Not for service

Experiences of injustice and despair
in mental health care in Australia

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in Mental Health Care in Australia

SUMMARY

Note: All written submissions are directly quoted in this report.

Cover quotes:
"Recently when I phoned the triage service for help I was told that I had been categorised by the Mental Health Team as 'Not for Service'."   (Consumer, Victoria, Morwell Forum #17)

"I think for those who are severely ill and are isolated in the community due to their illness they often have no form of support even from family or friends. For people like that they are in the community living like ghosts – they are dying alone." (Consumer, Male, Victoria, Footscray Forum #11).

Suggested reference:
Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia, Mental Health Council of Australia, Canberra, 2005.

FOREWORD

Dr Sev Ozdowski OAM

Human Rights Commissioner and Acting Disability Discrimination Commissioner
Human Rights and Equal Opportunity Commission

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

International Covenant on Economic Social and Cultural Rights, Article 12

Australia has made a commitment under international human rights law to provide the 'highest attainable standard' of mental health care. As one of the wealthiest nations in the world, this commitment means that Australia should be setting the example for others to follow. This report demonstrates that while Australia has made many advances, there is still a long way to go.

Since starting my term as Federal Human Rights Commissioner in 2000, I have met hundreds of people all over Australia from all walks of life. During the many conversations I had over the first few years, I was struck by the large number of people who came to me saying that their friend, neighbour or relative had a mental illness and that I simply wouldn't believe the trouble that they had in getting adequate care. I was therefore delighted to work with the Mental Health Council of Australia (MHCA) and the Brain and Mind Research Institute (BMRI) last year on community consultations regarding the human rights of the mentally ill.

Of course, the Human Rights and Equal Opportunity Commission (HREOC) has substantial background in this area. More than 10 years ago the Commission published the ground-breaking *'Burdekin Report'* on Human Rights and Mental Illness. And just last year the Commission published a report on children in immigration detention – *A last resort?* One of the primary findings of that report was that children in long-term immigration detention were at high risk of mental illness and did not enjoy their human right to the highest attainable standard of mental health care.

This report is slightly different to the Commission's two other reports because its primary purpose has been to capture the personal stories of those people who interact with Australia's mental health care system on a daily basis. It was our view that governments needed to hear how Australia's mental health consumers and professionals felt about the system that they were dealing with.

Some of the stories we heard demonstrated the incredible strength of the human spirit and perseverance of mental health professionals doing the best they possibly could in the circumstances. However, it must be said that the vast majority of stories described a crumbling mental health care system that brought about anguish and desperation.

There have been positive changes since the 1993 *Burdekin Report* was published. One has been a trend towards the de-institutionalisation of Australia's mentally ill. Another has been the development of a National Mental Health Strategy that contains some positive policy initiatives which reflect Australia's human rights obligations towards the mentally ill.

However, the stories we heard during these consultations suggest that the process of de-institutionalisation has not been accompanied by corresponding supports for mentally ill people to live in the community. This has left many people with serious illnesses without the help that they need and deserve. Further, Australia has some way to go before the ideas in the National Mental Health Strategy translate into a mental health care system that delivers 'the highest attainable standard' of health care.

While HREOC has been glad to lend its expertise to the consultation process, this report has been drafted by the MHCA and BMRI. I am extremely grateful for their enormous efforts and I feel privileged to have been involved in this project. I would particularly like to thank Keith Wilson, Dr Grace Groom, Professor Ian Hickie and John Mendoza for giving me the opportunity to learn from them. I also want to thank the various State, Territory and Commonwealth Government Ministers and officials who opened their doors to us and listened to what we had to say throughout this process. I hope that this report serves as a wake-up call and prompts our politicians into bringing about real change.

However, I am most grateful to the mental health consumers and their carers, the mental health practitioners and the community groups who so generously shared their very personal stories with us. They took the time to write submissions and to come to the community consultations. I thank them for their efforts and hope that this report does justice to their stories.

FOREWORD

Keith Wilson
Chair, Mental Health Council of Australia

In a very real sense any attempt to provide a foreword to this report is unnecessary - it speaks eloquently for itself as a chronicle of the recorded voices speaking directly to all who read it. These voices speak of the ongoing pain, hopelessness and grief for the loss of life opportunities taken for granted by government and the majority of those whose families have never been impacted by mental illness and don't wish to broach the issue.

Many of those whose stories are recorded here were told with tears because their stories were recalling the experience of loved ones whose deaths were in many cases preventable but for which no one seemed accountable. These hundreds of stories speak of the daily lived experiences of Australian citizens, citizens of a wealthy nation, denied their basic right of access to appropriate and sustained quality health care.

I applaud the deep interest and readiness of the Human Rights and Equal Opportunity Commissioner, Dr Sev Ozdowski to partner the Mental Health Council of Australia in the public forums held in every state and territory and in numerous other meetings as well as in the huge task involved in writing a report that would respect the authenticity of its sources. There is no doubt that the direct participation of the Commissioner added enormous credibility to the hearings and the willingness of hundreds of others to lodge written submissions. His direct involvement brought a sharper focus to the seriously neglected human rights issues implicit in many of the submissions and presentations made during the community forums.

I also applaud the invaluable commitment and expertise contributed by Professor Ian Hickie of the Brain and Mind Research Institute in the University of Sydney. Professor Hickie collaborated closely with our former CEO, Dr Grace Groom, in devising the research framework and setting up the basis for the public forums at most of which he was present as a panelist. He was of course central to the difficult task of writing up such a large report.

An additional feature of this report has been the specific focus on the community's response on the current status of mental health reform in each state and territory. Those of us who attended the nationwide forums were struck by the similarity of the stories of systemic failure, neglect, the lack of accountability and the continued neglect of workforce issues in all parts of Australia.

Regrettably, we have seen from a number of jurisdictions a level of defensiveness and a rejection of the findings from this community assessment. The responses from a number of governments pointed to a 'lack of rigor' or 'poor research method' and 'the need for strategic analysis'. In some cases there was a concerning tendency to 'blame the victim'. These claims ignore the fact that our governments have not implemented basic and routine needs assessments nor regular and system-wide evaluations. Such responses also ignore the

growing body of support for the findings from this review – reviews by Parliamentary committees, Auditors Generals, Public Advocates and others empowered to undertake ad hoc reviews of public services.

While such a response is indeed regrettable, it is not unexpected. An all too frequent response from some governments since the signing of the Second National Mental Health Plan in 1998 has been in the oft quoted mantra that "we must expect that progress on mental health reform will be slow". Unfortunately while this slow pace is comfortable for some, if change is not forthcoming, an increasing number of mentally ill Australians will find themselves "*not for service*".

If on the other hand senior members of government at state and federal levels are prepared to reflect on the forlorn truth of the accounts voiced in this report, to accept their validity and in response show real leadership, then all Australians will have their rightful access to quality mental health care.

I have reserved my concluding remarks to recognise the distinguished contribution made by Dr Grace Groom, our former CEO, in bringing this report to fruition. The huge effort required to develop the groundwork for the public forums in all states and territories, to correlate the resultant data and begin the analysis on a shoestring budget is a tribute to the enthusiastic and strong leadership, and passionate commitment to mental health reform that marked the whole of her two short years as an outstanding CEO of the Mental Health Council of Australia.

FOREWORD

Ian Hickie
Professor of Psychiatry and Executive Director
Brain & Mind Research Institute, University of Sydney

In the early 1990s, as a result of a decade of clinical innovations in community-based mental health care, Australia occupied a unique position internationally. Community, political and professional enthusiasm for a major overhaul of mental health was evident. National leadership was clear and major policies and plans were set in place. Innovation was supported directly by national funding and key movements to promote better community understanding were born. It can be argued that a great deal was achieved between 1993 and 1998. Services were largely moved out of asylums and the needs and rights of those with mental illness and their families were formally recognised. The development of a broad population-based agenda for both prevention and treatment of common mental disorders was supported. National standards for specialist services were constructed. The national mental health survey detailed the extent of mental disorders in the community. The patterns of health care usage described provided the evidence-base for other major reforms in community education, preventative psychiatry and general practice reform.

Since the late 1990s, however, there have been persistent and disturbing reports of fundamental service failures. These reflect disorganised and dislocated health and welfare systems and a lack of commitment to the provision of quality mental health care, particularly in the public sector. Community-based care depends not only on organised health services but coordination of welfare, housing, police, justice and emergency care services. Multiple state-based inquiries have been conducted by health departments, coroners, auditor-generals, parliamentary committees and non-government organisations. The Brain and Mind Research Institute has now worked with the Mental Health Council of Australia on two national reports. *'Out of Hospital, Out of Mind'* was published in 2003 and now '*Not for Service'* in 2005. Both have been based on a combination of qualitative and quantitative methods. Fundamentally, they rest on extensive consultations with persons with mental illness, their families and carers. Additionally, they include the perspectives of those health care professionals who provide services at local level. Tragically, the themes from all these investigations converge. When any of us seeks mental health care we run the serious risk that our basic needs will be ignored, trivialised or neglected.

In our view, such *ad hoc* reports of system failures should be unnecessary. We should have in place government-supported but independently conducted systematic reviews of access to care, experiences of care and human rights. Contrary to the view put by most State and Territory governments, and consistent with data collected in 2003/04 in Victoria, we suspect that the adverse experiences we reported in 2003 and again now in 2005 are not isolated or unusual incidents. Instead they appear to be the tip of an iceberg of poor quality and disrupted experiences of mental health care. In the Victorian survey of persons utilising adult mental health services, negative experiences (related to access to care, information, protection of rights and meeting of individual needs) were reported by 28-42% of consumers and 42-55% of carers. It should be clearly

unacceptable within our health systems for somewhere between a third and a half of persons to report such negative experiences.

We urgently need all Australian governments to commit to a process of genuine and well-resourced reform. *What we do not need* is continued blaming of those who use the services, those professionals who provide the services or those independent bodies who report on them. Continuation of this culture of blame will only worsen the workforce crisis in public sector mental health services. Consistent with this approach, we were advised by Health Departments that this report represented a further threat to the viability of the mental health care system. We were implored to write a 'balanced' rather than 'accurate' report. It was clearly assumed by most States and Territories that they provide high quality care on a day to day basis, despite the lack of any substantive data to support that claim.

For genuine and rapid progress we now need more than committed individuals. Most of our current leaders have recently expressed some support for national reform. However, we need major actions, support for innovation in mental health care and enhanced whole-of-government approaches (e.g. to solve accommodation or employment issues). Independent and genuine scrutiny of progress is essential. Given the likelihood that every family in Australia will be affected by mental health problems at some stage, it can no longer remain an isolated and marginal concern.

While many 'blueprint' documents for mental health reform have been produced by governments, what has been unclear is whether any government is prepared to accept responsibility for implementing real actions. As demonstrated by our organisations over recent years, together with our community and legal partners, we will continue to monitor closely the adverse impacts of systematic neglect on the lives of those who experience mental illness.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The drive for national mental health reform in Australia in the early 1990s had its origins in the convergent desires of consumers, families, carers and mental health professionals to see a high quality, comprehensive and responsive mental health care system. It coincided with the adoption by the United Nations of the *Principles for the Protection of People with Mental Illness and the Improvement of Mental Health Care* (UN General Assembly Resolution 46/119, 17 December 1991; United Nations, 1991), which emphasised community-based care options and respect for the basic rights of persons with mental illness.

In Australia, the 1993 *Report of the National Inquiry into the Human Rights of People with Mental Illness* (Burdekin Report; Human Rights and Equal Opportunity Commission) brought many issues to wider public attention. It focused on violations of the human rights of people with mental illness, particularly within boarding houses and other sub-optimal forms of community care. Since that time the Human Rights and Equal Opportunity Commission (HREOC) has maintained an active interest in the experiences of persons with mental illness. In 2004, HREOC launched its report on the adverse consequences of prolonged incarceration of children in immigration detention centres (*A last resort?*; Human Rights and Equal Opportunity Commission, 2004).

In response to ongoing community criticism of experiences of care, in 2004, the Mental Health Council of Australia (MHCA) and the Brain and Mind Research Institute (BMRI, University of Sydney), in association with HREOC initiated a new national review – the subject of this report. The goal of this review was to capture the current critical themes in mental health care from the perspective of those who use and deliver its services on a daily basis.

Not for Service is based on national data collected from 2003 to 2005 and utilises a combination of qualitative and quantitative methods. Our goal was to determine the key concerns of those who have recently sought primary care or specialist mental health services. Additional information was provided by health professionals, non-government organisations and other private health care providers. The nature of the partnership between the MHCA, BMRI and HREOC meant that a particular emphasis was placed on collection of data relevant to the human rights of those with mental health problems. The primary mechanisms used to collect data for this review included:

- open community forums in each state and territory;
- individual meetings with specific community, professional and non-government groups;
- a call for written submissions; and
- two community surveys conducted by the MHCA and BMRI.

Due to the broad nature of the consultation process, submissions were received from many individuals and organisations covering a wide range of issues. It was agreed by the MHCA, BMRI and HREOC that the most useful framework for organising the vast amount of written and verbal data collected through the consultation process was the *National Standards for Mental Health Services* (the Standards). The Standards were agreed to by all governments in 1996-97.

Following the systematic collation of the primary data, each government in Australia was given the opportunity to comment on a draft report. Almost all governments responded by highlighting recent initiatives that suggest active responses to some of the concerns raised in the report.

Despite the fact that evidence was not specifically sought in order to prove or disprove the successful implementation of the Standards, the volume and consistency of the information demonstrates the gaps and the difficulties governments have had in meeting these Standards. This report is careful to present the data as a cumulation of personal experiences rather than definitive proof of neglect of the Standards.

The great majority of written and verbal submissions focused on deficits in key aspects of mental health care services. While a wider range of community and other welfare, housing and custodial services were the subject of individual or group submissions, the fundamental issue of inadequate access to quality health services for persons with mental illness dominated the discourse. The contrast between experiences of care when presenting with a physical illness as compared to presenting with a mental illness was profound. A lack of respect for persons with mental illness or their families was commonly reported. The combination of this lack of respect, poor resources and inadequate facilities appeared to underpin the numerous reports of reduced safety within mental health care services. Pleas for the provision of basic care with dignity were almost universal.

Consumers and their family and carers prioritised a number of aspects of health care and related services – and these are generally consistent with other independent notions of delivering quality health care services. These included:

    i)   access to professional care, particularly in emergency and other acute care settings;
    ii)   treatment with dignity and concern for the individual irrespective of location of care;
    iii)   prioritisation of safe and high quality services;
    iv)   an emphasis on clinical care, rather than 'containment' of those with mental disorders;
    v)   earliest possible access to professional care in acute and non-acute circumstances;
    vi)   response to individual needs, including recognition of the complexity of comorbid substance abuse, personality dysfunction or socio-economic deprivation;
    vii)   coordination of health, welfare and related community support services;
    viii)   access to programs and support to live independently and work;
    ix)   respect for the legitimate interests of family and carers in accessing care and participating in ongoing treatment decisions;
    x)   support for those who provide direct clinical services;
    xi)   provision of appropriate community housing options; and,
    xii)   access to appropriate medical as well as psychological services.

What this cumulative data shows is that after 12 years of mental health reform in Australia, any person seeking mental health care runs the serious risk that his or her basic needs will be ignored, trivialised or neglected. The adverse health, social and economic effects of Australia's mental health care system falls largely on those with recurrent or chronic disorders and their families and carers. These are some of the most vulnerable people in our community.

In the short-term, the system as it currently operates may result in a failure to provide basic medical and psychological health care, inappropriate use of short term seclusion, confinement or over-reliance on sedating medications. Longer-term, the impact may include deteriorating mental health and wellbeing, suicide, higher rates of homelessness, prolonged unemployment, incarceration or increased financial burden and poverty. Failure to attend to the urgent needs of those with severe mental disorders on a systemic basis may also lead to

infringements of the wider rights of the community to reside in a safe and secure environment. For many people, ongoing financial and personal support from family and friends is the only real safeguard against these outcomes.

A number of individual participants in the consultations for this report expressed distress at repeating their own or their family's tragic experiences. Some said that they had sought resolution with a wide range of authorities such as health services, complaints commissions or other state authorities but had failed to achieve any specific outcome. The general tendency of these authorities was to portray an adverse experience as an isolated occurrence within an otherwise well-functioning mental health system. However the consistency of these types of stories proved to be powerful indicators of systemic weaknesses.

In short, the available evidence suggests that persons with mental illness still struggle on a daily basis to access appropriate health care or be treated with respect or dignity when they do enter our health care systems. These same human rights concerns were raised in the Burdekin Report, 12 years ago.

Despite the slow pace of real progress since the Burdekin Report, there have been notable examples of political leadership and commitment. Successive Federal governments have continued to support a national approach to reform and Commonwealth investments have increased by 128% in the last nine years. New national organisations such as the Mental Health Council of Australia and *beyondblue: the national depression initiative* represent strong steps forward in terms of destigmatising mental health. There have also been significant reforms of the primary care sector through the *Better Outcomes in Mental Health* initiative. These are positive initiatives, but they are insufficient to address the problems identified in this report.

Given the likelihood that every family in Australia will be affected by mental health problems at some stage, it can no longer remain an isolated and marginal concern of the health care system.

There have been many 'blueprint' documents to guide mental health reform produced by governments over the past 12 years and most share common themes. This report and the stories it contains point to the substantial gaps between the aspirations expressed in these documents and the reality of Australia's mental health care system.

The findings of this report are supported by a substantial body of evidence contained in reports from parliamentary inquiries, ministerial reports, and independent assessments which point to the systemic problems with mental health care services in Australia. In our view, ad hoc reports such as *Not for Service* should be superseded by systematic annual reviews of experiences in the mental health care system. We suspect that the adverse experiences presented to us represent the tip of an iceberg of poor quality and disrupted mental health care.

It is now urgent for all governments, state, territory and national to work together and commit to a process of genuine and adequately resourced reform. In simple terms this will involve:

- a recognition by all Australian governments that mental health reform is a national priority;
- real leadership at the most senior political and bureaucratic levels to drive change through a whole-of-government response;
- real and sustained increases in the overall funding for mental health care services over the next five years to align mental health and disability burden with funding;
- an emphasis on accountability at all levels on a nationally consistent basis to ensure funding is delivered and the impacts and outcomes of the investment are available to the Australian community on a timely basis; and
- urgent and resolute action to address the looming crisis in the mental health care workforce.

RECOMMENDATIONS

The Mental Health Council of Australia and Brain and Mind Research Institute recommend:

1. Leadership and governance

a. a whole of government service model must be developed and agreed to by the Heads of Australian Governments (through the Council of Australian Governments – COAG) based on collaboration, integration, community need, accountability, flexibility and innovation;

b. that leadership for mental health reform be primarily vested in the Federal Cabinet Minister for Health;

c. that new governance arrangements be developed to ensure true collaboration between government, non-government and private sectors and the participation of consumers and carers; and

d. inter-government service agreements (such as those recently developed under COAG leadership for delivering real outcomes in Indigenous communities) should be developed to provide an improved basis for whole-of-government responses to address the issues raised in this report.

2. Policy framework

a) that a fundamental shift occur from a preoccupation with process and statutory relationships to providing services under a re-invigorated National Mental Health Strategy (NMHS);

b) that national prevalence studies to determine and monitor the extent of mental health problems and mental illness within the Australian community must be undertaken on a tri-annual basis thus enabling informed, on-going policy decision-making;

c) that national strategies and policies relating to alcohol and other drugs be reviewed and aligned to ensure they are effectively integrated with the NMHS and National Mental Health Plans (NMHP); and

d) that the NMHS and associated policy documents be reviewed and simplified to address the recommendations of this report.

3. Funding

a) that all Australian governments increase expenditure on mental health care services by 1% per annum for each of the next five years such that by 2010 expenditure will be equivalent to 12% of total health care funding in real terms;

b) that funding to NGO service providers be significantly increased from the current national average level of less than 6% to around 15% of mental health funding;

c) that a greater proportion of new funds for mental health care be allocated to special needs populations (youth, Culturally and Linguistically Diverse, rural and remote, Indigenous), early intervention and other forms of community-based assessment and care;

d) that funding to support integrated drug and alcohol and mental health services become a high priority;

e) that funding be increased for community education to raise the level of mental health literacy and overcome continuing widespread stigma;

f) that new funding be allocated to enhance the role of consumers and carers in the development and implementation of the NMHS;

g) that research funding be increased from the current level of less than 4% of health research funding to around 10% to ensure that more effective diagnostic and treatment options are available to the Australian community; and

h) that specific funds be allocated through a non-medical organisation to conduct research into effective care and improving outcomes for people with a mental illness.

4. Legal and Human Rights

a) a) that all governments work to achieve the highest attainable standard of mental health care as required by the International Covenant on Economic, Social and Cultural Rights and the Convention on the Rights of the Child and apply the UN 'Principles for the protection of persons with mental illness and the improvement of mental health care';

b) that as a matter of urgency all jurisdictions develop nationally consistent guidelines on the assessment, sentencing and provision of specialised mental health care (according to the NMHS) for mentally ill people in contact with the justice and/or detention systems; and

c) that all Australian jurisdictions provide specialised legal services, diversionary and reintegration programs for people with a mental illness in contact with in the justice and/or detention systems.

5. Workforce

a) that all governments recognise the need for urgent and resolute action to address the declining morale and chronic skills shortages now evident in the mental health care workforce;

b) that programs and additional resources to attract and retain staff in mental health care services are implemented in all jurisdictions in the forthcoming year;

c) that there be better use of and access to the psychology workforce, which is available and skilled, and can reduce pressure on other areas of the workforce;

d) that training programs to integrate the drug and alcohol and mental healthcare workforces be undertaken in all states/territories; and

e) that consumers become part of the mental health care workforce.

6. Accountability

a) that the Commonwealth Government establish an annual formal reporting mechanism (The National Mental Health Report Card) to the Prime Minister and Heads of all Australian Governments on specific key indicators;

b) that the National Mental Health Report Card include real 10-year targets for mental health outcomes as well as more intermediate outcomes and impact measures based on consumer, carer and service provider needs;

c) that responsibility for The National Mental Health Report Card be vested in an independent national office with direct access to the Prime Minister;

d) that independent monitoring of the experiences of care and the experiences of treatment should be undertaken by the Mental Health Council of Australia on an annual basis; and

e) that funding agreements at national, state, territory and area service levels be based on the principles of other successful pay-for-performance models.

STORIES OF INJUSTICE AND DESPAIR

The following are just a small sample of the stories and themes of injustice and despair that were revealed during the community consultations and in written submissions. Further stories can be found throughout this report.

Preventable deaths?

