and developmental context: Specialised mental health treatment and support which respect and utilise for optimal benefit, the consumer's social and cultural values, beliefs, practices and stage of development.

Continuous and coordinated care: Specialised mental health treatment and support are provided in a continuous and coordinated manner by a range of service providers in and between a range of settings.

Comprehensive care: Access to specialised mental health treatment and support services is available throughout the consumer's lifespan and is able to meet their specific needs during the onset, acute, rehabilitation, consolidation and recovery phases of their mental disorder and/or mental health. Each component of the mental health service, such as the psychiatric unit and the community mental health team, is equally valued by the organisation.

Individual care: Specialised mental health treatment and support are tailor-made for each individual.

Least restriction: Specialised mental health treatment and support which impose the least personal restriction of rights and choice in balance with the need for treatment.

Standard 11.1 - Access

The MHS is accessible to the defined community.

Criteria

11.1.1 The MHS ensures equality in the delivery of treatment and support regardless of consumer's age, gender, culture, sexual orientation, socio-economic status, religious beliefs, previous psychiatric diagnosis, past forensic status and physical or other disability.

11.1.2 The community to be served is defined, its needs regularly identified and services are planned and delivered to meet those needs.

11.1.3 Mental health services are provided in a convenient and local manner and linked to the consumer's nominated primary care provider.

11.1.4 The MHS is available on a 24 hour basis, 7 days per week.

11.1.5 The MHS ensures effective equitable access to services for each person in the defined community.

11.1.6 The MHS informs the defined community of its availability, range of services and the method for establishing contact.

11.1.7 The MHS, wherever possible, is located to promote ease of physical access with special attention being given to those people with physical disabilities and/or reliance on public transport.

11.1.8 Documented policies and procedures exist and are used to achieve the above criteria.

11.1.9 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 11.2 - Entry

The process of entry to the MHS meets the needs of the defined community and facilitates timely and ongoing assessment.

Criteria

11.2.1 The process of entry to the MHS is made known to the defined community.

11.2.2 The MHS has documented policies and procedures describing its entry process, inclusion and exclusion criteria and means of promoting and facilitating access to appropriate ongoing care for people not accepted by the service.

11.2.3 The MHS can be entered at multiple sites which are coordinated through a single entry process.

11.2.4 The entry process to the MHS can be undertaken in a variety of ways which are sensitive to the needs of the consumer, their carers and the defined community.

11.2.5 The entry process to the MHS is specialised and complementary to any existing generic health or welfare intake systems.

11.2.6 An appropriately qualified and experienced mental health professional is available at all times to assist consumers to enter into mental health care.

11.2.7 The process of entry to the MHS minimises the need for duplication in assessment, care planning and care delivery.

11.2.8 The MHS ensures that a consumer and their carers are able to, from the time of their first contact with the MHS, identify and contact a single mental health professional responsible for coordinating their care.

11.2.9 The MHS has a system for prioritising referrals according to risk, urgency, distress, dysfunction and disability.

11.2.10 The MHS has a system that enables separate assessment of more than one consumer at a time.

11.2.11 The MHS has a policy which acknowledges that assessment and the entry process to the service are linked.

11.2.12 The MHS has a system which ensures that the initial assessment of an urgent referral is commenced within one hour of initial contact and the initial assessment of a non-urgent referral is commenced within 24 hours of initial contact.

11.2.13 Documented policies and procedures exist and are used to achieve the above criteria.

11.2.14 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 11.3 - Assessment and Review

Consumers and their carers receive a comprehensive, timely and accurate assessment and a regular review of progress.

ASSESSMENT

Criteria

11.3.1 Assessments are conducted by appropriately qualified and experienced mental health professionals.

11.3.2 Wherever possible, the assessment is conducted in a setting chosen by the consumer. The choice of setting is negotiated by the consumer and the MHS and considers the safety of those people involved.

11.3.3 The MHS has a procedure for appropriately following up people who decline to participate in an assessment.

11.3.4 The MHS has a system for commencing and recording assessment during the consumer's first contact with the service.

11.3.5 The assessment process is comprehensive and, with the consumer's informed consent, includes the consumer's carers (including children), other service providers and other people nominated by the consumer.

11.3.6 The assessment is conducted using accepted methods and tools.

11.3.7 The MHS has documented protocols and procedures describing the assessment process.

11.3.8 The assessment is recorded in an individualised clinical record in a timely and accurate manner.

11.3.9 There is opportunity for the assessment to be conducted in the preferred language of the consumer and their carers.

11.3.10 Staff are aware of, and sensitive to, cultural and language issues which may affect the assessment.

11.3.11 Diagnosis is made using internationally accepted medical standards by an appropriately qualified and experienced mental health professional.

