Submission to the Senate Select Committee on Mental Health (Part 2)

June 2005

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Introduction

The Government welcomes the opportunity to present a second submission to the Committee. Part one outlined the nature and range of public mental health services provided in Queensland and highlighted the substantial changes that have occurred within this State since the beginning of the *National Mental Health Strategy* in 1992.

One of these changes has been the significant funding commitments the Government has made over the period of the Strategy, bringing the State closer to the national per capita average. This funding increase has been complemented by related budget initiatives. For example, for 2005/2006, an additional $43.59 million over a four year period will specifically address the complex health needs of people with a mental illness and/or alcohol and other drug issues, who are homeless in Queensland.

The Queensland Government is committed to further reforms to Queensland's public mental health system to ensure clients can receive a timely and quality service. These reforms need to encompass services beyond specialist mental health services – to incorporate appropriate prevention and promotion initiatives, and rehabilitation services so as to reduce the impact of mental illness on individuals, their families and carers, and the community.

Unfortunately, not all people with a mental illness have received the quality of care that they deserve and the community expects. There have been recent criticisms made of the public mental health system which particularly focus on systemic issues. The Government takes this seriously and will respond with specific actions to address the criticisms.

There are significant challenges confronting all jurisdictions in relation to trends and current demand, funding approaches, the interaction between public and private sectors, mental health workforce availability, and the need for effective partnership approaches.

Burden of disease predictions indicate that mental health is likely to rank second only to cardio-vascular disease by 2020 and increases in funding at Commonwealth level and from all jurisdictions are accordingly required to improve the quality of mental health services in Australia. In Queensland, gains made through the first wave of mental health reforms have proven increasingly difficult to sustain. While a restructure of the mental health system has occurred, reform

is struggling to keep pace with population growth, perpetuating difficulties in access and availability. In addition, the increasing demand for services has afforded little opportunity for consolidation and learning from new directions.

This situation is further compounded by national funding approaches, where the burden of responsibility for service provision rests largely with State and Territory Governments. The bulk of Commonwealth funding is allocated through MBS, PBS and private mental health systems, providing services to the community, generally on the basis of affordability. While recognising the valuable role that private providers and the non-government sector fulfil in providing services, the Commonwealth Government funding process needs to further support the essential services provided by the public mental health systems.

Existing and future demands on the mental health workforce are difficult to meet and will continue to be, particularly in light of current supply. We need to ensure that the workforce has an appropriate skill mix to implement clinical interventions known to lead to improved outcomes. However, in light of the predictions of the global burden of disease, there is an immediate demand for an increased focus on primary prevention. It is essential that this primary prevention is complementary to, rather than at the expense of, specialist mental health service provision.

The Queensland Government supports the current health workforce study being conducted by the Productivity Commission, at the request of the Council of Australian Governments. Its findings should assist all jurisdictions to identify constructive ways forward to meeting our health workforce challenges, including those relevant to the mental health sector.

Sustaining the mental health reforms demands collaboration across government and with the non-government and private sectors. A whole-of-government approach across Queensland Government agencies will improve the coordination and delivery of the many services that are required to constitute an effective mental health system. Queensland has a number of effective interagency arrangements that contribute to positive outcomes for people with mental illness including *Project 300*[1].

However, for the system to meet the requirements of clients, partnerships need to be broader. For example, more effective primary health care links between general practice, non-government

[1] For more information about *Project 300,* see pp 26-28 and 81.

organisations, and government-provided services are critical. This complex area of cross-sector service delivery poses significant challenges to all jurisdictions in Australia. The current system would benefit from a national review of the mental health sector (public and private) including current and innovative service delivery and models of care.

The Queensland Government is open to public scrutiny and recommendations on ways to improve its public mental health system. Two current inquiries underway in Queensland - the Bundaberg Hospital Commission of Inquiry and the Forster Review of Queensland Health Systems - will report on a range of matters which will be relevant to the considerations of the Senate Committee on Mental Health and of interest to mental health clients and stakeholders.

a) The extent to which the *National Mental Health Strategy*, the resources committed to it, and the division of responsibility for policy and funding between all levels of government, have achieved its aims and objectives, and the barriers to progress

The *National Mental Health Strategy* has provided a valuable framework to guide mental health reform across Australia.

Consistent with the aims and objectives of the Strategy, and since 1992, Queensland has:

- completed a restructure of the system of care making inpatient beds available in rural and regional centres
- expanded community mental health services
- put in place a process of case management within services.

The Queensland Government recognises that the aims and objectives of the Strategy have not been fully achieved within this State, with the breadth of reform, difficulty in establishing broader strategic partnerships, workforce issues, and changing societal needs creating significant barriers.

Resources committed to mental health

Queensland Government expenditure, as recorded in the *National Mental Health Report 2004*, has increased from $154.4 million in 1992-93 to $310.8 million in 2001-02, representing a 101.3 percent increase, and is reported as the second largest percentage increase, exceeded only by Western Australia. While Queensland continues to have low per capita expenditure relative to other jurisdictions, the growth has been significant over the period of the *National Mental Health Strategy*, bringing the State closer to the national per capita average.

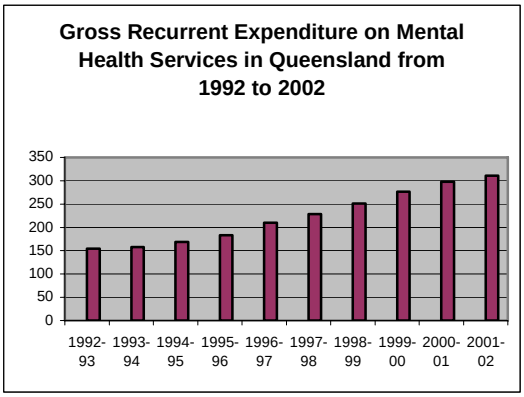
Investment in mental health services has been enhanced through State Budgets; however, it has not been sufficient to alter the original position of lowest per capita expenditure for two reasons:

- initial financial point of entry to the Strategy
- population increase at twice the national average.

Since 2001-02, enhancements have been made to mental health services through the State Budget totalling $61.4 million with a further $65 million which is allocated over four years towards the enhancement of community mental health services.

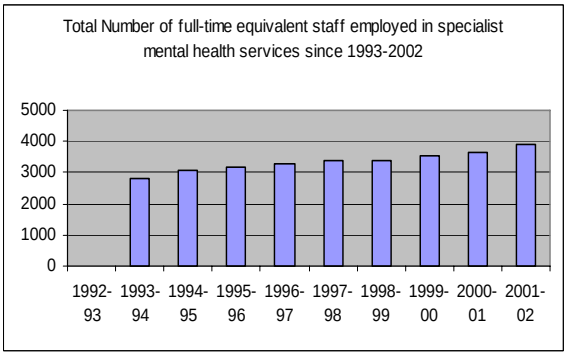
The *National Mental Health Report 2004* also indicates that nationally, the funding balance has now achieved a 49/51 percent split in favour of community, indicating that new monies have gone into establishing community services. These achievements represent the fulfilment of key aims and objectives of the *First National Mental Health Plan 1993*. Tables 1 and 2 indicate the levels of increased expenditure and staff increases over the period of reform.

Table 1: Gross recurrent expenditure on mental health services in Queensland from 1992 to 2002



(Source: National Mental Health Report 2004)

Table 2: Total number of full-time equivalent staff employed in specialist mental health services from 1993 to 2002



(Source: National Mental Health Report 2004)

Barriers to progress

The third *National Mental Health Plan (2003-2008)* represented a consolidation of the previous two. While the first Plan focussed primarily on the provision of specialist mental health services and the restructure of the care system, the second Plan expanded the

agenda into mental health promotion and prevention and the development of partnerships with key sectors.

The second Plan also stated that mental health services were for all, with the seriously mentally ill as a priority. Jurisdictions have experienced difficulty in meeting the increase in demand for public mental health services at the same time that the reform agenda was broadened.

The breadth of reform represents only one barrier to achieving the aims and objectives of the second Plan. The need for workforce reform, changing society needs and difficulty in creating effective broad strategic partnerships have been further contributors.

The reporting requirements inherent in the Australian Health Care Agreement tend to inhibit more flexible options for service delivery being developed.

Workforce

This has presented a barrier on a number of levels:

- insufficient tertiary training places to meet demand
- difficulty recruiting and retaining mental health staff in the public health sector, particularly in rural and remote areas
- the need to prepare and develop a workforce capable of delivering innovative and sustainable models of service delivery
- difficulty developing effective initiatives to address education and training of the existing mental health workforce
- training takes place only in the public sector but the expertise then moves from the public to the private sector.

Social

Changing societal needs present additional barriers to achieving aims and objectives established at the commencement of the Strategy. Such barriers include:

- increase in high prevalence disorders with depression predicted to rank second in the global burden of disease by the year 2020
- increasing social acceptance of recreational drugs with poor understanding of their associated side effects. Within mental health services, substance abuse has become a major

contributor in complexity, severity and violence in presentation

- trends such as increased cost of health care, constraints on the supply of social housing[2] increasing expectations of user-pay has contributed to the development of a social class marked by discrimination and poverty
- shifts in national employment policy including stricter requirements on job seeking and participation run the risk of marginalising those with a psychiatric disability, who are unable to seek or hold down employment, further exacerbating their mental health condition and sense of self worth
- a marked increase in the number of children prescribed medication for Attention Deficit Hyperactivity Disorder, and some evidence of people needing more help with parenting. These represent major contributors to the cycle of domestic violence, child abuse, vandalism, and criminal behaviour which ultimately increases presentations with mental health issues and increases in requests for professional intervention and support
- increasing prevalence of both social isolation experienced by younger people and social isolation of the elderly
- increased community and consumer expectations of access on demand to community services and acute inpatient services.

Partnerships

The importance of working more strategically across both levels of government and with the non-government and private sectors to improve mental health services has been identified as a key issue for Queensland. While a whole-of-government approach is recognised as the way to proceed, a focus on delivering specialist mental health services has dominated the attention and capacity of public mental health services.

[2] $5.6 million has been committed in the 2005-06 State Budget to establish 30 transitionary accommodation places for people with a mental illness through a whole-of-Government Homelessness initiative

For example…

The development, agreement and implementation of a Memorandum of Understanding between Queensland Health and the Queensland Police Service represents a high level of partnership between these two agencies as they strive to deliver improved services to people with a mental illness.

Importantly the agreement clearly demonstrates a commitment to the *National Mental Health Strategy* and is delivering new levels of outcomes for all people with a mental illness within the Queensland community.

To progress the *National Mental Health Strategy* the Queensland Police Service and Queensland Health have developed a collaborative partnership which is reinforced through an Interagency Steering Committee meeting on a bi-monthly basis involving key stakeholders from both agencies.

b) The adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care

Specialist mental health services

The notion of 'adequacy of care' is open to interpretation and debate. From the perspective of the objectives embodied in the *National Mental Health Strategy*, the Queensland Government has conscientiously followed the approach incorporating the necessary service components. In the intervening period, there has been an increasing focus on primary mental health care, promoting mental health and well-being, preventing mental health problems and intervening early. In addition, current thinking emphasises care that is consumer-focussed, and promotes recovery and optimal quality of life for consumers.

Specialist mental health services are being assessed against these new benchmarks for which they were not established to meet. As a result, there have been increased expectations on service responsiveness. Considerable pressure is being placed on mental health services to develop and provide alternative care options that deliver these expanded outcomes. Contemporary research and evidence indicates that these new concepts of adequacy are desirable; however, the service system that is currently operating will require considerable reform to meet these requirements.

The need for an increased range of options is endorsed unequivocally by the Queensland Government and is being actively progressed across the State. It is crucial that the core role of public mental health services be maintained and enhanced. The specialist functions performed by public mental health services in providing care for people with serious mental illness provide an essential foundation on which other service modalities are developed and operate. Mental health services are also involved in intervening early and identifying and engaging high risk groups through a variety of treatment models and partnerships.

Whilst innovative service models continue to be developed and a variety are operating within Queensland, the challenge for mental health service planners, managers and clinicians is to ensure that the services delivered are effective and appropriate. The challenge for policy makers and government is to ensure support is given to systematically deploy resources – both human and financial – to ensure that new services are innovative and effective.

One recent example of innovative service development is the establishment of Mental Health Child Safety Support Teams (MH-CSSTs). These teams will provide screening, assessment, crisis response, short-term intervention and long-term therapy and establish key linkages with other relevant providers, including general practitioners and non-government agencies.