[O]ne night [my son] started hallucinating. He was on a trip with a friend in NSW…The hospital called me to let me know what had happened and I was assured he would be OK...The hospital needed to get his patient history from our normal hospital in Echuca [Victoria] but there was a delay in getting this information…The Psychiatric Consultant who examined [my son] phoned me and told me he was going to be discharged as he was only homesick. I pleaded with him not to discharge him as he was really sick and needed help…[My son] was discharged the next morning and on the drive on the way home with his friend he killed his friend because he was still sick and hallucinating. He was sent to jail and had his glasses and hearing aid removed and not returned. He was supposed to be sent to a hospital with a psychiatric ward but instead he was sent to Silver Water jail…That is where he stayed for 2 months…[He was then] moved to Long Bay Jail where he was supposed to undergo a psychiatric assessment prior to his court hearing. On the day of the assessment the doctor never turned up …and neither did the solicitor who was acting on his behalf. As such the hearing never took place and as a result he became very suicidal...I informed and pleaded with the authorities to make them aware he was sick and suicidal. They informed me he would be put in a cell with another inmate who could watch him but in fact he was placed in a single cell on Friday…and hung himself on the Friday night. I would like to know why he was failed by three government departments? How did this happen? [October 2004]

(Carer, Mother, Victoria, Footscray Forum #8)

His suicide was tragic, made all the more so because it was preventable, we believe, but for the inadequacy of the public mental health system. [X] died just two weeks after his first suicide attempt, eight days after his discharge from the Canberra Hospital psychiatric unit, two days after being refused admission to the psychiatric [unit] following a second suicide attempt, and within hours of contact with the mental health crisis team. On the day of his death, [X] had contact with the mental health system no less than three times. [Suicide occurred early in 2004]

(Anonymous, Australian Capital Territory, Submission #288)

I was amazed on one of my visits to see my mother so distressed that after two days they were sending her home to us the family to give the care she had not received in the Hospital. May I add also that this particular incident occurred after her third attempt on life. She was so frightened because she knew she was not any better…it was having a huge affect on the whole family. The answer to my question to the doctor about how many attempts would be enough. Apparently the answer to that question as found out was five. Because on the fifth occasion, at approximately 1:30pm on the 15th October 2003, my mum decided to douse herself in petrol and set herself alight.

(Carer, Son, Queensland, Submission #184)

When is a crisis a crisis?

In the past I have been told by CAT [Crisis Assessment and Treatment] team members whilst in crisis "You know more about your diagnosis than we do, Call us back if you can't get it under control". In those days control usually meant I would SM [self mutilate] so badly I would have to sew or patch myself up. How far does a person have to go to say I need help and I need it now?

(Consumer, Victoria, Submission #112)

My sister had suffered with bi polar disorder for 30 years…Sadly she took her life on 18th June 2004. On that day I was going to take her shopping but she didn't feel well. She said to me what about Psychiatric Services. But she always presented so well when they interviewed her that I knew they wouldn't take her in, so I took her home. She said she felt better just talking to me on the way over to our place. And many times over the years I would bring her home for a few days or a week to help her get over her depression. The next day I was going to be home at 2:00pm from work. That morning she took her life. What a waste of life. If only the system had a more open door policy. I wouldn't feel so guilty for leaving her that day.

(Carer, Sister, Victoria, Submission #286)

A failing community care system?

The dream of closing psychiatric institutions and moving towards community based care has turned into a nightmare. Community care is under resourced and integrated services are lacking. Too many people are denied treatment and slip through the gaps.

(ARAFMI Tasmania, Tasmania, Submission #245)

The system is chronically under-funded and under-resourced. There is a chronic shortage of psychiatric beds. Community Clinics are overworked and under-resourced. Supported accommodation options for mental health clients are severely lacking. The Psychiatric Emergency Service is viewed as a joke by clinicians and clients alike and functions as little more than a telephone advisory service.

(Clinician, Western Australia, Submission #4)

Early intervention – reality versus rhetoric?

Regarding 'involuntary intervention'; although the Mental Health System espouses 'early intervention' and carers are encouraged to practice this, the constraints surrounding 'involuntary intervention' can make 'early intervention' impossible. From personal experience, it means that intervention will not be carried out without the consumer's consent until that person is acutely unwell and a 'crisis situation' arises. Although it will then, still be without the consumer's consent, probably even more so, and will probably mean a more forceful intervention, somehow this policy is considered more humane...As ridiculous as it sounds, it means that the behaviour of the unwell person has to disturb, alarm or frighten a member of the public enough to bring it to the attention of the police or the Mental Health Service - a carer's word that the person is at risk is not enough...and we talk about reducing the stigma of mental illness.

(Carer, Mother, Victoria, Submission #178)

Where is the follow-up care?

After exhibiting psychotic behaviour my son spent 21 days (detained) in Glenside Hospital in March 2002. He was counselled and medicated then turned out into the community with some medication but no follow up care. Shortly afterwards he stopped his medication, reverted to his anti-social, aggressive and irrational behaviour, a state he has been in unchecked for two years.

(Carer, Mother, South Australia, Submission #11)

Families and carers taking the brunt?

Major service gaps are on the rise, with plans, strategies, and government promises failing to meet the needs of this vulnerable community group. This results in carers, families and the community sector, being forced to take the brunt. As a result, the community sector feels under constant pressure to respond to hopelessness, helplessness, and the despair felt among consumers / carers as they attempt to do the impossible - fill the gaps, but at what cost?

(Mental Health Foundation ACT, Australian Capital Territory, Submission #256)

I am an NGO service provider – our surplus of funding from last year was taken from us by the Government without notice. The Government just doesn't think about the implications of taking away funding from NGOs. We already have long waiting lists and taking away funding makes them even longer. One of the young consumers who was on one of our waiting lists for four months was also caring for her mum – she killed herself because she felt she couldn't cope looking after her mum anymore without some support. Waiting lists for support from us have gone up from three weeks to four months.

(NGO Service Provider, Western Australia, West Perth Forum #29)

Police - the de facto mental health service?

When I turn up there and they are in crisis, I call the Crisis Assessment Team and they tell me to call the police! I want to know why I'm standing there alone and nobody is coming to help me.

(Carer, Mother, Victoria, Footscray Forum #1)

Even though they claim to be available 24 hrs a day/7 days a week through a 1800 telephone number, they are not providing a true 24/7 service…Currently, police are finding themselves being called prematurely and often unnecessarily to assist in the management of patients who have been released into the community or who are allegedly being treated while living in the community. They are also often being asked to retrieve AWL [Absent Without Leave] patients from the community without any attempt of the mental health teams to bring the patients back to hospital using their own resources.

(Police Association of New South Wales, New South Wales, Submission #59)

Where do people live if they can't get supported accommodation?

On the 6/8/04 my son rang distressed saying he had to have somewhere permanent to live if he had a CTO [Community Treatment Order]. Apparently it was suggested to him an alternative possibility would be a backpackers hostel. He asked to live with us again…Again whilst discussing suitable accommodation my son suggested he sleep at a friend's on a couch. I told the nurse this was not an option. My son then suggested sleeping in his car, something he did for periods prior to his hospitalisation. Again I expressed the belief that this is not conducive to his mental and medical rehabilitation. I was taken aback at her suggestion that living in the car is an option, it is an alternative lifestyle that some people like. This I believe is not an option for a vulnerable person in Australia in 2004. We have seen no evidence of my son being able to function alone.

(Carer, Mother, South Australia, Submission #11)

Prisons – the new institutions for people with mental illness?

The prison system is not the place to provide care for those with a mental illness. My work and the work of others has shown that many people who end up in jail do so as a result of not being able to access a mental health service. In many cases you will find it is deemed to always be the fault of the individual if something happens. We need to know why the services are never ever held accountable for failing to provide care?

(Consumer Advocate, Victoria, Footscray Forum #9).

What progress since Burdekin?

After 30 years of social work practice I've entered many SRFs [Supported Residential Facilities] – starting in 1970s. I can confidently say that the Burdekin Report made absolutely no difference to the lives of these men & women, most of whom experience mental illness. Their level of physical & mental health is at the same disastrous level as homeless & Aboriginal people…Going into some of the Facilities today, I feel like they are in worse shape than in the 1970s when many were established at the encouragement of the government to "empty out" the back wards of the psychiatric hospitals. And talking with the managers, it's clear that they do not feel that they and their residents are receiving anywhere near an adequate service from the mental health services.

(Family Member and Service Provider, South Australia, Submission #34)

PART ONE: METHODOLOGY

It's the patients who can best tell it "as it really is" and professionals need to develop the mechanisms and the skills to listen to patients with "authentic curiosity".

(Nicolls et al 2000; Quote appears in the *Office of the Chief Psychiatrist's Clinical Review Framework* Information Card, Office of the Chief Psychiatrist (WA), November 2003)

1.1   OVERVIEW

1.1.1   Background

The drive for national mental health reform in Australia in the early 1990s had its origins in the convergent desire of consumers, families, carers and mental health professionals to see a high quality, comprehensive and responsive mental health service system. It coincided with the adoption by the United Nations of the *Principles for the Protection of People with Mental Illness and the Improvement of Mental Health Care* (UN General Assembly Resolution 46/119, 17 December 1991; United Nations, 1991), which emphasised community-based care options and respect for the basic rights of persons with mental illness.

In Australia, the *1993 Report of the National Inquiry into the Human Rights of People with Mental Illness* (Burdekin Report; Human Rights and Equal Opportunity Commission) brought many of these issues to wider public attention. It focused on violations of the human rights of people with mental illness, particularly within boarding houses and other sub-optimal forms of community care. Since that time the Human Rights and Equal Opportunity Commission (HREOC) has maintained an active interest in the experiences of persons with mental illness, with a recent focus on those who are treated within restrictive environments such as immigration detention centres. In 2004, HREOC launched its report on the adverse consequences of prolonged incarceration of children in immigration detention centres (*A last resort?*; Human Rights and Equal Opportunity Commission).

Following the release in 2003 of *'Out of Hospital, Out of Mind'* (Groom et al, 2003), the MHCA and HREOC have continued to note community concerns that basic mental health and related community services are inadequate. For example, the 3rd National Mental Health Plan (2003-08), has been criticised for failing to attend to the major community priorities that were articulated in *'Out of Hospital, Out of Mind'* (including: early intervention, management of comorbid substance abuse, increased access to a wider spectrum of acute care settings, enhancement of services in rural, regional and poorly resourced areas, genuine implementation and adherence to the national mental health standards for specialist services). In response to ongoing community criticism of experiences of care, in 2004, the MHCA and the Brain and Mind Research Institute (BMRI, University of Sydney), in association with HREOC initiated a new national review. The goal of this review was to capture the current critical themes in mental health care from the perspective of those who use or deliver its services on a daily basis.

1.1.2   Overview of methods

The primary mechanisms used to collect data for this review included:

- the convening of open community forums in each State and Territory from 05 July – 14 October 2004 (see Appendix 3.1);
- individual consultation with specific community, professional and non-government groups (see Appendix 3.1);
- a call for written submissions on 05 July 2004 with a deadline of 30 September 2004 (late submissions were accepted until January 2005) (see Appendix 3.2 and 3.3); and
- two community surveys conducted by the MHCA and BMRI over 2003-2004.

In early November 2004, the Human Rights Commissioner wrote to all State and Territory governments seeking more detailed information about the levels of community need and the effectiveness of mental health services.

A first draft of the report was provided to each State and Territory government on 24 March 2005 and to the Commonwealth government on 5 April 2005. As at 27 May 2005, all but the Northern Territory and Western Australia provided comments for inclusion in this final report (see full report for copies of the responses).

The report is based on national data collected from 2003 to 2005 and utilises a combination of qualitative and quantitative methods. Our goal was to determine the key concerns of those who have recently used primary care or specialist mental health services. Additional information was provided by health professionals, non-government organisations and other private health care providers. The nature of the partnership between the MHCA, BMRI and HREOC meant that a particular emphasis was placed on collection of data relevant to the human rights of those with mental health problems.

1.2   COMMUNITY CONSULTATIONS

The MHCA, BMRI and HREOC convened community forums open to all members of the public. Advertisements for the community forums indicated that the aims were to "investigate claims that the system has turned its back on those in need of mental health care" or that the forums were "being held as part of national research into the human rights of people affected by mental illness". Advertisements also indicated that "the results of this research will allow HREOC and the MHCA to review progress made since the 'Burdekin Report' in 1993".

Two-hour forums were scheduled over a four month period in metropolitan and regional areas across Australia (see Appendix 3.1 for a list of consultations). Special care was taken to capture the diversity of experiences and concerns of all people trying to either access or deliver services. Participants were asked to consider sharing both positive and negative experiences in all contexts, not just the health care system. However, no specific questions were set during the consultations so as to avoid pre-empting or constraining the responses and attendees were free to raise any concerns or describe their personal experiences.

The consultations were co-chaired by the Human Rights Commissioner (Dr Sev Ozdowski), HREOC and the Chairperson (Mr Keith Wilson) or CEO (Dr Grace Groom) of the MHCA. Most forums were also attended by Professor Ian Hickie from the BMRI and other representatives from MHCA member organisations. A local consumer and a carer representative were invited to participate in the leadership of the meetings. Participants were encouraged to identify themselves and the nature of their role in using or providing health or other services. At times, participants were asked to clarify or elaborate their comments by the chairperson.

The forums were attended by a broad spectrum of people including: consumers, carers, general members of the community, clinicians, advocates, service providers (e.g. mental health, general health, accommodation providers), emergency personnel (e.g. police), academics and administrators. While participants were asked to identify the perspective from which they were speaking, no names or other identifying features were recorded during the meetings. Nineteen forums were held across Australia and an approximate total number of participants at all forums was 1180 (see Appendix 3.1 for a list of forums held by State / Territory).

Additionally, individual consultations were also held with certain community, professional and non-government groups (see Appendix 3.1 for a list of meetings) to cover specific issues.

1.3 CALL FOR SUBMISSIONS

Advertisements to the forums, and information on the MHCA website, indicated that written submissions could be lodged in electronic or hardcopy format with either the MHCA or HREOC. In order to encourage people to share their personal stories, it was emphasised that anonymous submissions would also be accepted. Similar announcements were also made at the beginning and conclusion of all community forums. A total of 351 submissions were received, 109 of which were confidential (see Appendix 3.3).

1.4 ANALYSIS OF SUBMISSIONS AND INFORMATION PRESENTED AT FORUMS

Due to the broad nature of the national consultation process, submissions were received from many individuals and organisations. They covered a wide range of issues.

It was agreed by the MHCA, BMRI and HREOC, that the most useful framework for organising the vast amount of written and verbal data collected through the consultation process, was the *National Standards for Mental Health Services* (The Standards; Commonwealth Department of Health and Family Services, 1996)*.* The Standards were agreed to by all governments in 1996-97. The Standards are a useful measure by which to gauge the extent to which governments are protecting the rights of people with mental illness according to the level agreed to by all governments.

Despite the fact that evidence was not specifically sought in order to prove or disprove the successful implementation of the Standards, the volume and consistency of the information demonstrates the gaps and the difficulties governments have had in meeting these Standards. This report is careful to present the data as a cumulation of personal experiences rather than definitive proof of neglect of the Standards.

The analyses of the submissions and forums are presented in three forms. First, from a national perspective, we highlight those common themes encountered across most States and Territories (Parts 2.2, and Parts 4 and 5 of the main report). Second, we emphasise the key regional and State differences. There are important differences in State organisation of services, responsiveness to community experiences, workforce attitudes, clinical leadership and service innovation and resource investment. Third, we provide data on the key issues raised within each State or Territory (Part 6 of the main report).

Due to the personal nature of many submissions, all identifying information has been removed from the text of the report and organisational names have appeared in the text only if permission was granted. With regards to the submission list in the Appendix, unless anonymity was specifically requested, the Mental Health Council of Australia sought permission to disclose identifying information from all those who made submissions and provided contact details. If confirmation was not received, identifying information has not been disclosed and "Anonymous" has been substituted for their name(s) in the Appendix.

Some organisations chose to submit material that had been prepared recently for other national or state reviews. Several described a sense of "submission fatigue", in that they were tired of responding to inquiries without evidence that such processes actually bring about systemic change.

A number of individual participants expressed distress at repeating their own or their family's tragic experiences. Some said that they had sought resolution with a wide range of authorities such as health services complaints commissions, the coroner or other state authorities but had failed to achieve any specific outcome. The general tendency was to portray their adverse experiences as isolated occurrences within an otherwise well-functioning mental health system. However the consistency of these types of stories proved to be powerful indicators of systemic weaknesses.

Some representatives of key provider and non-government organisations were also distressed by having to repeat their assertions about system failures. They expressed concern about possible retribution against individuals, particularly when those individuals were employed by State Health services. Additionally, non-government organisations were concerned that States might withdraw their ongoing financial support for speaking out. Service providers often felt blamed by both consumers of services and by the administrators of services for failing to protect the service from complaints. Consumers, carers and service providers who brought matters of concern to public attention all felt that they were in danger of being further marginalised by their local health services. It was their view that the system as a whole lacked perspective about the potential benefits that may flow from a more open critique of the gaps and failings of the current systems.

Some individuals and organisations expressed concern about the broader impact of conducting yet another national review. They were worried that a report may attract further public attention to current service inadequacies and that this, in turn, might lead to further demoralisation of existing workforces. However, the overwhelming majority welcomed the opportunity to continue to express their concerns to independent organisations like the MHCA, BMRI and HREOC.

Another criticism of this process expressed by a small minority of persons, and most State and Territory governments, was that a process focussing on the voice of mental health consumers and carers may not adequately detect or report significant improvements in care. By contrast, many others felt that it was necessary to continue to highlight discrepancies between government descriptions of an improved health care system and everyday experiences of that same system, particularly where such groups affected have little community recognition or an active voice.

1.5   SURVEYS

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!*' (Groom et al, 2003). The report highlighted deficiencies in care and developed community priorities for further action. As these priorities were not formally recognised by governments, and as little work had been presented by the National Mental Health Strategy that focused on actual experiences of service development or direct care, two specific survey mechanisms were designed.

The first survey evaluated the extent to which the national and community priorities identified within '*Out of Hospital, Out of Mind!*' (Groom et al, 2003; Table 2, p.38), have been implemented at either the local or state level. The survey was designed to be completed by both providers and users of our mental health services. The earlier stages of the survey which dealt directly with the community's perception of the key aspects of the National Mental Health Strategy were reported back to the Commonwealth Department of Health and Ageing in 2003. Key aspects of the community's disappointment with the lack of genuine progress against set policy goals were noted in the formal evaluation by the Commonwealth of the Second National Mental Health Plan.

The second survey, which was distributed through the MHCA to appropriate consumers and carers, was commenced in 2004. It assesses direct experiences of care, using internationally-developed benchmarks for quality health care (Picker Institute Europe; http://www.pickereurope.org). This approach assumes that the widespread collection of actual experiences of care can provide an ongoing overview of key changes within health care systems (Picker Institute Europe; http://www.pickereurope.org). While many health care systems utilise critical-incident reporting mechanisms for the same purpose (or analyses of collected critical-incidents such as the 2004 NSW Health *Tracking Tragedy* Report), such limited and ad hoc review mechanisms may be quite unrepresentative of more general experiences of care. Additionally, they may completely omit more common but less disastrous instances of poor quality care or variations in care.

The first survey provides a snapshot of the views of mental health stakeholders in 2003–04 as to the degree of progress that had been achieved after a decade of national mental health reform. The second survey is ongoing and will expand to become a continuing mechanism for active review of patterns of current service delivery. This approach has been widely utilised in other areas of quality improvement in health care services (Picker Institute Europe; http://www.pickereurope.org) and has recently been extended to the mental health field.

We believe that both of these survey mechanisms have provided a unique opportunity for genuine input by the broader mental health sector. To date, such mechanisms have not been actively promoted by government. In particular, the second survey mechanism could be easily taken up by regional, state or national health authorities.

PART TWO:
KEY SUMMARIES

2.1 MENTAL HEALTH AND HUMAN RIGHTS IN AUSTRALIA

2.1.1 INTERNATIONAL HUMAN RIGHTS AND THE RIGHT TO MENTAL HEALTH CARE IN AUSTRALIA

Perhaps it is time to frame the concerns of persons with mental disability not simply as a social problem, but as a human rights imperative.

(Gostin, 2004, p. 11)

It is commonly assumed that the only relevant human rights issues for people with mental illness in Australia relate to the protection from arbitrary detention and the right to humane and dignified care when treated in institutions. However, people with mental illness have exactly the same fundamental human rights as every other person, whether they are being treated in a hospital, or in the community. For example, everyone has the right to the highest attainable standard of health and the right to an adequate standard of living. The current international and national trend towards deinstitutionalisation and community-based care brings all those other rights into sharper focus.

Today, it is clear that, at least in relation to mental health problems, equality before the law should be complemented by equity in resource distribution, fraternity needs to be understood as solidarity with people who need help, and liberty should be interpreted in the light of duties and responsibilities that all of us should accept as members of societies that strive to be civic.

(Sartorius, 2002, p. 13)

The movement to consider the experiences of people with a mental illness within a human rights framework has gained momentum internationally. All countries struggle with the stigma and discrimination associated with mental illness and the negative personal, social and economic outcomes that arise due to inadequate health and social services. There is acknowledgement that human rights violations against the mentally ill are widespread, occurring both within and outside the delivery of health care (World Health Organization Europe, 2004). While many countries have attempted to tackle such violations by enacting legislation to protect such rights, some have argued that these measures have often failed to protect the rights of people with mental illness due to popular or political pressure (Gostin & Gable, 2004).

The shameful history of benign and sometimes malignant neglect of persons with mental disabilities is well understood: the deep stigma and unredressed discrimination, the deplorable living conditions, and the physical and social barriers preventing their integration and full participation in society. Countless promises have been made to right the wrongs, but new forms of neglect have always emerged. The mentally disabled have ended up in prison, in equally deplorable adult homes, or on the streets, homeless and destitute, while the wider society has averted its eyes.

(Gostin, 2004, p. 11)

Human rights jurisprudence involving involuntary detention, conditions of confinement, civil rights and access to mental health services has been growing in Europe and the Americas (Gostin & Gable, 2004). With regards to improving access to quality mental health care, WHO Europe suggests that legislation "can make a difference in ensuring parity with other health services and ensuring that what is provided is appropriate to people's needs" (WHO Europe 2004, p. 2). However, legislation is not of itself a guarantee against human rights violations (WHO Europe, 2004).

2.1.1.1 International human rights and the right to mental health care in Australia

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

(Universal Declaration of Human Rights, Article 25(1))

Providing the best possible health care is not just a desirable social goal, it is a fundamental human right and it applies to all people no matter who they are or what their illness. Associated with the concept of a 'right to health' is a growing body of international law of a 'right to health services' requiring 'nation states to take affirmative steps to assure that residents of the country have access to population-based health protection measures and also affordable health care in the context of the nation's economic resources and cultural mores' (Kinney, 2001, p. 1458). The international human right to health is established both via international treaties and a growing body of international customary law (Kinney, 2001). There is growing recognition that international human rights law is a powerful means by which to advance the rights and interests of people with mental illness (Gostin & Gable, 2004; Quinn & Degener, 2002; Kinney, 2001).

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

(International Covenant on Economic Social and Cultural Rights, Article 12)

Australia is a party to the International Covenant on Economic, Social and Cultural Rights (ICESCR; United Nations 1966a), the International Covenant on Civil and Political Rights (ICCPR; United Nations 1966), and the Convention on the Rights of the Child (CRC; United Nations 1989). Australia is therefore bound under international law to ensure that all people in Australia enjoy the following rights, amongst others:

- The right to the highest attainable standard of physical and mental health (Article 12 ICESCR; Article 24 CRC).
- The right to an adequate standard of living including food, clothing and housing (Article 11 ICESCR; Article 27 CRC).
- The right of children to an environment that fosters the health, self-respect and dignity of a children where they are in need of psychological recovery from neglect, exploitation, torture or trauma (Article 39 CRC).
- Where children have been placed under mental health programs they have the right to periodic review (Article 25 CRC) .
- The right of children with disabilities to access appropriate health and rehabilitation services (Article 23 CRC).
- The right to life (Article 6 ICCPR; Article 6 CRC).
- The right to freedom from cruel, inhuman or degrading treatment (Article 7 ICCPR; Article 37 CRC).
- The right to liberty and security of person (Article 9 ICCPR; Article 37 CRC).
- The right to be treated with respect for dignity and with humanity when deprived of liberty (Article 10 ICCPR; Article 37 CRC).
- The right to freedom of movement and choice of residence (Article 12 ICCPR).
- The right to freedom of interference with privacy or family life (Article 17 ICCPR; Articles 9 and 16 CRC).

