11/5/05

Ian Holland
Committee Secretary
Senate Select Committee on Mental Health
Department of the Senate
Parliament House
Canberra ACT 2600

Dear Mr Holland,

The Mental Health Association (Qld) Inc. welcomes this opportunity to comment on areas of concern mentioned in the terms of reference for the Senate Select Committee on Mental Health. Attached is a submission addressing a number of the terms of reference.

In summary, the Association is concerned that the laudable aims of the National Mental Health Strategy and other policy documents have been unable to be properly implemented partly because of lack of sufficient resources and partly because of lack of commitment of people charged with implementation.

The Association has particular concerns in the following areas:

- The effect of de-institutionalisation without sufficient resources committed to assisting people to engage with and remain in the community in all areas including supported accommodation, family and social support services, employment, respite care, community care.
- The effect of the above lack of support especially on people with complex and co-morbid conditions including intellectual disability and drug and alcohol dependence. Often people are refused a service from mental health services on the grounds that they require disability or drug and alcohol services first and vice versa.
- The additional effect of the lack of community supports on people with a mental illness or psychiatric disability and especially on people with co-morbid conditions who recycle into the criminal justice system and can wait up to a year to attend the Mental Health Court and be found to be unfit for trial.
- The difficulties for people who have gone through the criminal justice system; been found unfit for trial; been returned to the health system in

secure facilities; been found by the Mental Health Review Tribunal to be able to return to the community with support – only to find that no support is available (lack of resources for individual lifestyle support packages or P300 support packages from Disability Services Qld)

- The lack of sufficient resources in Queensland not only in the community but in Government Mental Health Services both community based and residential. Planning for such facilities was based on inadequate projections of population growth and the population explosion in Queensland due to migration from other states in recent years has meant that services are unable to meet demand. The effect of this is that there is very little attention given to primary health care in promotion, prevention and early detection. Services are barely adequate to address the most acute cases and consumers and carers constantly report being turned away from Government Mental Health Services as not being eligible even when the consumer and carer report severe distress and suicidal ideation and have existing diagnoses. Consultants working with consumers report that it is not worth trying to access services for simple depression, anxiety, obsessive compulsive disorder, that only people with severe bi-polar and schizophrenia with florid and uncontrolled symptoms can access services.
- Similarly lack of resources in both the public and community sectors means that discharge planning and management of chronic conditions is less than adequate. Consumers, carers and consultants report people being discharged without follow up, without appropriate accommodation, without community or family support.
- In geographically remote areas people can be discharged from a major centre with no means of transport to return home – often hundreds of kilometres from home and with no public transport available. Indigenous communities report members hitch-hiking home when discharged.
- There is a problem with coordination of care across different services both government departments and community services. Communication between services is often non-existent and demarcation lines are strictly enforced to the detriment of people trying to negotiate complex systems. Consumers routinely are trying to relate to Centrelink, Housing, Health, Disability Services, Community Support Services, Drug and Alcohol Services, and feel disempowered in relation to decisions made by all service providers.
- The lack of resources in existing services, lack of appropriate services, and lack of coordination between services often means very vulnerable people require advocacy services – which are promoted in the aims of the National Mental Health Strategy. However, there is only one Mental Health Advocacy Service in Qld – operated by the Mental Health Association and funded by Disability Services Qld for one full time worker. Generalist disability advocacy services across Qld have waiting lists and often feel insufficiently expert to work with people with a mental illness. While the policies reiterate the right of people to an advocate, resourcing has not supported this right.

- The Mental Health Act Qld 2000 provides for the right of a person under the Act to have an allied person to assist them to speak for themselves with the treating team and before the Mental Health Tribunal and to explain their rights. However, this is not known about by the community or by carers and consumers. Some Mental Health Services vigorously promote the role. Some do not see it as a high priority. An analysis of the whole state picture for the time period 1/7/04 to 13/12/04 shows that allied person attendance at Mental Health Review Tribunal hearings averaged around 10% of cases, with 317 attendances over 3198 hearings.
- While policy emphasises the need for consumer participation and education for consumers and carers to assist in treatment, recovery and support, in fact there is often very token attention paid to this. In 2005 a limited training program for health workers on recovery focus and consumer participation was held by Qld Health. In addition $99,000 was given as one off funding to the Mental Health Association to implement training for consumers and carers across the state in two areas
    1) Training in consumer and carer participation in a persons treatment and recovery
    2) Training for consumers and carers in how to work with the local Mental Health Services on Service planning, implementation and evaluation.

