Senate Select Committee on Mental Health

NSW Health Submission

Table of Contents

PART A
NSW Health Submission - Introduction and Background

Mental health is a major priority for the NSW Government. It is estimated that mental health problems and mental illness will affect one in five of the adult population in their lifetime and between 10-15% of young people in any one year.

NSW is a partner in the National Mental Health Strategy, which has provided a national framework for mental health issues since 1992. On 30 July 2003 Australian Health Ministers signed the third National Mental Health Plan that provides the strategic framework for mental health until 2008.

The Senate Committee is one of a number of recent inquiries seeking to examine mental health services. This includes:

- The NSW Legislative Council Select Committee Inquiry into Mental Health Services. The final report, making 122 recommendations was handed down in December 2002.

  The Government responded in December 2003. The report can be found at: http://www.health.nsw.gov.au/pubs/g/pdf/inquiry_mhs.pdf

- In December 2003, The NSW Mental Health Sentinel Events Review Committee, an independent body established to review and report on morbidity and mortality issues for people who received mental health care, released its first report. The Committee made 52 recommendations related to systemic issues arising from its investigations of inpatient suicides and homicides of mental health patients.

  The Government responded in December 2004. The report can be found at the NSW Health Department's website:

  http://www.health.nsw.gov.au/pubs/g/pdf/inquiry_mhs.pdf

- The second report of the Sentinel Events Review Committee, relating to homicides and suicides of patients within 28 days of discharge from inpatient care, was released in April 2005.

1.0 NSW Initiatives

NSW Demographics

Since one third of Australians live in NSW, the population demographics of NSW are fairly typical of Australia as a whole. Figure 1 shows the estimates for 2004-05. It also shows the estimated numbers of who do or do not experience some form of mental illness in a year (ILL/ WELL) with the ILL group divided by severity (MILD, MODERATE, SEVERE). The age groups 0-17, 18-64 and 65+ are shown because they are used in planning and mental health service monitoring. The three groups define the main mental health financial sub-programs in NSW, with the fourth being the Forensic sub-program.

Prevalence	WELL	MILD	MODERATE	SEVERE	ILL	TOTAL
Age 0-17	84.6%	7.9%	5.4%	2.0%	15.4%	100%
Age 18-64	82.2%	10.8%	4.2%	2.8%	17.8%	100%
Age 65+	87.1%	6.7%	4.2%	2.0%	12.9%	100%
All Ages	83.4%	9.6%	4.5%	2.5%	16.6%	

Pop 2004-05	WELL	MILD	MODERATE	SEVERE	ILL	TOTAL
Age 0-17	1,363,925	127,481	87,066	32,970	**247,518**	1,611,443
Age 18-64	3,500,819	459,962	178,874	119,249	**758,085**	4,258,903
Age 65+	796,609	61,063	38,393	18,054	**117,510**	914,119
All Ages	**5,661,353**	**648,506**	**304,333**	**170,273**	**1,123,112**	6,784,465

Figure 1: NSW populations, 2004-05, and estimated 12-month prevalence of mental illnesses, by severity and age group

1.1 Funding

The 2004/2005 mental health budget in NSW stands at a record $783 million **-** a $68 million increase over the previous financial year. The 2005/06 budget announced on 24 May added a further $71 Million. The NSW mental health budget has increased by 140 per cent since 1994/1995 - from $355 million to $854 million.

In April 2004 the NSW Government committed an additional $241 million in mental health funding over the four years to June 2008 – building on a $127.5 million enhancement over the three years to 2002-03. The 2005-06 increase includes $22 million in new mental health funding, on top of the $48 million from the $241 million package.

A $76 million mental health capital works program over the next three years will provide new and upgraded mental health facilities and better access to mental health services for people who require assistance.

This additional funding will increase NSW per capita expenditure to about $109.30 in 2007-08 (in 2002-03 dollars).

1.2 Quality Outcomes

Encouragingly, the suicide rate in NSW has declined from 15.1 per 100,000 persons in 1997 to 9.5 per 100,000 persons in 2003 – the lowest rate of suicide in Australia and the lowest in 20 years.

The NSW Government is committed to helping people with a mental illness where and when they need it - in our hospitals, in the community or in emergency situations.

1.3 Inpatient Services

Since June 2001, 250 mental health beds have been opened by the NSW Government. More than 240 new mental health beds will open over the next three years.

This includes a number of acute beds, 100 medium stay beds, child and adolescent beds, an older persons unit in the Illawarra and additional forensic beds and psychiatric emergency care beds.

Mental health units in NSW hospitals deal with approximately 26,000 overnight mental health patient admissions each year.

1.4 Community Services

In 2004/05 $356 million is being spent on community mental health services. This equates to 45% of the total funding for direct hospital and community services.

2,570 full time equivalent staff are employed in community mental health services, with an expected 2.3 million clinical contacts to approximately 100,000 people in 2004-05.

1.5 Child & Adolescent Services

In 1995, there was only one acute inpatient facility for children and adolescents. An additional 40 specialist beds have been opened by the Government, existing within a network that provides care to children and their families as close to familiar surroundings as possible.

The Government currently spends $80.9 million on child and adolescent mental health service provision, employing about 570 staff making 376,000 clinical contacts to about 10,000 children and their families.

1.6 Partnerships

The NSW Government recently expanded its successful supported accommodation program - the Housing and Accommodation Support Initiative (HASI), allocating $13.8 million over four years to provide low support outreach to a further 460 people with a mental illness living in community or public housing.

This program, a partnership between Health, Housing and the NGO sector, already provides medium to high-level accommodation support to over 118 people living in the community. The next stage in HASI will be further medium to high-level accommodation support to over 126 people in the community at a recurrent funding of $6.8 million from 2005/2006.

The Court Liaison Program, operating in 21 courts across the State, places mental health nurses in courts to divert people with mental illness, facing criminal charges, away from the prison system and into health treatment.

The three-year Integrated Services Project for Clients with Challenging Behaviour is being led by the Department of Ageing, Disability and Home Care. NSW Health and the Department of Housing are the other key agencies involved in the project. The Centre for Mental Health is the lead branch within NSW Health.

The program involves service provision in three phases – a three month assessment period, either in the client's current location or in a dedicated Assessment Centre; an intensive period of behavioural intervention and support for up to 12 months; and a short transition period to integrate the client into long term housing support and care arrangements.

Eight priority clients have been selected from nominees of a range of agencies. Services will commence in the second half of 2005. This will be followed by a regional and metropolitan selection process for continuing intake (approximately 8 persons quarterly) totalling 72 clients.

The program is a genuine pilot – a rigorous evaluation process to test its strengths and suitability for continuation are integral to the project plan.

1.7 Accountability

Whilst a considerable investment is being allocated to mental health service provision in NSW, the Government has established the Mental Health Implementation Taskforce, to ensure that the Government sees through commitments made as a result of recent Inquiries.

The Implementation Taskforce is chaired by the Hon. Dr Brian Pezzutti, who also chaired the Select Committee Inquiry, and includes representation from the NGO sector, consumers, academics, the Royal Australian College of Psychiatrists, Unions NSW, and regional mental health service providers.

An implementation strategy for Area Health Services is in place and monitored through the Taskforce that meets quarterly.

NSW is developing a cross agency approach to mental health. Human service and justice agencies are meeting regularly and working towards better cross government service provision, particularly in areas of overlap such as housing, community Services and disability services. This work is focused on the interface between mental health services and other agencies in the areas of prevention and early intervention, community support, and emergency responses.

1.8 Mental Health Act Review

In September 2003, the Minister for Health approved a comprehensive review of the Mental Health Act, the first major review of the Act since 1990.

Two discussion papers have been released for public comment- the first in February 2004, and the second paper was released in August 2004.

A draft exposure Bill will be tabled for further public comment later this year prior to the introduction of legislation.

The Review has considered the following:

- Information disclosure and the role of carers in the treatment of people with a mental illness;
- Provision of medical services to involuntary patients under the Act;
- The role of Local Courts and the Mental Health Review Tribunal in reviewing admissions of people with mental illness to mental health facilities;
- Clarifying and refining cross border transfer provisions, and
- The transport by ambulance of people with mental illness to and between mental health facilities.

The review will also ensure that the forensic mental health system functions more effectively and guarantees community safety at all times, by examining:

- Approaches to the exercise of executive discretion in the review of forensic patients;
- Forensic patient definitions to distinguish between general forensic patients and inmates receiving care after transfer from a correctional centre; and
- The role of the Mental Health Review Tribunal.