In addition to the fundamental human rights enshrined in the International Covenants, there are specific UN Principles that deal with some of the particular issues facing people with mental illness.

The *UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* (the UN Mental Health Principles; United Nations General Assembly, 1991) were adopted by the United Nations in 1991. While it is not a binding instrument in itself, the Commonwealth, State and Territory governments have recognised the value of incorporating those principles into policy, and attempted to do so in the First National Mental Health Strategy.

The UN Mental Health Principles reinforce the rights enshrined in the International Covenants and provide valuable guidance as to how those rights ought to apply to people with mental illness. For example Principle 8(1) makes clear that people with mental illness have the right to the same standard of health care as other ill persons and Principle 14 states that mental health facilities should have the same level of resources as any other health facility. Additionally, Principle 7 emphasises the right to be treated and cared for as far as possible in the community and Principle 9 emphasises the importance of 'the least restrictive' alternative in relation to treatment. The Burdekin Report treated the UN Mental Health Principles as a benchmark in determining whether or not the rights of people with mental illness were being protected (Burdekin Report; Human Rights and Equal Opportunity Commission, 1993, p31).

2.1.1.2 Recent international developments

The Council of Europe, comprising 45 member states, recently drafted a comprehensive set of recommendations to protect the rights of people with mental illness and to promote higher standards of care (Kingdon et al. 2004). The recommendations cover a wide range of areas including:

- the right to non-discrimination and mental health promotion;
- the right to be accommodated in appropriate environmental and living conditions while receiving treatment and support;
- the right to live and work in the community;
- limitations on the use of seclusion and restraint options of people needing treatment;
- criteria and procedures for involuntary placement and treatment;
- the right to individualised treatment;
- the right to treatment in the least restrictive environment;
- guidelines for the involvement of police (who should also receive appropriate training to respond appropriately), the courts and the prison system in the context of mentally ill persons; and
- guidelines for the treatment of 'minors'.

In reforming systems to protect the rights of the mentally ill, the Council for Europe also emphasises the fundamental need for monitoring quality standards in the provision of mental health services (Kingdon et al. 2004).

In the context of the general trend towards deinstitutionalisation and the growing rate of homelessness, incarceration of people with mental illness and community fears of danger, recommendations from the Council of Europe also emphasise the need for vigilance to ensure that involuntary orders are made 'for therapeutic purposes' and not solely for the purposes of removing the person from the community:

> *Involuntary placement should include therapeutic purpose. The mental health system therefore should not be used for custodial reasons alone, even when there is significant risk of serious harm to others. Where such potential for harm exists but no therapeutic intervention is indicated, this is a matter for the criminal justice system.*

> (Kingdon, Jones & Lönnqvist, 2004, p. 277)

The World Health Organisation (WHO) (Project on Mental Health and Human Rights; WHO 2005a) is also currently preparing a mental health legislation manual to assist countries to develop a legal framework to protect the rights of people with mental illness both within the health delivery context and in the broader community. Specifically, within health service delivery environments, WHO "frames the right to mental health in terms of population-based services and would require that countries offer screening for mental illnesses, mental health education, and psychiatric services" (Gostin, 2004). On a broader level, WHO argues that while mental health legislation is not sufficient to address the rights of the mentally ill, it is an essential complement to mental health policy and provides the legal framework with which to meet its aims and that it is an evolving process:

> *Mental health legislation can provide a legal framework for addressing critical issues such as the community integration of persons with mental disorders, the provision of care of high quality, the improvement of access to care, the protection of civil rights and the protection and promotion of rights in other critical areas such as housing, education and employment. Legislation can also play an important role in promoting mental health and preventing mental disorders. Mental health legislation is thus more than care and treatment legislation that is narrowly limited to the provision of treatment in institution-based health services.*
>
> (World Health Organisation, 2003, p. 2)

In 2002, the United Nations Human Rights Commission appointed a Special Rapporteur on the Right to Health. The Special Rapporteur has the mandate to collect information on the realisation of the right to the highest attainable standard of physical and mental health and make recommendations on how to ensure compliance with that right (http://www.ohchr.org/english/issues/health/right/index.htm).

2.1.2   A SUMMARY OF CHANGES IN AUSTRALIAN POLICY AND PRACTICE SINCE THE BURDEKIN REPORT

> *Little since the Burdekin Report has changed save that the process of deinstitutionalisation has hastened. While patients who are involuntarily detained now possess a number of enshrined rights that regulate the circumstances of their detention, increasing numbers of still psychotic patients are discharged under pressure for hospital beds. Problems continue to exist with the coverage of disability discrimination legislation. No appreciable increases in resources has been allocated for the escalating numbers of significantly symptomatic patients cared for within the community. In such circumstances, there is a real limit upon the extent to which it can be said that those with mental illness have rights to treatment and, in particular, to adequate treatment. A real issue within mental health law, as increasingly it is in within the wider area of law, is how patients can insist, with the assistance of the law, upon being provided with the treatment that they need for the alleviation of their pain and suffering.*
>
> (Freckelton & Loff, 1998, 267 at p. 285)

> *While the aims of the Second [National Mental Health] Plan have been an appropriate guide to change, what has been lacking is effective implementation. The failures have not been due to lack of clear and appropriate directions, but rather to failures in investment and commitment.*
>
> (Steering Committee for the Evaluation of the Second National Mental Health Plan 1998-2003, 2003, p. 3)

The neglect of mental health services in our society has a long and well-documented history. The personal and family consequences of decades of neglect were highlighted for the whole nation by the widespread publicity given to the 1993 National Inquiry into the Human Rights of People with Mental Illness (The Burdekin Report; Human Rights and Equal Opportunity Commission, 1993). In response to growing criticism regarding the quality of mental health services in the early 1990s, state, territory and federal governments attempted to enshrine human rights protection into mental health care policies.

The first of these attempts was in 1992, when all Australian State and Territory governments, as well as the Commonwealth Government, agreed to develop a common National Mental Health Policy and Strategy. This gave birth to the first National Mental Health Plan which covered the five-year period from 1993 to 1998. The Plan demonstrated a commitment to a human rights based approach to the reform of mental health care in Australia. Specifically, in 1992 all State and Territory governments agreed to develop legislation by 1998 that was consistent with the UN Mental Health Principles (Rees 2003, p. 33).

In 1996 the Attorney-General's Department developed a 'Rights Analysis Instrument' to measure compliance of State and Territory legislation with the UN Mental Health Principles (Watchirs & Heesom 1996). A review of mental health policies against that instrument found that the legislation did comply or that the Governments were in the process of appropriately amending their mental health legislation (Watchirs 2000).

Despite these advances, by 1998, when the Second National Mental Health Plan was developed, all reference to human rights had disappeared (Rees 2003, p. 34).

There has been some criticism of the effectiveness of the Rights Analysis Instrument as a measuring tool (Rees, 2003; Carney, 2003; Freckleton & Loff 1998). On the basis of the results of the Rights Analysis Instrument review, some commentators suggest that mental health legislation in all Australian States and Territories is now consistent with the UN Mental Health Principles (Whiteford & Buckingham, 2005; Whiteford et al. 2000; see also Rees, 2003). However, the stories related by consumers and practitioners during these consultations suggest that either the legislation is not yet consistent with the UN Mental Health Principles or that the legislation has not been effective in protecting consumers and carers against abuses.

In a recent critique of the capacity of mental health law and policy to respond to current and future challenges of community based care, Carney (2003) argues that while Australian legislation and policies may pass human rights scrutiny in principle, there is insufficient focus on the monitoring processes to ensure implementation and adherence to those measures (Carney, 2003, p. 12).

Since the Burdekin Report, there has been a more rapid move towards deinstitutionalisation and concurrently the rights of those who are still institutionalised seem to be better protected. However, the recent community consultations, and writings of academics, clearly suggest that it would be incorrect to assume that those advances have solved the multiple rights issues facing the mentally ill. While there is a lot to be said for preferring community treatment over institutional treatment, we cannot assume that community treatment is actually being effectively delivered. Just releasing mentally ill men, women and children into the community without appropriate supports is not an adequate reaction to the problems arising from institutionalisation.

In addition to the problems associated with institutionalisation in the early 1990's, the Burdekin Report dealt with some of the deficiencies in community care. The stories heard during these consultations suggest that little has changed since then, other than the fact that there are increasing numbers of persons relying on that community care.

> [A]nyone working within the public system today in any part of Australia or New Zealand (as well as in most Western countries) will be acutely aware of a range of problems in the post-deinstitutionalisation environment. Particular difficulties include the challenge of accessing inpatient care even in crisis situations; the heavy emphasis on pharmacological management of serious mental illnesses, generic case management leading to professional de-skilling, extensive use (over-use?) of compulsory treatment orders in the community; and inadequate resources allocation and staffing of mental health services. The result is arguably a sub-standard system of semi-institutionalisation within the community that lacks many of the best features of the old system. There cannot be said to be a true asylum for those with mental illnesses that need one. There is limited

availability of effective multidisciplinary approaches to treatment, especially for those with comorbidities. It is dubious whether there can accurately be said to be appropriate protection from harm to self and others for people suffering acute effects of their mental illness. Stigma and lack of community understanding and support leave many suffers of mental health problems with poor quality of life, inadequate community supports, and reduced functionality and capacity to contribute to and enjoy life and work.

(Freckelton & Lesser, 2003, p. v)

Further, ten years after the first National Mental Health Plan, the key reviews of the outcomes (as opposed to the written policies) by government, independent authorities and non-government bodies suggest ongoing problems in accessing appropriate care.

…the clear message from the community is that people continue to experience problems in accessing services during crises and finding services that are responsive to their individual needs.

(Christopher Pyne, Parliamentary Secretary to the Minster for Health and Ageing, Foreword, National Mental Health Report 2004; Commonwealth Department of Health and Ageing, 2005)

The stories told during these consultations and surveys by mentally ill persons and their families suggest a pattern of continuing neglect. It seems that, even where there has been good policy or law, the policy has not been translated into reliable, high quality health care. Genuine empowerment of persons with illness and their families does not seem to have occurred at a local, regional or state level. The quality of life of those living with enduring illnesses in the community appears to be continually compromised by discontinuities of care, stigmatising community attitudes and overt and covert discriminatory practices in employment, education and social welfare.

State and territory governments have once again declared their commitment to continued reform. In the last 18 months most Health Ministers have recognised the long-standing neglect. However, while stand-out programs can be identified, there is no clear evidence of a systemic commitment to improved access to quality care. In fact, these consultations and other reviews of the mental health system suggest that we now have reached a point of serious and systemic neglect. Some governments have argued that they cannot keep up with increased demand and high expectations of good quality services.

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. The mental health service system is now faced with a different set of challenges, arising from both the new demands of community service delivery and growing awareness of the need for mental health care.

(National Mental Health Report 2004; Commonwealth Department of Health and Ageing, 2005, p. 30)

However, governments have been fully aware of the major gaps in services since at least the early 1990s. They agreed collectively in 1993, 1998 and 2003 (when each five-year mental health plan came into being) to correct basic system failures. Ignorance of the nature and the extent of the problem can no longer be used as an explanation.

It is apparent that the priority placed on resources for mental health has been decreasing, rather than increasing. Total health expenditure has increased rapidly over the last decade with Australian national health spending reaching 9.5% of GDP in 2003 ($72.2 billion, up from 8.4% in 1995-96). However, as a proportion of this expenditure, total mental health spending (excluding aged care), has remained static at less than 7% of recurrent funding (National Mental health Report 2004; Commonwealth Department of Health and Ageing, 2005).

...current funding levels in all states and territories may not be enough to meet priority community needs.
(National Mental Health Report 2004; Commonwealth Department of Health and Ageing, 2005, p. 18)

There is a fundamental inequity in health care expenditure allocation in Australia (Hickie et al. 2004). Generally speaking, expenditure on chronic or recurring illnesses like respiratory, nervous system and musculoskeletal diseases is greater than expenditure on health issues that create shorter term crises like cancer, cardiovascular episodes or accidents. The exception in this trend is expenditure on mental health. In other words, unlike the situation of those with physical illnesses, expenditure on our mental health care services does not meet the needs of the recurrent or chronically-disabling disorders that most people with a mental illness suffer. Rather the services cater to short-term and limited care.

The question of whether the existing service configuration is appropriate to meet the demand for services, or whether a different service configuration is required, remains fundamental.
(National Mental Health Report 2004; Commonwealth Department of Health and Ageing, 2005, p. 31)

These inequities in resource allocation and the failure to develop innovative and comprehensive services have major health and social consequences for those with mental illness and the wider community. For example, when persons who are ill cannot access appropriate health care they are more likely to become unemployed, homeless or enter into the criminal justice system.

Multiple and disjointed short-term solutions have been attempted over the last decade. Currently, the states and territories focus largely on improvements in the acute care and forensic areas with specific responses. However, without recognition that systemic inequities in resource allocation and service development exist, Australia is unlikely to develop the more comprehensive system of community-based care that offers the best chance of a high quality of life and protection of the basic rights for those persons whose lives are disrupted by mental illness.

2.1.3   HUMAN RIGHTS AND THE NATIONAL STANDARDS FOR MENTAL HEALTH SERVICES

Throughout this report, we have attempted to align the key themes expressed in the public meetings, individual consultations and written submissions with the National Standards for Mental Health Services that were agreed by all governments in the mid 1990s (Commonwealth Department of Health and Family Services, 1996).

While these standards are not a direct replica of the UN Mental Health Principles, they do reflect a basic commitment to provide services that respect individual human rights and equitable access to high quality mental health services.

The National Standards for Mental Health Services underpin a nationwide movement to implement appropriate community-based services and reflect our national commitment to provide 'the highest attainable standard' of mental health care as required by ICESCR and the Convention on the Rights of the Child. As such, any genuine improvement in the provision of mental health services can be measured against these standards, and current failures in provision of services or respect for individual human rights amongst persons with mental illness are best understood against this background.

2.2 KEY THEMES FROM NATIONAL CONSULTATIONS AND WRITTEN SUBMISSIONS

The great majority of written and verbal submissions focused on deficits in key aspects of mental health care services. While a wider range of community and other welfare, housing and custodial services were the subject of individual or group submissions, the fundamental lack of access and failings in the access to quality health services available to persons with mental illness dominated the discourse. The contrast between experiences of care when presenting with a physical illness as compared to presenting with a mental illness was profound. A lack of respect for persons with mental illness or their families was commonly reported. The combination of a lack of respect, poor resources and inadequate facilities appeared to underpin the numerous reports of reduced safety within mental health care services. Pleas for the provision of basic care with dignity were almost universal.

A fundamental difference in perspective was evident between those who used services at a local or district level and those who administered services. Those who use services have grown tired and frustrated by presenting their individual stories to a long line of independent national or state-based reviews and inquiries. They feel exploited by the process and repeatedly traumatised. Many are frankly cynical about the process and do not feel that reporting their experiences now is likely to result in genuine government or professional responses. Nevertheless they did share their experiences with us.

Consumers and their family and carers prioritised a number of fundamental aspects of health care and related services – and these were generally consistent with other independent notions of quality of health care services (see Picker Institute Europe (http://www.pickereurope.org). These included:

i) access to professional care, particularly in emergency and other acute care settings;
ii) treatment with dignity and concern for the individual irrespective of location of care;
iii) prioritisation of safe and high quality services;
iv) an emphasis on clinical care, rather than 'containment' of those with mental disorders;
v) earliest possible access to professional care in acute and non-acute circumstances;
vi) response to individual needs, including recognition of the complexity of comorbid substance abuse, personality dysfunction or socio-economic deprivation;
vii) coordination of health, welfare and related community support services;
viii) access to programs and support to live independently and work;
ix) respect for the legitimate interests of family and carers in accessing care and participation in ongoing treatment decisions;
x) support for those who provide direct clinical services;
xi) provision of appropriate community housing options; and
xii) access to appropriate medical as well as psychological services.

After 4 January 2002 when our daughter had been transferred from the MHU [Mental Health Unit] into medical ward 2East, she was immediately treated by the staff as a whole person with dignity, respect, compassion and empathy. We observed that the medical ward staff was a professional caring team at all times, even when our daughter was a handful. They accepted the challenge with care, diligence, resourcefulness and a great team effort which achieved a great result in a short time in comparison with the five weeks that our daughter was in the MHU where she deteriorated badly. As parents, we are grateful for the clear concise and accurate information the medical ward team offered us, keeping us informed and assured that our daughter's medical treatment was on-track.

(Carers, Parents, New South Wales, Submission #106)

I have to wonder if it were a serious physical illness or aliment if medical personnel would allow an individual to go unmediated for such a long period of time.

(Anonymous, Queensland, Submission #82)

People with mental illness are not receiving the same care as those with physical illnesses. There is inequity in funding for mental health projects.

(St Bartholomew's House Inc, Western Australia, Submission #37)

In Esperance we have had no psychiatrist for 5 months. If consumers need acute care they have to be taken to a GP and then tranquilised and strapped to stretcher to be transported to Perth. I was told when I was suicidal, to drive myself to the city.

(Consumer, Western Australia, Perth Forum #45)

Why on earth are consumers who are exhibiting signs of a relapse not taken seriously? Why is it that the consumer needs to be either psychotic, suicidal, or in some other emergency before they are seen and treated?

(Carer, Husband, Western Australia, Submission #146)

We need a clinic we can walk into just like a 24 hr clinic you would attend for the flu. Why can't we have it? Why do I need to self harm myself to receive relief? Why do I need to overdose to receive attention? Do I and many, many more need to die before we attend to what we preach that mental illness is like a physical illness?

(Consumer, Victoria, Submission #202)

Although St Bartholomew's House continues to try and provide a quality service in supported accommodation (SAAP), the lack of resources, a staff ratio of 1:54, poor education of staff and the numbers of people requiring care limits the capacity to delivering safe quality care.

(St Bartholomew's House, Western Australia, Submission #37)

Our son had done no wrong and as a mentally ill person deserved to be treated with dignity, care and understanding not to be confronted by police.

(Carer, Father, Western Australia, Submission #175)

I had an incident a while ago when I went to hospital in Bunbury, I was put aside (waited) a couple of hours – I wanted to go home but the hospital wouldn't let me go. I finally went home and a few hours later the police came to take me back to the hospital. I went willingly and saw the doctor who said I needed an injection. I was threatened that the police would hold me down while I had the injection so I agreed to have it. After they injected me I was taken to Graylands Hospital in Perth but nobody informed my family of my admission to Graylands.

(Consumer, Western Australia, Bunbury Forum #1)

For me this is not strong language, during the ten years I have been a carer of a severely physically disabled mentally ill person, I feel I have been treated less then human, and the person I care for, as well as others with disabilities, looked upon as worthless citizens who the governments wished didn't exist. Our loved ones are offered inferior care, if care is what it can be called.

(Carer, Husband, Northern Territory, Submission #68)

When a patient needs assistance, the Ambulance usually will not transport and the caller is directed to phone the police. Police will transport the client to the hospital in the back of a police wagon. This is a very degrading experience!

(Supported Accommodation Service Provider, Northern Territory, Submission #217)

Because intervention comes so late, consumers and families report that once the police are involved and no matter how the police are, there is still a sense of not being treated with dignity. One consumer explained the situation: "I know when I get sick that I quickly lose insight and will resist treatment but I am sick and there I am being handcuffed by police. No other groups of people with an illness are treated like this. Why are we? Surely there can be a better way. I think it starts with me being able to say, I'm becoming unwell and clinicians taking me seriously."

(Mental Health Community Coalition Consumer and Carer Caucus, Australian Capital Territory, Submission #342)

By contrast, those who planned or administered services were perceived by consumers, carers and clinicians (evidenced by presentations at forums and in written submissions) to be preoccupied by:

i)   the location of care services rather than the actual provision of care;
ii)   the cost-efficiency of different models of care;
iii)   managing down rather than responding to the increased demand for better quality services;
iv)   avoiding direct accountability for specific service failures and failures to invest in new services;
v)   planning without consultation with staff, services, consumers and carers;
vi)   negating an emphasis on enhanced community care in favour of acute and custodial care; and,
vii)   rejecting legitimate critiques of the current systems of acute and community care.

Staff confidence in senior management involved in the redevelopment is at an all time low due to their refusal to listen to grass roots workers, consumers and carers. Front line continue to be pressured to provide more with less, services are fragmented, Staff are burning out, and positions are vacant for long periods due to the appalling pressure and conditions.

(Anonymous, Tasmania, Submission #254)

Despite the successes in making the changes outlined in the chapter on 'Changes Made' there are still unacceptable practices to be addressed. The outcomes though commendable do not represent 'best practice' or indeed in many cases even 'good practice'.

(Eamon Shanley, Professor of Mental Health Nursing, Western Australia, Submission #33)

Those who are conscious of the practical and economic problems in providing care to over half the population at some point and up to a quarter within a 12 month period, have argued that a diagnosis should be associated with substantial functional disability before treatment should be funded and accessed (Regier et al 1998, Spitzer et al 1998). This is superficially attractive, however it means that people are required to become functionally disabled by their symptoms before they can be offered help. Such disability is usually hard to reverse even when treatment is effective…Restricting access in this way is antithetical to preventive and early intervention approaches, would be completely unacceptable in general medical care where people with mild disorders, such as a viral illness, can gain ready access, and may prevent the most cost-effective phase of serious illness from being treated. Mild disorders should be able to access treatment of some kind for all these reasons (Kessler 2003).

(Patrick McGorry, Professor of Psychiatry, Victoria, Submission #180)

Deinstitutionalisation has not failed. What has failed is the political will to fund essential support services in the community. The existing services are overwhelmed by the heavy demand they currently face and they are not able to provide the level of care and support required to assist recovery. This lack of support options dramatically increases the hardships faced by people who have a mental illness and their families, in terms of their health and their budgets. Ultimately, it is a failure of systems which is making people sick and forcing them into the costly acute care sector.

(Anglicare Tasmania, 'Thin Ice: Living with Serious Mental Illness and Poverty in Tasmania', Tasmania Submission #144)

There is an increasing number of people accessing mental health services which dilutes the quality of existing services – so with the quality of existing services being poor already you can see we are heading for a disaster.

(Clinician, Victoria, Morwell Forum #4)

The ability of Mental Health Services to deliver quality care has been severely restricted by continual budget cuts and the lack of funding to community services.

(Anonymous, Tasmania, Submission #254)

I would like to know why mental health funding is dominated by the medical model when funding could be better used to develop mechanisms to provide assistance for when people are well. We need to give people an opportunity of a life worth living. In the ACT less than 5% of the funding for health goes into social programs to help people do what they want to do with their lives. People's expectations are so low…The medical model is about risk management. We neglect people when we leave them out to rot – in front of a TV all day! I lost all my social skills – I see so many of my fellow consumers who can't do this because they have been dominated by the medical model. People go into self-medication with pills and drugs – we are now the dominant group in the criminal justice system. We need case workers who have no more than 8-10 clients and who can give due attention to people's long-term needs.