Workforce

The fact that the quality of mental health care has not progressed as far as desired is a result, to some extent, of the national reform agenda's focus. The Strategy has not confronted issues relating to the necessary mix of interventions required for different illnesses or stages of illness, and what competencies and skills are most appropriate in delivering these interventions.

A key mental health service development issue is the need for greater multidisciplinary presence and influence in delivering specialist mental health services. The current workforce mix strongly influences the type and range of treatment approaches used. Treatment options tend to be determined on the basis of skill available as opposed to the best available evidence as to effective and appropriate treatments and interventions.

There is a compelling need to standardise at a national level the application of evidence-based treatment approaches throughout the mental health service system. A focus on workforce, training and staff development issues is required as it is essential that mental health practitioners possess an adequate level and range of competency in regard to evidence-based treatment and therapeutic interventions. Significant work is required by all governments in addressing the complexities of developing a suitable mental health workforce.

In Queensland, other initiatives include:

- the development of a statewide Mental Health Workforce Strategic Plan which has commenced with a comprehensive profile of the current mental health workforce
- establishment of a Transitional Centre For Mental Health Learning
- innovative pilots being conducted for the design of the future mental health workforce commencing in July 2005.

Strategic Partnerships

The Public Advocate has recently criticised the inability of health services to provide seamless service delivery that meets the broad and sometimes complex needs of this client group. This is currently being examined and addressed by Queensland Health through the development of an action plan. The Queensland Government recognises that the complex issues raised in the Public Advocate's report further highlight the need to advance partnerships at a whole-of-government level.

One key strategic intent of the *Queensland Health Strategic Plan 2004-2010* is 'Healthier Partnerships' defined as "working with others to harmonise programs and activities that impact on health". Consistent with the Strategic Plan, Queensland Health has developed a wide range of successful partnerships responding to the needs of a broad number of priority groups as well as key stakeholders. Queensland Health is working with other agencies to build on these successes by taking a more strategic approach to whole-of-government issues. This involves analysing the key potential partners in a range of health care delivery settings, as well as developing a better understanding of where health services interface with other sectors.

Examples of partnerships

Queensland Police Service

The Queensland Police Service is the agency charged with the statutory responsibility for delivery of first response services in any crisis situation. Whilst the determinations regarding modes of care for a person with a mental illness are not generally the primary responsibility of the police service, the Queensland Police Service recognises the need for persons to be treated with dignity and in a humane manner as a primary consideration.

In relation to prevention and early intervention, the Queensland Police Service:

- developed a partnership with Queensland Health to identify current and emerging issues and to develop strategies to improve service delivery through collaboration
- developed protocols in relation to early detection of repeat calls for service at a local level
- implemented joint training sessions to provide a greater knowledge of mental illness

- established the Voluntary Referral Project: identification and development of voluntary referrals for people with a mental illness
- continues to improve knowledge, skills, attitudes and values of the respective staff for both departments to ensure a coordinated system of care

In the 2005-06 State Budget, the Queensland Government has funded the establishment of *Mental Health Crisis Intervention Teams*. These teams will be skilled in de-escalating situations involving people with a mental illness and averting the development of crisis situations. Funding will support training of police officers, mental health clinicians, and ambulance officers.

Education Queensland

Education Queensland focuses on the provision of curriculum programs, appropriate corporate and school-based policies and the engagement of community agencies to address the mental health needs of young people in school settings. Queensland schools address mental health as part of comprehensive health programs. This enables students to gain knowledge, skills and values in a range of relevant health and well-being areas, including mental health.

It is a goal of Education Queensland that all schools plan developmentally appropriate programs and select resources to meet the identified needs of their students and local community.

Schools are also encouraged to develop policies and procedures that:

- support the early identification of young people who may be at risk of suffering from a mental illness
- refer young people to appropriate services for professional assessment and treatment as necessary
- provide school-based support for young people as necessary to allow them to continue their education.

Where deemed necessary, Education Queensland schools are required to refer students for a medical assessment by the relevant general practitioner or Queensland Health Child and Youth Mental Health Service. School personnel are not able to refer students to other community-based organisations or specific treatment services as Education Queensland personnel are not qualified to make a diagnosis in relation to the young person's medical needs.

There is growing pressure on Child and Youth Mental Health Services to provide appropriate diagnoses and referrals for young people and school personnel are often not able to access appropriate support for young people they identify as needing assessment in a timely manner.

Queensland Ambulance Service

The Queensland Ambulance Service has the responsibility for supporting and improving the health and well-being of individuals and the community including those with mental illness. This is achieved through the provision of emergency and non-emergency ambulance based primary health care and specialised health transport services.

In 2003-04 the Queensland Ambulance Service responded to approximately 9391 cases involving patients with mental illness, this represented a 12.6 percent increase on the previous year. In providing care for these patients, ambulance paramedics provided a range of services including acute primary care, crisis intervention and, where appropriate, transportation to a medical facility or an authorised mental health service.

Due to the vast geographic nature of Queensland, in some areas of the State, the Queensland Ambulance Service may be the primary source of contact for the mentally ill patient and be expected to provide after hours crisis services due to reduced access to medical services and/or dedicated mental health services at such times. The new *Mental Health Crisis Intervention Teams* will support the training of staff in appropriate early intervention techniques.

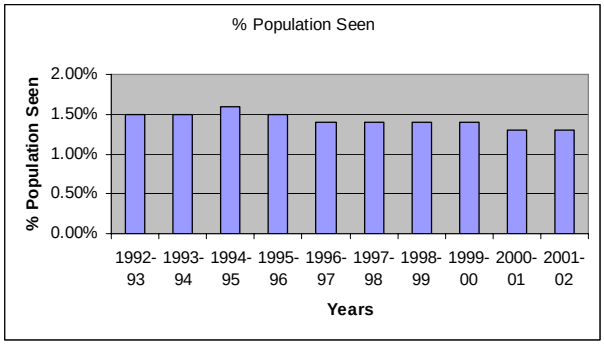
The Queensland Ambulance Service also provides Inter-facility Transfers (IFT) by road of patients with mental illness requiring specialised care or in cases where admission is not available locally.

c) Opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care

Identifying opportunities for improved coordination and delivery of funding and services presents some major challenges. As it stands, private psychiatry and psychology provide a valuable service based on affordability. However, access to private psychiatry is extremely limited. The benefit gap, which most people on welfare payments are unable to afford, presents an additional barrier, rendering the public sector the only available choice for a large proportion of people with mental illness. In addition, management of psychiatric crises are largely seen as the domain of the public sector.

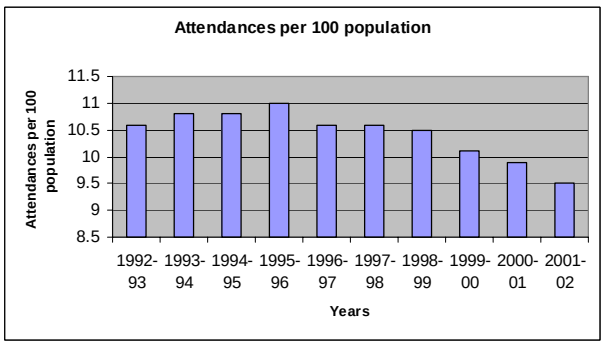
Of particular concern is the analysis of presentations (*National Mental Health Report 2004),* which indicates that numbers of patients treated in the private sector have been dropping consistently over the period of reform. See Tables 3 and 4 below. Any decrease in numbers treated in the private sector is likely to be balanced by increased presentations for treatment in the public sector, resulting in more pressure on public services.

Table 3: Percentage of population seen by MBS funded Consultant Psychiatrist Services



(Source: National Mental Health Report 2004)

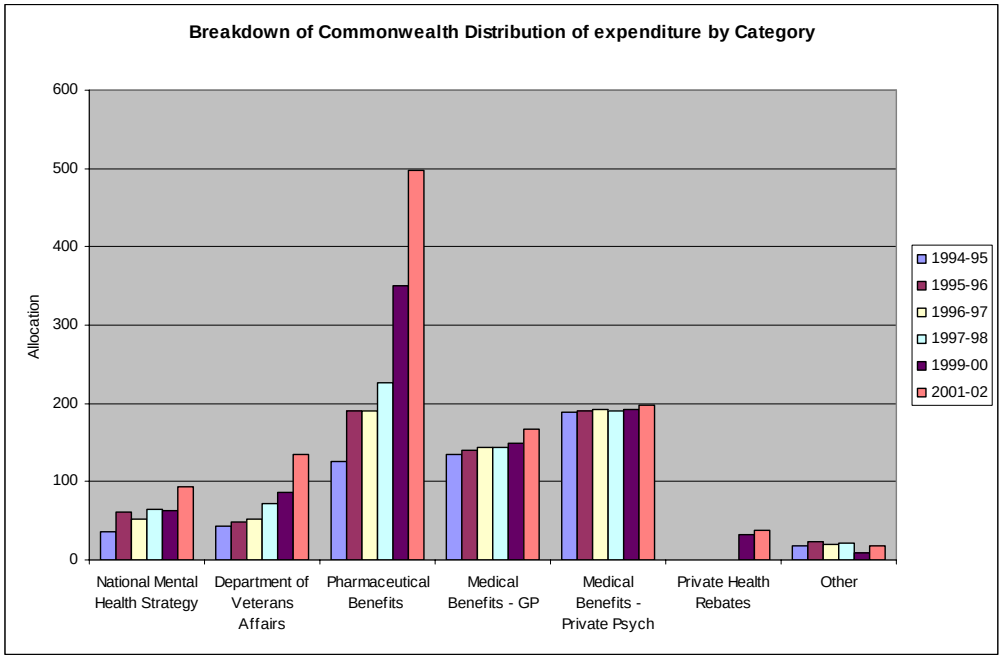
Table 4: Attendances per 100 population to MBS funded Consultant Psychiatrist Services



(Source: National Mental Health Report 2004)

A concerning statistic is the more than four fold increase in pharmaceutical benefits in the period from 1994 –2002 (Table 5).

Table 5: Breakdown of Commonwealth distribution of expenditure by category



(Source: National Mental Health Report 2004)

While increased expenditure on general practice is also recorded, further analysis is required to determine the nature of interventions provided, which might assist in identifying opportunities for shared coordination. Previous attempts to achieve this through increased benefit items to general practice have not been successful and no release of pressure on the public mental health system has occurred.

Funding

The Australian Government is responsible for the funding of Medicare, private psychiatry, and psychology. It also contributes mental health reform incentive funds to the states and territories through the Australian Health Care Agreement, on a non-recurrent basis. The State Government is required to invest new monies each year on a recurrent basis, representing real growth in monetary terms. Table 5 represents the distribution of Commonwealth expenditure by category. The imbalance in the approach places all pressures on state governments to fully fund reform. Private services are not subject to the same reforms.

Alternative funding models need to be considered and may include:

- pooled funding
- matched funding
- incentive funding to all key departments
- per capita funding across regions and sectors with weightings based on a Health Needs Index.

All of these options require further analysis and negotiation between the Queensland and Australian Governments. Queensland welcomes the opportunity to do so.

For example...

Operational Liaison Committees

Operational Liaison Committees have been established in a number of health service districts and consist of multidisciplinary representation from the Queensland Ambulance Service, Queensland Police Service, district health service managers and mental health practitioners. The aim of these committees is to identify and resolve local individual and system issues and to better coordinate the delivery of services to the mentally ill.

Mental Health Act 2000 Education and Training Project

The Queensland Ambulance Service has been involved with Queensland Health in the development of a training and education framework, on-line resources, resource guides and learning management system to enhance the knowledge of clinicians, including ambulance paramedics understanding of the Act as part of the *Mental Health Act 2000* Education and Training Project.

d) The appropriate role of the private and non-government sectors

The Queensland Government's strategic vision for meeting the health and health care needs of Queenslanders, - as enunciated in "Smart State: Healthy State – *A Vision For A Healthy Queensland in 2020*" - recognises that partnerships with the private sector, non-government providers and community organisations are fundamental to efficient, effective and integrated health care.

Within this framework, there is recognition that models of care must change to match the major global trends in health care, including the acknowledgement that 'health' is more than providing access to health services. The impact of the broad range of socio-economic factors on an individual's health and well-being is recognised. Thus, the health care system, whilst remaining important, is recognised as only one mechanism involved in improving the health of the population.

Non-government organisations

Over many years, community-based non-government organisations have played an important role in providing a range of non-clinical services and supports to people with mental health problems within Queensland communities. Queensland Health recognises the need for improved quality and scope within the non-government sector and is working collaboratively towards achieving a more holistic approach to improved mental health services. This is clearly an issue for priority consideration if Queensland is to have an effective service delivery system to people with a mental illness.