11.3.12 Where a diagnosis is made, the consumer and carers (with the consumer's informed consent) are provided with information on the diagnosis, options for treatment and possible prognoses.

11.3.13 Wherever possible, the MHS conducts face-to-face assessments but may use telephone and video technologies where this is not possible due to distance or the consumer's preference.

REVIEW

11.3.14 The MHS ensures that the assessment is continually reviewed throughout the consumer's contact with the service.

11.3.15 Staff of the MHS involved in providing assessment undergo specific training in assessment and receive supervision from a more experienced colleague.

11.3.16 New assessments are subjected to a clinical review process by the MHS.

11.3.17 All active consumers, whether voluntary or involuntary, are reviewed at least every three months. The review should be multidisciplinary, conducted with peers and more experienced colleagues and recorded in the individual clinical record.

11.3.18 A review of the consumer is additionally conducted when:

- the consumer declines treatment and support
- the consumer requests a review
- the consumer is injures themself or another person
- the consumer receives involuntary treatment
- there has been no contact between the consumer and the MHS for three months
- the consumer is going to exit the MHS
- monitoring of consumer outcomes (satisfaction with service, measure of quality of life, measure of functioning) indicates a sustained decline.

11.3.19 The MHS has a system for the routine monitoring of staff case loads in terms of number and mix of cases, frequency of contact and outcomes of care.

11.3.20 Documented policies and procedures exist and are used to achieve the above criteria.

11.3.21 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 11.4 - Treatment and Support

The defined community has access to a range of high quality mental health treatment and support services.

Criteria

11.4.1 Treatment and support provided by the MHS reflect best available evidence and emphasise positive outcomes for consumers.

11.4.2 Treatment and support provided by the MHS, including any participation of the consumer in clinical trials and experimental treatments, are subject to the informed consent of the consumer.

11.4.3 The MHS ensures access to a comprehensive range of treatment and support services which are, wherever possible, specialised in regard to a person's age and stage of development.

11.4.4 The MHS ensures access to a comprehensive range of treatment and support services which are specialised in regard to a consumer's stage in the recovery process.

11.4.5 The MHS provides access to a comprehensive range of treatment and support services which cater for the needs of people compelled to receive treatment involuntarily, whether in an inpatient or community setting.

11.4.6 The MHS ensures access to a comprehensive range of treatment and support services which address physical, social, cultural, emotional, spiritual, gender and lifestyle aspects of the consumer.

11.4.7 The MHS ensures access to a comprehensive range of treatment and support services which are, wherever possible, specialised in regard to dual diagnosis, other disability and consumers who are subject to the criminal justice system.

11.4.8 The MHS ensures access to a comprehensive range of treatment and support services which are, wherever possible, specialised in addressing the particular needs of people of ethnic backgrounds.

11.4.9 There is a current individual care plan for each consumer, which is constructed and regularly reviewed with the consumer and, with the consumer's informed consent, their carers and is available to them.

11.4.10 The MHS provides the least restrictive and least intrusive treatment and support possible in the environment and manner most helpful to, and most respectful to, the consumer.

11.4.11 The treatment and support provided by the MHS is developed collaboratively with the consumer and other persons nominated by the consumer.

11.4.12 Documented policies and procedures exist and are used to achieve the above criteria.

11.4.13 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 11.4.A - Community Living

The MHS provides consumers with access to a range of treatment and support programs which maximise the consumer's quality of community living.

Criteria

Self Care

11.4.A.1 The setting for the learning or the re-learning of self care activities is the most familiar and/or the most appropriate for the generalisation of skills acquired.

11.4.A.2 Self care programs or interventions provide sufficient scope and balance so that consumers develop or redevelop the necessary competence to meet their own everyday community living needs.

Leisure, Recreation, Education, Training, Work and Employment

11.4.A.3 The MHS ensures that settings for day programs provide adequate indoor and outdoor space for consumers.

11.4.A.4 The MHS ensures that the consumer has access to an appropriate range of agencies, programs and/or interventions to meet their needs for leisure, recreation, education, training, work, accommodation and employment.

11.4.A.5 The MHS supports the consumer's access to education, leisure and recreation activities in the community.

11.4.A.6 The MHS provides access to, and/or support for consumers in employment and work.

11.4.A.7 The MHS supports the consumer's access to vocational training opportunities in appropriate community settings and facilities.

11.4.A.8 The MHS promotes access to vocational support systems which ensure the consumer's right to fair pay and conditions, award (or above) payment for work and opportunities for union membership.

11.4.A.9 The MHS supports the consumer's desire to participate in Further or Continuing Education.

11.4.A.10 The MHS provides or ensures that consumers have access to drop-in facilities for leisure and recreation as well as opportunities to participate in leisure and recreation activities individually and/or in groups.