(Consumer and Consumer Activist, Victoria, Footscray Forum #3)

I feel the inpatient unit in Bunbury provides a second-rate service to the mentally ill in the region as it does not provide a multi-disciplinary team. The Therapy Department went from 4 Full Time Employees, providing a day-service to clients for six-weeks intensive therapy to prevent hospital admissions, to now only 1.5 FTE, providing only an abbreviated day program to the current inpatients. The therapy department is now housed in the nursing station of the High Dependency Unit, due to the Community Staff moving into their space when they lost their premises. The patients have lost their group room, which now houses community staff, desks and computers. The whole APU is an overcrowded situation with the community staff moving into the small premises.

(Clinician, Western Australia, Submission #55)

We found that the therapeutic situation in the MHU [Mental Health Unit] is unacceptable in its overall treatment of people with mental illness…We found that the management of the MHU raises issues of delinquency or malpractice, whether by inadvertence, incompetence or deliberation. We observed the MHU staff working under considerable pressure, their services being under-resourced and their numbers inadequate for their patients' safety. We are hesitant to single out particular staff, but we believe that individually it is their responsibility to practice appropriate duty of care and nursing similar to that demanded in hospital medical wards.

(Carers, Parents, New South Wales, Submission #106)

On a personal level, working in the APU [Acute Psychiatric Unit] provides a lot of anxiety for me at times. I feel there is no commitment by the hospital to provide a high standard of care for the mentally ill, funding is lacking, and the issue of safety, being an expensive one, does not hold high priority for the hospital or the current government.

(Clinician, Western Australia, Submission #55)

A constant catch-cry in feedback is the lack of community services. Failure to provide adequate community services perpetuates a revolving door outcome for the acute sector. There are numerous studies which demonstrate that well-structured community and support services are cost-saving to the health system in the long term.

(Mental Illness Fellowship of Australia, National, Submission #331)

What is needed are PROPERLY RESOURCED community based services which provide social and emotional supports, peer support and advocacy - which return to people their humanity, their dignity, their self-respect. (author's emphasis)

(Consumer Advocate, NSW Submission #153)

Only a fraction even of the most seriously mentally ill can gain secure tenure in this system. So even with a system heavily targeted to chronic schizophrenia, only a minority even of these cases gain appropriate coverage. The rest are referred back to unsupported GP's after the latest patch-up job otherwise called "episode of care".

(Patrick McGorry, Professor of Psychiatry, Victoria, Submission #180)

Just because it is becoming more common to relocate such community-based services in Emergency Departments and elsewhere on acute hospital sites, doesn't imply that this is the most effective deployment at all. This retreat to a "fortress" hospital mentality is ostensibly due to administrative staff OH&S concerns. However it is really due to Health Executives' "land hunger", plus the perceived need to make shortsighted attempts to assuage general hospital clinical pressures, eclipsing the real need for community based services which prioritise the best possible outcomes for service users and their families.

(Clinician, New South Wales, Submission #351)

There is a good reason for us to have a better community focus. Services at the moment are focused internally which is located in the hospital. To the Broken Hill people it may seem like just another hospital service.

(Clinician, New South Wales, Broken Hill Forum #9)

2.2.1 THEMES RELATING TO THE NATIONAL GOVERNMENT, NATIONAL MENTAL HEALTH STRATEGY AND NATIONAL RECOMMENDATIONS

The National Mental Health Strategy was developed over a decade ago to respond to obvious service failures and human rights concerns. An analysis of the current manifestations of that Strategy, namely the 2004 National Mental Health Report and the 2003-2008 Third National Mental Health Plan, suggest 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.

Submissions and presentations at forums make it clear that neither those who use nor those who provide services have any faith in the continuation of the current national processes. The submissions suggest that key issues such as: national implementation of early intervention strategies; coordination of national alcohol, drug, mental health and suicide prevention strategies; implementation and ongoing review of national mental health standards; enhanced access to public and private sector mental health services (particularly for those who live in rural and regional areas); introduction of national measures of quality and safety; improved clinical care for the aged; support for innovation, research and sustainable new systems; and prioritisation of supported employment and rehabilitation services will not be realised by the current governments employing conventional bureaucratic processes.

Submissions and presentations at forums highlighted issues which need specific attention at the national level. These included:

i)   poor access to psychiatrists, particularly outside major metropolitan centres;
ii)   poor access to psychologists, due to general lack of government or private insurance rebates;
iii)   lack of appropriate workplace-based rehabilitation and recovery programs;
iv)   declines in bulk-billing among general practitioners and psychiatrists over the past decade resulting in greater out-of-pocket expenses;

v)   difficulties in accessing private health insurance cover;

vi)   limited access to new medications in outpatient settings, especially restrictions on the provision of PBS scripts;

vii)   major difficulties in personal dealings with Centrelink and other Federal welfare and support agencies; and

viii)   major difficulties with restricted access to the Disability Support Pension (DSP), Carer Allowance or other related welfare and health benefits.

The Burdekin report stated that "restriction to access to psychologists results in important treatment options being denied to many individuals affected by mental illness and that the lack of access is incompatible with human rights and is economically unsound". It seems immoral that in 2004 clinical psychologists are not routinely available to people suffering mental disorders.

(ARAFMI Tasmania, Tasmania, Submission #245)

There's only a visiting psychiatrist for this area. They come one day a week. We need more access than that. But then the problem in Adelaide if you can get up there is that there's very little bulk billing psychiatrists in Adelaide. Earlier in the year I was told that I needed a psychiatrist but I couldn't find one that was bulk billing that was taking new patients. There's not even a social worker here now, no OT now, no psychologists after several years. It's all left to the mental health nurses who are expected to carry the load.

(Consumer, South Australia, Murray Bridge Forum #2)

There are no services available for the 25 to 55-year age range beyond employment programs, whose existence and quality are inconsistent across the region.

(Anonymous, Northern Territory, Submission #271)

Consumers in the community are left dry. They are put out into their flat and that's the end of it. The services we have are good but they lack staff resources and skill development. Some consumers are never given the opportunity to have rehabilitation.

(Carer, Mother, Northern Territory, Alice Springs Forum #13)

There is no supported employment program that meets the criteria of best overseas practice. My son would dearly love to work part-time, but in a field in which he has experience.

(Mental Health Community Coalition Consumer and Carer Caucus, Australian Capital Territory, Submission #342)

Australia is poorly served with employment programs for people with a mental illness and associated psychiatric disability. Traditional vocational rehabilitation services are far less effective than supported employment. As an example successful employment programs Trieste in northern Italy report an employment rate of 60% of people with schizophrenia whereas in Australia over 75% of people with schizophrenia are not working and on a disability pension.

(Mental Illness Fellowship of Australia, National, Submission #331)

People experiencing mental illness as well as their families frequently experience financial problems. For the people with the illness themselves, the longer they are sick or the more episodes they experience the more likely it is that their only income is Centrelink payments. It is very difficult to subsist on Centrelink payments. A Centrelink payment barely covers board or rent and people are often left with little for food, transport, clothing and other necessities. People with mental illness frequently have difficulty in affording health care and medications as well.

(Mental Health Community Coalition Consumer and Carer Caucus, Australian Capital Territory, Submission #342)

The following issues are of grave concern to us…A significant number of same-day hospital based psychiatry services require a co-payment to be met by the consumer, as the full cover of the services are not met by certain levels of cover offered by private health insurance funds. This effectively limits access to those services. If these co-payments increase, then some consumers will have to consider the option of dropping their private health insurance cover thus placing more strain on the public system.

(The National Network for Private Psychiatric Sector Consumers and Carers, National, Submission #225)

The following issues are of grave concern to us…The new atypical anti-psychotic medications should be available to consumers who suffer a mental illness, apart from schizophrenia. There is strong evidence that these medications can be used in low doses to very usefully to treat other disorders, particularly mood disorders. Currently, psychiatrists working in the public hospital system are able to prescribe these medications for disorders other than schizophrenia. However, psychiatrists in private practice are not, which effectively prohibits them from providing evidence-based best practice for many of their patients.

(The National Network for Private Psychiatric Sector Consumers and Carers, National, Submission #225)

2.2.2 KEY NATIONAL THEMES THAT EMERGE FROM REVIEW OF THE SERVICE ENVIRONMENTS WITHIN EACH OF THE STATES AND TERRITORIES

Review of the services within each State and Territory highlighted many common themes that fall within the responsibility of State and Territory governments. These included:

i) the scramble for acute care beds within each State;
ii) restriction of access to acute care by exclusion on the basis of diagnosis (e.g. personality disorder, drug-related mental health problem) rather than clinical need;
iii) premature discharge of unwell persons who remain at risk from inpatient and other acute care facilities;
iv) difficulties accessing professional care during onset and to prevent deterioration of illness;
v) lack of access to medium or long-term care facilities, institutionally or community-based;
vi) lack of coordinated and genuine youth-based or early intervention services;
vii) lack of rehabilitation or recovery services;
viii) poor state of forensic mental health services;
ix) poor and dangerous processes for transfer of mental health patients to clinical facilities;
x) inappropriate use of 'privacy' and 'confidentiality' considerations to exclude families and carers from treatment planning;
xi) lack of support for local clinical governance models, service innovation and local community partnerships;
xii) over-reliance on crude service access or risk checklists, service protocols and other arbitrary non-clinical tools to regulate local service characteristics; and
xiii) lack of genuine and transparent data mechanisms pertaining to assessment of ongoing safety and quality of services.

I work with young people aged 13-18 years, but this is getting pushed out to work with people as old as 25. I provided 24 hour support to a 21 year old recently who couldn't get care anywhere.

(Service Provider, Australian Capital Territory, Canberra Forum #20)

Parents have difficulty accessing limited child psychiatrists and psychologists for their disturbed youngsters. Adult facilities are inappropriate, overburdened and inaccessible. Early intervention and accurate diagnosis, stressed as priorities in the National Mental Health Plan 2003 – 2008, remain as rhetoric instead of reality.

(ARAFMI Tasmania, Tasmania, Submission #245)

The psychiatrist that was here before was great with feedback to other services and families – now the situation is hopeless. There are two of us (school counsellors) covering 8,000 people in this area. There is no child psychiatrist in the area and the service knew for about 12 months that he was leaving. Nothing has been done that I can see to replace him.

(Clinician, Western Australia, Bunbury Forum #8)

Young people's mental health services are the most difficult to access. Often they are told they are not sick enough and then told they can't get care because they have a comorbid drug and alcohol problem.

(Clinician, Queensland, Brisbane Forum #7)

No access to a spectrum of intervention, including whole of life span target groups. Anangu living on the NPY Lands have access only to a small range of acute mental health services whose responses are crisis driven and in circumstances where their involvement is most likely to be involuntary.

(Anonymous, Northern Territory, Submission #271)

People with personality disorders and those who self harm are treated with contempt and a lack of understanding particularly by unit staff. There is little or no expertise in working with people with this disorder.

(Anonymous, Queensland, Submission #113)

But there's nowhere to go when you get out of Flynn. There's no step-up or step-down care.

(Consumer and Consumer Consultant, Victoria, Morwell Forum #5)

It seems to me clear that staff were over anxious to discharge [X] due to the perennial shortage of beds at Mandala and that this is one of many cases which highlight Government neglect in the area of mental health facilities. Many promises are made but many do not eventuate or are delayed excessively. This is causing needless deaths in the community. The mental health beds at Wyong hospital have been promised for some time but are still not available. The public are entitled to expect that the mentally ill will be properly cared for by government funded services…The standard of care provided for [X] left much to be desired. After considerable questioning, this was reluctantly conceded by some of the doctors who gave evidence at this inquest…[X] was discharged with a minimum of formality and no guidance or assistance… (excerpt from the coroner's report) [Suicide occurred in December 2002, 10 hours after being discharged from the Mandala Psychiatric Unit on the Central Coast. He made 2 suicide attempts prior to admission. [X] was released from the unit after 36 hours in the hospital.]

(Carers, Parents, New South Wales, Submission #137)

What is acceptable about refusing to carry out early intervention until the person is 'acutely' unwell, which leads to a very distressing forceful intervention, then having to administer extremely strong dosages of medication which induce obvious physical side effects which take months to subside?…What is acceptable about not keeping people with a mental illness as well as they can possibly be, thus reaching and maintaining their full potential within the illness?

(Carer, Mother, Victoria, Submission #178)

Andrews has attempted to calculate how much of the burden associated with psychiatric disorders is avertable with modern evidence-based treatments (Andrews 2000). While it seems clear he has underestimated this for schizophrenia (Goldberg 2003, Warner 2003), his general conclusions seem to be that much of this burden, up to 40% on average across a range of disorders is potentially avertable. If evidence based treatment were made available and coverage were increased we could avert nearly 30% of the burden in contrast to the present 13%.

(Patrick McGorry, Professor of Psychiatry, Victoria, Submission #180)

2.3   NATIONAL SURVEY OF MENTAL HEALTH PRIORITIES IMPLEMENTATION

This national survey conducted by the Mental Health Council of Australia, with support from the Brain and Mind Research Institute, University of Sydney, (as of 2 November 2004) resulted in 714 completed responses. The majority of respondents described their role within the mental health sector as public providers of specialist treatment (n=246, 34%). This was followed by consumers and carers (n=162, 22%) and then non-government community service providers (n=74, 10%).

For the top five community priorities for national mental health reform (that were identified earlier by community surveying during the development of '*Out of Hospital, Out of Mind!*' [2003]), evidence of implementation at a local service level was extremely low. National rates for high level or full implementation of each of the priorities were:

- 17% for implementation of early intervention services;
- 11% for development of innovative services for those with comorbid substance abuse;
- 12% for development of a wider spectrum of acute and community-based care systems;
- 15% for implementation of the national standards for mental health services; and
- 9% for programs that promote attitudinal changes among health workers.

Importantly, these top priorities are not new, some were agreed targets of the previous national mental heath plan (1998-2003) – such as implementation of the National Standards for Mental Health Services, and all should be at the forefront of national and state/territory expenditure lists. They relate to the fundamental aspects of delivery of specialised mental health services in this country.

When respondents were then asked to rate other priorities that required implementation at a broader state/territory level, the low levels of national endorsement of high level or full support for implementation were equally disappointing. Worth highlighting were the low rates of:

- 13% for development of specific intergovernmental service agreements;
- 10% for innovation, research and service evaluation;
- 10% for introduction of specific schemes to enhance access to specialists;
- 11% for support of non-government agencies; and
- 11% for mechanisms for clear accountability of mental health strategy funds.

Finally, respondents living or working in rural, regional, remote or poorly resourced areas were asked about the extent to which service development was being supported in these areas. The national endorsement rates for high level or full support were so low (7% for rural and regional areas, 2% for poorly resourced areas) as to suggest a lack of basic interest or commitment by all governments to the development of new services in this high need areas.

2.4   NATIONAL SURVEY OF CONSUMER AND CARER EXPERIENCES OF CARE

Much of the work of the national mental health reform process in Australia has focused on moving the locus of care from institutions to the community-settings. By contrast, little work has actually focused on whether the experiences of care by those who use services have been enhanced by this process. What work has been done has tended to draw mostly from critical incident reviews rather than everyday experiences of care.

This novel survey mechanism introduced through the Mental Health Council in 2004, seeks to record ongoing experiences of care by those who actually use mental health services. It extends a framework initially developed in other areas of heath care to measure the quality of services provided (Hickie et al 2003 Australasian Psychiatry). It is in marked contrast to the mechanisms currently used or even proposed by the responsible governments. It relies on actual experiences of care and is not simply limited to critical incident reporting or *ad hoc* surveys of consumer participation or satisfaction with services.

As of 2 November 2004, 228 complete surveys had been received, including 127 (56%) from consumers, 58 from carers (25%) and 43 (19%) from family members or close friends. All respondents had experience (either direct or indirect) with mental health services during the previous twelve months. Forty-one percent (n=94) had contact with public health services, 30% (n=69) with private health services, and the remaining 29% (n=65) a mixture of the two.

With regard to key results from the survey, only 57% of respondents said that they were treated with respect and dignity always or nearly always, 69% felt that they did not have adequate access to services and 20% said that they were not able to find a health professional to talk to about their concerns. Two out of five (41%) participants felt they were given insufficient or no information about the condition or treatment. Of those respondents who wanted information given to family and friends, nearly 60% felt that not enough information was given. In situations where medication was prescribed for the mental health problem, only 24% responded that the purpose, benefits and side-effects were fully explained. Over one third (39%) did not feel they had enough say in decisions about care and treatment, and 19% had not had the diagnosis discussed with them (17% of consumers, 10% of carers and 37% of family members or close friends). Only five consumers (6%) had received a care plan, which is a document that outlines mental health needs and who will provide services. About one third (33%) of consumers rated the healthcare received in the last 12 months as poor to very poor, 30% as fair to good, and 37% as very good to excellent.

The Mental Health Council is committed to continuing this process of active review of individual experiences of care. It is not yet clear whether or not 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. However, current proposed Key Performance Indicators for Public Mental Health Services *(National Mental Health Strategy 2003-08)* do not include regular measures of consumer or carer outcome, or safety, nor do they propose such innovative measures of experiences of care.

2.5   NATIONAL MENTAL HEALTH REPORT 2004

The biennial National Mental Health Report has been the principal mechanism by which governments participating in the National Mental Health Strategy report their progress. It is based on primary data submitted by the States and Territories and the Commonwealth, which is then independently analysed. The focus of the report is largely on inputs and process variables, rather than actual services delivered or the quality or safety of those services. As the most recent report was released in November 2004 (detailing changes in expenditures up to mid 2002), it provides the most comprehensive national picture of the current state of mental health expenditures and service organisation.

The National Report (2004) indicates that 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. National spending on specialised mental health services still only accounts for 6.4% of total gross recurrent expenditure on health care, even though mental illness accounts for over 13% of total health burden, or over 15% if the additional burden due to suicide and self-inflicted injury are included. While

Commonwealth Government spending increased 128% during this period, two-thirds of that growth was due to new pharmaceuticals. State government spending increased only 40% or 26.2% in per capita terms. There continued to be wide variations between the States in terms of expenditure, service mix and implementation of quality and safety procedures.

> *The significant disparity that existed between jurisdictions at the commencement of the strategy largely remained nine years later… Differences in spending between the states and territories point to wide variation in the level of mental health services available to their populations.*
> (National Mental Health Report 2004; Commonwealth Department of Health and Ageing, p. 3)

The National Report highlights the change in allocation of spending from hospital-based to community-based services since 1992-93, with the latter now accounting for 51% of funds (up from 29%) and accompanied by a 109% increase in the number of clinical staff providing ambulatory mental health care. The support for non-government service providers has grown from 2% to 5.5% of expenditure, though varying from 1.9% in South Australia to 9.3% in Victoria. However, as the report highlights, much of the change is accounted for largely by radical changes within one State, namely Victoria. NSW had already instituted such changes largely before the Strategy commenced and some other States such as South Australia have still not moved away from their reliance largely on institutional services.

The number of beds in stand alone psychiatric hospitals has fallen by 60%, largely due to reduction in the non-acute service sector with these beds having been reduced by 53%. The number of beds located in general hospitals increased by 65% with the overall number of acute beds in the system therefore remaining largely static (approx. 3,700 beds, unchanged since 1993) and despite the increased growth in the population and demand for services since that time. 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. For all inpatient services, there was a 26% reduction in total beds and a 11% reduction in clinical staff.

> *All states and territories have experienced increased demand for mental health care right across the health sector, and in particular for inpatient care.*
> (National Mental Health Report 2004; Commonwealth Department of Health and Ageing, p. 7)

Over the same period, changes in use of outpatient medical services funded by the Commonwealth peaked in the mid to late 1990s and have been declining since. Although there are more registered providers of these services, they are increasingly working part-time. The disparity between rural and regional services provided and urban areas is great (Burgess Report).

> *Major disparities continue to exist between the states and territories in the level and mix of psychiatric beds provided to their populations…The number of beds required to treat and care for people affected by mental illness is also a function of whether alternative community based services are available.*
> (National Mental Health Report 2004; Commonwealth Department of Health and Ageing, p. 7)

The move away from institutional services was designed both to improve the spectrum of care services available as well as provide a more cost-efficient model. However, it seems that the movement away from a hospital base has meant that hospital-based services are now in short supply. Further, community-services and related workforces have not expanded sufficiently to meet the increased demand and the relative needs for increased expenditure on mental health seem to have lost out to the other traditional hospital-based and procedural areas of medicine (Hickie et al. submitted).

> *…these indicators (comparative per capita staff employed in ambulatory care) provide a simplified view of the relative progress by states and territories…they do not tell us about the ambulatory care workforce required to meet priority community needs nor the amount of care actually provided.*
> (National Mental Health Report 2004; Commonwealth Department of Health and Ageing, p. 21)

While the participation by mental health consumers in formal representation within mental health organisations has grown from 33% to 77% since 1992-93, actual participation rates in key processes (e.g. complaints review, 57%) are substantially lower. For carer participation, the rates are even lower (e.g. 48% for complaints review). From a quality and safety perspective, only 49% of public mental health systems had completed reviews under the National Standards by the previously agreed finishing date of June 2003.

> *Concerns about poor service quality were a major factor leading to the development of the National Mental Health Policy in 1992… Much of the previous and current criticism of mental health services concerns its alleged failures in these areas.*
> (National Mental Health Report 2004; Commonwealth Department of Health and Ageing, p. 32)

2.6 SUMMARY OF AUSTRALIAN PROGRESS AGAINST WORLD HEALTH ORGANISATIONS (WHO) RECOMMENDATIONS (2001) FOR MENTAL HEALTH REFORM IN BETTER RESOURCED COUNTRIES

TABLE 2.6.1: Progress on actions required for the improvement of mental healthcare in developed countries with a high level of resources (e.g. Australia) based on overall recommendations made by WHO (World Health Organization, 2001, Table 5.1, p. 114).

RECOMMENDATION	ACTION	NOTES ON PROGRESS IN AUSTRALIA
1. Mental health treatment to be provided in primary care	Effective management of mental disorders in primary care to be improved	Although significant primary care developments are now supported by the Australian Government, major barriers still exist with regards to access to appropriate non-pharmacological therapies. This is particularly the case for those treated in primary care environments. Consequently, there is over reliance on medications and under utilisation of effective psychological strategies (Hickie et al. 2001).
	Patterns of referral to be improved	Access to mental health specialists is inequitable in Australia and is contributed to largely by lower socio-economic status and significant distances between major population centres (Burgess et al. 2002).
2. Psychotropic drugs to be made available	Easier access to be provided to newer psychotropic drugs (under public or private treatment plans)	While Australia's PBS system does offer equitable access to most medicines at low cost to the consumer, differences do arise between availability of new compounds for inpatients versus outpatients. Specifically, over the last five years, submissions indicated that access to some of the newer antipsychotic agents has been effectively limited to those receiving care or through the public hospital sector.