Given the increasing emphasis on recovery-oriented service delivery, and the rising demand for mental health services, an expanded role for the non-government sector is, of course, desirable. The non-government sector has expressed a strong interest in meeting this expanded role.

Examples of successful recovery-oriented practice emphasise the importance of community integration for people with mental health problems and disorders, and the essential role non-government organisations have in promoting access to a range of skills, resources and services in the community.

Notwithstanding the impetus, an expanded non-government role consistent with the recovery concept and integrated care context presents a number of challenges:

- the capacity of the non-government sector is currently under utilised

- it is essential that an appropriate strategy is developed which addresses the infrastructure, frameworks, skills, and knowledge within the non-government sector to allow this service capacity to be fully realised.

Private sector

As outlined in the response to term of reference (c), private psychiatric hospitals currently operate in parallel to public sector services and attract consumers from the group who are able to afford private health insurance and veterans who are funded through the Department of Veterans Affairs. Their role is generally complementary to the public mental health system and a number operate as authorised mental health services in Queensland.

While this represents a relevant option for the community, it does not fully alleviate the pressure on the public mental health system.

Workforce

Skill development of the private sector mental health workforce has been resourced to a large extent through infrastructure and funding provided by public sector mental health during undergraduate clinical education, postgraduate training and subsequent employment.

The consequences for public sector mental health is that mental health personnel, once trained, often move to the private sector resulting in problems with recruiting and retaining experienced staff.

Solutions to this issue need to be considered and may include:

- paying specialists in public hospitals both a basic salary and a clinical component based on fees from paying patients, often associated with private facilities within public sector hospitals
- Commonwealth and State governments engage the public, private and non-government sectors in meaningful discussions about:
  - the role of each sector in prevention, early intervention, treatment and rehabilitation mental health services
  - the competencies required by the mental health workforce to fulfil the respective roles
  - the responsibilities of each sector in providing funding and infrastructure for the training of this workforce.

e) The extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes

Appendix 3 lists some key initiatives that have been achieved by various State government agencies during the *National Mental Health Strategy*.

Accommodation

A recent snapshot of mental health inpatient beds conducted in December 2004 indicated that 30 percent of patients did not need hospitalisation if other options were available. Similar pictures occurred across most jurisdictions which participated in the exercise. Difficulty in accessing suitable support and accommodation was the key factor preventing discharge. This represents substantial numbers of patients accommodated in inpatient care, effectively blocking throughput and being accommodated, often at acute bed day costs, placing further pressure on systems already operating at maximum level and with finite resources.

Queensland Health and the Department of Housing are exploring ways of providing accommodation and support to a number of these patients to identify the most effective ways of providing and linking support and accommodation. The Queensland Government 2005-06 budget package includes substantial funding to establish treatment, support and rehabilitation services for people with mental illness who cannot be discharged from hospital because they lack adequate support or suitable accommodation.

Supported Accommodation Assistance Program

Under the Supported Accommodation Assistance Program (SAAP), funding is provided to community-based organisations for the provision of crisis transitional supported accommodation and related support services to people who are homeless and at risk of homelessness. Since its commencement in 1985, SAAP has operated as a cost shared program, and is the Australian and Queensland Governments' primary policy and program response to the needs of homeless people or those at imminent risk of becoming homeless.

The SAAP has been implemented through five-year agreements between the Australian and all State and Territory Governments, with the current Agreement concluding on 30 June 2005.

The Commonwealth and all State and Territory Governments have indicated their commitment for a new agreement for the period 2005 – 2010 and negotiations for a new agreement are under way. In Queensland, the Department of Communities is the state agency responsible for the administration of the Program.

Homeless people frequently have diverse needs in addition to their lack of accommodation. The findings of the report, *Appropriate Responses for Homeless People Whose Needs Require a High Level and Complexity of Service Provision (1999),* indicate a growing concern among SAAP service providers about the increasing incident of clients with high and complex needs who require support from services beyond SAAP. The Report also identified the difficulties experienced by SAAP clients in engaging with other service systems, including mental health.

The SAAP National Coordination and Development Committee undertook a project to pilot an assessment tool to better understand the group of SAAP clients who require a high level and complexity of service provision. The Project Report indicates that of the number of assessment forms that were completed during the pilot 29 percent of SAAP clients required intensive and/or ongoing assistance with mental health issues. In 56 percent of these cases SAAP agencies rated the prospect of obtaining assistance as 'nil' or 'poor'.

The Report also states that in many instances mental health issues are compounded by issues related to drug and alcohol abuse. The findings from this project represent a compelling argument for a more coordinated and integrated service response to the complex needs of people who are homeless or at risk of homelessness.

The *Report of the National Evaluation of SAAP* (2004) indicates that homelessness does not occur in a vacuum but is a manifestation of other precipitating factors and deeper underlying causes that must be resolved as well. Homelessness results from both individual and systemic/structural circumstances. People who are homeless may have backgrounds of domestic violence or other physical, sexual or emotional abuse, have alcohol or drug dependencies, mental illnesses, poor education or employment prospects, have limited social skills and community connections.

The Queensland Government endorsed the findings of the 2004 SAAP Evaluation Report in relation to the directions for SAAP for the next Bilateral Agreement, which are:

- providing better assistance to people who present with a number of support needs

- increasing involvement in early intervention and prevention strategies
- providing ongoing assistance to ensure stability for clients post-crisis.

Residential Services Reform

A recent study undertaken by the Department of Housing with assistance from Centrelink provides a profile of the extent of mental health issues in residential services such as boarding houses and hostels providing supported accommodation. It should be noted that this data is only in relation to those residents in receipt of a benefit although they are a large proportion of residents. It may also underestimate the level of mental health issues particularly where there is a dual diagnosis with other disabilities.

This data found that more than half of boarding house residents receiving Disability Support Pension had some form of psychiatric or psychological disorder (55 percent, or 603 persons). Of those, almost one half (284 persons) had a severe form of this disability. Around 40 percent of all supported accommodation residents with a disability (477 persons) had some form of psychiatric or psychological disorder. Of those, almost two thirds (283 persons, or 59 percent of this group) had a severe form of this disability.

In August 2002, the Queensland Government commenced a major reform of private residential services, including boarding houses, supported accommodation and aged rental accommodation. This involved the introduction of legislation to improve safety and physical standards for residents as well as fire safety of buildings and to protect resident's tenancy rights. A range of resident and industry assistance initiatives were also introduced in support of these new laws.

The reforms include:

- expansion of tenancy support services to residents in this sector
- expansion of the Community Visitor Program
- improvements for residents' access to support services
- financial assistance for operators to prevent closures and reductions in affordable housing.

Since the introduction of the reforms, human services agencies have cooperated to provide assistance to residents displaced by service closures.

Employment

Recent research from New Zealand provides insight into the nature of the discrimination encountered by people with mental illness in regard to employment. Findings included:

- perceptions of unsuccessful job seeking due to disclosure of mental illness
- inappropriate questioning by employers and colleagues regarding the mental health history of the person
- job loss due to employers' attitudes to mental illness
- actual targeting for harassment and abuse on the grounds of their mental illness
- differing conditions of employment
- inaccurate and stereotyped attitudes held in the workplace regarding mental illness
- fear of discrimination preventing personal disclosure of mental illness.

In October 1998, the Queensland Government implemented the *Breaking the Unemployment Cycle* initiative in response to the high unemployment rate that prevailed at that time.

The *Breaking the Unemployment Cycle* initiative comprises a range of labour market programs that are aimed at raising the job competitiveness of the most disadvantaged unemployed jobseekers, including people with a disability, Aboriginal and Torres Strait Islander peoples, the long-term unemployed, people from non-English speaking backgrounds, mature age people and parents and carers.

The most recent data that is available on participation by people with a disability is for the period October 1998 to 31 December 2004. During this period people with a disability accounted for 5 percent (3654 persons) of the 75 301 jobs that had been created under the *Breaking the Unemployment Cycle* initiative during this time and 5 percent (5249 persons) of the 100 174 persons who received some form of assistance. This 5249 persons assisted includes people with a mental illness although there are no statistics relating specifically to this group.

The Department of Employment and Training also funds the *Disability - High Support Needs* vocational training program. People who have mental illness have been accessing this program to develop their skills and then moving into (or returning to) further vocational training, employment or employment preparation programs.

Family and social support

Disability Services Queensland is the Queensland Government Department responsible for providing leadership in disability services and programs for people with a disability, their families and carers. Disability Services Queensland's key roles include:

- leading Queensland Government policy and strategies on disability issues
- connecting with the disability sector and keeping in touch with the needs, views and ideas of people with a disability
- providing funds to buy support services for people with a disability, their families and carers
- providing services directly to people with a disability and their families.

Disability Services Queensland have received a substantial increase in funding for 2005-06 which will assist supporting people to live fulfilled lives in the community. For the small percentage of people with a mental illness who experience a long-term and significant reduction in their capacity, disability services may assist people make their own choices and decisions, participate in daily living activities and facilitate their involvement in community life.

Disability services to people with a psychiatric disability are provided through a number of programs and services. These may be programs that seek to provide support to a broad group of people with a disability or may be specifically targeted to supporting people with a psychiatric disability. Programs and services may be targeted to support the person with a disability, their family or community. In this way, available resources are utilised to maximise the capacity of communities to include and support people with a disability.

Disability Services Queensland administers *Project 300* – an individualised funding program that assists consumers to move from extended psychiatric treatment and rehabilitation facilities to live in the community. The program provides housing, supported accommodation, community access services and other supports. It

operates through the collaborative efforts of disability, mental health and housing services. The *Project 300* model of support is unique, focusing on community integration and participation. It operates with the support of, but not within, a medical model. *Project 300* has assisted 270 individuals to return to the community of their choice. The success of the model is highlighted by reductions in the level of support required by many individuals as they recover and as informal support networks increase within their own community.

The Public Advocate in Queensland has been very positive about *Project 300* stating in his most recent Annual Report (2003-04) "that *Project 300* remains the best available example of interagency collaboration in Queensland to date for people with a decision-making disability".

For example…

What sets* Project 300 *apart from other service responses in Queensland?

- *Project 300* was devised to meet the needs of a group of people who had suffered a long period of systemic neglect, during which time it was generally believed that no other option existed for their care, other than long-term/permanent institutionalisation.
- *Project 300* was a collaborative response by Queensland Health, Disability Services Queensland and the Department of Housing.
- There was in-built accountability to ensure that all three departments delivered tangible outcomes.
- Dedicated and recurrent funds were set aside for *Project 300*.
- Project targets were established with respect to the number of people to be served.
- An holistic vision was developed for people, one that encompassed their health, disability support, community integration, and housing needs.
- Both government and non-government agencies provided, and continue to provide integrated service responses as part of *Project 300.*
- Some years after the project's inception, vulnerable people continue to benefit from *Project 300*. (Negotiations are currently underway between Queensland Health and Disability Services Queensland for the movement of more people from long-term institutionalisation under *Project 300*).

Office of the Public Advocate, Annual Report 2003-04

f) The special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and comorbid conditions and drug and alcohol dependence

Australian society today is marked by social diversity and complexity. The acceptance of multi-culturalism and the tolerance of difference has become a well established factor of the Australian psyche. However, within our society there remains the need to consider some groups requiring specialist attention. In particular, the poor health status of Aboriginal and Torres Strait Islander People warrants a more intensive approach to address problems and generate outcomes which are culturally acceptable. Equally challenging for the health system are the emerging problems of comorbid drug and alcohol dependence. Queensland is exploring a more strategic approach on this issue, in particular.

Children and adolescents

Childhood and adolescence present a primary opportunity for the promotion of mental health and well-being and early identification, enabling early intervention with the aim of preventing or minimising the sequelae of serious mental illness, wherever possible.

In recognition of the differing and specific needs of subgroups within the category of 'children and adolescents', Queensland has provided substantial investment in a range of initiatives targeting families, which are evidence-based. They include:

- a home visiting program for new mothers deemed to be 'at risk'
- a statewide multi-level parenting strategy (ie. Positive Parenting Program referred to as Triple P)
- a school-based youth health nurse in all state secondary schools.

These initiatives are complemented by the establishment of community child and youth mental health teams to service those children and young people with more complex social and emotional problems and indications of mental illness or serious mental health problems requiring clinical intervention.