Such a small resource given as a one off only funding can obviously barely begin to offer a small minority of communities limited training in these matters.

The Mental Health Association holds the view that with appropriate early intervention, appropriate public mental health services and sufficient support in community settings, rehabilitation and recovery is often possible for people with mental illness. However, the expansion of community-based and non-government mental health services will be required to achieve this goal.

Yours sincerely.

Susan Stephenson M.A. (Qld) M.A. (Leeds)
Director

Submission to the Senate Select Committee on Mental Health

<u>Resources and Community Care</u> ***Re: Senate Inquiry Terms of Reference a.b.e.& m.***

With the move towards de-institutionalisation and policy development emphasising community care most people with a mental illness now live in community and are looking for supports within the community.

However, more needs to be done to progress the aims of the National Mental Health Strategy with regard to moving toward a community-based system of care including increased outreach services, psycho-social rehabilitation, residential support, employment opportunities and services provided by non-government organisations.

Both the level of funding and the frameworks in which funding is made available to organisations which work with people with a mental illness need improvement.

In Queensland only $6.8 million dollars is spent on community based health funded support services – less than the cost of a carpark for a football stadium

The *SANE Mental Health Report 2004: 'Dare to Care'* reports that Australia spends less than 8% of its National Health Budget on mental health. The same report indicates that comparable OECD countries spend upward of 12% of their health budgets on mental health. This is of particular concern for Queenslanders because according to the *National Mental Health Report 2004*, Queensland spends less per capita on mental health than any other Australian state or territory.

Moreover, this expenditure is within a context where demand for mental health services constitutes 20% of public health service demand. (*Mental Health and Wellbeing Profile of Adults ABS Cat No 4326.0; Sphere Supplement Medical Journal of Australia July 2001)*

Of even greater concern is the fact that a disproportionate amount - 91% - of this funding goes to clinical, medical and biological services with only 9% going to community based services. (*Mental Health and Wellbeing Profile of Adults ABS Cat No 4326.0; Sphere Supplement Medical Journal of Australia, July 2001)*

Moreover, it needs to be acknowledged that mental health transcends government departmental responsibilities. Housing, Income Support, Drug and Alcohol Services, Disability Services all work with people with a mental health problem. In Queensland, for example, significant responsibility for lifestyle support in the community (Individual Lifestyle Support Packages, P300 Support Packages) is administered by Disability Services Qld. The difficulty of obtaining such packages is attested to by the number of requests for assistance compared to the number of people able to be assisted. While data analysed according to disability type is not available, total applications at 30 June 2002 were 6,314of whom only 1000 were successful. A fuller analysis of this issue is made in the attachment *determining Equity and Accountability of Disability Services Queensland Funding in Appendix4.*

Requests which have not been able to be met include applications from people in serious need. Applications are only sometimes refused because they do not meet eligibility

requirements. They are frequently refused to eligible applicants simply because the resources available to the Department for the packages are totally inadequate.

As an example, a young woman being assisted by MHAQ had three requests for an adult lifestyle support package and two for a P300 package rejected over a period of three years. This is in spite of the fact that she was ascertained as having priority 1 rating (top) by Disability Services Qld.

This young woman had previously been institutionalised at Wolston Park during her teenage and early twenties adult years and was discharged into the community without support. She subsequently committed a number of offences and spent nearly a year in jail waiting for the Mental Health Court to find her unfit for trial. With the assistance of individual advocacy services she was transferred to Franklin where she has been resident for over two years. Had she stood trial for her offences she would have been returned to the community long ago. She is currently inappropriately resident with people who have a history of serious violence and murder.

This young person is still currently resident in Franklin High Secure Unit at the Park Centre for Mental Health although her treating team and the Mental Health Review Tribunal are of the opinion that she can manage life in the community with support. They are not prepared to discharge her without support. This not only means she is inappropriately in a residential facility, but it utilises a place that other people need.

Her needs and those of every person with a mental health problem are not simply medical and clinical – She requires appropriate community housing, income support, access to meaningful activities such as work, volunteer work, recreation, training in lifestyle skills and companionship. Her chances of surviving in the community rest on this – residence in a hostel, for example, would increase the probability of her recycling through the system; lack of meaningful activities would increase the probability of her mental health issues resurfacing.