RECOMMENDATION	ACTION	NOTES ON PROGRESS IN AUSTRALIA
3. Care to be given in the community	Remaining custodial mental hospitals to be closed down	Considerable progress has been made with regard to closure of stand alone or custodial hospitals (National Mental Health Report 2004). However, some very large institutions remain, most notably Glenside Hospital in South Australia.
	Alternative residential facilities to be developed	Submissions indicated that development of alternative residential or community-based long-stay facilities has not been prioritised and remains a major gap in the services structure.
	Community care facilities to be provided (100% coverage)	Submissions noted that while community-based treatment services are universal in their coverage, access to emergency care or effective ongoing care through such facilities is limited.
	Individualised care to be given in the community to people with serious mental disorders	Case-management systems have been the standard mode of care, emphasising individual treatment plans. However, submissions challenged whether the quality and effectiveness of such plans is ever audited.
4. The public needs to be educated	Public campaigns to be launched for the recognition and treatment of common mental disorders	The Australian Government in association with lead states such as Victoria established *beyondblue: the national depression initiative.* Some major states, notably NSW and WA, declined participation in the national program with adverse effects for their constituents (Jorm et al. 2005). Other schools-based programs such as *MindMatters* make a significant contribution (Waring 2000).
5. Communities, families and consumers to be involved	Advocacy initiatives to be fostered	The Mental Health Council of Australia was established and supported by the Australian Government to represent views to the Minister. It incorporates the views of consumers and families, and includes provider and other non-government organisations. Australian Government also provides support to other national consumer networks. Support for other specific consumer, carer or community advocacy agencies, particularly at a state and local level has been more episodic (National Mental Health Report 2004).
6. National policies, programmes and legislation need to be established	Fairness in healthcare financing (including insurance) to be ensured	Medicare related systems have underpinned equity in individual health care access for those with mental disorders. However, submissions indicate that more recent developments in private health insurance now pose a serious threat to these principles. At a population level, mental health is not resourced appropriately relative to its disease burden or the availability of effective treatments (Hickie et al. 2004).

RECOMMENDATION	ACTION	NOTES ON PROGRESS IN AUSTRALIA
7. Human resources need to be developed	Specialists to be trained in advanced treatment skills	Currently, services provided by psychiatrists in the private sector are in decline (National Mental Health Report 2004). In some States difficulties now exist with regard to recruitment to specialist psychiatrist training (e.g. NSW in 2005). Psychiatrists working in the public sector report increased dissatisfaction with their roles (Rey et al. 2004)
		Submissions indicated that there is a major workforce shortage in mental health nursing and that specialist psychologists are relatively underutilised in the Australian health care system.
8. Other sectors need to be linked	Special facilities to be provided in schools and the workplace for people with mental disorders	While increased mental health literacy programs are now promoted to some schools and in some workplaces, actual access to care is not mandatory.
	Evidence-based mental health promotion programmes to be initiated in collaboration with other sectors	Mental health promotion has been supported in Australia, but the reach and intensity of programs is limited in reach and duration.
9. Community mental health needs to be monitored	Advanced mental health monitoring systems to be developed	Mental Health Information systems, particularly with regard to tracking experiences of care in individual persons, are in their infancy in Australia. Submissions highlighted that basic issues of service and the maintenance of quality and safety have received inadequate attention.
	Preventive programmes to be monitored for effectiveness	Where new preventative programs have been established, evaluation has been accepted as an intrinsic component (Hickie 2002, 2004).
10. More research needs to be supported	Research on the causes of mental disorders to be extended	National expenditure on basic and clinical research is low by developed world standards (Hickie et al. 2004).
	Research on service delivery to be carried out	Health services research is poorly supported by current mechanisms (Jorm et al. 2002).
	Evidence on the prevention of mental disorders to be investigated	Significant preventative trials have been supported directly and indirectly by the Australian Government and NMHRC. (Hickie 2002)

Note: "Actions" accompanying each recommendation for countries with low and medium levels of resources for mental healthcare are described in the original report.

2.7 STATE / TERRITORY BASED SUMMARIES

While many common issues were presented across the country, there were also significant differences in various states and territories.

The following text attempts to summarise some of those differences and their implications as derived from data obtained from the consultations and submissions, the MHCA surveys and the 2004 National Mental Health Report. However for a fuller consideration of the mental health care system in each state and territory please refer to the full report.

a) From the National Mental Health Report 2004

The National Mental Health Report shows that state/territory differences have decreased marginally between 1993 and 2002 but this has been insufficient to lift services to a comparable level across jurisdictions. Comparisons between the jurisdictions has therefore failed to lift spending in most states that were lowest on the table in 1993. A more effective response would be to assess the level of funding required to meet community needs. While measurement of jurisdictional funding levels should be secondary to measurement of consumer service levels, in the absence of such data, we are restricted to comparing expenditure levels, staff numbers and bed numbers.

The better performers:

- _Western Australia_ leads per capita spending - $110.82 (national average of $92.03) and has improved from fourth position in 1992-93.
- _Western Australia_ reports the highest number of clinical staff working in ambulatory mental health services (42.9/100,000).
- _Victoria_ reports the highest percentage of expenditure to non-government organisations (9.3%) and has the best developed psychiatric rehabilitation services.
- _Tasmania_ reports the highest number of total inpatient and 24 hour staffed residential beds (51.0/100,000) and the highest number of clinical service delivery staff (104.0/100,000).
- _Victoria_ reports the most dramatic growth in expenditure on community and general hospital services ($291.2 million) and the most dramatic reduction on spending in stand alone facilities ($180.5 million).

The poorer performers:

- Of the bottom four states and territories (NSW, NT, ACT and QLD) in 1992-93, _New South Wales_ had the lowest per capita percentage growth over the next decade (23.0% in NSW compared with 36.9%, 38.3% and 41.8% in the others respectively).
- _Queensland_ reports the lowest number of clinical staff working in ambulatory mental health services (29.8/100,000).
- _South Australia_ reports the lowest percentage of expenditure to non-government organisations (1.9%).
- The _Northern Territory_ reports the lowest number of total inpatient and 24 hour staffed residential beds (16.2/100,000), while of the states, _New South Wales_ reports the lowest at 34.0/100,000. Similarly, the NT has the lowest number of clinical staff (78.1/100,000) while NSW is almost as bad (81.2/100,000).
- _South Australia_ reports no reduction in expenditure on stand alone psychiatric facilities and only a modest growth in expenditure on community and general hospital facilities ($37.8 million). South Australia has the highest proportion of psychiatric beds still in stand alone facilities (73%).

b)   From the MHCA Surveys

The MHCA surveys discussed in Part 3 of the main report suggest the following:

The better performers:

- Perceived implementation of national mental health priorities is somewhat better in _Victoria_ and the _Australian Capital Territory_.
- _Victoria_ demonstrates the greatest commitment to mental health promotion, destigmatisation and illness prevention.
- _Victoria_ houses the most innovative service development systems in youth and early intervention services.

The poorer performers:

- Perceived implementation of the national priorities in mental health is poor in _South Australia_ and _New South Wales._

c)   From the Public Consultations and Written Submissions received

The written and oral submissions made by consumers, advocates, mental health professionals and others suggest the following:

The better performers:

- _Victoria_ is perceived to be the national home for service development for _early intervention_ for persons in the initial stages of psychosis or other severe mental disorders.
- _Victoria_ is perceived to be at the forefront of community-based initiatives to improve understanding of depression, anxiety and other common mental disorders.
- _Victoria_ has implemented a new service specifically for persons with severe personality disorders.
- _Victoria_ has the standout forensic mental health institutions.
- _South Australia_ has an impressive magistrates court diversion program.
- _Tasmania_ is perceived to be in the process of significant increases in resource allocation.

The poorer performers:

- _New South Wales_ has the highest degree of demoralisation and dissatisfaction among mental health clinicians, consumers and carers.
- _New South Wales_ and _Queensland_ are perceived to have a high emphasis on a 'law and order' rather than enhanced clinical care approach.
- _New South Wales_ is perceived to be backing an institutional and emergency care focus at the expense of community service development.
- _South Australia_ is perceived to have made little genuine commitment to support persons with mental illness to live effectively in the community.
- _Western Australia_ is perceived to have made few efforts to deal with the problems faced by regional and remote communities.

d)   State and territory perspectives

As Part 1 of this report sets out, each State and Territory was provided a draft of this report for comment. The full text of those responses can be found at Appendix 8.2 of the main report.

2.7.1   NEW SOUTH WALES

2.7.1.1 Overview

The deficiencies in mental health services in NSW continue to attract widespread media and community attention (see Appendix 8.7). In December 2002, after a comprehensive analysis of the current state and delivery of mental health services, the Hon Dr Brian Pezzutti, the Chair of the Legislative Council Select Committee on Mental Health stated:

> *The objectives of the Richmond Report and the deinstitutionalisation process have been undermined by practical problems arising during implementation. Consequently, NSW has a community mental health sector with a large responsibility for mental health care, but not the necessary resources. The weight of evidence presented to the Committee highlights that mental health services in NSW need revolutionary improvement. Deinstitutionalisation, without adequate community care, has resulted in a new form of institutionalisation: homelessness and imprisonment.* (p. xv)

The Select Committee not only highlighted inadequacy of funding but also raised concerns about the model of resource allocation and the accountability of funds once disbursed. Implementation of State policy at an Area Health Service level was cited as a serious problem. Additionally, with regard to the Burdekin Report, the Select Committee stated:

> *The Burdekin Report identified not only inefficient planning and organisational arrangements to integrate services within hospitals, but also a lack of procedures to involve families in the community treatment process. It was considered that these issues had not been adequately addressed. Evidence received by this Select Committee indicates that in NSW these issues still require further attention. (p. 13)*

The Pezzutti inquiry led to a number of specific State Government responses. In December 2003 the NSW Mental Health Sentinel Events Review Committee reported on its systematic review of suicides and homicides amongst mental health patients. It stated:

> *Such events are an unmitigated tragedy for the victims, their families and their friends, and also result in great distress to the staff of mental health services and to other patients. The fear and concern they raise in the community is significant, and is largely responsible for the continuing and unjustified stigmatisation of the vast majority of people suffering from mental illness who pose no risk except to themselves. (p. v)*
> (NSW Mental Health Sentinel Events Review Committee (2003). Tracking tragedy: A systemic look at suicides and homicides amongst mental health inpatients. First report of the Committee, December 2003)

More specifically, the report acknowledged that many people with mental illness are not able to access care in times of crisis:

> *Admission to mental health beds is widely seen as the most effective short-term risk mitigation strategy in high risk cases. However, anecdotal evidence strongly suggests that on occasions patients are not being admitted, or are being discharged early or without comprehensive follow up, due to an inability to access an available inpatient bed. (p. v)*

The report also highlighted concerns with regard to assessment procedures, communication and documentation practices, lack of family involvement, staffing issues and non-uniform implementation of NSW Health policies and guidelines which may "act to impede the efficient provision of a standardised approach to care delivery". (p. ix)

(NSW Mental Health Sentinel Events Review Committee (2003). Tracking Tragedy: A systemic look at suicides and homicides amongst mental health inpatients. First report of the Committee, December 2003)

The release *Tracking Tragedy* attracted community criticism as some of its recommendations emphasised increased security and further restriction of patient's rights within acute hospital settings rather than enhanced clinical care (Sydney Morning Herald, Jan 2004). A major alliance of non-government organisations and professional groups wrote to the Premier in early 2004 to express their lack of confidence in the provision of mental health services in NSW. Ongoing media criticism was high and coronial reports continued to highlight major service deficiencies, particularly for young people with severe disorders.

The NSW Health Minister responded positively and met with community stakeholders and professional groups. In mid 2004 the State Government announced that an additional $241 million would be spent on mental health over the next four years. Further, it prioritised the development of new forensic mental health services, announcing its intention to build a new forensic hospital on the existing Long Bay Gaol site.

The subsequent release of the National Mental Health Report (NMHR, November 2004), indicated, however, that there had been little improvement in NSW's comparative position over the last decade (the NMHR 2004 is based on 2001-2 data). Key indicators included overall expenditure (now ranked sixth out of eight states and territories), low bed availability and limited employment of new community-based staff. NSW now faces serious manpower shortages across all clinical disciplines.

Issues raised by the formal submissions and the community forums included the Government's failure to respond positively to workforce demoralisation, its dismissal of clinicians' objections to the introduction and utility of the new clinical outcomes documentation and that its failure to integrate clinical and academic leadership with local service innovation or clinical service development. The fierce criticisms by professional groups of the central administration of public mental health services were consistent with an independent survey of practicing psychiatrists reported in 2004 (*Walter and Rey, 2004)*.

The future capacity of NSW to attract high quality staff to meet basic service requirements may well be compromised by a lack of attention to basic clinical leadership, clinical governance and clinical career development issues. It appears that central and local bureaucracies demand greater reporting by clinical staff without providing the support or space for local clinical innovation, clinical leadership or resources for significant local service initiatives. In 2005, NSW instigated an urgent review of the training of psychiatrists in the state. (Medical Training and Education Council of NSW (MTEC), 2005)

While NSW has supported the development of a specialist mood disorders research Institute (Black Dog Institute. Available at: http://www.blackdoginstitute.org.au), it remains the only state not participating in the national depression initiative: *beyondblue*. Additionally it has been under-represented in the early take-up of new general practice-based and federally-funded access to allied mental health practitioner programs (Hickie et al, 2004). The building of a new forensic hospital on an existing corrective services site does not suggest that expansion of clinical care and reduction of the stigma associated with severe mental illness is a high government priority.

While substantial new financial commitments have been made for the period 2005-09, the accumulated deficit in recurrent funding is large and there seems to be a preference towards funding acute hospital and forensic services. The emphasis on building new Psychiatric Emergency Care Centres (PECC) in Emergency Departments may lead to a re-segregation of persons with mental disorders from persons with other physical health emergencies. One major driver to this process is the poor quality of acute care provided to persons with mental illness. However, it is possible that the belief of at least some emergency room clinicians that persons with mental illness are "interfering with" or "detracting from" the acute care of other patients may also be influencing this new trend.

The relationship between poor ongoing community care and increasing demand for acute care services and the relative failure to partner effectively with consumers and carers, general practice and other non-government service providers does not appear to have yet received serious attention. Data from NSW indicates a continuing rise in the number of acute admissions to psychiatric facilities and an increasing proportion of admissions occurring on an involuntary basis.

Even though there were positive accounts of the success of court diversion programs in NSW, there were many more stories that spoke scathingly about the increased focus on security in NSW. The perception remains that the main State's for people with a mental illness is overly focused on incarceration or detention rather than expansion of non-custodial clinical care. There is no doubt that the increasing presence of security staff, rather than health professionals such as nurses and psychologists, within acute care facilities reinforces this perception.

The introduction of a transparent and efficient system for monitoring and reporting not just the quantity but the quality of services provided, with a specific emphasis on deaths and critical incidents among those seeking or receiving mental health care, remains a priority. Consumers and carers remain unconvinced that there is any serious interest in monitoring either routine experiences of care or implementing changes evident from these critical incident reviews.

The release of *Tracking Tragedy 2004* (the second report of the NSW Mental Health Sentinel Events Review Committee) in March 2005 also highlights areas of concern regarding access to services. This Report was a systematic review of homicide by mental health patients and suicide death of patients recently discharged from mental health inpatient units over a five-year period (1999-2003). The Committee concluded:

> *Overall the group data provided some evidence for a link between reduced access to inpatient care and higher rates of post-discharge suicide death. Area Health Services with lower numbers of mental health beds relative to their estimated population-based bed requirements had higher rates of post-discharge suicide death. People dying by suicide within one month of discharge had a shorter length of stay than the overall population of people being discharged from mental health services, and in particular, a higher number of short (2-3 day) admissions. In individual cases inappropriately short length of stay may have contributed to the poor outcome.*
> (NSW Mental Health Sentinel Events Review Committee, 2005, p. viii)

On 11 March 2005, the Government released another new blueprint for mental health services in NSW (The NSW Government's Plan for Mental Health Services) and re-announced its $241 million commitment to increased funding over a four year period. The new Plan commits the Government to opening 240 new mental health beds in the next three years, expansion of the PECCs from two to five hospitals, introduction of new electronic medical record systems, and expansion of the Housing Support Accommodation Initiative (HASI) to a further 460 people in public and community housing. The documentation claims that the increased expenditure will lift NSW's per capita spending by $14.30.

In May 2005, the NSW Auditor-General released a report on the performance of Emergency Mental Health Services (Auditor-General's Report, Performance Audit, Emergency Mental Health Services, May 2005). The report states the following view:

The increase in demand for emergency mental health services has offset many (and perhaps all) of the gains from funding increases. The system is under considerable pressure, and patients can face lengthy delays before being admitted to a bed.

There is a continuing cycle over the past few years of adverse reports, followed by announcements by the government to address the mental health care system, followed by further reports indicateing little change. This is cause for a fundamentally different approach, consistent with the recommendations in this report, to tackling the systemic issues evident in the NSW mental health services.

2.7.1.2 Key issues raised by consultations and submissions

The major issues highlighted by the consultations and formal submissions in NSW were:

i)   the apparent emphasis on a 'law and order' agenda rather than enhanced clinical care;

ii)   the emphasis on enhanced security measures within acute care settings, with increased use of security rather than clinical care staff;

iii)   continued and widespread difficulties in accessing acute care services, particularly outside business hours and through emergency departments of general hospitals;

iv)   a critical lack of mental health beds including not only acute care beds but also medium term services;

v)   lack of support for community-based acute and ongoing clinical care;

vi)   lack of support for non-government service providers, particularly in employment support and rehabilitation services;

vii)   lack of support for genuine consumer and carer participation in planning, review and distribution of services;

viii)   workforce shortages across all disciplines leading to further demoralisation of the existing workforce;

ix)   inadequate and inappropriate forensic mental health services;

x)   lack of accountability for mental health spending, service deficits and critical incidents in the mental health sector;

xi)   resentment at the manner of introduction of new outcome-based clinical measurement systems at the expense of enhancement of actual clinical services; and

xii)   poor coordination of inter-departmental responsibilities and most notably those that involved service provision and protection of children.

2.7.1.3 Positive developments

While the general level of distress expressed by NSW consumers, carers, non-government and professional bodies was among the highest nationwide, our attention was also drawn to a number of positive state-wide developments or local initiatives. These included:

i)   statewide development of a forensic mental health service to be managed by Justice Health rather than the Department of Corrective Services;

ii)   the development of a statewide Court Liaison service in 2003/04 program for persons with mental disorders presenting to magistrate and district courts;

iii)   recent NSW commitments to support a new mind and neuroscience research strategy as well as a Professor of Schizophrenia-related research in association with NISAD;

iv)   very positive attitudes to mental health being expressed by police and emergency services, reflecting a major change in attitudes over the last decade;

v)   development of a joint initiative between NSW Health, the NSW Department of Housing and other non-government organisations (HASI) to improve the community and housing supports for those with very high levels of disability; and

vi)   increased commitment by NSW Health to monitor systematically experiences of care by consumers and carers within its services and report publicly,

New South Wales: Court Diversion Programs

The diversion of individuals with mental health issues and/or intellectual disability is exemplified by recent changes to Section 32 of the Mental Health (Criminal Procedure) Act 1990. Courts are now able to divert individuals to treatment and able to enforce such orders by virtue to the individual being returned to court following notification by COS [Community Offender Services] of failure to comply with Section 32 treatment orders. These changes in legislation are a result of negotiation and agreement between COS, the Attorney General's Department, NSW Health and the Department of Disability, Home Care and Ageing.

COS provide sentencers with a range of community-based sentencing options including Community Service Orders and the Intensive Supervision Program as alternatives to incarceration. However, both the Community Service Orders and the Intensive Supervision program require a degree of stability, including stable accommodation and appropriate intervention resources.

In order to meet the conditions of the order and the offending needs of the individual, COS both develops and delivers core programs and brokers a range of services from government and non-government agencies that are funded to provide services within the community. Major partners in the provision of services and programs to offenders with complex needs are the Department of Housing, NSW Health (Community Mental Health and Community Health), the Department of Ageing, Disability and Home Care, the Department of Education, Employment and Training and Centrelink.

(Community Offender Services, Probation and Parole Service, Department of Corrective Services, New South Wales, Submission #317)

Housing and Support Initiative

The Housing and Supported Accommodation Initiative (HASI) aims to strengthen the partnership with Housing and NGO's in delivering accommodation support to people with mental illness to live successfully in the community. The initiative is underpinned by policy, by statewide tender programs to ensure standard levels of care and by evaluation and review mechanisms. The development of the HASI program for NSW will be a staged process:

- *Stage One – 118 Medium to High Support places in the community*
  NSW Health is funding $5m/year recurrently to mental health non-government organisations (NGOs) for high-level accommodation support.
  The DOH has provided housing stock of approximately $7.8m.
  Preliminary outcomes in the South Eastern Sydney trial over a twelve month period show that inpatient beds days for enrolled patients decreased from 197 days to 32 days.

- *Stage Two - 460 Low outreach support places to people in public and community housing*
  NSW Health is funding $15m over 4 years to mental health NGO's for low-level disability outreach support for people with mental illness and disability associated with that illness already living in community and public housing.

- *Stage Three - 126 places in medium to high support*
  The 2005/2006 mental health budget announced on 24 May 2005 has allocated an additional $8 million for NGOs to provide moderate to high-level accommodation support. Housing will fund stock component. These places will be allocated across all Area Health Services. This program is due to go to Statewide tender processes within the next two months for the NGO support component.

…(after 3 years) the Government will be providing support to an additional 700 people with a mental illness to live a quality life in the community, not hospital.

(Media Release 24 May 2005 and supporting information from the office of the
NSW Minister for Health, Hon. Morris Iemma.)

2.7.1.4 National Mental Health Report (NMHR) 2004 (analysis of expenditure and services)

According to the NMHR 2004, NSW finishes sixth out of the eight states and territories in terms of per capita expenditure ($85.13), and remains well below the national average ($92.03). It was ranked fifth in 1992-93 at the start of the national strategy. Over the last decade, mental health spending has increased 23% in per capita terms with the national state average being 26.2%. Only Victoria reporting a lower per capita increase (14.2%). In NSW, there has been a considerable growth in community and general hospital services ($170.9m, compared with the highest, Victoria, at $291.2m), but only a modest reduction in spending on stand alone institutions (a $35m reduction compared with Victoria's reduction of $180.5m).

In terms of clinical staff employed in ambulatory care settings it ranks sixth (35.2/100,000 population compared with national average of 35.9 and a high of 42.9 in Western Australia). With regard to clinical care staff, NSW ranks seventh (81.2/100,000) only outperforming the Northern Territory (78.1) and below the national average of 90.0 and the high of 104.0 in Tasmania. NSW ranks seventh in terms of funding to non-government organisations (2.4% of mental health funding compared with national average of 5.5% and the highest being in Victoria at 9.3%). NSW ranks sixth in terms of total inpatient and 24 hour staffed residential beds per 100,000 population (34.0 compared with the highest nationally of 51.0 in Tasmania). Total public sector inpatient beds in NSW ranked fifth in the Commonwealth (30.3/100,000).

2.7.1.5 Mental Health Council Survey Reports

As expected, the largest number of responses to the survey were from NSW organisations and individuals (n=239). There remains a low level of perceived support for or actual implementation of the community's top five priorities for mental health reform at a local level (namely early intervention [15%], innovative services for comorbid substance abuse [10%], wider spectrum of acute and community care [11%], implementation of the national mental health standards [14%], programs to support attitudinal change [8%]). With regard to state-wide initiatives, again there was a very low level of perceived support for or implementation of key initiatives (namely, specific inter-governmental service agreements [13%], support for innovation [8%], enhanced access [12%], clear accountability for funds [12%]).