Family, Relationships, Social and Cultural System

11.4.A.11 The consumer has the opportunity to strengthen their valued relationships through the treatment and support effected by the MHS.

11.4.A.12 The MHS ensures that the consumer and their family have access to a range of family-centred approaches to treatment and support.

11.4.A.13 The MHS provides a range of treatments and support which maximise opportunities for the consumer to live independently in their own accommodation.

11.4.A.14 Documented policies and procedures exist and are used to achieve the above criteria.

11.4.A.15 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 11.4.B - Supported Accommodation

Supported accommodation* is provided and/or supported in a manner which promotes choice, safety and maximum possible quality of life for the consumer.

* Psychiatric inpatient accommodation is addressed under Inpatient Care (Standard 11.4.E)

SUPPORTED ACCOMMODATION PROVIDED BY THE MHS

Criteria

11.4.B.1 The MHS has guidelines for the provision of accommodation which are adhered to.

11.4.B.2 Consumers and carers have the opportunity to be involved in the management and evaluation of the facility.

11.4.B.3 The accommodation program is fully integrated into other treatment and support programs.

11.4.B.4 Accommodation is clean, safe and reflects as much as possible the preferences of the consumers living there.

11.4.B.5 Access to the accommodation is non-discriminatory and determined on priority of need alone.

11.4.B.6 A range of treatment and support services is delivered to the consumers living in the accommodation according to individual need.

11.4.B.7 Consumers living in the accommodation are offered maximum opportunity to participate in decision making with regard to the degree of supervision in the facility, decor, visitors, potential residents and house rules.

11.4.B.8 There is a range of accommodation options available and consumers have the opportunity to choose and move between options if needed.

11.4.B.9 Where desired, consumers are accommodated in the proximity of their social and cultural supports.

11.4.B.10 The accommodation maximises opportunities for the consumer to participate in the local community.

11.4.B.11 The accommodation maximises opportunities for the consumer to exercise control over their personal space.

11.4.B.12 Wherever possible and appropriate, the cultural, language, gender and preferred lifestyle requirements of the consumer are met.

11.4.B.13 Consumers with physical disabilities have their needs met.

ACCOMMODATION PROVIDED BY AGENCIES OTHER THAN THE MHS

11.4.B.14 The MHS supports consumers in their own accommodation and supports accommodation providers in order to promote the criteria above.

11.4.B.15 The MHS provides treatment and support to consumers regardless of their type of accommodation.

11.4.B.16 The MHS does not refer a consumer to accommodation where he / she is likely to be exploited and/or abused.

11.4.B.17 Documented policies exist and are used to achieve the above criteria.

11.4.B.18 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 11.4.C - Medication and Other Medical Technologies

Medication and other medical technologies are provided in a manner which promotes choice, safety and maximum possible quality of life for the consumer.

Criteria

11.4.C.1 Medication and other technologies used are evidence-based and reflect internationally accepted medical standards.

11.4.C.2 Medication and other technologies are prescribed, stored, transported, administered and reviewed by authorised persons in a manner consistent with legislation, regulations and professional guidelines.

11.4.C.3 The MHS obtains the informed consent of the consumer prior to the administration of medication or use of other medical technologies such as Electro Convulsive Therapy.

11.4.C.4 The consumer and their carers are provided with understandable written and verbal information on the potential benefits, adverse effects, costs and choices with regard to the use of medication and other technologies.

11.4.C.5 Wherever possible and appropriate, the MHS provides the option of medication being prescribed and administered in a setting of the consumer’s choice.

11.4.C.6 The MHS ensures that a system exists which monitors to prevent - and promptly provides the consumer with appropriate treatment for any adverse effects of medication.

11.4.C.7 Where the consumer’s medication is administered by the MHS, it is administered in a manner which protects the consumer’s dignity and privacy.

11.4.C.8 “Medication when required” (PRN) is only used as a part of a documented continuum of strategies for safely alleviating the consumer’s distress and/or risk.

11.4.C.9 The use of medication and other technologies is monitored and reported utilising nationally accepted clinical indicators and other benchmarks.

11.4.C.10 The MHS ensures access for the consumer to the safest, most effective and most appropriate medication and/or other technology.

11.4.C.11 The MHS promotes continuity of care by ensuring that, wherever possible, the views of the consumer and, with the consumer's informed consent, their carers and other relevant service providers are considered and documented prior to administration of new medication and/or other technologies.

11.4.C.12 The consumer's right to seek an opinion and/or treatment from another qualified person is acknowledged and facilitated and the MHS promotes continuity of care by working effectively with other service providers.

11.4.C.13 Where appropriate, the MHS actively promotes adherence to medication through negotiation and the provision of understandable information to the consumer and, with the consumer's informed consent, their carers.