Over recent years, increasing state and national policy focus has been placed upon the specific issues of providing quality, timely and developmentally appropriate mental health care to young

people in the age range of 16 – 25 years. This focus recognises that late adolescence has the highest prevalence of symptoms that may lead to a mental disorder, as well as high prevalence of actual mental health problems and disorders. There are long term and disabling individual, social and economic costs and consequences of undiagnosed and untreated mental health disorders in this age group. Growing evidence highlights the importance of early diagnosis and treatment of young people with mental health problems.

Other barriers to access have been well documented through research and consultation with young people. Some barriers relate to service factors such as intake criteria and waiting lists whilst others relate to developmental and specific factors pertaining to young people. Factors documented within literature include:

- fear of stigma
- lack of knowledge of services
- concern about cost
- being male
- travel
- cultural appropriateness.

Furthermore, the scope of mental health treatment for this age group must take into account the formative nature of the various domains of the young person's life, all of which are highly vulnerable to the disabling impact of a mental illness. Therefore, engaging young people in treatment – especially young people with complex and severe mental disorders – requires sensitive, creative and innovative approaches that transcend existing service boundaries and traditional models of service delivery.

Education services

A range of support services is available to support young people in school settings. Education Queensland funds over 400 guidance staff who support schools and their communities to enhance the educational, physical, social, emotional and intellectual development of children. They are able to provide personal counselling in relation to individual safety and crisis management.

Education Queensland funds Community Education Counsellors and District Community Education Counsellors who provide educational counselling and support services within specific secondary schools and education districts to assist Aboriginal and/or Torres Strait Islander secondary students and communities.

There are a number of other school-based support services funded by other government departments to support young people. There are 159 School-Based Youth Health Nurses funded by Queensland Health who provide opportunities for students, parents and members of the school community to access a health professional in relation to health and well-being matters in secondary school settings. There are also currently 27 School-Based Police Officer positions servicing 40 State secondary schools. These positions are intended to support community involvement and preventative approaches to crime by helping to provide a safe and supportive learning environment for all students.

As a result of a partnership between the Department of Education and the Arts and the Department of Communities, by June 2005, there will be 113 Youth Support Coordinators working in state and non-state secondary schools and TAFE institutes to support students at risk of disengaging from learning and to provide links to welfare and community support where required. Youth Support Coordinators provide prevention and intervention services depending on local need, targeting young people who are still connected to education or training.

Children in need of protection

The Queensland Government has demonstrated its capacity to address the difficult issues associated with protecting children. Queensland's child protection system is undergoing significant reform in response to the findings of the Crime and Misconduct Commission's (CMC) inquiry into the abuse of children in foster care in 2003. A key feature of the new system is the establishment of the Department of Child Safety to focus on children and young people who have experienced or are at risk of abuse or neglect.

In line with the findings of the CMC Inquiry, the Government has adopted a holistic and whole-of-system approach to the issue of child protection. In its broadest sense, the child protection system provides a continuum of services, from prevention through to statutory interventions, for children and young people and their families. A broad range of government and non-government agencies have significant roles to play in supporting and resourcing Queensland families, and especially vulnerable families who may be at risk of coming into contact with the statutory child protection system.

The creation of the position of Child Safety Director in ten government departments with child protection responsibilities has

ensured strategic focus on the delivery of child safety services and the coordination of these responsibilities across government.

Services that respond to special needs

Parents with a mental illness may face additional challenges in creating a safe and protective environment for their children. When undertaking a formal investigation and assessment process, the Department of Child Safety considers a number of factors including:

- the child's home environment
- level of care and supervision provided to the child
- relevant support services available to parents.

As identified in the CMC report, children who are entering care are more likely than other children to suffer from varying degrees of emotional and behavioural problems. While some of these children may be appropriately placed in a traditional foster care home and receive outside treatment, for others the severity of their dysfunction necessitates a different approach including therapeutic care.

It is estimated that 43 percent of children currently in care fall into high, complex and extreme categories of care need with 17 percent in the extreme and complex categories. In response to the Crime and Misconduct Commission's Report, the Department of Child Safety, in collaboration with other government agencies, is working to identify, implement and evaluate therapeutic treatment programs for children in care with severe psychological and behavioural problems.

These initiatives include:

- the establishment of Mental Health Child Safety Support Teams (MH-CSSTs) to provide screening, assessment, crisis response, short-term intervention and long-term therapy and establish key linkages with other relevant providers, including general practitioners and non-government agencies
- the design and construction of purpose built residential buildings
- the implementation of a Multi-Systemic Therapy research program
- and a project to ensure that relevant government agencies work collaboratively to provide the expertise, resources, interventions and supports to meet the needs of children in care with high, complex or extreme needs.

Aboriginal and Torres Strait Islander peoples

Research shows that Aboriginal and Torres Strait Islander peoples have a life expectancy of around 20 years less than the general population and death rates between two and four times higher. Key social or economic indicators such as poverty, employment, housing, education, incarceration and health show that Aboriginal and Torres Strait Islander people:

- are at higher risk of disadvantage
- experience much higher levels of illness and premature death
- are more likely to be incarcerated
- are more likely to experience family violence
- have less education and employment prospects
- suffer from excessive use of alcohol and other substances.

Given the background of historical physical and emotional trauma and ongoing social and economic disadvantage that Aboriginal and Torres Strait Islander peoples experience, it is no surprise that mental illnesses, either singularly, but more often in association with drug and/or alcohol abuse, are common.

Lack of reliable statistical data prevents precise estimates of the prevalence and economic costs of mental illness among Aboriginal and Torres Strait Islander people, but it is clear that depression, anxiety and psychotic illness such as schizophrenia account for the bulk of diagnosed mental disorders. Evidence shows that Aboriginal and Torres Strait Islander people are nearly twice as likely as the rest of the population to be admitted for overnight psychiatric care.

Queensland Government has recently allocated funds as part of a whole-of-government investment to improve the health of Indigenous Queenslanders and implement the Queensland Government's Plan for the National Strategic Framework for Aboriginal and Torres Strait Islander Health. This initiative includes:

- health and safety of children, young people and families
- responses to alcohol and substance misuse
- increased Indigenous representation in the workforce in a range of settings including mental health services and child health services.

Intentional injury

Rates of intentional injury, whether self-inflicted or caused by assault, are an indicator of psychological illness and distress in the community. The rate of hospitalisation for Aboriginal and Torres Strait Islander males due to assault is six times higher than the general population, and for Aboriginal and Torres Strait Islander females almost 19 times higher. The rate of hospitalisation due to self-harm for both males and females is twice as high as that for the general population.

Suicide in Aboriginal and Torres Strait Islander communities is also solidly embedded in the historical context of colonisation, racism and discrimination. The harrowing statistics are a powerful barometer of the ongoing extent of disadvantage, marginalisation and hopelessness experienced by sections of the Aboriginal and Torres Strait Islander population. Recent Queensland data indicates that Aboriginal and Torres Strait Islander people in Queensland suicide at over twice the rate of the total Queensland population. This discrepancy is greatest in young Aboriginal and Torres Strait Islander males (15 – 24 years) with a rate of suicide almost three and a half times that of all young males in Queensland. Aboriginal and Torres Strait Islander males aged 25 – 34 years died by suicide at a rate twice that of the State average. The majority of Aboriginal and Torres Strait Islander suicides within Queensland are under the age of 35 at the time of death.

Service provision

Although the holistic view of health encompassing physical, emotional, spiritual and mental health and the importance of connections to family, community and land are widely reflected in policy and strategic approaches to Aboriginal and Torres Strait Islander health and well-being, there is still significant work required for a genuine impact on service provision.
All three levels of government in Australia are key players in improving Aboriginal and Torres Strait Islander health and all levels of government must work in genuine partnership where roles and responsibilities are negotiated and agreed.

Achievements

The Queensland Government has, in recent years, successfully worked with Aboriginal and Torres Strait Islander peoples to achieve healthier outcomes in a range of areas:

- legislative changes impacting on liquor supply
- enhanced community justice structures

- reformed community governance legislation and developed a Community Governance Improvement Strategy to assist Councils enhance their accountability, functions and compliance requirements
- expanded programs to foster leadership
- implemented a Safer Communities Strategy aimed at improving police responses to crime prevention
- enhanced the Indigenous workforce based on the results of a trial environmental health initiative funding the employment of Indigenous Environmental Health workers by Cape York communities
- enhanced primary health care services for Aboriginal and Torres Strait Islander people in urban, regional and remote populations
- increased representation of Indigenous people in the workforce.

The Queensland Government's commitment to improving Indigenous health outcomes was evidenced by the recent State Budget announcement of $89.5 million for Indigenous health initiatives which are being implemented collaboratively across six departments – Health, Aboriginal and Torres Strait Islander Policy, Local Government and Planning, Housing, Justice and Communities.

Older people

The special needs of this group of the Queensland population are identified and addressed in the *Queensland Health's Directions for Aged Care 2004-2011*. This document provides a clear guide for delivering even better health services including mental health services to older people. With the ageing of the population, there will be more people with pre-existing mental illnesses living well beyond the age of 65, who will require both mental health and aged care services.

The preferred option for acute inpatient services for older people with mental illness in Queensland is for collocation with geriatric acute units while maintaining close links with existing mental health services.

For example…

Queensland currently has several dedicated specialist older persons mental health units. Within these units there are well established formalised links between mental health and geriatric services, staff morale appears high, complaint level is low and specialised training, consultation liaison and community care are occurring. This represents an ideal model, well equipped to deliver optimal care to this population. Seven extended inpatient units are now collocated within state run residential aged care facilities.

Initial evaluation of clinical outcomes for clients moved from centralised facilities to decentralised collocated units, reveals that the clients had a positive response to the process demonstrating improvement in their level of long-term functioning and behaviour as a consequence.

Older people with mental health issues currently access the generic aged care services provided by Home and Community Care services, non-government and private organisations, including community, respite and extended care. Queensland continues to welcome dialogue with the Commonwealth on the Home and Community Care renegotiation to ensure that disadvantaged groups such as older people with mental illness receive the appropriate services.

People from a non-English speaking background

The mental health of people from non-English speaking backgrounds is an element of the Strategy, which presents particular challenges as a result of the broad cultural diversity within Australian society today. The statewide Queensland Transcultural Mental Health Centre (QTMHC) provides consultation and advocacy across the state, facilitating access to mental health treatment for culturally and linguistically diverse (CALD) clients. Through its pool of sessional bilingual mental health consultants covering over 60 language and cultural groups, QTMHC provides cultural and linguistic clarification to district mental health services, ensuring cultural appropriateness, and decreasing the possibility for diagnostic and treatment errors as demonstrated by research and practice evidence.

QTMHC also provides a limited clinical consultation service to complement and enhance the process of diagnosis, treatment and

care for CALD consumers within mental health services. Evidence indicates that early involvement of a bilingual mental health consultant facilitates a more comprehensive assessment leading to better treatment compliance and ultimately better outcomes.

Opportunities for the development of targeted strategies and greater collaboration to maximise outcomes do exist. However, funding for multicultural services is spread across a range of sectors and levels of government and increased opportunities would result from greater alignment in priority setting.

The recent release of the Framework for the *Implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia,* presents a unique opportunity for collaboration across all levels of government, the alignment of state and federal priorities, the development of targeted approaches, and the pooling of resources to more effectively meet the needs of this group. Queensland is working with the Commonwealth on this issue.

People with a dual diagnosis

The terms 'dual diagnosis' or 'comorbidity' refer to people with coexisting substance use and mental health disorders. Clinical presentations involving dual diagnosis are commonplace and constitute a significant component of the mental health system's core business. The prevalence of dual diagnosis for people with a mental illness is estimated as being very high. Owing to their complexity of needs, frequency of relapse, and relatively high use of hospital and emergency services, people with a dual diagnosis are significantly more costly to treat. The Centre for Mental Health Research in Queensland is examining such costs in a current study which is discussed under the term of reference (n).

Traditionally, separate roles, responsibilities and philosophies of the mental health and substance use health services have impeded progress to the optimum development of integrated services for clients with complex needs. Clearly, Queensland Health needs to address these structural impediments; recommendations for change that result from the current review of health services and systems will be used to inform this process.

The *Queensland Health Dual Diagnosis Strategic Plan 2003* outlines the department's approach to dual diagnosis. The plan identifies the need for mental health services to reorient service delivery to include prevention and early intervention programs and initiatives, consistent with the *National Mental Health Plans*. In addition, the development of promotion, prevention and early

intervention programs and initiatives that target the broader community and those at risk of developing dual diagnosis require further development.

Suicide in Queensland

Queensland has experienced consistently higher than national suicide rates over the past 15 years. Despite placing a high priority on preventing suicide through the *Queensland Government Suicide Prevention Strategy*, the complex and multi-factorial nature of risk presents very real challenges to achieving sustained impacts on suicide mortality.