In this case, due to consistent advocacy work over four years a number of organisations and agencies have begun to address these whole of life needs. Housing Qld has placed her on top priority listing and accommodation will be made available in the form of a house with bedrooms for the person and any carer who may live with her once she is discharged.

This is not an isolated story. 24% of people living with a psychotic illness in Australia live in marginal housing (i.e. homeless, crisis shelter, rooming house, hostel, rented hotel room) Only 4.9% live in purpose-run supported accommodation (*National Survey of Mental Health and Wellbeing Bulletin 5, National Mental Health Strategy 2002)*

The unavailability of community-based and non-government health and human services has resulted in many people remaining untreated, homeless and at great risk of offending or coming to the attention of police. One deeply concerning result is that people with mental illness who once were institutionalised in the health system are moving into the prison population.

Dual disability

In one area alone, MHAQ is aware of at least 13 people with a dual diagnosis (Intellectual disability and Psychiatric disability) currently in Qld prisons. Its advocacy service has

been successful in having only two transferred from the prison to the Park and only one to this date returned with appropriate supports to the community.

People with a dual diagnosis – and often a multiple diagnosis eg Drug usage, intellectual disability, physical ill health and mental illness have complex and high-level support needs. Often services are not offered to people on the grounds that the primary need is for a different service i.e. mental health services refer people to drug and alcohol services and vice versa. This can result in people receiving fragmented services or even no services. People with these complex needs may present in crisis which results in reactive service responses rather than a planned, proactive approach. People may receive no services until they present in crisis or until they commit a crime at which stage the criminal justice system takes over and within this there is less scope for attention to the mental health issues than when the person was in the health system or in the community.

Estimates of the prevalence of people with a dual diagnosis vary widely due to differences in methodology and definitions. However, it clearly exceeds that for the general population, ranging between 30 – 40% across the different mental disorders and levels of intellectual impairment. Serious mental health problems and mental illness occur amongst people with an intellectual disability 3 – 5 times more frequently than the general population. (*Queensland Centre for Intellectual and Developmental Disability, 2002).* The *Second National Mental Health Plan (1998)* recognised this group as one for whom improved mental health service access and better service responses are essential. However, this has yet to eventuate.

The *Strategic Plan for Psychiatric Services and Support 2000-2005* also identifies people with a dual diagnosis as amongst those who need improved access to the broad range of government and non government services. Agencies need to work collaboratively, providing specialist training in dual diagnosis and access to tools, information and training packages.

With appropriate support in community settings, rehabilitation and recovery is often possible for people with mental illness. However, the expansion of community-based and non-government mental health services will be required to achieve this goal.

Adequacy of various modes of care for people with a mental illness ***Re TOR b***

In tandem with the lack of resources to support people's integration into the community and recovery, in Queensland particularly there is a shortage of resources to provide early intervention, appropriate acute care, inpatient care, discharge planning and respite care.

Partly this is a result of planning based on population projections which did not take into account recent steep curves in population increases in South East Queensland through migration from other states.

Forums held throughout Qld over the past four years have indicated that the general public, consumers and carers experience severe frustration and suffering in all of these areas. Information from people at forums, from callers to MHAQ (we make over 30,000 calls a year and receive approximately double that) and from participants and consultants in the Personal Support Program and advocacy program offered by the Mental Health Association (over 2000 people referred in the last two years) confirm that there are difficulties throughout the state in these areas.

Consumers complain that while they can get access to a first assessment at a health service, they are often sent away without treatment as not having severe enough symptoms. They report that when they become severely unwell they receive treatment but are often discharged without follow up. They complain that where once they would see a psychiatrist they are often now sent back to a GP. While this is in line with policy from health it is not what people themselves are saying that they want.

Consultants confirm that people they are working with in the personal support program will attend a health service expressing suicidal feelings and are sent home – and then act on those feelings eg one man tried to hang himself, one girl took an overdose, one young woman jumped off a bridge and severely injured herself.

Consultants confirm that it is only useful to take a person to the mental health services if they have severe symptoms of eg bi-polar or schizophrenia, that simple depression, anxiety, obsessive compulsive disorder etc, will be assessed as not in need of the service. The services seem to have only resources enough to service those in crisis. Those people will receive services, possibly even in-patient services. However, the services are limited, follow up is not sufficiently in depth and there are not adequate community services to link people in to with discharge planning.

Carers also complain that they take their loved one to a health care service and are refused a service as the person is assessed as not having a severe enough problem to warrant a service.