2.7.1.6 Conclusions

NSW is faced with the dual difficulties of a combination of an extended period of low per capita expenditure on mental health and low confidence among clinicians about its capacity to bring about rapid improvements. Additionally, there appears to be a focus on expansion of old models of acute and hospital-based services rather than genuine service innovation or new partnerships with non-government or primary care service providers.

2.7.2   VICTORIA

2.7.2.1 Overview

The deficiencies in the provision of mental health services in Victoria have continued to attract widespread media and community attention, with a particular focus on deficits in acute and emergency care. Deficiencies in acute care services were highlighted by a report of the Victorian Auditor-General (2002) *Mental Health Services for People in Crisis.*

> *This audit identifies a range of concerns about the timeliness of service provision, the completion of key service delivery processes in compliance with relevant standards and guidelines, and the burdens placed upon carers and families. In making these findings, I do not wish to impugn the many dedicated professionals providing mental health services. It is clear that the service system is under significant stress, due to demand pressure, work force shortages and the increasing complexity of mental disorder in our society.*
>
> <div align="right">(J. W. Cameron, Auditor-General, 14, p. vii)</div>

The negative impact of poor mental health on consumers, their families and the wider community was also cited in the Victorian Auditor-General's Report (2002) as was the higher rate of unemployment, substance abuse, physical illness and social dislocation amongst people with mental disorder. These problems have also been identified in each of the three National Mental Health Plans.

This audit sought to examine mental health services for people in crisis and found:

> *Increasing service demand and associated levels of unmet demand are resulting in service access difficulties for many consumers, early discharge from hospital, and increased burden on family and carers. These outcomes increase the likelihood of future unplanned re-admissions.*
>
> <div align="right">(Victorian Auditor-General's Report, 2002;, p 6)</div>

Many recommendations were made regarding assessment procedures, documentation, timeliness and appropriateness of service responses to crises, discharge practices, integrated care, involvement of carers and families, rights of involuntary patients and evaluation of the effectiveness of mental health services. The Auditor-General noted that many of the recommendations arising from this audit were promptly recognised and incorporated in the new five-year plan for the delivery of public mental health services *New Directions for Victoria's Mental Health Services: The Next Five Years* (2002).

The stated underlying guide of the *New Directions for Victoria's Mental Health Services: The Next Five Years* (2002) is Victoria's whole-of-government social policy framework *Growing Victoria Together*. This approach puts the plan in an ideal position to deal with the associated health, social and economic ramifications experienced by many people with mental illness and their families and carers. The *New Directions* five-year plan identified the following key areas as the focus of reform over this period:

1. *manage the growing demand for mental health services;*
2. *respond to increasingly complex consumer needs — particularly the needs associated with increasing drug use amongst young people with mental illness;*
3. *develop improved responses to consumer and carer needs, including developing new models of care - particularly for people with high needs;*
4. *establish and maintain an appropriate balance between inpatient and community-based services;*
5. *address workforce challenges, including education, training, recruitment and retention; and*
6. *ensure the future sustainability of services.*

(New Directions for Victoria's Mental Health Services: The Next Five Years, 2002, p.5)

Resource distribution, both between inpatient and community based care and allocation to rural and regional areas, and the benefits of focussing on early intervention to reduce demand on acute care and negative impacts on consumers were also addressed. Many short- and long-term initiatives were outlined in this plan to redress gaps in service provision.

Two recent reports also outline initiatives to redress gaps in the provision of mental health services and protection of the rights of people with mental illness: *Victoria's Implementation of the National Standards for Mental Heath Services: Progress Report (September 2004)* and the *Annual Report 2003 Office of the Chief Psychiatrist (November 2004)*. However, both documents failed to self-identify areas of concern and disappointingly, no attempt was made to benchmark progress against the implementation of the National Standards for Mental Health Services (NSMHS). However, under each of the eleven NSMHS, lists were presented (not against specific criteria) describing some current and possible future initiatives. The list for Standard 11 (Delivery of Care), the most detailed of all the Standards, was minimal.

Victoria has seen considerable mental health promotion and prevention development under the independent auspices of VIC HEALTH and the recent commitment to establish a research centre devoted to this task. It has also led the development of the national depression initiative: *beyondblue* (which is now supported by the Australian Government for a further four years to June 2009) and has been one of the active participants in the new general practice-based and federally-funded access to allied mental health practitioner programs.

It has been at the forefront of Australian developments in institutional forensic mental health services through the establishment of Forensicare at the Thomas Embling Hospital. Academic clinical service and basic neuroscience research developments, particularly related to psychosis, have been of international standing. The establishment of Orygen Youth Health through community and service partnerships has been a major development. However, the internationally-leading work of Professor McGorry and colleagues with regard to early intervention in young persons with psychosis (recognised by an NHMRC Program Grant 2005-2009) has not yet been implemented substantially throughout the state.

> *In Australia the requirement for entrenched disability or life-threatening risk operates at a high threshold at the entry points to specialist care. Primary care access is theoretically better, however practically still a problem. Generally, treatment for milder disorders and earlier phases of disorder is provided through little better than a lottery system in which affluence and local factors are key influences. Such people are often derided as the "worried well" even within psychiatry. They may not need years of treatment but they do have a right of access to appropriate treatment. Why not acknowledge that ready access to mental health care of some kind, much of it relatively simple, even informal and self-care, is as necessary as access to general medical care? This should not be controversial.*
>
> (Patrick McGorry, Professor of Psychiatry, Victoria, Submission #180)

Since the commencement of the National Mental Health Strategy in 1993, Victoria is the state that has undertaken the most systematic reforms consistent with the spirit of that strategy. That is, it has drastically reduced its reliance on beds in stand alone psychiatry hospitals with a significant move to new beds in general hospitals, other community-based beds and support for longer-term services provided by non-government organisations (Vic Auditor-General's Report 2002; New Directions Report 2002). It has also fared well in amending legislation to protect many rights of people with mental illness (Watchirs 2000, Carney 2003).

At a macro-level, therefore, it is easy to comprehend the direction of service reform. However, it is also clear that expenditure growth has not backed this process of systematic reform and that there is considerable variation in quality of services provided across the state. Gaps in service provision are common. Medical staff shortages in rural and regional areas are being filled largely with overseas trained doctors. Access to private sector services is strongly tied to inner and eastern Melbourne. The main focus of care in Victoria still appears to be on acute care and the protection of rights of involuntary patients rather than early intervention and protection of the broader rights to social, economic and political participation of people with mental illness and mental health problems. The impact of inadequate mental health services in emergency departments has been particularly emphasised by both health professionals and users of the services.

The recent announcement of the *Victorian Strategy for safety and quality in public mental health services 2004-2008* by the Victorian Department of Human Services heralds a major breakthrough for the improvement of safety and quality of practice in the delivery of mental health services. To date, the inclusion of mental health within broader health, safety and quality assurance programs have failed at both state and national levels. This new initiative should assist with the identification of systemic problems and issues of accountability. Victoria's commitment to the rights of people with mental illness is also evidenced by the recent release of *Patient Rights Booklets* in twelve languages in December 2004.

Just prior to the release of this report, Victoria announced a new mental health package value at approximately $180 million over four years, with approximately $55 million devoted to capital works and $125 million in recurrent spending over four years. Just over $30 million per year is an approximate increase of 5% in recurrent spending. Increases in funding were announced to acute community-based assessment teams, support for assessments in emergency departments and for facilities that can function as alternatives to acute hospitalisation.

2.7.2.2 Key issues raised by consultations and submissions

The major issues highlighted by the consultations and formal submissions in Victoria were:

i) continued and widespread difficulties in accessing acute care services, particularly through emergency departments of general hospitals;

ii) a critical lack of mental health beds, including not only acute care beds but also medium term services;

iii) lack of support for community-based acute and ongoing clinical care;

iv) inadequate rural and regional services, with a strong emphasis on providing minimal intervention services; and

v) lack of accountability for mental health spending, service deficits and critical incidents in the mental health sector.

Although the mental health system in Victoria is more appealing at a macro level than many of the other state-based services, the general level of distress expressed by Victorian consumers, carers, and non-government and professional bodies was still very high. Critical incidents and day-to-day service failures were not perceived to be given sufficient priority by government and professional bodies.

2.7.2.3 Positive developments

Our attention, was drawn to a number of positive state-wide developments or local initiatives. These included:

i) the Orygen Youth mental health services providing early interventions for young people with psychosis;

ii) institutional forensic mental health services, and in particular the Thomas Embling Hospital services which are of a high international standard;

iii) Victorian support for a wide range of mental health promotion (VIC HEALTH), illness awareness and destigmatistion campaigns (*beyondblue*: the national depression initiative) and mental health and neurosciences research (Neurosciences Victoria, Mental Health Research Institute); and

iv) development of a wider spectrum of step-up and step-down acute care facilities.

In the process of consultation with the Victorian Department of Human Services, we were provided with the outcome of a 2003-04 survey of consumer and carer experience of Victorian Public Adult Mental health services. Throughout our national consultations, this was the only substantive piece of work provided to us by any government department that had actually recorded systematically experiences of care. The associated documentation described a process dating back to 2001/02 and conducted by an externally-commissioned agency. Consumers between 18 and 64 years of age who had used adult mental health services (AMHS) during 2003 were surveyed. Although the target population had been 300 consumers and 200 carers in each of 21 AMHS, there were only 1,586 respondents (908 consumers, 678 carers) giving an overall response rate of 15.1%. While the report focused on the net 'positive' response rates (% rating an aspect of care as good, very good or excellent) we found the high rate of net 'negative' responses to be consistent with the pattern of our own consultations in Victoria.

While we commend the Victorian Department for commencing such a process, we question why the survey has not been repeated. For the key indicators chosen (see table) negative response rates by consumers ranged from 28-42% and, importantly, for carers from 42-55%. These high levels of negative responses are not consistent with the expressed view of the Government (see Appendix 8.4.2 of the full report) 'that service quality in Victoria is generally of a high standard'.

	Negative responses	
	Consumers	Carers
Provision of Information about rights and responsibilities when needed	33%	44%
Understandable information about rights and responsibilities	33%	45%
Enabling access to help	28%	43%
Getting help when needed	29%	42%
Provision of treatment information when needed	42%	53%
Understandable treatment information	43%	55%
Meeting Individual Needs	37%	51%

Victoria: ORYGEN Youth Health – Expanding Access and Care for Young Persons

At Orygen youth health, we do have the capacity to treat around 600 new 15 –25 year olds with non-psychotic disorder each year, however we still have to refer out large numbers of patients (1400 referrals p.a.) who really need a specialist approach (as one index of this, 25% of those we are unable to accept have attempted suicide recently and are clearly significantly impaired). Moreover, we have no consultation-liaison team to work with GP's or counsellors to manage these and other cases.

(Patrick McGorry, Clinician and Academic, Victoria, Submission #180)

ORYGEN is a unique organisation made up of a specialist youth mental health service, a research centre and a range of education, advocacy and health promotion activities. The overall goal of ORYGEN is to integrate knowledge gained from clinical practice and research activities to implement, and advocate for, high quality mental health services for young people.…The Clinical Program at ORYGEN Youth Health is part of Victoria's public mental health system and provides mental health assessment and treatment to young people aged 15 to 24 years who live in the western and northwestern areas of Melbourne. Traditionally, the Victorian public mental health system is divided into Child and Adolescent Mental Health Services (1-18) and Adult Mental Health Services (16-65). In 2002 however, ORYGEN Youth Health decided it was time for a new approach. ORYGEN Youth Health began offering services to young people aged 15 to 24 years, the first youth-specific mental health service ever developed in Victoria. This decision highlighted the fact that mental health issues are the most common health concern for young people and that the development of specialised services minimises the impact of mental illness on a young person's learning and development.

(Information obtained from ORYGEN website. Accessed 18 May 2005.
http://www.orygen.org.au/contentPage.asp?pageCode=ABOUT)

Victoria: Spectrum – The personality disorder service for Victoria

I have also been reading about Spectrum in Melbourne which is the State-wide Borderline Personality Disorder Service. It is so good that, at last, people are starting to put just a little money into people with Borderline.

(Consumer, Victoria, Submission #203)

Victoria has a statewide personality disorder service. This has come after a realisation that the State had to do something! It is very useful but it is insufficient. They cannot possibly cover all the need across the State. It would be like having one State-wide Schizophrenia service.

(Consumer, Advocate, Victoria, Submission #166)

Spectrum is an Australian state-funded service providing consultation, training, treatment and research in relation to people with severe and borderline personality disorder who are at risk from serious self harm.

Since the early 1990s there has been a growing body of research and clinical wisdom about effective treatment strategies for this client group. In 1993 the Second National Mental Health Strategy clearly endorsed the right of these clients to access state mental health services.

Spectrum was established in late 1998 with two aims:
- *provision of support to state mental health services in the process of change towards new treatment strategies*
- *provision of specialised intensive assessment and treatment services for clients with particularly complex needs.*

We are located in East Ringwood but we provide services to the whole of Victoria.

Spectrum provides four types of services.
- *consultation to staff within the state mental health services to support their work with clients who meet the criteria for a diagnosis of Borderline Personality Disorder*
- *training to staff from state mental health services*
- *residential assessment and treatment*
- *research*

(Information obtained from the Spectrum website: http://www.spectrum-bpd.com/front.htm.
Accessed 22 March 2005)

2.7.2.4 NMHR 2004 (analysis of expenditure and services)

According to the NMHR 2004, Victoria finishes second out of the eight states and territories in terms of per capita expenditure ($98.81), above the national average ($92.03). However, it was ranked first in 1992-93 at the start of the national strategy. Over the last decade, mental health spending has increased only 14.2% in per capita terms, well below the national state average of 26.2% and the lowest in the Commonwealth (the highest nationally being Western Australia at 52.4%). In distinct contrast to all other states and territories, there has been a marked increase in growth in community and general hospital services spending (now at $291.2m) and a correspondingly marked drop in spending on stand alone institutions (-$180.5m).

In terms of clinical staff employed in ambulatory care settings it ranks fifth (37.3/100,000 population compared with national average of 35.9 and the highest of 42.9 in Western Australia). With regard to clinical care staff, Victoria ranks fourth (93.7/100,000) and is above the national average of 90.0 but well below the highest nationally (104.0 in Tasmania). Victoria is the leading state in terms of funding to non-government organisations (9.3% of mental health funding compared with national average of 5.5%). Victoria ranks third in terms of total inpatient and 24 hour staffed residential beds per 100,000 population (41.6 compared with the highest of 51.0 in Tasmania). Surprisingly, total public sector inpatient beds in Victoria ranked a poor sixth in the Commonwealth (23.3/100,000), only outperforming the NT and the ACT.

2.7.2.5 Mental Health Council Survey Reports

A total of 134 responses to the survey were received from Victorian organisations or individuals. Although there was a low level of perceived support for actual implementation of the community's top five priorities for mental health reform at a local level (namely early intervention [21%], innovative services for comorbid substance abuse [11%], wider spectrum of acute and community care [16%], implementation of the national mental health standards [17%], programs to support attitudinal change [9%]), the results for early intervention and a wider spectrum of services were better than in other states and territories. However, with regard to state-wide initiatives, there was a very low level of perceived support for, or implementation of key initiatives (namely, specific inter-governmental service agreements [12%], enhanced access [6%], and clear accountability for funds [10%]), though recognition of support for innovation [16%] was somewhat higher than elsewhere.

2.7.2.6 Conclusions

Against most of the agreed indicators, Victoria may be seen as the leading state in mental health services delivery. It has supported both community-based innovations as well as systematic reorganisation of its service structures. The reality for consumers of the services, however, is that insufficient attention has been placed on increasing real investments and recurrent expenditures and supporting key innovations such as the early psychosis and forensic movements. Additionally, insufficient attention has been directed to responding constructively to consumers' and carers' experiences of care.

2.7.3 QUEENSLAND

2.7.3.1 Overview

Issues relating to security and the perceived threat to the community posed by persons with mental disorders have received excessive and unbalanced media attention in Queensland. Government responses have emphasised a strong 'law and order' rather than expanded clinical care approach. While mental health spending has increased in Queensland in recent years, it comes after many years of low funding and given the difficulties in servicing such a geographically-spread and diverse population, it is unsurprising that there are many reports of poor access to basic services throughout the state. The government faces a very large resource and workforce challenge if it is to provide acceptable community-based mental health care in the major regional and larger rural centres.

In 2002, *Smart State 2020: A Vision for the Future,* was released by the Queensland Government. In both the Summary Discussion Paper and Directions Statement, while mental health is briefly acknowledged as contributing to increasing disease burden, changes to mental health service delivery or the overall prioritisation of such activities are not evident. For example, in the futuristic description of the health system in *2020*, one of the 12 descriptors refers to "mental health and aged care services delivered in community or home environments as opposed to institutional settings" (page 13). Again, while depression and suicide were nominated as two of the six target areas for major health gains, the strategies identified failed to address the current critical barrier of access - the very limited, if any, services for people with mental illness or mental problems. The strategies identified were:

> *Actions to reduce the incidence and impact of depression include:*
> - *proactive mental health promotion programs including intersectoral action to create supportive environments*
> - *promoting resilience strategies in children and youth*
> - *assisting people to recognise depression early when it does occur encouraging those affected to seek help and facilitating access to appropriate services*
> - *provision of effective treatment and management strategies*
> - *reducing the stigma and discrimination experienced by people with mental health problems.*
> (Smart State 2020: A Vision for the Future – Directions Statement, 2002, pages 21-22)

The *Smart State 2020* report was used to develop the 2004 Queensland Health Strategic Plan. Consequently, there was very little mention in the Strategic Plan of specific reform to the delivery of mental health services, although integrated mental health services were listed as an 'output' in the diagram of the strategic planning framework (page 10). The 2004 Health Determinants Report highlighted mental health issues for children, but only fleetingly mentioned it as a factor for the whole population. The 2004 Strategic Plan does not mention mental health as a health risk factor.

In budget announcements for 2004-2005 on 11 November 2004 the Queensland Government only allocated $13 million for improved mental health services out of a total announced package excluding capital works and partnerships of $135.2 million. Mental health was not mentioned when the Government announced a new team to lead Queensland Health, and the major issues of concern were described as follows:

From next year, for the first time anywhere in Australia, we will be looking to train doctors in the private sector, develop more community health care campuses, introduce new programs to deliver more elective surgery and more dental treatments, and take on the difficult decision-making around Australia's current shortage of specialist medical staff.

(Queensland Minister for Health, Media Release, 27 December 2004)

This trend of discussing mental health reform but not translating talk into concrete actions and observable differences in the lives of people with mental illness has also been highlighted recently by the Office of the Public Advocate in Queensland.

The national mental health reform process marches on with the most recent third National Mental Health Strategy – yet, for many people with a psychiatric disability, this policy process is yet to be fully realised in their daily life. The ideals that drive the language of our policy makers – the promise of recovery, genuine and available alternatives to acute admission, whole of government responsibility for mental health, seamless service delivery from clinic to community, access to timely and effective services for all – are yet to be shaped into the fully resourced organisational arrangements that can make a significant difference to this marginalised group of Queensland citizens.…

Nowhere is the stigma and discrimination of which the Public Advocate spoke before more evident than in such an inequitable resource allocation. It is hard to imagine a significant improvement in the quality of mental health care without a sizeable increase in funds. … I should note that our critical concern around many of these issues is directed less to mental health services staff, than to the underlying systemic cause of much of this – the stigma and discrimination practised by many ordinary citizens, the consequent low priority given to mental health issues in the political domain, and the consequent under-resourcing of the area regardless of what the facts tell us about the national burden of disease.

(Lindsay Irons, Office of the Public Advocate, 'Mental Health in Queensland Today', Speech delivered at the Public Advocate's Mental Health Forum, Brisbane 01 June 2004, page 1)

It is now well acknowledged that the predictive factors of emotional and social well-being are diverse indeed. It has been said many times before that, while there is considerable focus on inpatient hospital care, it is not the health system which largely determines the community's health – contrary to what most medical clinicians might believe. Nowhere is this more apparent than in mental health. In fact, many risk and protective factors for mental illness lie beyond not only the field of psychiatry, but also beyond the health system itself. These factors are complex, and obtain from the circumstances of our everyday lives – material well being, education, community inclusion and acceptance, employment opportunities, social cohesion and, perhaps most importantly, housing and accommodation.

(Lindsay Irons, Office of the Public Advocate, 'Mental Health in Queensland Today', Speech delivered at the Public Advocate's Mental Health Forum, Brisbane 01 June 2004, page 3)

2.7.3.2 Key issues raised by consultations and submissions

The key issues identified in Queensland were:

i) limited access to key services, particularly in larger regional and rural centres;
ii) poor resource distribution across the state;
iii) stigma and stereotypes being apparent in the community and perpetuated by the media;
iv) very poor treatment of Indigenous persons with mental disorders;
v) lack of rehabilitation and supported employment programs;
vi) lack of adequate consultation measures with consumers, families and carers;
vii) unresponsive complaints processes; and
viii) lack of support by a wide variety of government departments (health, housing, employment, justice) to enable persons with illness to reside in the community.

2.7.3.3 Positive developments

Attention was drawn to a number of positive state-wide developments or local initiatives. These included:

i)   use of e-health and telepsychiatry mechanisms to attempt to overcome some of the geographical challenges;

ii)   better coordination of GP-based mental health developments; and

iii)   Queensland's Mental Health Court.

Queensland: Queensland's Mental Health Court

At this time [28 February 2002] The Mental Health Court was established to make determinations in relation to persons with a mental illness or intellectual disability who are charged with a criminal offence. It also hears appeals against decisions of the Mental Health Review Tribunal and is empowered to conduct enquiries of the detention of patients in authorised Mental Health Services…

The Mental Health Court is constituted by a Supreme Court Judge. The Judge is assisted by 2 Assisting Psychiatrists…The functions of the Court are: to decide references of the mental conditions of persons; to hear appeals from the Mental Health Review Tribunal; and to investigate the detention of patients in Authorised Mental Health Services…The matter of a person's mental condition relating to an indictable offence may be referred to the Court if there is reasonable cause to believe that: the person is mentally ill or was mentally ill when the alleged offence was committed…

Once a reference is made, criminal proceedings are suspended until the Court has made its decision on the reference …

Where a person is found not of unsound mind and fit for trial the Court orders the proceedings continue according to Law and, depending on the person's mental health and the circumstances of the case, it may order that he/she remain in hospital, be remanded in custody or be granted bail. Where the Court finds that the patient was of unsound mind at the time of the offence or that he/she is unfit for trial it may make a Forensic Order. The person then becomes an involuntary patient at an Authorised Mental Heath Service. The Court may order that he/she be placed in a Secure Unit or other Service for inpatient treatment and care and may approve limited Community Treatment. A person found to be unfit for trial but not permanently so will be subject to regular reviews by the Mental Health Review Tribunal…

It is the view of the Court that it must take into consideration not only the patient's treatment needs but the protection of the community and always in the context of the seriousness of the crime.