Consequently, suicide is recognised in Queensland as a significant public health issue that needs to be addressed as a priority. The Queensland Government is committed to a sustained reduction in the rates of suicide and attempted suicide across the State, while still recognising that suicide prevention is a whole-of-community issue.

The whole-of-government development and implementation of the *Queensland Government Suicide Prevention Strategy 2003-2008* recognises the importance of the following components of an effective health program:

- a partnership approach
- a strong focus on prevention, health promotion and early detection
- health service delivery systems that are integrated, responsive and comprehensive
- continued development of a research culture and capability.

Statewide Early Intervention Program (EIP)

This program contributes to the enhancement of early intervention options for known high-risk groups and target service gaps associated with the early detection, comprehensive assessment, management and follow-up of suicide risk in priority groups and settings identified in the strategy.

Through the implementation of the statewide EIP, a range of initiatives has also been successfully implemented to increase the early detection, intervention, treatment and follow-up of individuals at risk of suicide, eg. Follow-up Care Program (Logan), Integrated Mental Health Services competency based training package (West Moreton) to increase staff competency in the detection and intervention of individuals presenting with suicidal behaviour.

g) The role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness

Over the last decade, significant progress has been made towards implementing key priorities of the *National Mental Health Strategy* with respect to consumer and carer issues. Nevertheless, consumer and carer organisations continue to raise concerns requiring further priority action by government. These include increasing responsibilities and pressures being placed by the community on primary carers of people with mental illness. Additionally, consumer groups have called for a reorientation of mental health services towards recovery. In acknowledging that more needs to be done in these two areas, the Queensland Government has demonstrated a commitment to both recognising carers as health care partners and promoting recovery-oriented service delivery.

It is anticipated that changes in the population during the next decade will see the role of carers becoming increasingly important. In October 2003, the Queensland Government released a *Carer Recognition Policy* that provides the basis for the acknowledgment of carers in the delivery of policy and services by government departments.

Since the early 1980s, increased support has been directed towards carers of people with mental health problems in Queensland, including the funding of carer related services through such organisations as:

- Association of Relatives and Friends of the Mentally Ill
- Schizophrenia (Mental Illness) Fellowship
- Mental Health Association of Queensland
- Children of Parents with Mental Illness.

This has also been accompanied by a significant shift in mental health service responsiveness to the needs of carers, involving such initiatives as carer representation in service governance and greater inclusion of carers in treatment planning. The Queensland Government has a continued commitment to supporting carers in their role.

h) The role of primary health care in promotion, prevention, early detection [intervention] and chronic care management

The domains of promotion, prevention and early detection have distinct conceptual, skill and activity bases, as well as differing levels of research support and evidence. It is, therefore, essential that there be clearer articulation of the appropriate and cost effective role of primary care providers across the continuum of mental health care.

General practitioners

General practitioners represent a very significant primary health care resource. For mental health clients, they also represent a relatively expensive clinical resource. Therefore, the strategic approach within Queensland in regard to the general practitioner role has focussed on the development of early detection, and collaborative and shared care approaches as an appropriate role investment. The important early detection function performed by general practitioners is fully acknowledged; however, the improved treatment and care for people with mental disorders and problems within the Queensland primary health care context requires ongoing collaboration and support from the public mental health system.

Queensland Health has implemented comprehensive and well resourced strategies aimed at developing collaborative mental health service delivery models based on partnerships between mental health services, general practitioners, and consumers. Largely, general practitioner ongoing involvement in mental health care provision has been found to be dependent upon, and correlates with, the level and intensity of the mental health service involvement.

Such involvement and collaboration needs to be appropriately resourced and the arrangements need to be administratively simple and responsive to the needs of the partners. So far, the consultation-liaison approach has remained largely a doctor-to-doctor process. Some exploration of alternative arrangements with alternative providers and the development of appropriate and necessary psychosocial primary care interventions are required.

A range of other issues have been identified within the Queensland context that impact on general practitioner engagement in mental health care. In particular, general practitioners vary considerably in regard to the level of their interest and capacity with busy

schedules to service people with serious mental disorders. When engaged, there is a discernable tendency for general practitioners to be involved more frequently with high prevalence disorder management.

Access to general practitioners is also an issue in metropolitan and regional areas. The tightly scheduled appointment-based structure and other general practice environment factors can limit the suitability for some mental health consumers.

Continued support needs to be given to the development of general practitioner competencies in early detection and ongoing management of mental health disorders and problems.

Chronic care

A significant issue in regard to primary health care is the interrelatedness of physical and mental health. There is a well acknowledged complex interplay between mental and physical disorders. Untreated mental disorders result in poor outcomes for comorbid physical illness and persons with mental disorders have documented poorer physical health status. Persons with chronic physical illness are significantly more likely than other people to suffer from mental disorders.

There is compelling evidence regarding the deficits in identification of and appropriate treatment of physical health problems of people with mental illness. This highlights the importance of general practitioners and other primary care providers being encouraged to more actively contribute to the physical health and well-being of people in the community with mental health problems through application of their core skill and knowledge area.

The *Queensland Chronic Disease Prevention and Management Implementation Initiative 2005 – 2015* is a mainstream health initiative of the Queensland Government identifying ways of preventing behavioural risk factors and supporting better health care for people with chronic disease. This initiative provides a valuable framework encompassing the full spectrum of health care services, from primary care to acute care and health maintenance. The chronic disease initiative also acknowledges the interrelatedness of chronic conditions with mental health problems and disorders and identifies the prevention and management of depression as a comorbidity of chronic diseases as a key priority of the strategy.

An area of relatively untapped and under-resourced potential proportionately with the emerging evidence of the preventative and early intervention capacity, is the early antenatal, early childhood, and to a lesser but still important extent, youth primary health care sectors. There is growing prominence being given to the strength and effectiveness of early years investments, home-based interventions, and parenting and school-based strategies. This is one area where it has been well established that investment provides significant health returns. The importance of the prevention agenda is recognised in the *Queensland Health Strategic Plan 2004-2010* and in the Queensland Government's endorsement of the *Strategic Policy Framework for Children's and Young People's Health 2002-2007*.

i) Opportunities for reducing the effects of iatrogenesis and promoting recovery focussed care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated

Recovery focussed care

While recovery is identified as both a principle and key outcome of the *National Mental Health Plan 2003-2008*, there remains considerable divergence of understanding of recovery-oriented service delivery across the national mental health system. Often the terms of 'recovery', 'consumer and carer participation', 'peer support', 'rehabilitation' and 'relapse prevention' are used interchangeably. This lack of a common national understanding of recovery in mental health could be addressed through a national publication using language based on the consumer experience of recovery rather than a policy maker's perspective

At the state level, Queensland has recently undertaken a number of initiatives to promote recovery-oriented service provision. In early 2005, the Queensland Human Services Chief Executive Officers Committee endorsed the *Recovery Orientation in Mental Health – Position Paper* which will provide contemporary guidance to human services agencies as they plan and delivery services to people with a mental illness.

Queensland Health is also developing collaborative recovery-oriented policy and planning processes as well as formal partnerships with agencies such as Housing, Communities, Disability Services, Employment and Training, Child Safety, Commonwealth Rehabilitation, Centrelink and the non-government sector.

Over recent months, Queensland Health has developed and piloted a training curriculum in the philosophy and practice of recovery that targets mental health professional, operational and support staff. This value-based education is resource intensive and requires further development of an infrastructure of consumer trainers. Following its formal evaluation, consideration is likely to be given to adapting this training to the promotion of recovery across other government departments and the non-government sector.

Workforce

Queensland recognises that consumer and carer participation is integral to recovery practice, both at an individual and systems

level. Queensland Health has recently developed and piloted a training package for the mental health workforce to improve consumer and carer participation at the individual care planning and management levels.

At a systems level, consumer consultants are employed in many district mental health services. Future work will be done to address current variations in job descriptions and employment conditions for the consumer workforce. The establishment of a statewide network of consumer consultants has provided needed peer support and opportunities to address broader consumer/carer issues and a future statewide consumer and carer advisory model based on statewide and zonal consumer/carer coordinators is planned.

Throughout the literature, peer support has been identified as an important element of a recovery-oriented service system. There is an opportunity for greater emphasis on consumer employment in national and state mental health workforce planning. Queensland Health will strengthen the part played by consumers through its consideration of new roles and new ways of working in future service and workforce planning.

Some initiatives that Queensland mental health services are currently trialling and that use peer support workers, are:

- Indigenous spiritual liaison support
- consumer companions
- mental health recovery support workers.

Future possible directions

There are significant opportunities for promoting recovery focussed care through consumer involvement, and peer support and education of the mental health workforce, in this regard. More coordination and planning are required. It is proposed that consumer-driven recovery-oriented service delivery in mental health be promoted by a substantial and appropriately resourced community infrastructure. This would require significant innovation on the part of both National and State governments in generating incentives for the development of recovery-promoting organisations in both the non-government and private sectors.

Such organisations could offer a range of services including consumer-focused service evaluation, recovery or consumer/carer education programs and peer support or other consumer workforce initiatives. Some of these programs may be offered by consumer-operated services.

However, while the ability to deliver effective recovery-oriented services is an essential assessment criterion for determining the value of any such agency, it should not be considered either necessary or sufficient that the agency be consumer-operated.

With regard to preventing iatrogenesis in mental health care, it may also be helpful to reconsider the approach of governments to the provision and evaluation of quality services. There has been increasing focus over recent years at a national level on the measurement of clinical outcomes. Most recently, this has been supported by an emphasis on risk management measures such as:

- sentinel event reporting
- root cause analysis
- clinical incident reporting.

While these measures are necessary, they represent a small component of what actually constitutes quality service provision. Greater gains may be achieved by rethinking quality in terms of self-determination.

Self-determination

This focus on self-determination involves individuals having the primary role in choosing pathways to mental health recovery. It requires the facilitation of community networks (families, friends, classmates and work colleagues) that are able to collaborate in the support of this recovery.

This requires clear articulation of the package of the services or treatment programs being made available to consumers (for example, in current terms, cognitive behaviour therapy, crisis intervention, medication management, vocational support) and the evidence that supports the use of these measures.

It requires the development of a workforce that comprises varying roles, competencies and levels of expertise, that is prepared to work in new and different ways, and most importantly, that operates to support consumer self-determination.

The development of the capability of the existing and future mental health workforce is currently a key priority area for Queensland. Queensland Health is developing a Centre for Mental Health Learning that will provide statewide coordination of the prioritisation, design and delivery of mental health continuing education initiatives and/or their brokerage to external training

providers in the higher education, vocational education or private sectors.

However, there are ongoing difficulties associated with the ability of States to influence the pre-service preparation of the mental health workforce, issues that, to some extent, are related to the Commonwealth responsibility and funding for higher education places.

Queensland Government is keen to ensure that it continues to have an influence over the supply of a suitably qualified workforce to meet increasing demand across a range of health services.

j) The over-representation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people

This paper does not deal with the issues associated with the Cornelia Rau and Vivian Young cases. The Palmer Inquiry has been established by the Federal Minister for Immigration and Multicultural and Indigenous Affairs to investigate the specific features of both of these events, and any recommendations relevant to Queensland made by the Palmer Inquiry will be considered separately by the Queensland Government. The purpose of this paper is to provide a systemic view of the mental health system in Queensland – not to address individual cases or incidents.

Over-representation

Whilst research indicates that there is an over-representation of people with a mental illness in the criminal justice system, the Queensland criminal justice system has no readily available statistics in this regard.

Whilst some people have their mental illness diagnosed for the first time while they are in custody, the majority have had dealings with mental health services prior to their incarceration.

Reasons for over-representation of people with mental illness in prison include:

- insufficient levels of community mental health services
- high rates of substance misuse complicating mental illness
- general disadvantage within the community.

Improved levels of integrated services for mental illness and substance misuse, as well as assistance in areas such as housing, social, and disability support, would reduce the likelihood of people with mental illness coming in contact with the criminal justice system.

Protecting human rights

Protecting the rights and interests of this population necessitates a broad range of strategies aimed at minimising inappropriate involvement, ensuring early identification and access to specialist mental health services, and providing processes that take account of vulnerabilities and special needs of people with mental illness.

These objectives are reflected in Queensland's legislative and service provision framework. The general principle for Queensland government departments is to have processes and policies in place to ensure the human rights and dignity of all people.

For example…

The Queensland Police Service has a number of processes and policy instruments in place to ensure the human rights and dignity of all persons, and particularly those with special needs (including those with a mental illness) are protected and safeguarded.