2.0 Roles of the States, Territories and the Commonwealth

The provision of public sector mental health services has grown in complexity and demand in recent years. This is related in part to increasing prevalence of substance abuse, breakdowns in social structures, and increasing socio-economic disadvantage.

Issues at the interface of Commonwealth and State provision of mental health care include:

- Treatment of high prevalence disorders (depression and anxiety, usually treated by GPs) and low prevalence disorders (serious and persistent mental illness), usually treated by public sector mental health services.
- Capacity to respond to need and risk across the illness spectrum. This includes recognition that illnesses will sometimes progress in severity which highlights the need for partnerships between GPs and public sector mental health services.
- The need for a whole of government approach to mental health care, to ensure access to a range of support services across State and Commonwealth agencies. These include health, housing, aged care, respite services and vocational support.
- Workforce strategies to ensure an adequate number of suitably skilled professionals, who are capable of providing the necessary interventions.

3.0 Implementation of the National Mental Health Plan 2003- 08

The *National Mental Health Plan 2003-2008* provides a five-year framework for further reform. The NSW Government, as co-signatory to the National Mental Health Strategy, is committed to this Framework.

NSW's mental health policies support these directions, including *Caring for Mental Health: A Framework for Mental Health Care in NSW*, and the *NSW Strategic Plan for Mental Health 2005-2010*, a major policy initiative currently under development to articulate the Government's vision for Mental Health Services in NSW.

The *National Mental Health Plan 2003-2008* emphasises a population health framework, timely access to services when a person's mental health is 'at risk' and continuity of care. The population health framework recognises the importance of

mental health issues across the lifespan, the effect of co-morbid conditions and the fact that effective linkages must be forged across sectors.

The *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health* outlines national directions for this area across priority groups. The strategy identifies for each priority group, outcomes, rationale, evidence and National action.

Part B
Terms of Reference

A select committee, to be known as the Senate Select Committee on Mental Health, was appointed on 8 March 2005 to inquire into and report by 6 October 2005 on the provision of mental health services in Australia, with particular reference to:

1. 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;
2. 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;
3. 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;
4. The appropriate role of the private and non-government sectors;
5. The extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;
6. The special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;
7. The role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;
8. The role of primary health care in promotion, prevention, early detection and chronic care management;
9. Opportunities for reducing the effects of iatrogenesis and promoting recovery-focused care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;
10. The overrepresentation 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;
11. 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;
12. 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;
13. 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;

14. The current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;
15. 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; and
16. The potential for new modes of delivery of mental health care, including e-technology.

NSW Health Response to the Specific Terms of Reference

1.0 Achievements under the National Mental Health Strategy

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.

1.1 Summary of Issues

In this component of the NSW response we have focused on two major issues that have come to dominate debate about the Strategy:

- Have adequate resources been committed to meet the stated aims and objectives?
- How can investments by all levels of government be used to meet these aims and objectives?

Adequacy of resources: To address the first aim, within the existing division of clinical health services across public and private, specialist and general, NSW Health developed a planning model in 1999-2000, known as the Mental Health-Clinical Care and Prevention (MH-CCP) model. It is a quantitative model, based on existing epidemiological data and service models, and in essence it shows that an adequate clinical service is feasible at a level of expenditure that would have the following effects:

- The mental health share of Australian health expenditure would rise from the current 6.5% to about 9%.
- The relative position of Australia within the OECD countries on per capita mental health expenditure would rise from 27th to about the same level (12th) as we occupy on general health expenditure: alongside Sweden (13th), a little below Canada (5th), above the United Kingdom (17th) and New Zealand (20th).
- There are many gaps in the information base needed to build such a model, but they can and have been addressed in various ways. MH-CCP then serves to define, for a population, the quantity of standard resources (acute and non-acute/ transitional beds, ambulatory care clinical staff) needed to provide care for each age group; the outputs to be expected from the system; and – after application of standard resource unit costs – how much funding is needed. This then allows the gap between “met need” and “need” to be expressed as a percentage of funding, or beds, or staff, or service outputs.

The “gap analyses” from the model have been used since 2000 to guide the allocation of an 18% increase in real per capita funding over the three years 2000-01 to 2003-04, and a further increase of about 13% per capita over the four years 2004-05 to 2007-08. Subsequently, a number of other jurisdictions have used the model for planning (NT, ACT, SA, Tasmania) and have found it useful.

NSW Health has always regarded the quantification of "need" for particular levels and types of services as essential before it is possible to have a constructive debate about the adequacy of resources. In the absence of a national approach to this, we have taken the initiative with the MH-CCP model, and, as already noted, other jurisdictions have independently chosen to follow this approach.

Division of responsibility: In broad terms the MH-CCP model accepts the current division in which specialist public mental health services operated by States and Territories provide the vast majority of care for people with severe illness, and especially those who currently consume 50% of state resources, namely people who are so ill that they must be treated under the involuntary care provisions of mental health legislation. The other 50% of State services extend as far towards moderate and mild levels of illness as resources permit. The "care packages" in the model assume an increasing role for non-specialist clinical services, especially in primary care, for the high prevalence by lower severity illnesses. Most of these would be expected to be provided under Medicare, though generalist community health services would also be involved, especially in rural and regional areas where – for example – private psychiatry is either non-existent or extremely scarce.

As it currently stands, MH-CCP does not model non-State services in detail. However, we are currently revising the model to take account of new epidemiological data and to make it somewhat easier to apply with other populations and types of services.

1.2 Policy

In principle, there has been no division of responsibility for policy in relation to mental health. The National Mental Health Strategy (the Strategy), and the sequence of three National Mental Health Plans to implement it, all derive from the commitment made by Australian Health Ministers in the National Mental Health Policy (the Policy). Successive Health Ministers in all jurisdictions have endorsed the Policy ever since 1992. It is thus important to begin with that agreed position:

- "*The National mental health policy is a joint statement by the Health Ministers of the Commonwealth, States and Territories of Australia which is intended to set a clear direction for the future development of mental health services within Australia.*
- *As such, it aims to ensure that appropriate services are readily accessible to all Australians with mental health problems or mental disorders.*
- *Although the policy primarily addresses the provision of mental health services, both private and public, it recognises that people with mental disorders often require access to, and support from, a complex array of other health and community services, such as housing, employment and income support. The policy focuses on the need for better linkages between these services in the mental health system.*
- *The National mental health policy acknowledges that priority in the allocation of resources should be given to people with severe mental health problems or mental disorders who, because of the nature of their condition, require ongoing and, at times, intensive treatment.*

- *However, the policy <u>also</u> recognises the impact of mental health problems more generally on individuals, their families and the community. In keeping with this, the policy outlines ways of promoting the mental health of the Australian community and reducing the incidence of mental health problems and mental disorders and their impact on the lives and well being of individuals. The development of effective mental health promotion, prevention and early intervention strategies and the enhancement of training and support for primary care service providers, is fundamental to the achievement of these objectives."*

Source: Australian Health Ministers. *National Mental Health Policy*. Canberra: 1992 (foreword: emphasis added).

1.3 Existing Reviews of the Strategy

There have been a number of formal reviews and evaluations of the National Mental Health Strategy since it began, including those commissioned under the Strategy itself (Fig 1). However, these have not explicitly addressed the issue of adequacy of overall resources for implementation.

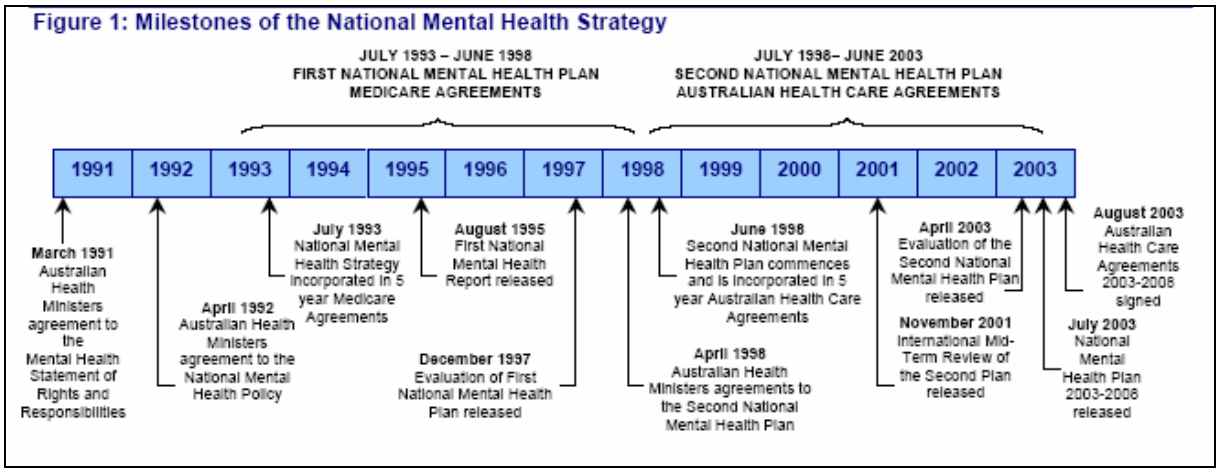

Figure 1: Reviews of the National Mental Health Strategy.