The Mental Health Court works well, as did its predecessor, the Mental Health Tribunal. It is unique and innovative. Its values have been under recognised in the fields of Law and Mental Health and its forensic interface. Public confidence in the system is warranted. … mentally ill offenders are identified early, treatment provided and ensured where necessary in a way which will protect the public…. Expansion of rights and responsibilities, accountability and best practice in law and medicine does not come cheaply. There must be no deterioration through attrition.

(Lawrence JM, (2004) Queensland's Mental Health Court: The first twelve months)

2.7.3.4 National Mental Health Report 2004 (analysis of expenditure and services)

Although Queensland still finished _last_ in per capita spending on specialised mental health services when compared with all other jurisdictions ($84.83, national average of $92.03), mental health spending had increased 41.8% in per capita terms over the last decade (with the national state average being 26.2%). In Queensland, there has been a considerable growth in community and general hospital services ($151m,

compared with the national high of $291.2m in Victoria), and a modest reduction in spending on stand alone institutions (-$27.9m compared with Victoria's national high of –$180.5m).

In terms of clinical staff employed in ambulatory care settings Queensland finished last again (29.8/100,000 population compared with national average of 35.9). With regard to clinical care staff, Queensland ranks fifth (89.7/100,000), just below the national average of 90.0. However, Queensland finished second highest in terms of funding to non-government organisations (7.0% of mental health funding compared with national average of 5.5% and a national high of 9.3% in Victoria). Queensland ranks fourth in terms of total inpatient and 24 hour staffed residential beds per 100,000 population (37.3 compared with a national high of 51.0 in Tasmania). Total public sector inpatient beds in Queensland ranked second in the Commonwealth (35.1/100,000).

2.7.3.5 Mental Health Council Survey Reports

A total of 95 responses to the survey were received from Queensland organisations or individuals (see Part 3 of the full report). As Queensland has been consistently one of the lowest of all jurisdictions with regard to expenditure, and given the specific geographical and population challenges it faces, it is unsurprising that it mirrors the national trends for low implementation of key priorities (namely early intervention [16%], innovative services for comorbid substance abuse [10%], wider spectrum of acute and community care [7%], implementation of the national mental health standards [19%], programs to support attitudinal change [9%]). The Queensland system appears to rely particularly heavily on hospital bed-based notions of acute care. Similarly for state-wide initiatives, there was a low level of perceived support for or implementation of key initiatives (namely, specific inter-governmental service agreements [11%], enhanced access [11%], clear accountability for funds [11%], or recognition of support for innovation [12%]).

2.7.3.6 Conclusions

Over the past year, the Office has endeavoured to gain a better understanding of the experience of Queensland citizens who have a mental illness or psychiatric disability. In doing so, the Office has witnessed divergent, almost irreconcilable, views of policy-makers and patient advocates across the state…Policy-makers highlight the achievements already made in mental health…However there is a widespread view on the part of the patient advocates across Australia that the mental health system is in crisis…..

The Office acknowledges the progress achieved by the Queensland mental health system over the past decade, and the ongoing reform process that is underway. However, these should not blind us to the systemic problems identified within the service system, nor to the level of scrutiny and resolve that will be needed to address them.

(Annual Report 2003/4, Office of the Public Advocate, Queensland)

The conclusions reached by the Queensland Office of Public Advocate are consistent with the submissions and presentation made to the MHCA. As in many jurisdictions, the Office has pointed to the gap between the views of policy makers and those responsible for administering care; and those who use the services and the clinicians employed.

The challenges facing mental health development in Queensland are large. There have been decades of neglect and low expenditure and there are cultural, demographic and geographical hurdles to face. There needs to be changes in resource investment, accountability mechanisms and workforce development to improve experiences of care within mental health services. While there have been important developments in Queensland child and family mental health, Indigenous health, population mental health and significant new

commitments in basic neurosciences, there is no clear commitment to a radical enhancement of services, particularly within the larger regional centres and rural communities. Political, professional and community leadership is urgently required. Additionally, an emphasis on blaming the existing workforces for failures in service delivery needs to be rejected. The current inquiries into Queensland Health established in May 2005 offer an opportunity for fundamental reform of the entire health care system.

2.7.4   SOUTH AUSTRALIA

2.7.4.1 Overview

Crises in mental health services are rarely out of the news in South Australia. The services have undergone multiple reviews over the last decade. There have been now been three directors of the state mental health service since late 2001 (although one of these changes was brought about by the tragic murder of Dr Margaret Tobin).

However, as reported in the National Mental Health Report (2002), the task of substantive reform and a move way from an institutionally-base service system has only made limited progress. Since the election of the Rann Government, there has been little perceived progress in terms of resolution of the long-standing service organisation and delivery problems. The recently formed Mental Health Coalition has produced a blueprint of major items requiring urgent attention.

Over the years, South Australia has repeatedly acknowledged that it has neglected mental health and failed to implement reforms within adequate time frames. For example, in 2002 SA stated:

> *In the National Mental Health Report 2000, South Australia acknowledged inadequate demonstration of progress and lack of coordinated focus towards achieving the nationally agreed objectives. This year we are able to report significant progress toward these objectives. South Australia continues to strive toward implementing the Second National Mental Health Plan, while acknowledging that we are still actively pursuing completion on some components of the First National Mental Health Plan.*
>
> (National Mental Health Report 2002, p. 92)

More recently, in June 2003, after the release of the Final Report of the Generational Health Review (2003), the SA Government again acknowledged it had neglected mental health reform:

> *Mental Health has been neglected in this State for almost 10 years. Independent audits have proven our state is far behind national standards. This must change. On coming to government we immediately committed an extra $34 million over four years for mental health reform, to build much needed services in the community. This is just the beginning. We will continue to implement mental health reforms and build the necessary supports our community deserves.*
>
> (First Steps Forward – South Australia Health Reform, June 2003,
> Hon. Mike Rann, Premier, and Hon. Lea Stevens, Minister for Health)

Specifically, the Final Report of the Generational Health Review (2003) identified that in SA there were significant health inequalities for some population groups and that these groups had very poor health or limited access to health services. Included in these groups were: people with mental illness, Aboriginal people and young children. It was acknowledged in this report that the health system alone could not address these inequalities and a whole-of-government approach was required (Recommendation 6.1). With regards to people with mental illness, the report made the following specific recommendation:

Recommendation 6.15 The State Government as a priority, fund DHS to implement the ongoing mental health reform agenda, including provision of parallel capacity, a capital and service development plan, legislation, workforce, improved service system coordination, community mental health reform, and community consultation and communication.

The mental health reform agenda referred to is *The Action Plan from Reform of Mental Health Services 2001-2005* (Mental Health Services, Department of Human Services, 2001). Despite these acknowledgements and pledges of funding and implementation of reform, to date, little has changed with regards to mental health service delivery. As stated earlier in this Report, South Australia still has a major focus on the provision of acute inpatient care and has failed to divert resources to the expansion of community based services.

Unlike many other states, the SA Government has acknowledged that poor health and limited access to services for people with mental illness is a human rights issue, and that in SA certain groups are discriminated against and inequity has resulted.

Enjoyment of the highest attainable standard of health is a fundamental right of everyone.…Health as a human right means universal access to adequate health care, but also access to education and information, and the right to food in sufficient quantity and quality, to decent housing and to live and work in an environment where known health risks are controlled…Nonetheless Australia, like all other countries, does have human rights blemishes and ongoing work is required to guard against human rights abuses. The purpose of this section is to specify several population groups that require specific effort. **The right to health is not equitably distributed**. *GHR [Generational Health Review] has identified the following population groups for priority attention:…People with mental health issues...All need to be considered within a whole-of-government approach. (author's emphasis)*

(Final Report of the Generational Health Review, 2003, pages 153-154)

The continued and increasing presentation of people with mental illness before the criminal justice system is reaching crisis point, especially with the piloting of a new police prosecution policy in 2004. The increasing number was linked both with the policy, but more importantly, with the failure of mental health services to provide adequate treatment and support resulting in police and the criminal justice system becoming the de facto mental health service:

That the police are the only agency that will take the calls of members of the community upon whom the actions of the mentally ill may be impacting does not mean courts are then required to engage in long and expensive criminal justice processes resulting in people with mental illnesses being rebadged as criminals and institutionalised in jails instead of in hospitals…There comes a point at which it is necessary to say 'enough', and this court has reached that point.

(Quote by Magistrate Rosanne McInnes in article by Rebecca DiGirolamo
"Law row over man who thinks he's god", The Australian, 30 July 2004)

Perhaps the best indication of the ongoing crisis in mental health services in SA was the resignation of the Director of Services, and past President of the RANZCP, Dr Johnathon Phillips in May 2005. He was reported by *The Advertiser* as saying he had "left a system that had hit the wall". The Government has attempted to respond to these challenges but the experiences of care reported by those who use services remain poor.

2.7.4.2 Key issues

The key issues raised in the public consultations and formal submissions in South Australia were:

i)   there is an urgent need for new models of care to be adopted. The strong and ongoing reliance on institutional and inpatient models has limited the development of community-based care;

ii)   there is a major lack of basic services in most smaller communities outside of Adelaide;

iii)   there is a general lack of community based health and accommodation services;

iv)   lack of meaningful consultation with consumer and carer representatives;

v)   lack of attention to the needs of Indigenous people;

vi)   lack of services for children and adolescents; and

vii)   high levels of stigma and discrimination in the community, with particular emphasis on potential for violence.

2.7.4.3 Positive developments

Against this backdrop of considerable community frustration, some model programs have been developed and implemented. For example: the Magistrates Court Diversion Program; the Medical Specialist Outreach Assistance Programme in South Australia; the uptake of new General Practice Initiatives and the development of a Mental Health Coalition of Providers to advocate for immediate reforms.

South Australia: The Magistrates Court Diversion Program – Diverting people with mental illness out of the criminal justice system

The pilot Magistrates Court Diversion Program (MCDP), which…commenced operation in the Adelaide Magistrates Court in August 1999…was the first 'problem solving' court in Australia designed to deal with offenders with mental impairment…The impetus for this court came, in part, from South Australia's then Chief Magistrate who recognised that courts needed to improve their ability to identify and respond to people who had a mental impairment. He noted that people "who did not belong in the criminal justice system" were continually appearing before Magistrates and were "being punished for things which were nothing but a manifestation of their problems. (Alan Moss, 1999).

Aims and Objectives of The Magistrates Court Diversion Program…The MCDP was designed to 'better ensure that people with a mental impairment who come before the court have access to appropriate interventions that will assist in addressing their offending behaviour' (Justice Strategy Unit, 2000). Overall then, in line with other courts predicated on a therapeutic jurisprudence model…the aim was to use the defendant's contact with the criminal justice system as a vehicle for providing a treatment and support program designed to effect behavioural change.

Description of The Program Persons suspected of a mental impairment and who are charged with a summary or minor indictable offence are referred to the program, generally at the time the charges are laid. Upon referral, the individual is assessed to determine his/her suitability for the program. At that time, the defendant's willingness to participate is also ascertained. Those who do not want to participate are referred back to the normal court process...If a defendant is accepted onto the program, his/her case is then adjourned and an individualised intervention plan is developed which outlines appropriate intervention strategies designed to address the individual's mental impairment issues, any associated factors such as homelessness, and drug and alcohol addiction. For many clients who are already in treatment, the program aims to reinforce and support their continued engagement with their treatment or service provider. For others, it may involve referral to new treatment agencies and services. It should be noted that the court itself does not provide treatment. Instead, the client is referred to existing treatment and service providers…At the end of the program (which generally extends for between 4 to 6 months), the charges against some defendants are withdrawn by

prosecution. In the majority of cases, though, the defendant is sentenced, with his/her progress while on the program taken into account at that point. The majority of defendants are given a good behaviour bond.

Evaluating The Program…Overall, the results showed a reduction in both the number of participants who were apprehended for offending post-program compared with pre-program, as well as a reduction in the actual number of incidents charged against this group. In particular: There was a significant reduction in the number of participants who offended as well as in the number of incidents detected post-program. Two thirds (66.2%) of program participants did not offend during their post-program year 1. At an individual level, just over three quarters (76.4%) of the participants either became non-offenders or were charged with a smaller number of incidents post-program…Although these findings must be treated with caution, they suggest that the program may be having a greater impact on the more serious pre-program offenders…These findings…auger well for its future.

(Office of Crime Statistics and Research, Attorney-General's Department, Government of South Australia,
South Australia Submission #278)

The Medical Specialist Outreach Assistance Programme in South Australia – Improving services to rural and regional areas

November 2003 marks the second anniversary of the expansion of visiting psychiatric services to rural South Australia under the Medical Specialist Outreach Assistance Programme (MSOAP)…The MSOAP-funded psychiatrists now visit 20 towns and communities in rural and remote South Australia. They provide consultation/liaison services that emphasize the upskilling of local general practitioners (GPs) and other health-care workers. Although most of the visiting psychiatrists provide adult services, child psychiatrists now visit four regional centres. The child psychiatry services have been an important development for MSOAP because this is an area of special need and clinician numbers are quite limited. Local child mental health services are highly desired. The disruption to family life is substantial when a child is ill and treatment always involves the inclusion of one or both parents and often other family members. If treatment occurs in the capital city, there is inevitably a major disruption to the family routine, with substantial stress arising from the added costs and social dislocation. Furthermore, the provision of child psychiatric services in the local community facilitates the mobilization of the community resources for the immediate treatment and ongoing management of the child's condition. The new MSOAP services are likely to improve continuity of care and will help prevent future complications and trauma, both for the patient concerned and the local community. Indigenous South Australians are also beginning to benefit from MSOAP initiatives.

(Nigel Cord-Udy, Psychiatrist, South Australia Submission #274)

2.7.4.4 NMHR 2004 (analysis of expenditure and services)

According to the NMHR 2004, South Australia finishes third out of the eight states and territories in terms of per capita expenditure ($96.19), just above the national average ($92.03). It was ranked second in 1992-93 at the start of the national strategy. Over the last decade, mental health spending has increased 25.5% in per capita terms, close to the national state average of 26.2% but well below the national high in Western Australia [52.4%]). In distinct contrast to all other states and territories, there has been very modest growth in community and general hospital services spending ($37.8 m, compared with Victoria's $291.2m) and a zero reduction in spending on stand alone institutions (compared with the highest reduction Victoria of –$180.5m).

In terms of clinical staff employed in ambulatory care settings South Australia ranks fourth (39.0/100,000 population compared with national average of 35.9 and the highest of 42.9 in Western Australia). With regard to clinical care staff, SA ranks second (102.2/100,000) and is above the national average of 90.0. SA is the lowest state in terms of funding to non-government organisations (1.9% of mental health funding compared with national average of 5.5%). SA ranks second in terms of total inpatient and 24 hour staffed residential beds per 100,000 population (45.0 compared with the highest of 51.0 in Tasmania), but is quite different from other

states in that nearly all such beds are within hospitals and that 73% of such beds are within stand alone psychiatric hospitals (compares to the national average of 39% and the lowest in Tasmania at 6% and Victoria at 11%.). Total public sector inpatient beds in South Australia are the highest in the Commonwealth (43.7/100,000).

2.7.4.5 Mental Health Council Survey Reports

A total of 69 responses to the survey were received from South Australian organisations or individuals (see Part 3). As expected, given the very high reliance on traditional institutional approaches to mental health care in SA, there was a very low level of perceived support for actual implementation of the community's key priorities for mental health reform at a local level (namely early intervention [7%], innovative services for comorbid substance abuse [9%], wider spectrum of acute and community care [12%], implementation of the national mental health standards [7%], programs to support attitudinal change [6%]). The results largely reflect those same characteristics of lack of real action that were reported by the state Mental Health Unit in 2002. Similarly for state-wide initiatives, there was a very low level of perceived support for or implementation of key initiatives (namely, specific inter-governmental service agreements [6%], enhanced access [9%], clear accountability for funds [7%], or recognition of support for innovation [6%]).

2.7.4.6 Conclusion

Despite repeated inquiries and multiple government commitments, there has been little evidence of substantial mental health reform in South Australia. It remains the State with the greatest emphasis on institutional forms of care. While a great deal of community, media and professional criticism has been expressed about proposed changes to the mix of hospital and community care, there is also a clear desire for real reform. Reform will need to be backed by genuine resource investment as well as real leadership.

2.7.5 WESTERN AUSTRALIA

2.7.5.1 Overview

Whilst the West Australian Government has signed each of the National Mental Health Plans over the last decade, and significantly increased its per capita expenditure relative to other states, its actions have not yet led to implementation of an effective mental health system. Current mechanisms for leadership, reform implementation and accountability in mental health have failed to bring about the necessary changes. Although very recently new funding commitments have been made, other aspects of current planning suggest that the size and scope of the problem is not apparent to those who drive health reform in WA.

Evidence of the current dissatisfaction with both the availability and quality of mental health services was recently reported by the Standing Committee on Environment and Public Affairs in its inquiry into the provision of Mental Health Services in Western Australia. The Interim Report released in November 2004 stated:

> *The majority of the submissions expressed serious concerns that the mental health services in Western Australia are inadequate and consumers cannot get access to services when needed. Also expressed was a frustration at the lack of funding going into the mental health system, which has resulted in poor conditions and an increased level of need.*
>
> (Standing Committee on Environment and Public Affairs, Report 12, November 2004, p 7)

Furthermore, the recent Report of the Health Reform Committee *A Health Future for West Australians* fails to recommend significant changes to redress inequities of access and improved service delivery for people with mental illness. In the 86 recommendations made by the Committee only three recommendations were made directly pertaining to mental health. These recommendations were broad, and hence inadequate for facilitating genuine reform:

> *Recommendation 12:* Recognising the importance of mental health and the projected growth in mental illness, a whole of government approach to mental health and mental illness is needed to provide a framework for action by government departments, the non-government sector and the community.
> *Recommendation 13:* A major focus in the treatment of mental health should be in prevention and early intervention programs and services.
> *Recommendation 14:* Initiatives aimed at improving community-based mental health care and the integration of these services with the hospital, mental health hostel and supported accommodation sector should be pursued.
>
> <div align="right">(Health Reform Committee, A Health Future for West Australians, March 2004)</div>

Other recommendations spoke of the reconfiguring of hospitals to provide mental health services (viz Recommendations 26 and 28) indicating a failure to commit to the improvement of community-based services but instead returning to hospital-based forms of care. This is supported by the Committee's analysis of expected growth in demand for hospital bed days in psychiatry and failure to realise that if community-based treatment and support services were improved, potential crises resulting in the requirement for hospitalisation could be averted.

> *The expected dramatic growth...in psychiatry where the additional demand will take up 315 beds by 2013/14.*
> <div align="right">(Health Reform Committee, A Health Future for West Australians, March 2004, p. 13)</div>

Importantly, in the section devoted to 'Equity in Health and Health Care' people with mental health problems are identified as one of three major groups where there are 'significant disparities and gaps in health status and access to health care' (the other two groups being Indigenous people and people of lower socio-economic status). Apart from being a listed group requiring focus in 'Reducing Inequities' very little substantive information was provided to address this. Even Recommendation 72, which advocated a funding model that quarantined funding for mental health services and programs, lacks the clarity need for decisive implementation action.

2.7.5.2 Key issues

The community consultation process and formal submissions in WA highlighted many of the issues associated with providing accessible and reasonable quality services across a vast geographical area and within the context of historically-low levels of investment. The key issues raised were:

i)   very poor access to basic levels of services, particularly in any of the major centres outside of Perth;

ii)   tendency to replace real clinical services with telephone triage services;

iii)   inadequate community-based health and housing services;

iv)   excessive use of physical restraint and sedation for the purposes of transfer for psychiatric assessment;

v)   lack of consultation with consumers, families and carers;

vi)   lack of services for children and adolescents; and

vii)   increasing reliance on security guards and services rather than expansion of clinical services.

2.7.5.3 Positive developments

Western Australia has been recognised previously for significant developments in general practice-based mental health partnerships and Indigenous mental health service developments. The uptake of the Federally-funded *Better Outcomes in Mental Health* program in Perth, Fremantle and surrounds is particularly notable (Hickie et al. 2004). This has increased access to clinical psychologists and associated non-pharmacological treatment options.

The development of a state-wide service quality review program through the Office of the Chief Psychiatrist is seen as a key quality and safety initiative. The Office of the Chief Psychiatrist has conducted 11 reviews with three of these being the pilots for the development of a clinical governance framework (visit http://www.chiefpsychiatrist.health.wa.gov.au*)*. The new framework includes consumers and carers in the review process. Training is provided to them to enable more effective participation alongside clinicians. Most importantly, the framework adopted by the Chief Psychiatrist's Office recognises the consumer's experience of care "as paramount".

> *The Chief Psychiatrist's Clinical Governance Review Program commenced in November 2003 with the introduction of the Chief Psychiatrist's Clinical Governance Review Framework and the development of methodology designed to assess levels of clinical governance implementation. As part of the program development the Chief Psychiatrist has completed three pilot reviews...*
>
> *These three sites provided the Chief Psychiatrist with the opportunity to test the review methodology in three different settings including metropolitan, rural and in a statewide forensic environment. Each of the reviews provided challenges in relation to the methods used to assess clinical governance implementation and in particular the recruitment of consumers and carers to participate in the review process. As a result of the three pilots the Chief Psychiatrist has expanded the review methodology to enable consumers and carers to provide feedback in a variety of ways. A Clinical Governance Review Guide for Mental Health Services is currently being developed and will be available from the Office of the Chief Psychiatrist (OCP) website in March 2005.*
>
> In addition to refining the methodology the pilots also provided the Chief Psychiatrist with the opportunity to further develop the Clinical Governance Reviewer Training Program. The program offers a one-day training session for clinical governance reviewers and includes consumer and carer reviewers. Reviewers are provided with a background in clinical governance, an in-depth review of the methodology to be employed during the site visit and are also given an opportunity to practice the types of skills that will be required of them during the review period. A Clinical Governance Reviewer Training Manual has been developed as part of the program.
>
> (Office of the Chief Psychiatrist, WA, Inform Newsletter, Summer 2005, p. 4)

The potential for this process to impact on local services is significant. It is hoped that data from this exercise will be publicly released on an ongoing basis.

2.7.5.4 NMHR 2004 (analysis of expenditure and services)

Western Australia led the way in per capita spending ($110.82, national average of $92.03), having substantially improved its position from fourth in 1992-93. Over the last decade, mental health spending has increased 52.4% in per capita terms with the national state average being 26.2%. In WA, there has been a considerable growth in community and general hospital services ($107m compared with the national high of $291.2 m in Victoria, but only a modest reduction in spending on stand alone institutions (-$13.8 m compared with the national high in Victoria of –$180.5m).

In terms of clinical staff employed in ambulatory care settings WA also ranks first (42.9/100,000 population compared with national average of 35.9). With regard to clinical care staff, WA ranks third (101.5/100,000) well above the national average of 90.0. WA ranks third in terms of funding to non-government organisations (5.7% of mental health funding compared with the national average of 5.5%). However, WA ranks fifth in terms of total inpatient and 24 hour staffed residential beds per 100,000 population (34.4 compared with the highest nationally of 51.0 in Tasmania). Total public sector inpatient beds in WA ranked third in the Commonwealth (33.2/100,000).