One parent for example rang in saying her son had gone three times to the local community mental health service and was repeatedly sent away. The parents took him once and the Doctor on duty asked him if he was going to kill himself. When he answered no the doctor said there was nothing wrong with him and sent him away. He then drove his car through the hospital front doors and was subsequently admitted for three days. On release they told him he only has anger management issues. He had previously been diagnosed with paranoid schizophrenia. She could not look after him at home because her husband is also ill and her elderly father had just moved in. The son was causing problems with his landlady and other tenants in his current accommodation. She was desperate for him to access help. She was talking to the Health Rights Commission and to her local member. Even with an active parent as an advocate access to appropriate accommodation and support seemed impossible.

Another parent rang in upset because her son had been admitted to hospital the previous evening and been heavily sedated. They rang her the next day to say they were discharging him and would send him home in a taxi. She asked them to hold him another two hours so she could pick him up herself after work. They refused and sent him home by taxi. He then drove his car away and three days later she could not locate him.

Another elderly parent, Betty Day (see Appendix 1) has two sons diagnosed with mental illnesses and with drug and alcohol problems. She has been vigorously campaigning for years for better services for dual diagnosis. This month one son and his partner have just been jailed for drug related offences. She now has the care of their four month old child. Her husband requires her care as he has a broken pelvis. Her second son is mentally ill and has drug and alcohol problems. She took him to the local mental health service that refused him a service saying it would be a waste of resources and that he should attend first to his drug and alcohol problems.

Access to and quality of treatment ***Re: Senate Inquiry Terms of reference b.c.d.e.f.h.&i***

Access to appropriate treatment is difficult even within the metropolitan area with consumers and carers asking for access to counselling, cognitive-behavioural therapy and other forms of non-drug based therapy often after years of lack of success with drug based and medical model therapies. These therapies are not available to them.

In country areas access to doctors, psychiatrists, psychologists is also severely limited with people having to travel hundreds of kilometres to the nearest service. Transport, even for people who have been sent by the health service to a coastal service for involuntary assessment, is problematic. People being flown by the RFDS in small planes are doubly constrained – medically and physically – while being transported and have expressed dismay at this. Return transport is worse. Unless a person has private transport, in some remote areas there is no public transport and people report hitching home to communities after discharge.

62% of people with psychiatric disorders do not utilise mental health services. Reasons given include poor distribution and costs of specialist services, inappropriate public services, stigma and fear of medical treatments (*Out of Hospital, Out of Mind, Mental Health Council of Australia 2002.)*

Employment and Education -Stigma ***RE:Senate Inquiry Terms of Reference e&m***

The Queensland Government's *Breaking the Unemployment Cycle Initiative* includes those living with a mental illness. Recent Australian data shows that 72% of people living with psychotic illness were unemployed at the time of survey, 58.3% were unable to report a major occupation during the previous twelve months, and only 15.5% named wages from an employer or their own business as their main source of income. The same study reports major deficits in employment skills and training for this population, reflecting the disruptive impact of mental illness upon educational progress.

A person who has been unemployed for a long period of time is most susceptible to developing a mental health issue i.e.: Depression/Anxiety which compounds the unemployment issue, which compounds the mental health issue. While it does sound as though the author's last statement was going around in circles; reality is that is exactly what it is like for a person with the double jeopardy of both unemployment and a disability. (Bigby 1997 & Kailes 1990).

Working in paid participant situations which are single employment positions within an ordinary workplace provides a better springboard to open employment than training in group or sheltered situations with high levels of support. A survey conducted by Inge & Bank (1998) support this view. The survey Sheltered Employment versus Supported Employment clearly showed that the quality of life for those in supported employment was much higher than those not. These quality of life issues included areas such as greater employment experience, language development, community participation and social skills.

The Mental Health Association has programs funded through the State Department of Employment and Training under the Community Jobs Plan which assist people who have experienced a mental illness and are long term unemployed or at risk of long term

unemployment to return to work. Participants are employed by the Association for up to 6 months while they relearn job skills and seek employment.

This program has been highly successful. 70 -100 % of participants in 11 projects run over the last four years have gone on to employment or further training. The program generally – which is run by other community organisations for long term unemployed but not specifically for people with an experience of mental illness – does not have as high a rate of success.