11.4.C.14 Wherever possible, the MHS does not withdraw support or deny access to other treatment and support programs on the basis of a consumer's decision not to take medication.

11.4.C.15 Documented policies and procedures exist and are used to achieve the above criteria.

11.4.C.16 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 11.4.D - Therapies

The consumer and the consumer's family/carer have access to a range of safe and effective therapies.

Criteria

11.4.D.1 Therapies offered or recommended by the MHS reflect best available evidence and are conducted by appropriately qualified and experienced mental health professionals.

11.4.D.2 The MHS provides access to a range of accepted therapies according to the needs of the consumer and their carers.

11.4.D.3 The extent to which therapies are directly provided by the MHS is determined according to the assessed need of the defined community and the documented priorities of the MHS.

11.4.D.4 The consumer is supported to make an informed choice on the most acceptable form of therapy from the range available.

11.4.D.5 The consumer is informed by the MHS of the potential benefits, potential adverse effects, financial costs and any other foreseeable inconvenience associated with the provision of a particular therapy.

11.4.D.6 The MHS promotes continuity of care for consumers referred outside the MHS for a particular therapy.

11.4.D.7 Therapies provided by the MHS are provided in an environment which is safe, private, comfortable and affords minimal disruption.

11.4.D.8 Documented policies and procedures exist and are used to achieve the above criteria.

11.4.D.9 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 11.4.E - Inpatient Care

The MHS ensures access to high quality, safe and comfortable inpatient care for consumers.

Criteria

11.4.E.1 The MHS offers less restrictive alternatives to inpatient treatment and support provided that it adds value to the consumer's life and with consideration being given to the consumer's preference, demands on carers, availability of support and safety of those involved.

11.4.E.2 Where admission to an inpatient psychiatric facility is required, the MHS makes every attempt to promote voluntary admission for the consumer.

11.4.E.3 The MHS ensures that a consumer who requires involuntary admission is conveyed to hospital in the safest and most respectful manner possible.

11.4.E.4 The MHS ensures that the admission assessment includes the views of other current service providers and the consumer's carers.

11.4.E.5 The MHS ensures that there is continuity of care between inpatient and community settings.

11.4.E.6 As soon as possible after admission, the MHS ensures that consumers receive an orientation to the ward environment, are informed of their rights in a way that is understood by the consumer and are able to access appropriate advocates.

11.4.E.7 The MHS assists in minimising the impact of admission on the consumer's family and significant others.

11.4.E.8 The MHS ensures that the consumer's visitors are encouraged.

11.4.E.9 The MHS ensures that there is a range of age appropriate day and evening activities available to consumers within the inpatient facility.

11.4.E.10 The MHS provides opportunities for choice for consumers in regard to activities and environment during inpatient care.

11.4.E.11 The MHS seeks regular feedback from consumers on the activities and environment associated with inpatient care.

11.4.E.12 The MHS, where appropriate, enables consumers to participate in their usual religious and/or cultural practices during inpatient care.

11.4.E.13 Consumers and their carers have the opportunity to communicate in their preferred language.

11.4.E.14 The MHS provides a physical environment for inpatient care that ensures protection from harm, adequate indoor and outdoor space, privacy, and choice.

11.4.E.15 Documented policies and procedures exist and are used to achieve the above criteria.

11.4.E.16 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement performance as part of a quality improvement process.

Standard 11.5 - Planning for Exit

Consumers are assisted to plan for their exit from the MHS to ensure that ongoing follow-up is available if required.

Criteria

11.5.1 Each consumer's documented individual care plan includes an exit plan which is begun during entry to the MHS to ensure ongoing continuity of care once the consumer has exited from the MHS.

11.5.2 The exit plan is reviewed in collaboration with the consumer and, with the consumer's informed consent, their carers at each contact and as part of each review of the individual care plan.

11.5.3 The exit plan is made available to consumers and, with the consumer's informed consent, their carers and other nominated service providers.

11.5.4 The consumer and their carers are provided with understandable information on the range of relevant services and supports available in the community.

11.5.5 A process exists for the earliest appropriate involvement of the consumer's nominated service provider.

11.5.6 The MHS ensures that consumers referred to other service providers have established contact and that the arrangements made for ongoing follow-up are satisfactory to the consumer, their carers and other service provider prior to exiting the MHS.

11.5.7 All services provided by the MHS are planned and delivered on the basis of the briefest appropriate duration of contact consistent with best outcomes for the consumer.

11.5.8 Documented policies and procedures exist and are used to achieve the above criteria.

11.5.9 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

Standard 11.6 - Exit and Re-entry

The MHS assists consumers to exit the service and ensures re-entry according to the consumer's needs.

Criteria

11.6.1 Staff review the outcomes of treatment and support as well as ongoing follow-up arrangements for each consumer prior to their exit from the MHS.