2.7.5.5 Mental Health Council Survey Reports

A total of 99 responses to the survey were received from West Australian organisations or individuals (see Part 3). As Western Australia has been at the higher levels of expenditure when compared with other jurisdictions, one would anticipate more evidence of implementation of key community priorities (namely early intervention [26%], innovative services for comorbid substance abuse [15%], wider spectrum of acute and community care [13%], implementation of the national mental health standards [17%], programs to support attitudinal change [12%]). The result for implementation of early intervention strategies was one of the better results nationally. For state-wide initiatives, the reporting of implementation was comparable with other states and territories (namely, specific inter-governmental service agreements [16%], enhanced access [11%], clear accountability for funds [8%], or recognition of support for innovation [11%]).

2.7.5.6 Conclusions

While WA has increased its spending in mental health and made major commitments to primary mental health care (in association with Federal funding enhancements) it faces considerable cultural, geographic and professional challenges. There is a real need to articulate an agenda for the development of community-based care and quality primary and secondary mental heath services in the larger regional and more remote rural centres.

2.7.6   AUSTRALIAN CAPITAL TERRITORY

2.7.6.1 Overview

Over the past three years the ACT Government has committed substantial energy to devising a new framework within which to improve the mental health and well-being for those living in the Australian Capital Territory. In November 2002, ACT Health released *Health Action Plan 2002* which set the direction for public health services in the ACT for the subsequent three to five years. Importantly, the Health Action Plan prioritised mental health as a strategic area of focus and recognised the health inequalities (both in terms of health status and access to services) experienced by people with mental illness.

The Health Action Plan also acknowledged that the ACT was ranked last in comparison with other states and the Northern Territory in 1999-2000 with regard to expenditure on mental health and that increasing the resources allocated to mental health was a key priority for the future. The Government indicated that these additional resources would not be dependant on additional resources being committed to the health budget; instead "the Government will place a high priority on increasing the funding for key priorities in the annual budget processes" (Health Action Plan 2002, page 5).

The identification of mental health as a key priority area resulted in the Department of Health and Community Care conducting a wide consultation process to develop the *ACT Mental Health Strategy and Action Plan 2003-2008.* The Mental Health Strategy and Action Plan continues the emphasis on equity for all people with mental illness and the community as articulated in the Health Action Plan:

> *The principles that underpin the Plan reflect a **framework of human rights** and promote a fresh and innovative approach to managing mental health issues…It is important to note that the vision for mental health in the ACT focuses on maintaining good mental health. The Plan acknowledges that mental health is the responsibility of the whole community **and it aims to facilitate a shift in emphasis away from treatment towards a well-being model**. This shift will require clinical and welfare services, accommodation services and other social and economic services in the community committing to this cultural change…The Plan is aligned with the broader policy framework of the Canberra Plan and, in particular the Social Plan, together with the ACT Health Action Plan and a range of other strategies being developed in the ACT and nationally. (emphasis added)*
>
> (ACT Mental Health Strategy and Action Plan 2003-2008, p. 4)

Key features of the strategy include: emphasis on mental health promotion; expanded support for prevention and early intervention initiatives; emphasis on access and integrated service delivery especially for high prevalence disorders; a focus on recovery and improved links with supported accommodation, vocational training and rehabilitation services; and systems which enhance accountability and the planning, implementation and evaluation of service delivery.

> *Both consumers and carers reported that in the ACT it is almost impossible to get intervention or be listened to at an early stage when warning signs are initially beginning to appear.*
>
> (ACT Mental Health Consumer and Carer Caucus, Australian Capital Territory
> Submission # 342)

As a consequence of the Strategy, the *ACT Mental Health Promotion Prevention and Early Intervention (PPEI) Plan 2004-2008* was released in December 2004. The PPEI Plan uses a whole of community model for mental health and lists actions to promote mental health, prevent illness and enable the consumer and the mental health system to respond to early warning signs for established illness to reduce the impact of illness. The PPEI Plan identifies specific strategies and actions for priority groups which address critical gaps in mental health service delivery, whole of government approaches and stigma reduction and community acceptance campaigns. The plan however, fails to address the key problem of shortage of services (mental health, accommodation etc) and clinicians to support the responses required.

2.7.6.2 Key issues

The key issues identified in public consultations and formal submissions in the ACT were:

i) great deal of difficulty accessing services, even in a crisis;
ii) totally inadequate approach to management of forensic mental health issues;
iii) lack of basic hospital and rehabilitation services;
iv) little attention to issues of early intervention;
v) major staff shortages impacting on quality of services delivered;
vi) large role played by police and emergency service in acute mental health care;
vii) lack of community-based health and housing services; and
viii) inadequate responses to serious incidents.

2.7.6.3 Positive developments

The most positive development in the ACT is the willingness of the Government to recognise the inadequacies of the current system. Generally, the Government has been non-defensive and willing to work with other national developments. The government has undertaken a number of reviews of the mental health services – in 2002/03 the "Investigation into Risk of Harm to Clients of Mental Health Services" (Patterson report) and in 2003 "*The review of the design and operation of the Psychiatry Services Unit (PSU), Canberra Hospital*" (Mann/LaRoche Report). The Government has acted quickly to implement all 58 recommendations of the Patterson report and commit to capital works to address the problems at the PSU.

Another notable development of the ACT Government has been the enactment of Australia's first Bill of Rights under the ACT Human Rights Act in 2004. The Government has engaged Monash University to audit the ACT Mental Health Act 1994 against the Human Rights Act. The results of the audit will be of interest to all those involved in mental health care in Australia.

2.7.6.4 NMHR 2004 (analysis of expenditure and services)

According to the NMHR 2004, the ACT finishes seventh out of the eight states and territories in terms of per capita expenditure ($84.86), well below the national average ($92.03) and unchanged from its ranking in 1992-93. Over the last decade, mental health spending has increased 38.3% in per capita terms, above the national state average of 26.2% but well below the nation's highest increase in Western Australia [52.4%]). In terms of clinical staff employed in ambulatory care settings the ACT ranks second (42.6/100,000 population compared with national average of 35.9). With regard to clinical care staff, the ACT ranks sixth (82.6/100,000) - well below the national average of 90.0. The ACT is mid-ranking in terms of funding to non-government organisations (5.5% of mental health funding compared with national average of 5.5%). The ACT ranks seventh in terms of total inpatient and 24 hour staffed residential beds per 100,000 population (21.9 compared with 51.0 in Tasmania). Total public sector inpatient beds in the ACT ranked last in the Commonwealth (14.7/100,000).

2.7.6.5 Mental Health Council Survey Reports

Given the population of the ACT, there was a larger than expected number of responses to the survey from ACT-based organisations and individuals (n=43). The level of perceived support for actual implementation at a local level of the community's top five priorities for mental health reform was better than in most other states (namely early intervention [21%], innovative services for comorbid substance abuse [16%], wider spectrum of acute and community care [21%], implementation of the national mental health standards [23%], programs to support attitudinal change [23%]). With regard to territory-wide initiatives, there was generally a low level of perceived support for, or implementation of key initiatives (namely, specific inter-governmental service agreements [26%], support for innovation [12%], enhanced access [5%], and clear accountability for funds [16%]).

2.7.6.6 Conclusions

The most important aspect of recent developments in the ACT has been the clear commitment of the Government to rapid improvement in mental health services. There appears to be both community and political awareness of the parlous state of services. The range of infrastructure, attitudinal and workforce challenges, however, are considerable.

2.7.7   NORTHERN TERRITORY

2.7.7.1 Overview

Mental health services have a long history of neglect in the Northern Territory, particularly in the rural and remote regions and specifically for Indigenous persons. The socio-demographic, health and population profile of persons living in the NT, however, indicates that from a mental health perspective it is one of the most at-risk groups in the nation. However, there has recently been a state-wide review of mental health services and a commitment to improve services outside Darwin.

While the Government has committed an additional $12.7 million extra funding into mental health services, the recent *Building Healthier Communities: A Framework for Health and Community Services 2004-2009* mentions gaps in the delivery of services as though they were minor irregularities amidst a "high quality health and community services system" (page 18). It states that "most Territorians enjoy services as good as – or better than – those in other parts of regional Australia" (page 3). These remarks neglect the reality of poor service access and health outcomes for Aboriginal Territorians and people living outside Darwin or Alice Springs in remote communities. Very little specific detail was provided with respect to programs or areas targeted for development.

The *Building Healthier Communities* framework was developed after the review of the Department of Health and Community Services by a team led by Alan Bansemer. The Bansemer Report specifically noted that there were significant problems with the health and community services budget and 'inadequate management in key areas, lack of transparency in resource allocation, poor budget control, and service "creep"' (page 13). With regard to mental health services, the report identified that given the poor level of coverage of services across the Territory, there was need for mental health services to be brought 'to a parity level with other Australian jurisdictions' (Recommendation 082). Furthermore, given the magnitude of the problem of substance abuse and its relationship with mental health in the Territory, the Bansemer Report recommended that 'A Mental Health and Alcohol and Drug Services Division should be established and should be charged with responsibility for ensuring the provision of a full range of mental health services across the NT' (Recommendation 081). This recommendation was not adopted.

In August 2002 the NT Department of Health and Community Services engaged Healthcare Management Advisors (HMA) "to assess and make recommendations on the core elements of a Mental Health Service System Development Strategy". The final report was released on February 2003. In its review of mental health services during 2002, HMA noted the relatively limited emphasis on mental health promotion, the limited emphasis on the development and implementation of mental health prevention strategies and early intervention, and that these were poorly addressed within the system. This was attributed to the relative scarcity of resources and a focus on the treatment of acute mental illness (HMA Final Report, 2003).

The following characteristics were also noted as significant considerations for the planning of mental health services: the NT is characterised by two populations (those residing in metropolitan Darwin and those in smaller remote communities across the Territory); the large Indigenous population and the social, economic and cultural strains placed on Indigenous communities in remotes areas distinguishes the NT from other States and Territories regarding planning and resource distribution; the need for a whole of government approach is particularly important given the diverse social and economic factors which impact on mental health in the NT. The HMA recommended that due to the magnitude of the problems to be addressed and population distribution, that "consideration be given to allocating a minimum of 1.5 times the national average per capita funding for the population living outside the Darwin and Alice Springs metropolitan areas" (recommendation

3). Due to the lack of detail in the *Building Healthier Communities* report, it was difficult to determine the level of adoption of the recommendations made in this report.

2.7.7.2 Key issues

The key issues identified in the public consultations in the Northern Territory were:

i)   lack of access to basic assessment and treatment services, even during periods of crisis;

ii)   tendency to rely heavily on police and other emergency and custodial services rather than providing mental health care;

iii)   lack of services for persons with comorbid mental health and alcohol or other substance abuse disorders;

iv)   lack of focus on any prevention or early intervention programs;

v)   lack of appropriate medical, nursing and other staff to support service developments in services outside of Darwin;

vi)   lack of sufficient development of culturally appropriate treatment services for Indigenous persons, particularly within remote communities;

vii)   lack of attention to the close relationships between poor physical health and mental health problems, particularly in Indigenous persons;

viii) lack of support for non-government organisations and for provision of housing and accommodation services;

ix)   lack of sufficient consultation with relevant consumer, carer, family and cultural groups; and

x)   less access to accepted forms of effective treatment.

2.7.7.3 Positive developments

Some of the positive developments in the Northern Territory include:

i)   some development of innovative primary care and other Indigenous programs to service remote communities; and

ii)   enhanced support by the Government and the responsible Minister.

Culturally Appropriate Services

> *One initiative to provide culturally appropriate mental health services is the employment of Aboriginal Mental Health Workers (AMHW). AMHWs play an instrumental role in overcoming challenges at the individual and community level by contributing to the delivery of well-informed information and interventions to Aboriginal people. They work hand in hand with the mainstream mental health professionals to provide services and act as brokers and mediators, as well as providing mental health assessments, management and education at an individual, family and community level.*
>
> (NT Department of Health and Community Services, Northern Territory, Submission #259)

2.7.7.4 NMHR 2004 (analysis of expenditure and services)

According to the NMHR 2004, the NT finishes fifth in terms of per capita expenditure ($85.56) and well below the national average ($92.03). Over the last decade, mental health spending has increased 36.9% in per capita terms, above the national state average of 26.2%. In terms of clinical staff employed in ambulatory care settings the NT ranks third (40.3/100,000 population compared with national average of 35.9). With regard to clinical care staff, the NT has the lowest number (78.1/100,000) and is well below the national average of 90.0. The NT ranks fifth in terms of funding to non-government organisations (5.4% of mental health funding, consistent with the national average of 5.5%). The NT ranks last in terms of total inpatient and 24 hour staffed residential beds per 100,000 population (16.2 compared with the highest nationally of 51.0 in Tasmania). Total public sector inpatient beds in the Northern Territory are also low (16.2/100,000), only outperforming the ACT (14.7).

2.7.7.5 Mental Health Council Survey Reports

Given the population of the NT, there were only a small number of responses to the survey (n=9). Although it is difficult to draw conclusions from this limited database, it was suggestive that major service developments are limited in the Territory.

2.7.7.6 Conclusions

In the past, mental health services have been seriously neglected in the Territory, particularly outside Darwin and specifically for the needs of younger persons and Indigenous people. In recent years the NT Government seems to have brought a stronger commitment to improving mental health however the results are not yet clear. As in Queensland and WA however, the challenges of culture, workforce, demographics and geography are large. A great deal of coordination of national and state-based enhancements is urgently required.

2.7.8 TASMANIA

2.7.8.1 Overview

Tasmania faces a range of medical workforce, infrastructure and community development challenges but has achieved some major reforms during the decade of the mental health strategy. The recent release of the *Bridging the Gap: Review of Mental Health Services* report in October 2004 and the accompanying $47 million four-year funding increase (announced 09 November, 2004) to implement some of the major recommendations of the report, heralds a significant opportunity for improving the delivery of services to people with mental illness in Tasmania.

Prior to this review, the Department of Health and Human Services in Tasmania had acknowledged that critical gaps existed in the delivery of services to people with mental illness as a result of the move from institutional to community-based care and incomplete implementation of three National Mental Health Plans (1993, 1998, 2003). *Bridging the Gap* addressed these and other pressing issues in the reform of service delivery and the announced funding package indicates the magnitude and breadth of problems faced by people with mental illness and/or mental health problems in Tasmania.

This package will fund an historic expansion of community mental health services to provide earlier access to more effective treatment. There will be a significant statewide increase in supported accommodation, and a new network of regional recovery programs.

(Media release, David Llewellyn, Deputy Premier,
$47 million to Bridge Gaps in Mental Health, 09 Nov 2004)

The comprehensiveness of this review, the areas targeted for reform and level of detail in the recommendations was made possible due to the composition of the Review Team and Reference Group and willingness to incorporate findings from a number of other recent reviews. In particular, findings from the *Supported Accommodation for People with Mental Health Problems Strategic Framework* (Department of Health and Human Services, final report released 24 November 2004) and *Thin Ice: Living with Serious Mental Illness and Poverty in Tasmania* (Anglicare Tasmania, May 2004) were used:

The overwhelming conclusion from this research is the urgent need for an increased range and supply of support services to assist people with serious mental illness and their families to live successfully in the community. Deinstitutionalisation has not failed. What has failed is the political will to fund essential support services in the community. The existing services are overwhelmed by the heavy demand they currently face and they are not able to provide the level of care and support required to assist recovery. This lack of support options dramatically increases the hardships faced by people who have a mental illness and their families, in terms of their health and their budgets. Ultimately, it is a failure of systems which is making people sick and forcing them into the costly acute care sector.

(Anglicare Tasmania, "Thin Ice: Living with Serious Mental Illness and Poverty in Tasmania",
Tasmania Submission #144, p2)

The report made recommendations in seven areas: quality and safety; specialist resource levels; community-based care (including supported accommodation); comprehensive care for all consumers; workforce development; strategic planning; and legislation and patient rights. Importantly the recommendations bring to life some of the theoretical underpinnings of the National Mental Health Plans that have previously prevented the realisation of community based care: lack of staff and resources in the community to provide early intervention and prevention services and supported accommodation options for people to live in their community. *Bridging the Gap* appears to lay the foundations for increasing community-based services across Tasmania. Increased funding to non-government organisations was also provided for, as was the distribution of resources to rural and regional areas, the growth of child and adolescent mental health services and immediate targeted expansion of the clinical workforce.

Anglicare CEO, the Rev'd Chris Jones, praised the fact that the $47 million investment would go to the areas those people had identified as vital to their ongoing survival within the communit. 'This money is going, as they said it needed to, into a range of supported accommodation models, increased resources for community mental health teams, and the establishment of a range of services in the community to assist them with their recovery and with everyday activities," he said. "However, it is imperative that their needs be recognised as a priority by State Governments beyond the life of this four-year package."…The Rev'd Jones said that people affected by serious mental illness and workers in the field had been struggling with a lack of support and resources for years. "It is gratifying that their voices have finally been heard and responded to," he said.

(Anglicare Tasmania website www.anglicare-tas.org.au 23 December 2004)

Another positive development to protect the rights of people with mental illness has been the Mental Health Tribunal Representation Scheme. This Scheme is described below.

2.7.8.2 Key issues

The key issues identified through the public consultations and submissions inevitably draw attention to the deficiencies in the service system that have also been identified and recognised by the Tasmanian Government. These include:

i)   lack of access to basic services, particularly for those who did not fit a narrow band of diagnostically-driven group of persons to be assisted;

ii)   lack of community-based health and housing services;

iii)   lack of attention to prevention, early intervention or recovery meant that most effort was reactive and acute care-based;

iv)   lack of service provision outside Hobart, with particular emphasis on workforce and resource shortages in the Northern parts of the States;

v)   lack of concern for persons with comorbid mental health and alcohol or other substance abuse problems; and

vi)   lack of consultation with consumers, staff and NGO service providers in the planning and delivery of services.

2.7.8.3 Positive developments

The Government's commitment to major new investments is the most positive development in Tasmania. Other examples, however, included:

i)   Tasmania's Mental Health Tribunal Representation Scheme.

Tasmania: Tasmania's Mental Health Tribunal Representation Scheme - Steps to protect the rights of people with mental illness

[T]he Tasmanian Mental Health Act 1996, s57, grants representation for people appearing before the Mental Health Tribunal in keeping with the United Nations Principles for the Protection of Persons with Mental Illness…Until the Representation Project was commenced this had not happened, despite the fact that Tasmanians can be, and are, deprived of their liberty in psychiatric hospitals across the state for 6 months, and beyond…This lack of representation was brought to Advocacy Tasmania Inc's attention in 2000 by Ms Debra Rigby, President of the Mental Health Tribunal…Ms Rigby expressed concern that people appearing before the Tribunal were unrepresented. She believed it was a denial of their rights and potentially disadvantageous for them. Of 102 hearings held in 1999/2000 only 2 clients were represented. Ms Rigby enquired as to whether the state mental health advocate's role included representing those mentally ill people appearing before the Mental Health Tribunal…

The mental health advocate, Ms Valerie Williams, did not, and could not provide the necessary representation as time and resources did not allow for the sole mental health advocate to provide a service for so many clients. However, Ms Williams…made the commitment that achieving representation for this group of mental health clients would be the mental health program's priority systemic issue and began working to achieve this goal.

In accordance with this commitment, Ms Williams, with the support of Advocacy Tasmania, the Mental Health Tribunal, the University of Tasmania, and a small grant from the Department of Health and Human Services (Mental Health Services), developed the Mental Health Representation Project. University of Tasmania Law Students offered their free time to undertake extensive training prior to providing voluntary representation for, arguably, Tasmania's most vulnerable citizens.

The project commenced in a limited way, offering representation before the Tribunal to patients in the Psychiatric Intensive Care Unit (PICU) and the Department of Psychological Medicine (DPM) at the Royal Hobart Hospital. Since commencement in early December 2003, at least 86 people have been offered free representation…The project has received positive support from patients, volunteers, the Mental Health Tribunal, Mental Health Services, clinicians, the Law Society as well as the University of Tasmania Law School and the Legal Practice Course. The Law School is planning to integrate the training of students into their mainstream program as an elective Mental Health Advocacy unit in 2005.

While the scheme has only operated in 2 of its 7 sites where Mental Health Tribunal hearings are held, it is aimed to expand the project to cover all of Tasmania within the coming months…The Pilot Project demonstrated that it is an effective model for providing representation to patients appearing before the Mental Health Tribunal. Prior to the commencement of this project the only means was for the patient or their family to employ a lawyer to provide the representation, which few are able to afford.

A long term expected outcome will be an improved quality of legal representations to people with a mental health disorder in the wider community because of the training and experience of lawyers when they were students. A long term unexpected outcome has been the response from other Australian states, with states such as Victoria, SA, WA and NSW expressing interest in the Scheme, and WA requesting Ms Williams to undertake specific training for a group of university students in Perth, where an elective in Mental Awareness is already established.

(Advocacy Tasmania Inc - Mental Health Tribunal Representation Scheme, Tasmania, Submission #189)

2.7.8.4 NMHR 2004 (analysis of expenditure and services)

According to the NMHR 2004, Tasmania finishes fourth in terms of per capita expenditure ($93.86) just above the national average ($92.03). Over the last decade, Tasmanian mental health spending has increased 25.7% in per capita terms, consistent with the national state average of 26.2%. Additionally, there has been a substantial reduction in expenditure on stand alone psychiatric hospitals (-$16.1m) and a growth in community and general hospital services ($26.2m). In terms of clinical staff employed in ambulatory care settings Tasmania ranks seventh (31.9/100,000 population, below the national average of 35.9). With regard to clinical care staff, however, Tasmania ranks first (104.0/100,000) well above the national average of 90.0. Tasmania ranks sixth in terms of funding to non-government organisations (3.3%, well below the national average of 5.5%). Tasmania ranks first in terms of total inpatient and 24 hour staffed residential beds per 100,000 population (51.0). Total public sector inpatient beds in Tasmania are mid-range at 30.9/100,000.

2.7.8.5 Mental Health Council Survey Reports

Given the size of Tasmania, it was not surprising that there was only a limited number of responses from local organisations and individuals (n=26) (see Part 3 of the full report). Although this is a limited data set there was little indication that the community's key priorities for mental health reform have been implemented (namely early intervention [8%], innovative services for comorbid substance abuse [4%], wider spectrum of acute and community care [0%], implementation of the national mental health standards [15%], programs to support attitudinal change [4%]). With regard to state-wide initiatives, there was generally a low level of perceived support for or implementation of key initiatives (namely, specific inter-governmental service agreements [8%], support for innovation [4%], enhanced access [12%], and clear accountability for funds [12%]).

2.7.8.6 Conclusions

Tasmania has recently made some significant new investments in mental health reform. However, it faces many significant workforce and service development challenges. Previously, political and community awareness of these challenges did not translate into improved experiences of care for those who use services. More innovative approaches will be required to achieve both population coverage and improved quality of service delivery.

PART THREE: APPENDICES

3.1   LIST OF COMMUNITY CONSULTATIONS BY STATE / TERRITORY

Table 3.1.1 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 3.1.2 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

3.2   SUMMARY OF SUBMISSIONS RECEIVED BY STATE / TERRITORY

Table 3.2.1: 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**

3.3   LIST OF SUBMISSIONS RECEIVED BY STATE / TERRITORY

3.3.1   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

3.3.2   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.

3.3.3   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

3.3.4   LIST OF SUBMISSIONS RECEIVED - SOUTH AUSTRALIA

Anonymous x 10
beyond...(Kathleen Stacey & Associates) 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

3.3.5   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

3.3.6   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

3.3.7   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

3.3.8   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

3.3.9   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