The annual National Mental Health Reports present comparative data across State-Territory jurisdictions, and present Commonwealth expenditures; but they do not relate these to any objective benchmarks. The results are always presented with the qualification:

- *"<u>It is not known how much spending on mental health services is required</u> to <u>meet the priority needs of the Australian population.</u> However, surveys conducted of the extent of mental illness in the community have highlighted a high level of unmet need. Similar findings have been reported in other countries." (National Mental Health Report 2004: Emphasis added)*

By contrast, funding is a major focus of criticism by the Mental Health Council of Australia. Professor Patrick McGorry's foreword to one of these reports identifies the problem as "trying to deliver mental health services on the cheap" and "totally inadequate funding". (Fig 2). It also refers to "cosy bipartisan neglect of mental health by both sides of politics" and "lack of political will", which may reasonably be taken as a commentary on the division of responsibility between Governments.

Despite its demonstrated capacity for innovation, Australia has not translated recent advances into better mental health care. The report demonstrates that this is primarily a matter of lack of political will and totally inadequate funding. The expertise and effective models of care are readily available but are not supported. Australia is still trying to deliver mental health services on the cheap. In the more visible post-institutional era, this is now having serious consequences for our community as a whole. Only the cosy bipartisan neglect of mental health by both sides of politics, and the lack of effective mobilisation of the population, enables this to persist. Other societies would not tolerate this.

Figure 2: Foreword to *Out of Hospital Out of Mind* report (Extract).

Likewise, the submission of the Australian Medical Association to the present Committee lists overall funding as the first of its seven key issues (Figure 3):

- **Mental health services get low funding priority:** In Australia, the provision of mental health services receives an inappropriately low priority having regard to the large number of people affected, the high burden of disability, the untoward impact on service-deprived sub-groups within the community and the missed potential for the cost-effective achievement of better health outcomes. International comparisons of mental health spending are dated (circa 1993) but suggest a spending shortfall in Australia compared to Canada, the US and the Netherlands.

- **Existing resources are not being used as well as they could or should:** Governments decry and undervalue the large contribution of the private psychiatric sector. The separation of some services results in significant inefficiency eg between mental health, drug and alcohol services, and there is scope to improve patient outcomes by integrating these services. Existing funding mechanisms favour defined episodes of care. However the mental health conditions that generate the highest burden of disease are chronic conditions and they require longitudinal care. The Commonwealth/State funding arrangements are dysfunctional, funds are wasted in duplication of administration and policy formulation while a silo mentality detracts from the continuum of care.

- **Access to hospital services is increasingly problematical** for public mental health patients. The AMA does not believe that there is consistency between the National Mental Health Strategy and the resources applied to mental health in the public hospital sector.

Figure 3: Executive summary to *Submission to the Senate Select Committee on Mental Health* (Canberra: Australian Medical Association, 2005).

The evidence in the National Mental Health Report 2004 is that mental health expenditure to 2001-02 had been substantially increased in real per capita terms since 1992-93, but had not been increased by more than the general increase in health expenditure over the same period (Fig 4):

- *"Growth in mental health spending by governments paralleled growth in the overall health sector. Although significant, the implication is that the mental health sector has maintained its position, but not increased its share of the health dollar." (National Mental Health Report 2004).*

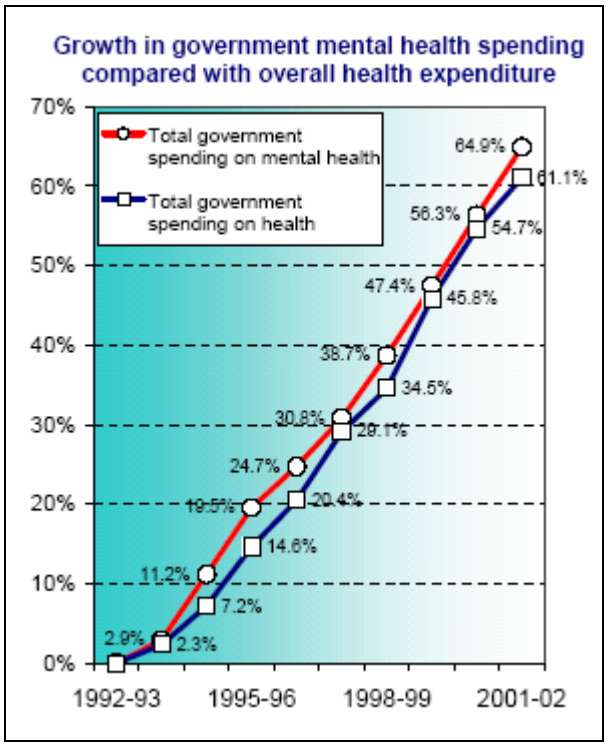

Figure 4: The National Mental Health Strategy has not increased the mental health share of the health dollar, overall, in Australia [Source: National Mental Health Report 2004].

Clearly, unless we have a clear definition of what we mean by "the priority needs of the Australian population" in relation to mental health services, and community agreement about what they are and how to meet them, these comparative analyses of health expenditures are of limited use. Unfortunately, the Strategy as it currently exists has not progressed past the point of relative statements about need.

Of the 38 specific Objectives of the Strategy, there are several relating to the issues of the adequacy of funding, and the way in which Governments in Australia were to collaborate, but two can represent the whole:

Objective 8: To develop formalised policy and planning arrangements at Commonwealth, State, Territory and Area/ regional levels to ensure that all programs relevant to those with severe mental health problems and mental disorders adequately address their needs.

Objective 15: To identify areas where the separation of Commonwealth and State funding for mental health treatment services compromises the targeting, integration and distribution of mental health services and to introduce measures to overcome this.

Considered against those global objectives, the Strategy has failed to do a number of essential things:

- It has never explicitly defined the target population whose needs were to be addressed: that is, while objective 8 limits the scope to "those with severe mental health problems and mental disorders", the group is undefined.

- It has never defined what was meant by "all programs relevant" to the target population: that is, the scope of the programs needed, and the scope of "health" programs within that.
- It has never defined the "needs" of the target population, or what level of service would be consistent with "adequately" addressing them
- It has not recognised that limiting Objective 15 to "mental health treatment services" is inconsistent with the reference to "all programs" in Objective 8, because the move to community-based care means that many human service agencies need to be involved in providing programs for people with mental illnesses, and the separation of Commonwealth and State responsibility for funding programs can either assist or compromise care delivery.

Some of these defects were noted by Dr Ron Manderscheid from the US Centre for Mental Health Services, in his 1997 review[1] of the Strategy in relation to the "appropriateness of national mental health policy settings from an international perspective". Manderscheid concluded that " *[Australia] …needs to develop a framework or map that disaggregates the Australian population into subgroups (perhaps by age, diagnosis and disability, e.g., adults with severe mental illness, adults with serious mental illness, adults with other mental illnesses, adults with risk factors, remaining adults) to examine current and needed insurance coverage, current and needed services, major gaps, and strategic actions that could be planned to remedy deficits. Such a strategy could also have the benefit of developing a common vision of mental health for the entire population of Australia. This work could provide an excellent transition toward a population focus."* [underlining added].

The consequence of having an informally defined scope for the Strategy has meant that it is liable to criticism for failing to address needs in any area that anyone regards as relevant to mental illness. This has been exacerbated by the expanded scope of the National Survey of Mental Health and Wellbeing (SMHWB) in 1997, which included substance use disorders within the scope of "mental illness", and (for technical reasons) concentrated on the high prevalence disorders of anxiety and depression. Thus the "prevalence of mental illness" of 18% includes substance use disorders, even though services for these disorders are not funded out of mental health budgets in Australia. Moreover, the conclusions about the main sources of treatment services from the SMHWB only apply to the high prevalence disorders, but have been widely (mis)interpreted as evidence about mental health services in general.