11.6.2 The MHS ensures that the consumer, their carers and other service providers and agencies involved in follow-up are aware of how to gain entry to the MHS at a later date.

11.6.3 The MHS ensures that the consumer, their carers and other agencies involved in follow-up, can identify an individual in the MHS, by name or title, who has knowledge of the most recent episode of treatment and/or support.

11.6.4 The MHS attempts to re-engage with consumers who do not keep the planned follow-up arrangements.

11.6.5 The MHS assists consumers, carers and other agencies involved in follow-up to identify the early warning signs which indicate the MHS should be contacted.

11.6.6 The MHS ensures that the individual clinical record for the consumer is available for use in any potential future contact with the MHS.

11.6.7 Documented policies and procedures exist and are used to achieve the above criteria.

11.6.8 The MHS monitors its performance in regard to the above criteria and utilises data collected to improve performance as part of a quality improvement process.

8.8 SNAPSHOT OF MEDIA REPORTS REGARDING CRISIS IN MENTAL HEALTH CARE

Table 8.8: Snapshot of media reports regarding crisis in mental health care

DATE	TITLE	AUTHOR	SOURCE
19 Aug 2003	Families, Counsellors Respond To Tale Of Hidden Tragedy	Steven Waldon & Julie-Ann Davies	The Age
2 Sept 2003	Mental Health Suicides Shock – Call For A Time-Out Facility	Danielle Cronin	The Canberra Times
12 Nov 2003	Psychiatric Procedures Questioned	Roderick Campbell	The Canberra Times
6 Dec 2003	System To Blame For Suicide – Coroner	Roderick Campbell	The Canberra Times
6 Dec 2003	Ex-Wife Blames Lack Of Support For Deaths	Emma Chalmers	The Courier Mail
26 Dec 2003	Mental Suicide Up – HOSPITALS IN CRISIS		The Daily Telegraph
30 Dec 2003	Fatal Error And Demand For Royal Commission – HOSPITALS IN CRISIS	Katherine Janks	The Daily Telegraph
31 Dec 2003	Hospital Failures Blamed For Suicides – HOSPITALS IN CRISIS	Zoe Taylor	The Daily Telegraph
25 Jan 2004	Flaw In Mental Health Service		The Canberra Times
28 Jan 2004	Jail Should Include Mental-Health Space: Advocate	Catherine Naylor	The Canberra Times
31 Jan 2004	Dilemma For Judges Who Deal With Mentally Ill		The Canberra Times
14 Feb 2004	Prison Politics	Ian Gerard & Drew Warne-Smith	The Australian
17 Feb 2004	Mental Health Patient Outcry: Courts 'Being Blackmailed'	Monika Boogs	The Canberra Times
19 Feb 2004	Worker Admits He Failed To Monitor At-Risk Patient	Roderick Campbell	The Canberra Times
19 Feb 2004	Suicide Warning For Mentally Ill	Carol Nader	The Age
20 Feb 2004	Patients Suffer As Mental Health Plans Fail – Essential Service Failure	Gosia Kaszubska	The Australian
20 Feb 2004	Hospitals Say Chief Psychiatrist 'Out Of Touch'	Carol Nader	The Age
21 Feb 2004	Let Those Who Know Speak: Call For Consumers, Carers To Be Involved In New Working Party	Danielle Cronin	The Canberra Times
21 Feb 2004	Coroner May Probe Patients' Suicides	Catharine Munro	The Age
27 Feb 2004	Mental Health: Call To Action		The Canberra Times
28 Feb 2004	Coroner Slates Care Of Mentally Ill	Roderick Campbell	The Canberra Times
28 Feb 2004	The Doctors Of Despair	Sandra McLean	The Courier Mail
12 Mar 2004	Mentally Ill Merit Much More Of A Fair Go From Us		The Canberra Times
17 Mar 2004	Critical Condition	Graeme Bond	The Age
23 Mar 2004	Officer Hid Her Dark, Sad Secret	Nicolle Fenech	The Daily Telegraph
25 Mar 2004	Inquiry Into Suicide Ordered	Danielle Cronin	The Canberra Times
27 Mar 2004	Suicides: Coroner's List Grows	Roderick Campbell	The Canberra Times