These procedures provide sound policy and clear directions for dealing with people with a mental illness, including when these people are suspected of criminal activities. The procedures outline the investigative and prosecution process to be followed in all matters. Relevant policy references within the *Operational Procedures Manual* are included at Appendix 1.

Legislation

A number of Queensland statutes operate to protect the rights and interests of mentally ill offenders in criminal justice processes. (Refer Appendix 2 for more detailed information). The *Mental Health Act 2000* provides the primary legislative interface between the criminal justice and mental health treatment systems. The Act serves a number of important functions:

- it establishes processes for an individual to access specialist inpatient mental health services from a court or place of custody. These processes may be applied at any stage in the criminal justice process (eg. individuals charged, awaiting appearance, trial or sentence, or serving a sentence of imprisonment)
- it provides an assertive scheme for examining issues of criminal responsibility and fitness for trial with a view to averting inappropriate conviction and incarceration in the correctional system. A psychiatrist's examination and report of these issues is required for all involuntary patients charged with an offence, regardless of their custody status
- it establishes processes to divert criminal matters from the usual court processes and provides for legal proceedings to

be discontinued in defined circumstances. Administrative determination of less serious offences by the Attorney-General averts the need for a court hearing and the consequent stress and adverse impact that can be associated with it. The Mental Health Court is established to determine more serious offences and enables a more timely, less adversarial system for examining mental health issues

- it provides for the involuntary treatment needs of mentally ill offenders and ensures appropriate protection of their rights within the involuntary treatment process. While additional safeguards apply to address detention needs (eg. for individuals transferred from a court or custody or subject to a forensic order), the statutory protections associated with involuntary assessment and treatment apply equally to offenders.

As identified in the Queensland Government Submission Part 1[3], *Mental Health Services in Queensland 2005*, the development and management of mental health services to mentally ill offenders is guided by the *Queensland Forensic Mental Health Policy (2002).* The Policy promotes the delivery of services in a manner which is consistent with principles of equitable and timely access, early intervention, continuity of care and service provision in the least restrictive environment. Specialised forensic mental health services provide support and/or direct service delivery for individuals with mental illness and complex forensic issues.

Other processes

Appendix 2 contains detailed information relating to the adequacy of Queensland's legislation and processes in protecting the rights of people with a mental illness in the criminal justice system and in custody.

Diversion programs

Significant enhancement of district mental health services has increased capacity to provide mental health services to offenders at the local level. This includes, for example, increased capacity to provide assessment services to people detained in police watch-houses and the provision of inpatient care for individuals diverted from a court or police or corrections custody. Supra-district services are accessed where security needs cannot be accommodated at the local level. The opening of secure facilities in

[3] For more information about the criminal justice system, see pp 9-11 of *Mental Health Services in Queensland 2005* (No. 377)

Townsville has enabled mentally ill offenders in North Queensland to receive inpatient treatment closer to their family and support networks.

Needless to say, the diversion of people with mental illness from the criminal justice system to health services should be strongly supported. A good model is in place in Queensland where a Mental Health Court[4], authorised under the *Mental Health Act 2000*, is empowered to determine issues of criminal responsibility and fitness for trial. The court may also make a forensic order to provide the person's ongoing treatment in the mental health system.

The Queensland Health Court Liaison Service provides a proactive system of identifying individuals with mental health needs in the early phases of the criminal justice process. Diversion to district mental health services is arranged from police watch-houses or through Magistrates Courts. Expert advice to Magistrates on the management of an accused with mental health needs is also provided where diversion is not indicated. Court Liaison Services operate in Brisbane and Townsville, with expansion to other areas of the State currently being explored.

Service provision

Specialist mental health services are provided in prisons and youth detention centres with the relevant custodial department responsible for the provision of these services. Visiting services are purchased from external providers reflecting an important separation between the provision of health services and the custodial provider.

To date, the focus of specialist services to mentally ill offenders has been on meeting the most critical areas of need. Within the prison sector, for example, priority has been given to the provision of medical services to people with psychotic, mood and anxiety disorders.

Due to the impact of substance abuse amongst prisoners in general, and amongst prisoners with mental illness in particular, it is important that prisons provide a range of quality treatment services for people who have substance misuse problems. Ideally, such services would be provided by community-based treatment services to facilitate continuity of care after prisoners are released.

[4] For more information about the Mental Health Courts, see Appendix 2: *Adequacy of Queensland's legislation and processes in protecting the rights of people with a mental illness in the criminal justice system and in custody*

Prisoners with mental illness face significant challenges when they are released. Recidivism is strongly linked to a lack of necessary social supports, such as accommodation and financial support. These are often a disadvantaged and marginalised group who have generally come into custody with poor education levels, low literacy, unstable social environments and general disadvantage. Expanded community services, including psychosocial rehabilitation services should be strongly supported and released offenders should be an important client group for such improved and expanded services.

Criminal justice system

With the exception of those matters considered by the Mental Health Court and the Mental Health Review Tribunal, in Queensland, the various arms of the criminal justice system do not publish statistics as to the number of offenders, victims or witnesses who are identified as having a mental illness.

The availability of data and the further development of research initiatives are integral to informing further policy and service development and in monitoring the effectiveness of service delivery in this area.

Queensland supports current national research being funded by the Criminology Research Council (CRC) which will examine issues relating to the identification of mental disorders in the criminal justice system as part of a wider project examining the relationship between mental disorders and offending.

Other national initiatives, supported by all jurisdictions, are also focussing on data needs in regard to mental illness. An example is the current agenda of the Commonwealth/state joint funded National Criminal Courts Statistics Unit (NCCSU) within the Australian Bureau of Statistics (ABS).

k) The practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion

While society recognises that detaining a person for treatment against their will represents a significant infringement of individual rights, there is also a clear community expectation that the health and safety of people with mental illness and that of others will be protected. The large majority of people with mental illness access treatment on a voluntary basis. However, for a variety of reasons, some do not.

The practice of seclusion is regarded by some as extremely aversive and its use as a substitute for other good management practices cannot be condoned in any circumstance. However, there are times when it is regarded as unavoidable. Detention and seclusion within Queensland mental health facilities is governed by the *Mental Health Act 2000*. The Act affirms the basic human rights of all individuals to which it applies (section 8) and requires that powers under the Act are exercised so that liberty and rights are adversely affected only if there is no less restrictive way to protect the person's health or safety or to protect others (section 9). It also establishes a range of safeguards to protect against inappropriate detention including:

- application of strict criteria for involuntary assessment and treatment
- a two-step authorisation process
- review by an independent statutory body.

A comprehensive review of Queensland's mental health legislation occurred between 1993 and 2000. The review was undertaken in the context of Government commitment to the National *Mental Health Statement of Rights and Responsibilities (1991)* and the *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*. Examination of adherence to the United Nations Principles utilising the National Rights Analysis Instrument demonstrated substantial to full compliance across the indicators assessed. While all significant rights safeguards are reflected in the legislation, areas of non-compliance relate to a number of minor requirements resulting to some extent from the scope of the legislative scheme. Queensland mental health legislation is focussed on involuntary

assessment and treatment while the United Nations Principles are of broader scope.

As identified in Queensland Health Submission Part 1[5], a number of strategies are directed toward ensuring the *Mental Health Act 2000* is administered in accordance with legislative requirements. Strategies proposed through the National Safety and Quality in Mental Health Partnership Group will provide additional focus on reducing inappropriate use of, and adverse events associated with, seclusion and restraint. Strategies include development of national standards relating to the use of seclusion, monitoring and reporting and identification of alternative interventions.

While legislative safeguards, practice standards and monitoring processes are of critical importance, their limitations in protecting and promoting individual rights and minimising restrictive practices need to be recognised. Such mechanisms need to be supported by policy, management and educational practices that specifically address the capacity of organisations and the capability of the workforce to identify and utilise less restrictive practices as alternatives to detention and seclusion.

This will require a more targeted approach than that currently outlined in the *National Mental Health Plan 2003-2008*. It requires Commonwealth and State collaboration and agreement on the design, implementation, evaluation and appropriate funding of a select number of projects/initiatives that are consumer-driven, recovery-oriented, informed by the latest evidence and focused on continuous quality improvement. Priority needs to be given to projects/initiatives concerned with clinical and workforce innovation, the values and skills of mental health service leaders, and stigma and discrimination in the community.

[5] For more information about activities that support the administration of the Act, see p13 of *Mental Health Services in Queensland 2005* (No. 377)

l) The adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers

The effect of stigma and discrimination on the lives of those affected by mental illness is profound and far-reaching. As well as discouraging help seeking by people with mental health problems and disorders, stigma has multiple impacts on the quality of life of consumers and their families – affecting employment, economic participation, community involvement and social connectedness.

Stigma, therefore, has not only significant individual impacts but also major social and economic consequences for the community. The Queensland Government is very mindful of the pressing need both for community education directed at the de-stigmatisation of mental illness and for greater availability and better coordination of service support information for people with mental illness, their families and carers.

The reduction of stigma and discrimination has been identified as a priority area within the *Queensland Mental Health Strategic Plan 2003 – 2008*. It is the considered view of the Queensland Government that given the pervasive nature of stigma and discrimination, the best approach to addressing this problem is through a nationally coordinated, multi-strategic and sustainable approach. This requires the continued cooperation of Commonwealth, State and Territory Governments in the development of a range of initiatives across a number of domains that build on the previous national community awareness campaign previously undertaken as part of the *National Mental Health Strategy*.

This insidious problem may be best addressed by state initiatives being developed within a nationally coordinated, multi-strategic and sustainable approach to reduction of stigma and discrimination.

There is increasing international evidence that mass media campaigns designed to improve mental health literacy can have a positive impact. However, the resource intensive nature of mass media campaigns and the expertise required in such developments provide a strong rationale for greater centralisation and the avoidance of duplication across states and territories.

Optimal effectiveness can be achieved by complementing such campaigns with other more direct approaches such as community activities or the dissemination of printed materials. For example,

the New Zealand project *Like Minds* has a strong record of challenging stigma and discrimination through a two-tiered approach which encompasses a national program (involving a range of projects including a mass media campaign) and regional programs contracted out to providers in public health units and non-government organisations.

In Australia, a nationally coordinated approach could facilitate ongoing dialogue and cooperation across programs such as those currently operating at the national level including the media focused *Mindframe* strategy, Sane's *Media Watch* and *Responsibility* targeting the tertiary training of teachers, journalists and other workers and the *MindMatters* discrimination component.

Over recent years, an increasing number of government agencies and non-government organisations have developed support service information for people with mental illness, their families and carers and there is a substantial amount of generic information regarding roles, responsibilities and services that could be offered. Greater coordination of the development and dissemination of this support service information is warranted at both state/territory and national levels.

m) The proficiency and accountability of agencies, such as housing, employment, law enforcement, and general health services, in dealing appropriately with people affected by mental illness

The past decade has seen a growing recognition of the rights of people with a mental illness to access services which are available to the general public. This requires all community-based agencies including housing, employment, law enforcement, disability, general health and mental health to provide services/supports in a coordinated and collaborative manner. In recognition of this, proactive arrangements across government agencies have been progressed. At this point in time, efforts to maintain people in their recovery have concentrated on access to shelter, support and safety.

Unmet need and funding issues are exacerbated by differing eligibility criteria, different regional boundaries, and different processes for accessing care/support packages, and housing.

Recent public criticism has been made by the Public Advocate particularly in terms of discharge planning and referral practices which have resulted in unsatisfactory outcomes for clients. Satisfactory resolution of these issues requires coordination across various agencies. Queensland Health is currently developing an action plan to address the issues raised by the Public Advocate, recognising these represent a significant barrier to better care outcomes for clients. The Morris Commission of Inquiry and the Forster Review of Queensland Health Systems are due to report by the end of September when they will present their recommendations for implementation to the Queensland Government.

Housing

Features of appropriate housing are a significant contributor to improving outcomes for people with a mental illness. They include affordability, access to social supports and services, tenure that is secure and flexible, privacy (in the home and in service delivery), and physical features which contribute to effective management and recovery. The Department of Housing recognises the need for appropriate service responses to people with a mental illness and is working with Queensland Health to improve access and security of tenure through social housing programs and private housing assistance. $235.52 million in the 2005-06 State Budget is directed towards addressing homelessness, including the complex needs of people with a mental illness who need transitionary accommodation.