Project Type – CJP/CEAP	Project Name/Number	No. of Participants	Job Outcomes	Further Training Outcomes	Percentage Of Success
CJP	Gold Coast 1	18	7	6	64%
CJP	Brisbane 1	15	9	2	73%
CJP	Brisbane 2	10	3	3	60%
CJP	Brisbane 3	14	8	4	85%
CJP	Brisbane 4	16	12	-	75%
CJP	Brisbane 5	12	5	4	75%
CJP	Ipswich 1	10	9	5	128%
CJP	Ipswich 2	12	9	2	91%
CJP	Ipswich 3	27	14	8	81%
CJP	Ipswich 4	12	9	2	91%
CJP	Ipswich 5 (on going)				

When it is considered that 47% of people with a mental illness do not complete secondary education and that 80% of people with mental illness in Australia are unemployed (*National Survey of Mental Health and Wellbeing Bulletin 5, National Mental Health Strategy 2002*) this success is worth examining. The participants included people who had not worked since leaving school, people who had not worked for 12-15 years, people with the full range of the affective disorders, schizophrenias, personality disorders, dissociative disorders.

There are two elements which seem to contribute to the success of this program.

1) The Association set out to address the element of stigma in the workforce which it sees as a major barrier to employment. The Association's experience is that consumers are their own best advocates. Consequently, rather than putting education programs in place for employers, the Association recruited employers to host participants on the program for six months in the workplace – so YMCA for example would have a person employed by the Association working in their program for six months. This has paid off in that up to 30% of follow on employment has been by the host employer who learnt during the placement how valuable the worker was.
2) The experience of six months paid employment seems to be of itself restorative. Major changes occur in participant's sense of competence and emotional wellbeing. Examples below:
    - Participant had been deeply depressed and unemployed for fifteen years with heavy medication and repeat hospitalisations. By the end of the six months self-reported feeling wonderful, her doctor had taken her off all medication, she had a part time job.
    - Participant could not even talk at the time of entry into the program has been full time employed for two years.

- Participant has been full time employed for three years and is in a management position.

The Association recommends that policies and programs be vigorously pursued which provide access points to employment for people with a mental illness or psychiatric disability and provide incentives to employers to employ people. It is clear that people with a psychiatric disability or mental illness are at a disadvantage in the open employment market but that when access is facilitated, they have a capacity to function well in open employment, be productive and at the same time enhance their own recovery through employment.

Consumer and Carer Participation *TOR g,i*

Training

While policy emphasises the need for consumer participation and education for consumers and carers to assist in treatment, recovery and support, in fact there is often very token attention paid to this. In 2005 a limited training program for health workers on recovery focus and consumer participation was held by Qld Health. In addition $99,000 was given as one off funding to the Mental Health Association to implement training for consumers and carers across the state in two areas

3) Training in consumer and carer participation in a persons treatment and recovery
4) Training for consumers and carers in how to work with the local Mental Health Services on Service planning, implementation and evaluation.

Such a small resource given as a one off only funding can obviously barely begin to offer a small minority of communities limited training in these matters.

Advocacy

One of the most potent routes to consumer and carer participation is effective advocacy. It is worth emphasising again, as an item in itself the role and need for advocacy for people with a mental illness or psychiatric disability. People often feel intensely vulnerable and only with the assistance of persistent individual advocacy services over many years are able to access services and reconstruct their lives.

Others without such advocacy are unable to access much needed health, income support, accommodation, personal and social support and other services. There is a case here for increased level of available services but also for increased availability of skilled advocacy.

At policy level Mental Health Planning sees a role and right for people to have advocates.
(*National Standards for Mental Health Section 2 Standard 1 Rights)*
The rights of people affected by mental disorders and/or mental health problems are upheld by the MHS
Individual advocacy services and support persons are actively promoted by the MHS and consumers are made aware of their right to have an independent advocate or support person with them at any time during their involvement with the MHS.

(Standard 11.4E Inpatient Care)
As soon as possible after admission, the MHS ensures that consumers receive an orientation to the ward environment, are informed of their rights in a way that is understood by the consumer and are able to access appropriate advocates.