31 Mar 2004	We Can't Stop Suicides, But With Better Services We Could Save Some		The Canberra Times
12 Apr 2004	Suicide Risk Claim In Hospital Change	Cathy O'Leary	The West Australian
5 May 2004	Rally Brings Suicide Into Spotlight	Pamela Magill	The West Australian
14 May 2004	Psychiatric Unit Under Fire	Carol Nader	The Age
24 May 2004	High Rates Of Mental Illness In Jail Inmates	Ian Munro	The Age
27 May 2004	Probe On Suicide After Hospital Turns Away Man	Danny Rose	The Hobart Mercury
27 May 2004	Be Aware Of Young People's Distress	Daniel Landon	The Canberra Times
30 May 2004	Patient Acted On Death Threats After Release	Alexandra Economou	The Advertiser
4 Jul 2004	Jail Should Not Become Refuge	Terry Sweetman	The Sunday Mail
31 Jul 2004	No Follow-Up On Mentally Ill Criminals	Leanne Craig	The Advertiser
2 Aug 2004	Inquiry Plea After Mental Health Deaths	Dawn Gibson	The West Australian
3 Aug 2004	Tragic Toll Hits Our Young – Not-For-Profit Organisations – A Special Advertising Report		The Daily Telegraph
4 Aug 2004	Psychosis 'No Excuse' To Escape Prison Cell	Leanne Craig	The Advertiser
14 Aug 2004	Singh Now A Crusader For Women In Jail		The Canberra Times
21 Aug 2004	Judge Hits Treatment Of Insane	Nick Clark	The Hobart Mercury
25 Aug 2004	Jail System A 'Sump' For The Mentally Ill	Rebecca DiGirolamo	The Australian
26 Aug 2004	Teenagers Locked Away With Criminally Insane	Dawn Gibson & Peta Rasdien	The West Australian
26 Aug 2004	Govts 'All Talk, Not Much Action' On Mentally Ill	Catherine Naylor	The Canberra Times
26 Aug 2004	Drugs Linked To Mental Health Crisis	Meaghan Shaw	The Age
3 Sept 2004	Three Sons Lost To The Island Of Despair	Tony Koch	The Australian
10 Sept 2004	Spotlight On A Dark Road	Steve Waldon	The Age
30 Sept 2004	Dawes Bond 'Manifestly Inadequate'	Lisa Miller	The Daily Telegraph
28 Oct 2004	Police To Decide Mental Health Treatment	Julie Robotham	The Sydney Morning Herald
30 Oct 2004	When A Girl's Mum Is The Only One Listening	Vanessa McCausland	The Daily Telegraph
5 Nov 2004	Police Left To Prop Up Ailing Mental Health System	Ruth Pollard	The Sydney Morning Herald
6 Nov 2004	Agony Over System That Failed Nigel	Michelle Paine	The Hobart Mercury
10 Dec 2004	Save Our Children – Society Fails The Innocent	Lillian Saleh	The Daily Telegraph
12 Dec 2004	Holding Bays Doling Out 'Subhumane Care'	Peter Ellingsen	The Sunday Age
12 Dec 2004	Suicide A Risk After Hospital	Liz Porter	The Sunday Age
12 Dec 2004	Threat To Oneself No Guarantee Of Care	Peter Ellingsen	The Sunday Age
12 Dec 2004	The Shame Of Our 'Forgotten People'	Peter Ellingsen	The Sunday Age
19 Dec 2004	80% Of Homeless Have Mental Disorder	Peter Ellingsen	The Sunday Age
18 Jan 2005	Prison Boom Will Prove A Social Bust	Eileen Baldry	The Sydney Morning Herald
31 Jan 2005	Brogden Wants More For Mental Health		The Daily Telegraph
5-6 Feb 2005	She's Australian And Mentally Ill – Yet Immigration Locked Her Up	Andra Jackson	The Sydney Morning Herald
5-6 Feb 2005	Mentally Ill Aussie In Detention Centre	Andrew McGarry	The Weekend Australian
7 Feb 2005	My Sister Lost Her Mind, And Australia Lost Its Heart When It Imprisoned Her	Chris Rau & John MacDonald	The Sydney Morning Herald