The fact is that the SMHWB has very little to say about the treatment population of people served by State and Territory Mental Health services, and nothing at all to say about those who consume about half those services, namely those who are so ill that

[1] Evaluation of the National Mental Health Strategy: Research Components. Mental Health Branch, Commonwealth Department of Health and Family Services, December 1997 (p. 5). The reviewer, Dr Ron Manderscheid, is the Chief, Survey and Analysis Branch, Division of State and Community Systems Development, in the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services, and formerly (1981-92) Chief, Statistical Research Branch, (US) National Institute for Mental Health. Dr. Manderscheid has been the one of the principal editors of the series, Mental Health, United States since its inception 1983.

they require involuntary treatment under Mental Health legislation. The separate "Low Prevalence" component of the SMHWB dealt with this group, but was confined to 3800 people already receiving care within the urban areas of Australian Capital Territory, Queensland, Victoria and Western Australia.

At the same time, the de facto scope of the Strategy had to be "historical", simply because there was no requirement to do more than maintain the historical scope (and funding) of specialist public sector mental health treatment services in States and Territories, Medicare-funded services of the Commonwealth, and a small volume of privately insured care.

In addition, there has been very little examination of how Commonwealth/ State responsibilities across the human services (general community services, housing, income support, residential aged care, family allowances, employment policies, etc) can compromise or improve the "targeting, integration and distribution of mental health services" and the ability to meet needs.

1.4 Assessing Need and Appropriate Services: The NSW Approach

Rather than review the National Mental Health Strategy, we prefer to state the solution adopted in NSW in 2000. From 1996 NSW began building a population-based approach to specifying the need for mental health services across all levels of severity, and specifying the treatment services that were in scope for State-funded specialist mental health treatment. From 1997 NSW began a program of adult population health surveying to identify variation in health across administrative regions, and included a mental health measure in these surveys. In 1998 the relevant policy framework document was released. In 2000 NSW adopted the findings of the Report of the NSW Health Council (March 2000), which recommended (in part):

- That NSW Health introduce more consistent classifications about the types of services funded under … mental health ….
- That there be clear performance agreements for these services, specifying the standard of service to be provided, clearly stipulating the priorities for service provision and clearly identifying required service outputs.

The Mental Health – Clinical Care & Prevention (MH-CCP) model was released for discussion in April 2000 and finalised in November 2000, in conjunction with an 18% increase in real per capita mental health program funding over three years to June 2003. This model applies the best available population data to estimate the number of people with mental health problems in the age groups 0-1; 2-4; 5-11; 12-17; 18-64 and 65 and over, by levels of severity; and within each level of severity it identifies sub-groups whose average mental health service needs over a year are specified.

Such a model is not demonstrably correct, since more specific evidence would be needed to be sure about some of the key parameters. Nevertheless, the MH-CCP model had the virtue of stating explicitly what was regarded in NSW as the treatment programs relevant to people with disorders of various levels of severity, and identifying the requirements for both specialist state-funded mental health services, and clinical services provided by others.

1.5 The Division of Responsibility

The current division of responsibility for funding clinical care for people with mental illnesses is workable, given clear definitions of the roles.

At present, the public mental health services of States and Territories provide all the hospital care for people being treated involuntarily, who currently consume more than half of all hospital bed-days (Figure 5), and mainly have schizophrenia or related disorders.

In addition, they provide the vast majority of all hospital care, except for a very small proportion of people with insurance or private means who access private hospital care. Those who require this level of care are a sub-group within the group identified as “Severe” in the MH-CCP planning model.

Care for the other two groups (Mild and Moderate) is currently divided between public mental health services funded by States and Territories, and publicly funded private care supplied under Medicare by General Practitioners and Private psychiatrists. In addition, there is a substantial Commonwealth expenditure for subsidised pharmaceuticals under the PBS – this last representing a rapidly increasing Commonwealth expenditure that accounts for about 60% of all increased Commonwealth expenditure on mental health since the outset of the National Mental Health Strategy.

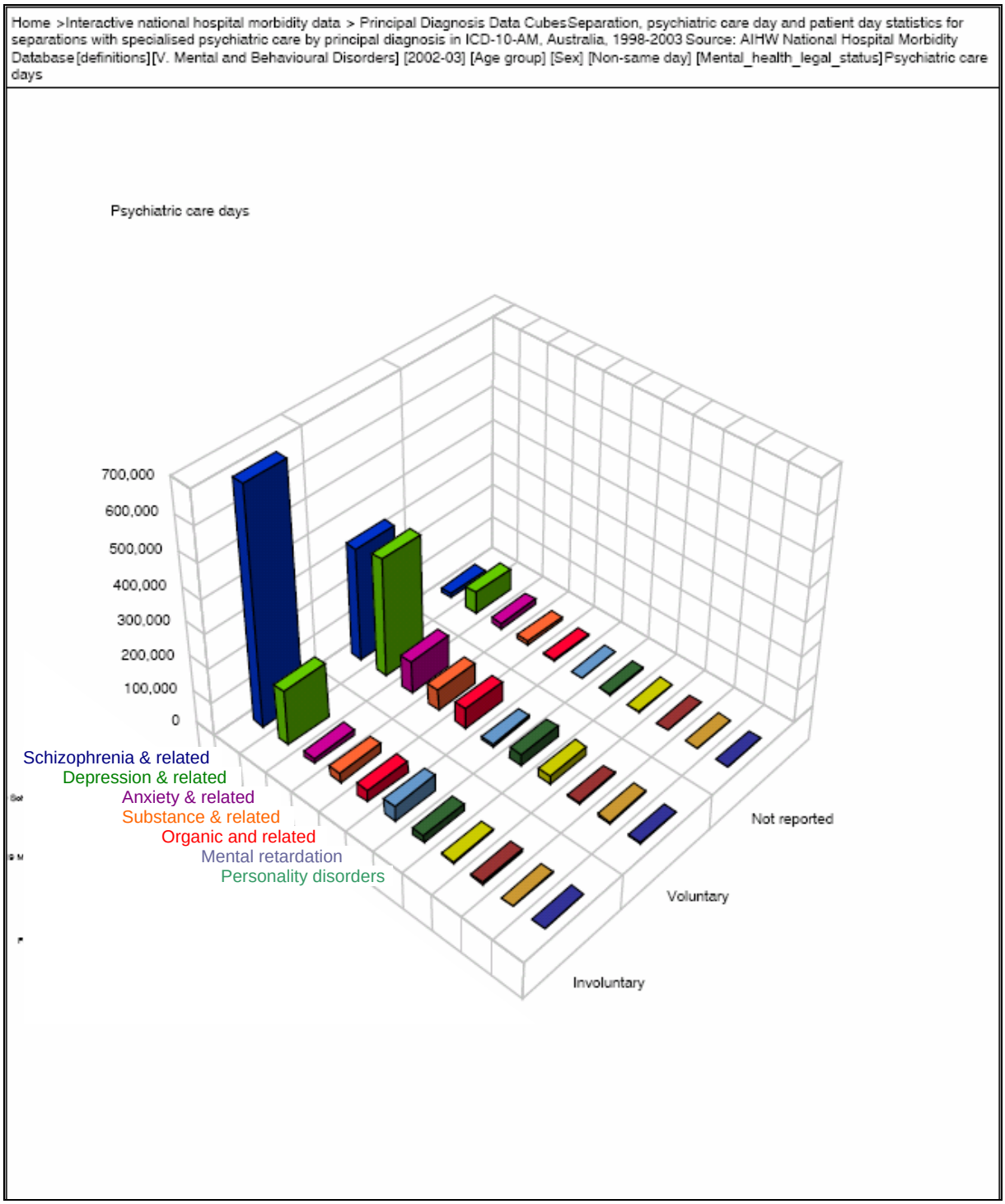

Figure 5: Psychiatric care Days in Australia, 2002-03, by main diagnostic group and Legal Status. Source: AIHW data cubes.

It has already been noted that the failure to specify the priority populations for care has led to a debate in which the needs of those who were to be given priority under the National Mental Health Policy have been combined with the much larger number of people in need of primary care and relatively low levels of specialist care. This is a long-standing issue in mental health, and for the same reason: all mental illnesses that warrant a diagnosis are "serious", but they are not all equally acute, disabling, or in need of the same kind of treatment.