There is a heavy reliance on the private boarding house and hostel sector. Recently introduced legislation relating to the registration and accreditation of residential facilities to improve the quality of these services has seen a reduction in the availability of residential services. This is because some providers have opted out of the system, despite a loan program offered to providers to assist in complying with legislation. In the 2005-06 State Budget, $50 million is being directed to the provision of boarding style accommodation for single people, and $2.32 million is directed to helping existing residential services stay open.

Cross-government protocols are also in place to address the needs of residents affected by closure or a change in status of residential services, however, challenges in the provision of suitable options impact on government's capacity to respond and to prevent homelessness. These include loss of stock, viability issues for providers, issues with new supply to replace bed losses, issues with the availability of, and access to, social housing options such as public housing in places where closures occur.

Coordinating housing and support to meet identified needs remains a challenge. Sometimes housing is available but further support is required, or vice versa. There are a number of reasons for restricted access to some housing options including:

- high and complex needs
- a need for further training and support for accommodation and support providers of the common behavioural and communication issues of people with a mild intellectual disability, psychiatric disability and/or an acquired brain injury
- potential discrimination against people who, for example, exhibit challenging behaviours or who have drug and alcohol dependencies
- land and infrastructure issues can constrain the development of new forms of accommodation
- community attitudes towards accommodation and care services in their locality.

Funding of $43.6 million over four years has recently been committed to address the complex health needs of people with a mental illness and/or alcohol and other drug problems who are homeless in areas of high need in Queensland.

Disability support services

With the adoption of a recovery-oriented and holistic approach to support for people with a mental illness, there has been increasing recognition of the need for community-based living supports to a range of people with mental illness. This may include:

- short-term support for a period of months following an admission to hospital
- medium-term or intermittent support for people with episodic mental illness
- life long support for those with the highest level of need.

Service types required may include:

- short, medium or long-term accommodation support
- community access
- advocacy
- respite
- peer support
- family support.

In Queensland, this need is met in part by disability services. Unlike other jurisdictions, people with a psychiatric disability may be recognised as eligible for the specialist disability services funded under the Commonwealth-State/Territory Disability Agreement. Psychiatric disability was recognised for the purpose of specialist disability funding and service delivery in 1999. Disability services are available to people who, as a result of their mental illness, experience a long-term and substantial reduction in their capacity to participate in a range of everyday life experiences and require support. These services are provided based on priority of need.

The Queensland Government recognises that there is an increasing demand for community-based living supports for people who do not have a long-term disability but who may require short to medium-term support in the community.

Employment services

Employment plays a number of important functions in regard to the mental health and well-being of individuals. As well as providing a source of income, meaningful employment impacts significantly on a positive sense of self and purpose. Formal collaborative arrangements between Queensland Health and government

employment agencies to improve access to employment options for people with a mental illness need to be developed.

While the State government has been involved in the delivery of labour market programs over the past six years as outlined below under the *Breaking the Unemployment Cycle*, this has been because of the Australian Government's withdrawal from the delivery of similar programs. In keeping with its responsibility in employment issues, the Australian Government should investigate and resource new opportunities to assist people with a mental illness find suitable employment.

The growing emphasis on the achievement of healthy workplaces needs to be expanded. This needs to be accompanied by programs that address the stigma of mental illness in the workplace and support the rights and responsibilities of people with a mental illness seeking and maintaining employment.

Another set of programs need to target and intervene early with people at risk. For example, employment agencies contracted as part of the Australian Government's Job Network need to be able to recognise and appropriately refer people who may require assistance with a mental health problem.

Research has shown significantly higher prevalence rates of mental disorders for people who are income support recipients compared to those of the general population. At the same time, unemployment may co-occur and/or have a cumulative effect on the early onset of a serious mental illness.

This may be compounded by other social disadvantage such as:

- poor educational background
- being from a culturally or linguistically diverse background
- geographical locations lacking social infrastructure and employment opportunities.

In terms of early intervention, mental health agencies need to be much more vigilant in ensuring people accessing services are not unnecessarily dislocated either from employment or from other social supports, such as housing, that impact on employment opportunities.

A diverse range of Australian Government employment related programs needs also to be available to assist the recovery of people with a mental illness. In this regard, there needs to be a significant shift away from the emphasis on institutionalised rehabilitation

programs towards meaningful engagement with paid employment. This will require continued investment in current initiatives as well as partnership across governments (Commonwealth, State and Local), private sector and non-government organisations in the design, implementation and evaluation of innovative services that significantly increase the employment opportunities and employment experience for people with a mental illness.

In October 1998, the Queensland Government implemented the *Breaking the Unemployment Cycle* initiative in response to the high unemployment rate that prevailed at that time. This initiative comprises a range of labour market programs that are aimed at raising the job competitiveness of the most disadvantaged unemployed jobseekers, including:

- people with a disability
- Aboriginal people and Torres Strait Islanders
- the long-term unemployed
- people from non-English speaking backgrounds
- mature age people
- parents and carers.

In addition, the initiative is aimed at alleviating skill shortages through creating more apprenticeship and traineeship opportunities.

People with a disability are a priority target group for assistance under the *Breaking the Unemployment Cycle* initiative programs. The most recent data that is available on participation by people with a disability is for the period October 1998 to 31 December 2004.

People with a disability accounted for 5 percent (3654 persons) of the 75 301 jobs that had been created under the *Breaking the Unemployment Cycle* initiative during this time and 5 percent (5249 persons) of the 100 174 persons who received some form of assistance. This 5249 persons assisted includes people with a mental illness although there are no statistics relating specifically to this group; however, two projects that cater specifically for people with a mental illness are currently being funded. One project operating in the Ipswich area targets young people with an intellectual impairment or with Aspergers Syndrome Disorder while the other program in Fortitude Valley targets people with dual mental health and substance abuse problems who are also experiencing various levels of homelessness.

Police services

The Queensland Police Service is the agency charged with the statutory responsibility for the delivery of first response services in any crisis situation. The Queensland Police Service has high rates of involvement with people with mental illness. Police are frequently the first to respond in times of acute need or crisis.

There has been a 17 percent increase in calls for service to this population between 2001 and 2003. Of these calls for service, 11 percent were related to crisis situations. Many of these presentations are related to substance misuse. The number of Emergency Examination Orders under the *Mental Health Act 2000* undertaken by police increased by 64 percent over three years with 27 percent in the last year.

In response to the increasing number of mental health crisis situations, some of which have resulted in fatalities and injury, the Queensland Police Service and Queensland Health have developed a model which uses Crisis Intervention Teams. Funding has recently been announced through the 2005-06 State Budget for the establishment of these teams. The teams will possess the skills to de-escalate situations involving people with a mental illness and avert the development of crisis situations. Funding will support training of mental health clinicians, police and ambulance officers across the State, to assist in preventing and safely resolving mental health crisis situations.

Part of the continuous improvement has been the development of a comprehensive training strategy for police which includes training in mental health issues at a number of levels - recruitment, first year constable program, the constable development program, Operational Skills and Tactics, the Mental Health Competency Acquisition Program and the Mental Health Situational Online Support. This strategy provides a platform for ongoing training interactions between Health and Police at the district level.

The clarification of the roles and responsibilities of these two agencies in regard to the *Mental Health Act 2000* and the *Police Powers and Responsibilities Act 2000* is an ongoing process. The responsibility for the transportation of people with a mental illness, in order to access assessment and treatment remains an issue, particularly in rural, remote and isolated areas. Working groups have recently been established to consider the complexities and propose solutions.

Emergency services

The Queensland Ambulance Service has a key responsibility for supporting and improving the health and well-being of individuals and the community including those with mental illness. This is achieved through the provision of emergency and non-emergency ambulance based primary health care and specialised health transport services.

Due to the vast geographical nature of Queensland, the Queensland Ambulance Service may be the primary source of contact for the mentally ill patient and be expected to provide after hours crisis services due to reduced access to medical services and/or dedicated mental health services. The Queensland Ambulance Service also provides Inter-facility Transfers by road of patients with mental illness requiring specialised care or in cases where admission is not available locally.

In 2003-04, the Queensland Ambulance Service responded to approximately 9391 cases involving patients with mental illness; this represented a 12.6 percent increase on the previous year. In providing care for these patients, ambulance paramedics provided a range of services including acute primary care, crisis intervention and where appropriate, transportation to a medical facility or an Authorised Mental Health Service.

Under the *Mental Health Act 2000*, ambulance officers now have the capacity to initiate an Emergency Examination Order (EEO); however, in the period July 2002 to June 2004, 10 percent of EEOs were performed by ambulance officers and 90 percent by police.

Clarification of roles and responsibilities of Health and Ambulance Services in relation to the *Mental Health Act 2000* and the *Ambulance Services Act 1991* continues. This includes:

- clarifying when to use an Emergency Examination Order
- the restraint of patients with mental illness who are being transported
- over-reliance on police assistance to ensure safety.

The geographical isolation of many Queensland communities provides additional challenges in safe transportation of people with mental illness. Retrieval from rural and remote areas of the State is facilitated by a number of agencies including Queensland Ambulance Services, Royal Flying Doctor Services and the Queensland Police Service. Queensland Health has recently initiated a collaborative project to develop an operational policy

and associated interagency guidelines for the emergency transport of mentally persons from rural and remote areas.

Justice

Recognising and understanding mental illness may not be easy for stakeholders in the justice system. Where a person within the justice system is correctly identified as having a mental illness, this recognition will indicate the accompanying procedures for progressing through the system as defined by the appropriate legislation. However, it is more difficult to gauge proficiency in dealing appropriately with people affected by mental illness where the system fails to recognise their illness. Justice personnel require specific training in dealing appropriately with people affected by mental illness.

Education

Education Queensland is committed to working in a coordinated way to ensure that the mental health needs of Queensland state school students are met. To this end, the Department is involved in a number of cross government and whole-of-government activities to develop strategies to maximise the use of available mental health resources.

The Queensland Health and Education Queensland Joint Work Plan 2004–2007 focuses on five key priority areas for joint action including mental health promotion.

As part of the *Queensland Government Suicide Prevention Strategy 2003-2008*, Education Queensland has developed a District Spectrum Plans project to support education districts to develop local plans to maximise the reach and impact of available mental health resources across a number of government agencies. During 2005, three pilot education districts will develop local plans to address student mental health and well-being from prevention through to early intervention, referral, and ongoing recovery support.

(n) The current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated

Research

The role of research in mental health reform is critical if new and innovative approaches are to be developed that will contribute to a responsive service system and support evidence-based clinical practice.

At a strategic level, the mental health sector would be considerably advantaged by the establishment of an independent national institute for mental health similar to that in the UK, which is mandated to support system transformation, workforce development and changes in practice through a research agenda and support to regions to put policy into practice.

Funding

Greater emphasis on industry participation in research by funding bodies could also lessen this gap. At the national level, funders should develop clear rationale for the allocation of research funding within a coordinated framework which involves jurisdictions in decision making. This would minimise potential for parallel processes at the national and state levels. The development of evidence-based practice is to date largely driven through the service delivery system, and occurs in those services where the need for change is recognised. It is unreasonable to expect that this arrangement is sustainable into the future, without other additional support mechanisms.

Queensland Health has funded research that has attracted international recognition. Initially, the major focus of the research was on schizophrenia, rather than the high prevalence disorders which are most likely to have serious economic implications into the future. More recently, the new Queensland Centre for Mental Health Research has incorporated health policy and economics into its agenda. Outcomes are beginning to emerge, providing analysis of mental health reform with implications for the development of mental health policy.

o) The adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards

Inadequate information about mental health has been seen as a barrier to the achievement of many of the goals of the Strategy that depend upon an 'informed mental health system'.

Substantial progress has been made in developing the infrastructure to support nationally consistent information collections. While the full contribution of such collections to assist the progress of reform is yet to be realised, the uptake of available information and the achievement of a culture within the sector of using and applying information to support and improve service delivery is improving.

While consistent statistical data has provided valuable markers on progress, debate continues regarding the suitability of existing nationally mandated collections to support the evolving reforms of the sector. Comparisons are limited to the level of participation and the data set being collected. Concern exists that limitations of current national reporting has inhibited the development of creative options and funding packages at jurisdictional level with the potential to produce more cost effective options for service delivery.

The development of data which reflects quality is essential to drive service development and ensure the provision of safe and quality services grounded in the current evidence base. In addition, with the emphasis on recovery-oriented service provision, consideration needs to be given to our capacity to capture recovery-orientated outcomes within current consumer outcomes measurement. This includes reflection of consumer perspectives on recovery and the outcomes that are important to that process rather than a service-driven definition. The use of qualitative information should be considered.