(Section 3 Glossary of Terms)
Advocates
People who have been given the power by consumers to speak on their behalf, who represent the concerns and interests of the consumer as directed by the consumer. Although governments and others may give power to advocates, such advocacy is token unless it is directly accountable to the consumer. (Mental Health Statement of Rights and Responsibilities, Australian Government publishing Service 1991)

The Mental Health statement of rights and responsibilities lists among consumer rights

- *The right to advocacy during assessment, diagnosis, treatment and rehabilitation*
- *Children and adolescents admitted to a mental health facility or community program* ***must*** *have available to them a person who will represent them and whose task it is to protect their rights.*
- *Every person admitted to a mental health facility or community program must have available to them a person who will represent them and whose task it is to advise and protect their rights as long as that person wishes to have such representation. The availability of such representation should be clearly offered to the person and they should be able to make an unhindered and informed decision about whether to accept such representation. Where the person wishes to secure the services of a lawyer, he or she must be able to do so/*
- *There is a whole section devoted to the rights and responsibilities of carers and advocates.*

In Qld, Disability Services Qld has issued a new set of service standards under the *Disability Sector Quality System 2004*, *Service Standard 7 Complaints and Disputes* These provide for service users *to be provided with information and support to access an independent person of their choice to assist them through a complaint process*
Core Evidence Question
*How does the service provide information to service users and support them to engage advocacy support to assist them through a complaint process**?***

The problem is that these policy statements are not supported by the resources required to implement them. There is only one service funded in Qld to provide advocacy within a mental health contest – funded by Disability Services Qld to the Mental Health Association to employ the equivalent of one full time equivalent worker. The Association is confined to the Greater Metropolitan Area in its advocacy work and is unable to meet the demand even there. Other generalist disability advocacy services are funded in Qld but report to the Association that their resources are not adequate to the demand and that they often do not have the specialist knowledge within the mental health system to assist people with a mental health issue.

The Mental Health Act (Qld) 2000 provides for people who are under the Act to have an ***allied person*** and to be informed of this right by the health services. The allied person has the right to talk with the treating team and to appear before the Mental Health Tribunal to assist the person to express their wishes. The Mental Health Association has travelled throughout Qld and met with many community organisations and consumers and there is very little knowledge of this right or of what the allied person is. Discussions with mental health services reveal that some are diligent in letting people know of this but particularly in rural areas it is not seen as important.

Statistics provided by the Mental Health Tribunal show that in looking at Allied Person attendance at hearings for the period 1/7/04 to 13/12/04 the following information was found:
Mt Isa = 0
Toowoomba = 44

At Mt Isa for that time period there have only been two Tribunals and one hearing (that is a very small AMHS from our point of view; for a full year 2003/4 there were only 4 Tribunals). Total attendances in any of the categories we measure was only 2 for the period measured.

At Toowoomba for that time period there were 40 Tribunals and 300 hearings. Total attendances in all categories was 720, so allied person attendance represents only 6% of all attendances. If you look at allied persons in relation to hearings, the allied person is present in around 15% of hearings. Patient attendance in Toowoomba for the same period is 173, which is about 58%.

Looking at similar sized AMHS to Toowoomba (in terms of the number of hearings per annum) I have compared Gold Coast and The Prince Charles Hospital. For the same period, both of those AMHSs have even lower AP attendance. At Gold Coast Hospital there were only 18 AP attendances which is around 5% of hearings and at TPCH there were 30 AP attendances, which is about 11% based on this year's figures. Patient attendance at TPCH for that period was almost 50% (130 attendances), and the Gold Coast for the same period was about 48% (161 attendances).

An analysis of the whole state picture for the same time period shows that allied person attendance averages around 10% of cases, with 317 attendances over 3198 hearings. As a total picture, patient attendance is sitting at around 50% over the last 6 months.

In summary we can see that allied person attendance is generally fairly low. Toowoomba fares a bit better than some other places. In only 1 in 5 of cases where the patient is present, is an allied person also present (estimate in that I have not analysed those cases where an AP is present but the patient is not - these would be very few).In Toowoomba this is a little better than 1 in 4 cases where the patient is present, compared with Gold Coast where it is 1 in 10; and TPCH where it is about 1 in 5 (equal to the State average).Toowoomba has higher patient and allied person attendance. Client Services Manager
Mental Health Review Tribunal

Summary
In summary, the Association is concerned that the laudable aims of the National Mental Health Strategy and other policy documents have been unable to be properly implemented partly because of lack of sufficient resources and partly because of lack of commitment of people charged with implementation.

The Mental Health Association holds the view that with appropriate early intervention, appropriate public mental health services and sufficient support in community settings, rehabilitation and recovery is often possible for people with mental illness. However, the expansion of community-based and non-government mental health services will be required to achieve this goal.