So far as clinical care is concerned, the MH-CCP model indicates the volumes, and the issue of which people should best be served by State/ Territory services as against Medicare-funded services can be discussed within that framework.

However, there are some key differences in the way these services are distributed:

- Because they are in effect funded through providers, Medicare services do not penetrate equally to all areas of Australia, since providers are not distributed evenly across areas.
- This is evident in the analysis of 1997/98 Medicare data for private psychiatry, which shows that people in the remote regions of States receive about one tenth the private psychiatry MBS payments per capita as those in inner-urban areas.
- Since the Commonwealth has not done an analysis of the distribution of General Practice MH-related care by region, no similar comparison is possible, but it is reasonable to assume that the differences would be less extreme, simply because GP's are more evenly distributed.
- Since States and Territories are expected to provide equitable access to health care, their community-based mental health services have to compensate for the gaps that arise out of the provider-based nature of Medicare payments.
- Thus a major issue in addressing the needs of people with mild and moderate illness, and in providing primary mental health care on an equitable basis, is the fact that Commonwealth funding for this form of care is not on a population basis, but on a provider basis.

The other main issue arising out of the division of responsibility is that there are key supporting (non-clinical) services needed by States and Territories in providing care for people with severe and disabling illness. These include:

- **Residential aged care**: As already shown, a significant proportion of older people with mental illness are accommodated in Residential Aged Care facilities. Unless these are jointly planned in conjunction with acute and transitional mental health care for older people, and in adequate supply, there is a shifting of costs from residential aged care onto hospital and other services.
- **Housing:** In general it is not a responsibility of health care providers to ensure that people have secure housing, but for both historical and practical reasons mental health is an exception to this rule. The ability to provide secure housing support to people with mental illnesses depends on the funding available outside the health portfolio, especially for public housing. This is not considered a "mental health" expenditure, but nevertheless,

Commonwealth/ State divisions in policy and funding for public housing can have a large impact on mental health costs.

- **Income Support and Employment Assistance:** As the debate around the Disability Support Pension changes has indicated, there is a tension between the need to ensure that DSP funding goes to those most in need, and also that opportunities to enter the workforce are made available, and supported, for people with mental illnesses. One of the problems in this area is that Commonwealth responsibility for policies in employment and disability support impact most heavily on the most severely disabled people with mental illness, most of whose care is the de facto responsibility of States and Territories. Thus, instead of State/ Territory services being able to plan longer-term client care on a secure basis, they are subject to the impact of Commonwealth decisions about eligibility for benefits, or the provision of employment related services which can drastically affect the psychosocial situation of clients.

These are only the main factors. The general issue is that coordination of policy and funding between levels of Government is needed in a range of areas beyond clinical health services.

1.6 Barriers to Progress

- There is a particular need to improve coordination and integration of national and State services for older people.
- There is a general need to build on the successes of GP involvement in primary mental health care through the extension of the Better Outcomes in Mental Health Care Initiative. Within that, it should be stressed that the willingness of GPs to participate in such programs depends to a considerable extent on them having support
- Need for addressing the misdistribution of access to private psychiatry that arises through the provider-based funding under Medicare. The in-principle equity of Medicare is not achieved in practice, nor has the national mental health strategy been able to have any substantial impact on the distribution of psychiatrists after 10 years of trying to do so. Funding other professions to address this gap may be the only way to achieve equitable access in rural and regional areas.

1.7 Adequacy of Funding – Older People

The *National Mental Health Plan 2003-2008* articulates a commitment to older people's mental health, particularly in relation to the priority themes of improving service responsiveness to people with diverse and complex needs and promoting continuity of care. Through the National Mental Health Working Group, all jurisdictions have acknowledged the need to develop integrated mental health/aged care service delivery models for the care of older people with severe behavioural disturbance associated with dementia and/or mental illness. However, at the national level, neither the *National Mental Health Plan* nor the aged care program has yet contained significant initiatives in this area.

NSW Health has worked cooperatively with the Commonwealth Department of Health and Ageing on a number of relevant initiatives, such as the National Framework for Action on Dementia and a project to develop an integrated model for

the management and accommodation of older people with severely and persistently challenging behaviours. Only through a commitment from the Australian Government to working collaboratively with the State and Territory Governments through both the mental health and aged care programs to fund and implement these initiatives, can the commitments under the *National Mental Health Plan* be translated into reality.

NSW has established a network of specialist elderly suicide prevention workers across NSW to address the specific issues around suicide and depression prevention in older people. This initiative was a response to the Burdekin Report, or *Human Rights and Mental Illness Report of the National Inquiry into the Human Rights of People with a Mental Illness* (1993), which identified that depression and suicide were major health issues for older people.

2. Modes of Care

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.

2.1 Summary of Issues

The level of psychiatric distress and disability in the community is rising. Reasons for this change are poorly understood but may include broad social changes, changes in social supports and social capital, increasing inequality, and changes in patterns of drug use. Available resources have not kept up with increased demand. Across Australia there are problems with access to acute care, continuity of care and the availability of coordinated and comprehensive community support[2]. A time lag exists between recognition of increased demand and construction and commissioning of new units and the development and implementation of community based programs.

We recognise the need for flexible, innovative and coordinated models of care across the lifespan, in different settings and across diverse communities and populations, in order to address the complexity of presenting mental health issues. Modes of care need to be coordinated across state/ Commonwealth jurisdictions and across state level agencies and organisations. These modes of care need to be based on agreed planning and service delivery models, and to be documented and evaluated to review their efficacy and to manage population change and demand as it occurs.

2.2 Adequacy of Modes of Care – Early Intervention

A focus on early intervention in New South Wales provides mental health programs in the framework of population mental health. This model takes into account the epidemiology of mental health problems and disorders for each age group, the spectrum of interventions that may be provided and the evidence base supporting the effectiveness of these. It also acknowledges the different levels of service provision from primary care to secondary and tertiary specialised services. The population approach to mental health services as outlined in the National and NSW policies

[2] Whiteford, H, and Buckingham W, Ten years of mental health service reform in Australia: are we getting it right? *MJA* Vol.182, No. 8, 18 April 2005, pp 396 – 400.

emphasize both the provision of continuous service across the lifespan as well as a spectrum of interventions from health promotion, prevention, early intervention, treatment and continuity of care.

There is a range of prevention and early intervention initiatives in place in NSW which are based on available evidence of need and effectiveness for different age groups and risk groups. They emphasise the use of evidence based tools and programs which have been evaluated and have been found to be effective (for example, Positive Parenting Program, Adolescents Coping with Emotions). However, at this stage there have been no large-scale evaluations of these initiatives, although there have been evaluations of local initiatives and a review of School-Link is currently underway.

Considerable progress has been made in the field of prevention and early intervention, but there still remains significant reforms to be undertaken to enhance awareness of mental health and mental illness across the community and all stakeholder groups and service networks and enhance their capacity to deal with mental health issues.

One of the major barriers appears to be the general lack of understanding of how to apply the Population Health model when there are competing priorities concerning lack of community care, particularly for people in crisis.

There is a need for good evidence based models to illustrate the medium and long terms outcomes for prevention and early intervention initiatives and their effects on the need for specialist mental health services. This may be achieved by putting aside specific Commonwealth funding for evaluation.

Health funding agreements between Commonwealth and States need to consider ongoing funding for Promotion, Prevention and Early Intervention to build on the evidence base.

2.3 Adequacy of Modes of Care – Crisis and Acute Care

The mode of care for emergency mental health response is currently being addressed as a major policy initiative in NSW Health, under the auspice of the Government. NSW is undertaking an expansive capital works program to increase acute care capacity in the mental health system. In addition to this, the following initiatives have or are being undertaken to provide access for people in an acute situation.

- Each Area Health Service has established a 24-hour 1800 phone number for effective response to people with mental health problems requiring emergency attention.
- 60 Clinical Nurse Consultants have been employed in 40 Emergency Departments to identify, triage and provide specialist care to patients with a mental illness in hospitals. The NSW model is now being replicated in other states and has attracted interest from the UK National Health Service.
- Psychiatric Emergency Care Centres (PECCs) have been successfully trialled at Liverpool and Nepean Hospitals. These PECCs have resulted in a reduction of the average length of stay in Emergency Departments for psychiatric patients.