8 Feb 2005	Queensland Hospitals Fail Patients	Jeff Sommerfeld	The Courier Mail
8 Feb 2005	Shameful Case Forces Change	Stephanie Peatling & Mark Todd	The Sydney Morning Herald
8 Feb 2005	Message Of Love For A Lost Child	Lisa Davies	The Daily Telegraph
8 Feb 2005	When Detention Begets Its Own Madness		The Age
8 Feb 2005	Shameful Case Forces Change	Stephanie Peatling & Mark Todd	The Sydney Morning Herald
8 Feb 2005	Funds For Mentally Ill Lowest In Nation	Jeff Sommerfeld	The Courier Mail
9 Feb 2005	Rau Is Only An Extreme Example – Our Prisons Are Full Of Mentally Ill People	Allan Fels	The Sydney Morning Herald
9 Feb 2005	Brogden Pledges Action On 'Mental Asylum' Jails	Anne Davies	The Sydney Morning Herald
12 Feb 2005	Out Of Mind	Ruth Pollard	The Sydney Morning Herald
12 Feb 2005	Loose Ends Thrown Up By		The Canberra Times
15 Feb 2005	Prison System Close To Crisis	Fergus Shiel & Meaghan Shaw	The Age
15 Feb 2005	Mentally Ill Trapped In Casualty	Carol Nader	The Age
18 Feb 2005	Battling Guilt And Society's Stigma	Pat Sutton	The Advertiser
18 Feb 2005	Mental Health Inquiry Tackles System In Crisis	Aban Contractor & Mark Metherell	The Sydney Morning Herald
19 Feb 2005	Suicidal Woman Who Drowned Son Not Guilty	Geesche Jacobsen	The Sydney Morning Herald
19 Feb 2005	Prescribing Passion For A Healthier System		The Canberra Times
20 Feb 2005	It's Time To Admit We've Created A Gulag	Russell Skelton	The Sunday Age
21 Feb 2005	Mental Health Care Called To Account	Kate Legge	The Australian
21 Feb 2005	NSW Govt Backs Senate Mental Health Inquiry	Sharan Burrow	Health Business Daily News
22 Feb 2005	Shock May Have Saved Man: Report	Danielle Cronin	The Canberra Times
25 Feb 2005	States 'Starving' Mental Health Sector Of Funds	Dan Brown	Health Business Daily News
2 Mar 2005	Training Needed, Says Report On Suicide	Danielle Cronin	The Canberra Times
5 Mar 2005	Treatment Of Mentally Ill As Bad As Ever: Expert	Danielle Cronin	The Canberra Times
5 Mar 2005	Agency Of Hate And Anguish	Dawn Gibson	The West Australian
5 Mar 2005	No Hospital Bed For Suicide Women	Wendy Pryer	The West Australian
5 Mar 2005	Suicide Woman Wanted Treatment	Wendy Pryer	The West Australian
16 Mar 2005	Crisis System 'Failed' Man Later Charged With Murder	Carol Nader & Stephen Moynihan	The Age
18 Mar 2005	Plea For Action On Prevention Plan As Tragic Toll Jumps Alarmingly: State Suicide Crisis	Gavin Lower	Hobart Mercury
24 Mar 2005	Country Set To Lose $1m Mental Funds	Jessica Strutt	The West Australian
29 Mar 2005	Shot Man Had Been Left Without Supervision	Jeff Sommerfeld	The Courier Mail
30 Mar 2005	Suicide Figures Justify Building 'Time-Out' Facility: Stefaniak	Danielle Cronin	The Canberra Times
31 Mar 2005	Jail Birds	Ian Munro	The Age
2 Apr 2005	Shedding Light On Despair's Dark Side		The Canberra Times

2 Apr 2005	When Blue Turns Black	Ruth Pollard	The Sydney Morning Herald
5 Apr 2005	Mentally Ill Warehoused In Jails, Says Parole Board Chief	Jessica Strutt	The West Australian
6 Apr 2005	Grown Men Should Have The Courage To Break Out Crying	Rex Jory	The Advertiser
9 Apr 2005	Suicide Rate High After Mental Unit Discharge	Gerard Noonan	The Sydney Morning Herald
13 Apr 2005	Black Kids Facing Mental Health Crisis	Amanda Banks	The Australian
18 April 2005	When jail becomes a psychiatric ward	Stephen Gibbs	The Sydney Morning Herald
19 Apr 2005	Call To Fix Mental Health Care Crisis	Ruth Pollard	The Sydney Morning Herald
19 Apr 2005	Alarm At Lack Of Treatment For Mental Illness Sufferers	Ruth Pollard	The Age
19 Apr 2005	System Fails Mentally Ill: Report	Rosemary Desmon	The Courier Mail
23 Apr 2005	Sick System Victim	Wayne Crawford	The Hobart Mercury
23 Apr 2005	Case Closes On Tragic Tale Of Gary Lee-Rogers		The Canberra Times
28 Apr 2005	Mental Health Patients Turned Away	AAP	The Sunday Telegraph
28 Apr 2005	Government ‘Failing’ The Mentally Ill	Saffron Howden	The Weekend Australian
5 May 2005	Govt Seeks Detainee Judgment Advice	AAP	The Herald Sun
10 May 2005	Mentally ill missing out on help, says AMA	Danielle Cronin	The Canberra Times