Investment in the area of information development in mental health is primarily through incentive Commonwealth funds; however, it should be recognised that the Queensland Government is pursuing the option of mainstreaming mental health data in the State collection. This will ultimately achieve a primary aim of the Strategy and facilitate access to data on components of health care outside the mental health area. As information is pivotal to the reform of the mental health sector, there is a need to ensure the

sustainability of all mental health information development strategies.

The *Queensland Mental Health Information Development Strategy 2005-2008* has recently been endorsed. This framework proposes strategies for the use of mental health information to contribute to quality and service monitoring. It endorses quality improvement in the area of national mental health information collections and outlines a number of key state priorities including:

- State population mental health monitoring to commence 2005
- development of State mental health information reporting capacity
- implementation of National Key Performance Indicators
- development of a linked database with sophisticated reporting capacity that will underpin service evaluation and monitoring
- development of strategies to support the evaluation of safety and quality of mental health care.

There is a need to view outcomes more flexibly than they are currently provided for the *National Mental Health Report*. The provision of safe and quality services requires that clinical practices be grounded in the current evidence base, and be guided by a quality improvement process.

p) The potential for new modes of delivery of mental health care, including e-technology

Service providers cannot continue to meet the growing demands for mental health services resulting from the increasing burden of disease within finite resources. This issue creates imperatives to introduce new ways of working including:

- innovative models of service delivery
- changes in workforce design and participation
- changes in the preparation and development of our mental health workforce.

In general, e-technology does provide opportunities for the mental health workforce to work in new and innovative ways, and to market this innovation.

E-technology, particularly telehealth, is being used in Queensland as an essential vehicle for supporting staff through its use in:

- case conferencing and review
- supervision/mentoring
- education and training
- to a lesser extent, in consumer assessment.

The broader use of e-technology will require e-assessment provider/clinical service relationship building; and increased consumer, community, and professional confidence and comfort with the use of communication technology. A principal barrier in terms of the use of e-technology as a service option is the complexity of e-health, such as legal and ethical issues relating to the security of sensitive and confidential client information. There is also a need for ongoing technological support and training.

An example of more specialised service use of e-technology is the establishment of a centre to provide statewide secondary mental health assessments for people who are Deaf or hearing impaired using a telehealth video link and appropriately skilled sign language interpreters. This enables culturally appropriate assessments, and providing advice about clinical treatment and management to services and consumers who could not normally access this service.

An industry partnership between Queensland Health and University of Centre for Online Health at the University of Queensland and the Australian Institute for Suicide Research and Queensland

University of Technology will result in the development of on-line assessment support services for workers in rural, remote and regional Queensland.

A two-year project is underway in Child and Youth Mental Health Services to provide access to specialised secondary assessment services, using a telehealth video link, for rural and remote services that cannot attract a visiting child psychiatrist.

This model provides significant cost savings when compared to flying in a child psychiatrist, or transporting the client to a service centre where there is a practising child psychiatrist. This service is complemented by the Mater Children's Hospital internet site to promote access to general information and services.

Following a 2004 election commitment, Smart Service Queensland and Queensland Health are developing a Queensland Health Contact Centre which will provide a 24 hour, 7 day-a-week, statewide health hotline to give easy access to health advice and information, referral and triage services. It is due to commence the first phase of operations in December 2005. Mental health will be mainstreamed into the Contact Centre intake triage process during this phase.

Distance presents a major challenge for people living in rural and remote areas of Queensland needing to access mental health services. Most service delivery occurs in an outreach model in which staff who are expected to travel long distances by road, air, or sea. These staff members are often sole practitioners who are largely isolated professionally and organisationally. This workforce has special needs in terms of professional development, supervision, and general support.

The establishment of the Queensland Centre for Rural and Remote Mental Health (QCRRMH) will enable effective cooperation and coordination across population-based and clinical approaches to improving the mental health and well-being of rural and remote populations. This will be achieved through enhancing service delivery, education and training, policy and program development, research, and the innovative use of information technology.

The proposed centre is being developed through an effective collaborative partnership that includes Queensland Health, the Royal Flying Doctor Service, industry partners such as Comalco, two major universities, and Indigenous Community Health Services with the support of the Commonwealth Office of Rural Health and Commonwealth Mental Health Branch.

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Appendix 1: Relevant policy references within the Queensland Police Service's *Operational Procedures Manual* to investigative and prosecution processes followed in all matters

Chapter 2	Investigative Process
Chapter 3	Prosecution Process
Chapter 6	Special Needs Groups
Chapter 10	Escorts and Extraditions
Chapter 13	Miscellaneous (S13.20.29 Mental Health Act)
Chapter 16	Custody.

Appendix 2: Adequacy of Queensland's legislation and processes in protecting the rights of people with a mental illness in the criminal justice system and in custody

Legislation

The Queensland Criminal Code refers to impairment and does not differentiate between an impairment caused by intellectual disability, acquired brain injury or psychiatric illness. The purpose of the statutory definitions is to ensure that a person is appropriately treated by the criminal justice system because of a particular impairment rather than a particular specified condition. It is a defence to any criminal offence for a person to establish that at the time the offence was committed the person was of unsound mind.

Other legislation contains definitions that may impact on people with a mental illness. The *Disability Services Act 1992* (Qld) applies to people with a disability. The definition would extend to include a person with a mental illness. Similarly, the *Guardianship and Administration Act 2000* sets out a substituted decision-making regime for adults with impaired capacity which may, in some circumstances, apply to persons with a mental illness.

The *Bail Act 1980* permits a police officer to release a person with a mental illness into the care of a person or to go at large if the person held on a charge is intellectually impaired (which has the same definition as provided for in the Criminal Code), the person appears not to understand the effect of entering into a bail undertaking and if the person ordinarily would have understood the nature and effect of the undertaking they would be released on bail.

Generally, when a person is charged with a criminal offence the course of proceedings is dependent on the nature of the offence and the decisions of the defendant. Forensic provisions of the criminal law provide for the situations where an accused may not be fit to plead or stand trial in a criminal trial or may not be criminally responsible for a particular offence. The defence is provided for in section 27 (Insanity) of the Criminal Code.

The *Police Powers and Responsibilities Act 2000* provides the ability to commence proceedings against an alleged offender by way of "Notice to Appear", rather than by arrest and charging within a police watch-house or police station thereby preventing any unnecessary detention of that person in a detention facility.

The *Evidence Act 1977* contains provisions to assist persons with a mental illness in a court hearing. Section 21A (Special Witness) defines a special witness to include "any person who, in the court's opinion, would as a result of a mental, intellectual or physical impairment or a relevant matter, be likely to be disadvantaged as a witness." A special witness may include a party to a proceeding or, in a criminal proceeding, the accused. The Act permits modification of the usual way a witness gives evidence. For example, the evidence can be given from another location or the witness can have a support person. The effect of the provision is limited to when the witness is giving evidence. It does not permit changes to trial procedures to accommodate the special needs that a person with a mental illness may have.

The *Evidence Act 1977* also gives the court the opportunity to control inappropriate questioning (section 21). When determining whether a question is inappropriate, the court must take into account any mental, physical or intellectual impairment of the witness.

The *Penalties and Sentences Act 1992* provides a substantial range of orders for an offender. While there are no specific sentencing orders available for a person with a mental illness, the general principles that govern sentencing may be applied to assist a person with mental illness. The principle of general deterrence may be given less weight on the basis that the person is an inappropriate person to be used as an example to others. Further, an offender's moral culpability may be diminished by their mental illness so that the importance of the principle of personal deterrence may be lessened. However, leniency of sentence because of mental illness cannot be assumed.

Determining criminal responsibility and fitness for trial

Determinations relating to criminal responsibility and fitness for trial may be made by a jury (under the *Queensland Criminal Code*) or the Mental Health Court (under the Mental Health Act). It is a defence to any criminal offence for a person to establish that at the time, the person was of unsound mind in relation to the offence (*Queensland Criminal Code*, section 27).

Under the Mental Health Act, issues of criminal responsibility and fitness for trial are required to be examined for all involuntary patients charged with an offence regardless of their custody status. Psychiatric reports addressing the key issues are provided to the Director of Mental Health. Simple offences and offences of a less serious nature (having regard to damage, injury and loss caused) are referred to the Attorney-General for determination. All other matters are referred to the Mental Health Court.

The Mental Health Court is constituted by a Supreme Court Judge who receives expert advice and assistance on clinical matters from two "assisting psychiatrists". References to the Court may be made by the accused or their legal representative, the Attorney-General, the Director of Public Prosecutions or the Director of Mental Health. The Court is not bound by the rules of evidence and may inform itself in any way it considers appropriate. To facilitate its inquiry into the mental state of the accused, the court is empowered to order examinations by psychiatrists and other health professionals.

The Mental Health Act sets out the consequences of findings of the Mental Health Court and provides processes for the Court to make determinations relating to the person's ongoing treatment and management needs:

- on a determination that the accused was of unsound mind in relation to an offence (ie. not criminally responsible) or that he/she is permanently unfit for trial, legal proceedings are discontinued. The Court may make a forensic order requiring treatment and management by a nominated authorised mental health service. The forensic order and related conditions that apply (eg. levels of community access) are reviewed

routinely by, as well as on application to, the Mental Health Review Tribunal

- on a determination that the accused is fit for trial, proceedings against the person for the offence are continued according to law. The Court may order that the person be detained in an authorised mental health service until brought before a court or granted bail
- where the Court finds that the accused is unfit for trial, but that the unfitness is not of a permanent nature, a forensic order must be made. The Mental Health Review Tribunal reviews the forensic order and the person's fitness for trial at prescribed intervals. Processes are established for proceedings to be continued (where the Tribunal subsequently deems the person fit for trial) or discontinued (on determination by the Attorney-General or after prescribed timeframes).

Additional protections are provided through the individual's right of appeal against findings of the Court or Tribunal and retention of their right to trial.

While the Mental Health Act establishes processes for determining charges, the Director of Public Prosecutions and the Queensland Police Service retain discretion to discontinue charges if continued prosecution is not in the public interest. It is recognised however, that the discontinuance of charges in the absence of concurrent mental health intervention may be less effective in addressing longer term concerns of repeat offending and the protection of individual and community safety and interests.

During 2003-04, 223 references to the Attorney-General had been finalised. For the same period, the Mental Health Court determined 212 matters, of which 110 held a finding of unsoundness of mind, 17 held a finding of not fit for trial (8 of which were of a permanent nature) and 85 held a finding of fit for trial. 89 forensic orders were made.

Appendix 3: List of Achievements

- Move by Department of Corrective Services to purchasing outpatient services from Queensland Health
- Development of national standards for Forensic Mental Health
- Development of the Queensland State Forensic Mental Health Plan
- Amendments to the *Mental Health Act 2000* which have overcome many of the problems related to treatment of offenders
- Queensland Police Service/Queensland Health development of the Memorandum of Understanding and development of the Mental Health State Steering Committee
- Queensland Police Service Education and Training strategy developed in partnership with Queensland Mental Health Services
- Development and implementation of the Voluntary Referral Program for mental health
- Queensland Police Service Development and implementation of statewide protocols and procedures in relation to dealing with people with a mental illness in partnership with Queensland Mental Health Services
- Queensland Police Service, Queensland Ambulance Service and Queensland Health have established Crisis Intervention Teams
- Project 300

  Disability Services Queensland administers *Project 300* – an individualised funding program that assists consumers to move from extended psychiatric treatment and rehabilitation facilities to live in the community.
- People with an intellectual disability and a mental illness

Queensland has sought to collaboratively address the specialised needs of people with a dual diagnosis of intellectual disability and mental illness through a joint project of Queensland Health and Disability Services Queensland.

The project recognised that adults with an intellectual disability who have a mental illness often have complex and high-level support needs requiring a collaborative response from multiple service providers. A planned approach to collaborative service delivery between disability and mental health services across Queensland and the development of specialised knowledge in dual diagnosis were introduced and evaluated.

Preliminary results of the evaluation have identified positive progress in collaborative service delivery to people with an intellectual disability and a mental illness by disability and mental health services across Queensland. There are identified improvements in information sharing, inter-agency collaboration and joint planning for individuals, with some evidence of reduced number and severity of crisis situations and increased access to services for some people.

- Access to disability services by people with a psychiatric disability

  According to the 2003 Australian Bureau of Statistics Survey of Disability, Ageing and Carers, people with a psychiatric disability represent approximately 8.3 percent of people with a disability and 10.5 percent of people with a profound or severe core activity restriction. Approximately 10 percent of Queensland's disability service users identify psychiatric disability as their primary disability (2003-04 CSTDA National Minimum Data Set).