The PECCs are dedicated services, situated adjacent to the Emergency Department, staffed 24 hours a day, 7 days a week by mental health specialists for emergency assessment and treatment of people presenting with serious mental illnesses. The NSW Government will expand these trials- St Vincent's and St George will commence operations this year with Hornsby Hospital to follow.

- A Rural Mental Health Emergency Care Pilot is being trialled on the Mid North Coast for patients who present to rural hospital Emergency Departments with a mental illness or behavioural disturbance and who may require transport to another hospital for care.
- Area Health services will commence using a *Mental Health Unique Patient Identifier* system by late 2005. Health service clinicians who treat a patient will have a method of viewing the past treatment history of that client by public mental health services in the Area and will be able to request detailed records from these services, to ensure comprehensive risk assessment and continuity of care.

2.4 Adequacy of Modes of Care – Community Care

The NSW Government is committed to providing a range of appropriate clinical focussed inpatient and community services as well as, in partnership with other departments and organisations, a range of community based support services for people with mental health disorders.

The NSW Government invests $356 million per year on community mental health services - 45 per cent of the total mental health budget. In 2004/05, 2,570 mental health staff are working in the community – up from 1,398 in 1994-95; and 2.3 million clinical contacts will be made with patients in the community. NSW has expanded community mental health programs to include a range of assertive outreach and case management services for consumers in both metropolitan and rural Areas.

Community support services, including non-acute inpatient services, are essential to reduce exit blocks from acute services, prevent relapse and avoid/reduce readmission rates, and facilitate recovery, rehabilitation, independent living and community participation for people with mental illness. Community support services need to be underpinned by a client focus to care planning, evidence based interventions, equity of access, focus on early intervention and prevention of further disability through both clinical rehabilitation and disability support, community participation, engagement with consumers and families and carers, and fostering of individual empowerment and self management.

High demand for mental health beds (acute, non acute and long stay) and high case loads in community mental health place increasing burdens on the capacity of community mental health services to adequately respond to the complex range of psychosocial needs of many people discharged into the community.

Community mental health care systems need to be strengthened to sustain people in their own home environment wherever possible (either as an alternative to hospitalisation or to enable early discharge from inpatient care) with services which co-ordinate and optimise their clinical care. There is a significant need to describe, develop and evaluate improved models of care for family and carer mental health

support programs. Previous models of care are limited or not available and where available, are not evidence based or integrated across mainstream, NGO and jurisdictional boundaries (see also respite care in this section). Support for families is essential in these situations (See Section 7 for more details).

Evidenced based models of community care and the components that enable this need to be further developed and supported. Appropriate support agencies need to be engaged, to be clear on their roles and responsibility, have access to the supports and understanding required to provide their service to this population, and employ integrated care planning as care partners.

2.5 Adequacy of Modes of Care – NGO Service Provision

In response to policy direction and good practice, non-government services and other community organisations are providing mental health support services for people with mental health problems, often complex, high need issues. The capacity for effective service delivery by this sector needs to be strengthened in order to ensure coordination and continuity across clinical and disability supports.

Non-government organisations, particularly consumer and carer organisations, can be a powerful resource for mental health promotion, with appropriate support. For example, the Mental Health Association, NSW is taking on a significant role in this area, by providing the Mental Health Information Service, support groups (including training and establishment of new groups), mental health promotion and advocacy.

Building effective rehabilitation programs in line with the *NSW Health Framework for Rehabilitation for Mental Health* guidelines is imperative. This Framework sets out a system of inter-service work in Area Health Services (Rehabilitation Development Groups) to address the rehabilitation and community support needs of people with mental health problems and disability support needs. It seeks to assist individuals with mental health problems to achieve a level of wellness that promotes symptom management, prevents relapse, reduces the needs for hospitalisation, and assists integration back into community life.

It is essential to have in place co-coordinated rehabilitation programs that support recovery and facilitate recovery i.e. recovery from the mental illness itself as well as its consequences. Partnerships with NGO's are essential to provide a full range of rehabilitation services that are available, accessible and well resourced to support people with mental illness to live successfully in the community.

(See also Part C for information about the Housing and Accommodation Support Initiative - HASI).

2.6 Adequacy of Modes of Care – Respite Care

One of the most significant issues facing consumers and carers of people with mental illness is a lack of access to respite care options. Studies have shown that access to respite care reduces levels of stress, anxiety and depression for the carer and improves the quality of life for both carers and the consumer. Another critical factor for carers is access to adequate carer payments. Access to carer payment has been further decreased by recent changes to assessment criteria that focus on provision of physical support in care.

There is a need for cross-jurisdictional planning and program development in order to provide a range of accessible, flexible and responsive options for families and carers of people with mental illness. Families and carers need access to a range of generically available support and services offered via other jurisdictions eg respite services. The Family and Carer Framework NSW Mental Health Services (under development) identifies access to respite care as an element required in a comprehensive system of support for families and carers. Currently access to these services is inconsistent across the state, and carers report lack of flexibility in responding to their needs.

3.0 Opportunities for Improvement

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.

3.1 Summary of Issues

The Australian Burden of disease indicators show that mental disorders are the leading cause of years lost to disability (30% of the non fatal burden in Australia).

For people who have experienced a mental illness the risk of future episodes is increased; effective interventions to prevent the recurrence or intervene early in another episode are essential to reduce the impact of illness on the individual, the family or carer, and on the community. Timely intervention, continuity of care and coordinated service delivery can prevent or lessen the disability associated with mental illness.

This is particularly important in relation to early intervention before a diagnosis of mental illness has been made, for example, in the prodromal stages of first onset psychosis or with adolescents at school who score at a clinical level on measures of depression. Coordination with other agencies, for example, education or youth health services is necessary to identify those needing early intervention and to work together with mental health services to implement appropriate programs. The School-Link initiative is an example of such coordination, involving collaborative training to improve the skills of school and TAFE counsellors, implementation of indicated prevention/early intervention programs in schools and education of school personnel about mental health literacy.

There is a specific need to examine and improve the coordination of planning and service delivery models across state and Australian Government levels. The Centre

for Mental Health is working collaboratively with other agencies to facilitate early identification and appropriate treatment and care for people with mental illness.

Effective clinical assessment and treatment provided by specialist mental health services underpins the work of partner services such as disability and accommodation support providers, housing and education and employment services, the Police, General Practitioners, and family and consumer groups. Specialist mental health services continue to develop appropriate partnerships between interagency organisations to identify pathways to clinical care, to assist staff to recognise early signs and symptoms through improved collaboration and education and training initiatives, and care review across all relevant agencies.

There should be strong care co-ordination mechanisms plus local partnerships to ensure the patient has access to the full range of community support and rehabilitation services.

Poor socio-economic status is associated with levels of mental illness. The mental health system alone is unable to address spectrum of mental health needs.

Service coordination and continuity of care are key issues in appropriate and effective care for all age groups who experience mental health problems. For older people with mental health problems, for example, there are challenges ahead for all government jurisdictions and the range of care providers as services attempt to manage more complex presentations in the elderly and to keep pace with the growth of the older population.

For individual care co-ordination it is essential that whatever model is utilised it is backed by regular monitoring and evaluation of its effectiveness. The greater the possibilities for consumer, family and carer to have understanding of and engagement in the process involved, the more likely it is that co-ordination can be effectively utilised. There needs of course to be recognition of the burden of illness for all involved and opportunities for positive components and respite. Further research, including the use of technologies to assist, is also required. Co-ordination also needs to involve other areas of health care, other government departments, non-government agencies, private sector stakeholders and organisations and thus requires skills to deliver seamless and effective care, even when agencies are pressured by service demand.