8.9 STATE / TERRITORY FUNDING ANNOUNCEMENTS

Table 8.9: State / Territory Funding Announcements 2004/05

S/T	Amount	Date of Announcement	Details of Announcement
ACT	$610,000	May 2005	Awarded to University of Canberra to operate a Centre for Health, Promotion and Wellbeing over 3 years
NSW	-	April 2005	Strategy to recruit 400 mental health nurses in NSW. 150 in 2005 building to a target of 400 in 2006
	$13.8 million	April 2005	Program to provide disability support to 460 people across the state with a mental illness.
	Four new 20 bed sub-acute mental health units	February 2005	Funded from the $241 million to enhance mental health services as announced in the April 2005 budget.
	$68 million real increase	February 2005	$783 million dedicated to mental health services in 2005 up from $715 million the previous year. All money seems to be allocated to beds and not community services.
	$1.6 million	August 2004	New acute 8 bed paediatric in-patient ward at The Children's Hospital at Westmead
NT	Extra $1.5 million for MH services	May 2005	Extra $1.5 million per year for MH services. This is a repeated commitment from the previous year. Funding breakdown includes $200,000 for improved 24 hr emergency response and $350,000 for four extra rural child and adolescent psychiatrist positions
	$1.2 million	May 2005	For community based residential facilities in Darwin and Alice Springs for 24 hour support for those with a mental illness.
		October 2004	Launch of animated indigenous character and mental health seminar
		October 2004	Launch of 'Mind your Mind kit' to promote positive youth mental health.
	$1.5	June 2004	Extra $1.5 million per year for MH services reported.
	$490,000	April 2004	$490,000 over three years to help those with a mental disorder access individual rehab programs.
QLD	$63,000	October 2004	New money from Qld Health for Mental illness Fellowship of Nth Qld ' Family Participation Program
	$6.9 Million	July 2004	Funding for community organisations for new and expanded mental health services
SA	$80 million	March 2004	Mental health building program for 3 new 20 bed specialist community rehab facilities. To be completed by the end of 2007
	$13 million recurrent funds and $56 million over five years	August 2004	Announcement of audit on State's MH Act. $13 million in new funding and $56 million to support residential facilities in the community.

TAS	$47 Million over 3 years	November 2004	To be used for; 62 packages of care to support clients living in the community new 12 bed cluster house new 12 bed high support community facility $3.78m to drive quality and safety reform $4.52 upgrade of existing govt and non-govt facilities and services.
		April 2005	Govt announcement that offenders with acute mental illness will be managed within secure mental health units rather than prison.
		April 2005	Govt announcement that it has accepted all 26 recommendations from the Ward 1E report in mental health facilities conducted by the Health complaints commissioner.
VIC	$180 million and some new money	April 2005	Govt announces extra money for crisis assessment teams, rebuilding of Bunjil House and building a 50 bed facility at Maroondah hospital
	$9.45 million	March 2005	Govt announces that work on the new $9.45 million adult acute inpatient unit and specialist MHS at Austin hospital had begun.
	$8 million	December 2003	Govt announces that work on the new $8 million community MH facility at Traralgon would commence by the end of the year. Will take 12 months to construct and 80 staff based there will service a 14 bed community care unit.
	$200,000	October 2004	Govt announces that 5 separate rural health services would each receive $40,000 to improve consultation-liaison psychiatry services.
	$483,870	October 2004	Govt announces that new early psychosis services in Hume and Loddon Mallee will receive $483,870 for five additional clinical positions. Govt announces nearly $200 million in additional recurrent funding for MH since 1999 and $650 million would be provided in 2004.
	$447,000	September 2004	Govt announces that new early psychosis service has opened at Barwon
	$75,000	August 2004	Govt announces that a Young Persons' Psychiatric Disability and Rehabilitation support service in Wodonga would be strengthened.
		August 2005	Govt announces that a new ministerial advisory committee would be established.
		July 2004	Govt announces frontline feedback to the Government could assist in how the Govt spend an additional $15 million on rural MH services
	$500,000	June 2004	Govt announces opening of a new mental health service in Flemington. The service is an 8 bed community mental health facility.
	$1.1 million	March 2004	Govt announces opening of a new country 'mid way house' for those with mental illness located at Shepparton in the Goulburn Valley.
	$500,000	March 2004	Govt announces opening of a new high dependency unit in Dandenong.
	$200,000	March 2004	Govt announces 3 hospitals to share funding for new obstetric consultation liaison psychiatry service for new mothers.
	$126,000	March 2004	Govt announces Seniors in Victoria with a serious mental illness will be able to access an $126,000 in social and recreational support.
	$1.5 million	January 2004	Govt announces new money for mental health beds in Sunshine, Burwood East and Melbourne.

WA	$173 million	October 2004	Govt announces establishment of a Mental Health Advisory Group to oversee the implementation of the Govt's $173 million mental health strategy.
	$173 million	October 2004	Govt announces $173 million mental health strategy. This includes • $65m – 113 new impatient beds and 425 new staff • 420 extra community beds • $23.6m for specialist MH teams in emergency departments • $11m for MHS targeting school aged children • $8.7m to improve safety for MH staff
		November 2004	Govt announces allocation of $700,000 from the Govt's $173 million mental health strategy to the beyondblue to raise awareness of the issue of depression in WA.