3.2 Opportunities for Improved Co-ordination

Areas that present opportunities to improve the coordination and delivery of funding and services at all levels of government and across jurisdictions to ensure comprehensive care include:

- Commonwealth to take leadership in identifying gaps in research and evidence based practice for particular mental health problems and populations – for example, Culturally and Linguistically Diverse communities – prevalence and morbidities, care coordination models across public and private sectors and different government agencies.
- Improve access to Commonwealth respite care options and resources for families and carers of people with mental illness

- Need to coordinate planning between Commonwealth/ State in coordinating service provision for the newly arrived refugees who settle in NSW and can present with significant range of posttraumatic symptoms, physical and psychosocial problems. This presents enormous challenges for the health system due to the lack of appropriate cultural and linguistically services too support these groups. Mainstream mental health services need to develop expertise and knowledge base to deal with these particular populations.
- Ensuring access to appropriate in-home supports
- Greater coordination of care and referral pathways needed between mental health sector, primary care and NGOs for particular needs population such as Aboriginal and Torres Strait Islanders and CALD population due to cultural and language barriers, under-utilisation of mental health services and low mental health literacy levels
- The development and review of new models of coordinated care for high risk clients is a challenge faced by all states and the Commonwealth human service sectors
- There is a challenge to develop effective and integrated models of care for people with mental health and drug and alcohol problems.
- Vocational education and training programs

Making cross-agency collaboration effective requires models which can broker or co-ordinate care from multiple sectors including public and private sectors, government & non-government service & different levels of government

3.3 NSW Initiatives

NSW Health has a number of initiatives where sharing funding resources with other agencies has maximised service delivery for a shared target population. An example is the Housing and Accommodation Support Initiative, a shared funding initiative between NSW Health and the Department of Housing, supported by specialist NGO services.

NSW has developed an integrated model for the management and accommodation of older people with severely and persistently challenging behaviours associated with dementia and/or mental illness. Implementation of the model, which draws on best practice from international literature and current models across Australia, will require support from both the Australian and NSW Governments, and partnerships involving Area Health Services (aged care and mental health services), residential aged care providers and other key stakeholders such as GPs and community care services.

The Senior Officers Group on Mental Health (SOG) is developing a *Cross-Agency Mental Health Strategy*, which identifies a number of activities that relate to multiple agency involvement in the care and support of people with mental illness. A number of activities are being progressed where greater coordination of care across services will lead to better health and social outcomes.

NSW Health strongly supports models of care that further integrate shared National and State funding, including:

- Prevention and early intervention

- Integrating care with GP service provision;
- Building networks to facilitate better access for clients within their own environments; and
- Commonwealth funding for mental health services occurs through the Better Outcomes in Mental Health Care (BOiMHC) program and Medical Specialists Outreach Assistance (MSOAP) program. These programs have significantly increased access to mental health services (largely psychiatrists and psychologists) for GPs and have improved the range and coverage of services. There is, however, a risk of developing parallel mental health services funded by the commonwealth and state respectively, with potential for poor integration and collaboration between the services. As it stands there is no imperative to coordinate the services.

4.0 Role of Private and Non-Government Sectors

The appropriate role of the private and non-government sectors.

4.1 Summary of Issues

The NSW Government has identified increased involvement in health care provision by the non-government (NGO) sector as a key policy commitment.

From a mental health perspective, the Burdekin Inquiry into the human rights of people with mental illness clearly recognised and strongly supported the role of NGOs in the mental health field. The inquiry particularly noted that NGOs are responsive to the mental health needs of consumers and that they are flexible in their approach to service delivery. The role of NGOs in the area of disability support for people with mental health problems was also clearly identified as distinct from the clinical role of Area mental health services.

Key policy documents under the National Mental Health Strategy, including the Second National Mental Health Plan and the Population Health Model for the Provision of Mental Health Care, further identify the need for formalised NGO partnerships through policies, procedures, protocols and funding. These policy directives have translated into significant partnerships between public sector mental health services and mental health NGOs in NSW during the lifespan of the National Mental Health Strategy.

Some of the main issues needing address by state and Commonwealth are:

- The need to further scope and clarify the role of NGOs in service delivery
- Development of partnerships with ethno-specific welfare services and peak organisations is important for referral and coordination of care as they are often first point of call for people from CALD backgrounds. This emphasises the need for capacity building in workforce development in NGO sector and areas of HASI, management of clients from CALD background and Aboriginal peoples in the mental health sector.

- Greater coordination in the implementation of Commonwealth and State plans for particular needs populations such as Aboriginal peoples and Torres Strait Islanders and CALD population to:
    - develop consistent and complimentary service delivery models;
    - enhance evidence base;
    - foster improved working relations between the mental health sector, primary care and NGOs; and
    - encourage the sharing of best practice, resources and information across states.
- Partnerships between government and business are essential to effectively link training and work opportunities.
- The need to require state and commonwealth governments to jointly encourage private sector to provide more secure and sustainable employment opportunities for people with mental illness.

Key issues surrounding planning and funding issues for mental health NGOs working with people with mental illness include:

- The development of working partnerships between NGOs and the public health system to share the responsibility for improving the health of the community requires joint planning processes
- Administration of NGO funding by Area Health Services, including the need for performance indicators and evaluation
- Formal accreditation processes for NGOs
- Capacity building, training and education
- Tendering for NGO services, including the issue of fixed price versus competitive tendering.
- The proportion of mental health funding spent on NGO services

NSW Health provides significant support to the mental health NGO sector through the devolved NGO Grants program, whereby all Area Health Services receive funding for local initiatives. NSW Health also provides funding to specific statewide initiatives such as HASI, which has been tendered at state level and require three-year contracts between Area Health Services and NGOs providing the accommodation support. In addition, NSW Health supports peak NGOs through funding of the Mental Health Coordinating Council and other organisations, including NSW CAG, ARAFMI and Schizophrenia Fellowship.

NSW has provided funding for the NSW Mental Health Coordinating Council, the peak NGO organisation in NSW, to undertake a three-year NGO Development Program aimed at boosting NGO mental health service delivery capacity in NSW.

4.2 Private Sector

The NSW Government recognises the importance of promoting strategies that improve access to private psychiatrists, which may include improving referral

pathways, increasing the timeliness of assessments and increasing the availability of out-of-hours services.

Public sector partnerships with the private sector to date have included funding for GP related initiatives:

- Teams of Two, an initiative by the Alliance of NSW Divisions, seeks to foster partnerships between public sector mental health and GPs. A total of 1,400 GPs, mental health workers and other clinicians have participated in the program to date.
- A new distance-learning Graduate Certificate in Mental Health for General Practitioners has been developed by NSW Health and the Institute of Psychiatry to improve primary care services for people affected by mental illness. Eight rural general practitioners and twelve metropolitan based general practitioners will be the first to commence the course in March 2005.

Primary mental health care is provided through Commonwealth funded initiatives. It is recognised that better incentives are required for GPs to effectively engage in both primary care and long-term support for people with mental illness.

5.0 Unmet Need for Support Services

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

5.1 Summary of Issues

There is a lack of comprehensive community based support for people with, or at risk of, mental illness and this is seen to be a major impediment to their recovery and effective rehabilitation. As well, limited support to family and carers of people with mental illness is a key obstacle to an individual's ability to live in the community. Without appropriate accommodation, disability, employment and social and leisure support to this population, people with psychosis and complex mental health needs experience frequent hospitalisation and become a marginalised and alienated sector of the community.

Systems of care that provide clinical support in crisis and acute situations, family and carer support, rehabilitation, disability support and recovery oriented programs, housing and supported accommodation and education and employment programs are central to ensuring people at high risk are able to access and maintain stable secure and affordable accommodation, and live successfully as part of their family and community.

NSW Health, the Centre for Mental Health is providing leadership in the identification of strong policy guidelines and best practice models of coordinated care to enable people of high risk to live in the community.

5.2 Supported Accommodation

Shelter is one of the most fundamental requirements for optimal health and health improvement. Stable accommodation is essential to maximise mental health treatment outcomes. People with mental illness often cannot access and sustain tenancies or stable housing in the community due to recurrence of their illness, the disability associated with their mental health problems or the limited income and avenues for social inclusion.

They also may experience difficulty living safely and in harmony within their family. Older adults with mental illness who are still living with their family often have carers who are themselves ageing and have concurrent frail age issues. Adults with mental illness can be part of a family where the child or older adult or spouse is the prime carer.

Without effective support to stabilise their housing, people with mental illness can experience more frequent and prolonged episodes of hospitalisation, become homeless, and experience an increased disability.

Many people currently in acute and non-acute mental health inpatient care could be more appropriately cared for in community settings if appropriate supports were available. There is strong evidence that appropriate community care produces better clinical and longer-term outcomes, reduced disability and promoting better quality of life.

The NSW Government has made significant advances in development of programs to ensure better access to accommodation. This includes the *Joint Guarantee of Service for People with Mental Health Problems Living in Aboriginal, Community and Public Housing* (JGOS) and the development of the *Housing and Support Initiative* (HASI).

HASI Stage 1 is a joint initiative between Health, Housing and non-government organisations to provide co-ordinated disability support, accommodation and health services to over 118 people requiring high-level support to live in the community. This includes 42 people in regional and rural NSW. Preliminary outcomes in the South Eastern Sydney trial over a twelve-month period show that inpatient beds days for enrolled patients decreased from 197 days to 32 days.

HASI Stage 2 is an expansion of Stage 1 and contracts are currently being finalised with NGO's to provide disability assistance to a further 460 people who are currently residing in public and community housing across NSW.

The 2005/2006 Budget allocated an additional $8 million to Mental Health NGOs to implement the third phase of the HASI program- supporting an additional 126 people requiring medium to high level disability support in their homes.

There remain, however, a number of consumers who are unable to access these programs. NSW will be increasing the number of supported accommodation places it provides for people with a mental illness.

People affected by mental illness are an identified priority group for assistance by public and community housing, both as current residents and of those applying for

public and community housing. HASI is a successful program jointly funded by Health and Housing to address the housing and accommodation support needs of people with a mental illness.

5.3 Employment

People with mental illness are amongst the most marginalised and socially excluded in our communities. Participation in education, training, employment, or community-based activities such as volunteer work, provides opportunities for individuals to contribute to broader social, economic and personal wellbeing and become more "included" members of our communities.

However, employment rates for people with mental health problems and disorders are lower than for any other disability group, in spite of a range of relevant support services provided across state and Commonwealth jurisdictions. Such low employment participation rates place significant cost burdens on government, society and individuals.

Historically there has been little attention on employment strategies for people with mental illness. This is compounded by the generally low uptake of people with mental health disability into specialist disability and mainstream Vocational Education and Training (VET) services. The NSW Government is keen to explore options to improve this situation.

A scoping of the services and issues in this area has revealed that there is:

- Little consistency across service locations;
- Poor integration of evidence based practice in some areas of service delivery;
- Little collaboration or partnership across services to ensure the provision of comprehensive service options;
- General confusion about how to access information and support across agencies;
- The number of disability employment and rehabilitation services is relatively low and funding for these programs is capped.

There is a need for more coherent and integrated service plans and pathways and coordination across State and Commonwealth services to overcome structural barriers to workforce participation, vocational education and training.

This will require agreement on roles and responsibilities and development of local service networks. Ensuring workforce participation will require specialist and flexible delivered support. This would produce better employment outcomes for this cohort and reduce service overlaps.

5.4 Family and Social Support Services

See TOR 2 and 7.

6.0 Special Needs Groups

> *The special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence.*

6.1 Summary of Issues

There are particular sub groups of our population that experience specific problems that may have a direct impact on their social and emotional wellbeing. This may be due to cultural, linguistic and religious factors, low mental health literacy, greater vulnerability, social isolation and alienation, limitations in appropriate service provision and geography/environment/migration factors. These groups may need to have their needs specifically addressed.

These populations may suffer neglect of their illnesses, barriers in access to care or may suffer additional stressors which add to their health impact; may experience shame or misunderstanding which constitutes a difficulty for them in seeking care; may have adverse experiences when health systems are not culturally attuned to their needs in terms of culture, language and resources; and when they are far from centres of service provision.

6.2 Children and Adolescents

6.2.1 Summary

There is a spectrum of specific prevention and early intervention initiatives that have been widely implemented in NSW to attempt to cover the infants and families, children, adolescents and young people (*Improving Mental Health and Wellbeing in NSW* –NSW Department of Health 2003*).* These have been supported and coordinated at a state level and implemented by Area Health Services in collaboration with other appropriate partners and networks.

14% of children and adolescents, 27% of young people and 18% of adults had a mental health problem or disorder in a six or twelve-month period, respectively. The impact of mental health problems and disorders is significant, often impairing schooling, work-life and social and cognitive development.

6.2.1 Initiatives for Infants, Families and Children

The *Integrated Perinatal and Infant Care Program* (IPC) is a new and important initiative, in partnership with a diversity of health care sectors, which focuses on the antenatal (before the birth of the baby) and postnatal (after the birth) periods.

- 10-15% of women had postnatal depression after the birth of their baby.

- 50% of postnatal depression commences during pregnancy
- These illnesses and other mental health problems can have a profound impact on attachment between the parent and infant and the development of behavioural and emotional problems in children.

IPC links to NSW Health's Health Home Visiting initiative and the NSW Government's Families First program.

The NSW Parenting Program for Mental Health also links to Families First and is aimed at developing a coordinated and comprehensive approach to implementing parenting programs to reduce the incidence and prevalence of mental health problems in young children.

NSW Health is committed to improving the responses of mental health services to the children of people affected by mental health problems and disorders. NSW Health has supported the development and implementation of a range of programs to assist these children and young people.

6.2.2 Initiatives for Adolescents and Young People

The NSW School-Link initiative is a very successful collaborative partnership between the NSW Department of Education and Training and NSW Health that is being implemented statewide and locally to promote mental health and improve prevention, treatment and support for children and adolescents with mental health problems. The initiative has been established over the past six years and has focussed on depression and related disorders in adolescents.

The School-Link Training program for school and TAFE counsellors and mental health workers has included a series of advanced modules covering complex conditions.

The NSW Early Psychosis Program aims to improve outcomes for young people experiencing psychosis and their families. It involves promoting and implementing a statewide framework for early psychosis in NSW, including professional education, systems for monitoring outcomes of early psychosis programs and initiatives.

6.2.3 Child & Adolescent Mental Health Services (CAMHSNET)

In 1995, there was only one acute inpatient facility for children and adolescents. Since then, an additional 40 specialist beds have been opened by the Government, existing within a network that provides care to children and their families as close to familiar surroundings as possible.

The Government currently spends $80.9 million on child adolescent mental health service provision, employing about 570 staff making 376,000 clinical contacts to about 10,000 children and their families.

CAMHSNET links specialised inpatient services and supporting specialist child and adolescent mental health nurses who consult to paediatric and general hospital inpatient services.

A child and adolescent telepsychiatry service has been established from the Children's Hospital at Westmead, which provides specialist telemedicine support for 8 rural services and families, complemented by outreach visits.

The provision of Child and Adolescent Mental Health Services (CAMHSNET) in NSW has been reviewed. This has resulted in:

- A comprehensive plan that ensures that children and young people with the most serious mental health problems will be given access to appropriate care and treatment;
- The establishment of three clear networks for child and adolescent services Northern Network, Southern Network and Western Network;
- The recruitment this financial year of Directors of Child and Adolescent Services for these networks;
- Service planning for best practice inpatient and community services; and
- Workforce strategies to attract and train professional staff.

6.2.4 Young People in Custody

The recent survey of young people in custody found that the rate of mental health problems of young people in the juvenile justice system was significantly higher than the general population. NSW Health is working with other government agencies to investigate how best to support young people in the juvenile justice system who present with a mental illness, to improve their life outcomes and reduce recidivism.

The Children's Hospital Westmead has been involved in developing prevention strategies for a number of key populations. These include psychological interventions for young people who have been through juvenile justice, the needs of those with chronic illness, parenting skills for youngsters with disruptive behaviour and training clinicians in the skills building approaches of emotional regulation for example for self harming adolescents.

The 2005/2006 funding enhancement for community mental health services will aim to divert young people with emerging mental illness away from the criminal justice system.

6.3 Older People's Mental Health

6.3.1 Summary

The Australian population is ageing and approximately one third of Australia's older people live in NSW. Population ageing will result in increased demand on health and aged care services that are already under substantial pressure and will impact heavily on families and carers. According to current NSW population projections and prevalence estimates, the number of older people in NSW with a diagnosable mental health problem would be expected to increase from 114,347 in 2003 to 191,504 in 2022. These numbers are substantially higher if we take into account the needs of older people with severe psychiatric symptoms associated with dementia for specialist mental health services.

Physical illness, disability and mental health disorders are closely linked in old age and the causes, presentation and management of mental disorders in older people

are complex. The incidence of disease is significantly higher amongst older people than other age groups, and multiple disease conditions are more common. Mental health problems affect physical health and rates of mortality, increasing the burden of disease for older people. Increasing social isolation and physical health problems in turn impact on the mental health status of older people. Older people often have a range of chronic and complex care needs, may respond differently to medications compared with younger people and generally require longer recovery times.

Key strategic priorities for responding to the complex needs of older people with mental health problems are as follows:

- Improving the capacity of mental health services, aged care services, GPs, community support services and supported accommodation services to respond to the needs of older people with recurrent, life-long or emerging mental illness who are ageing, and to engage in appropriate mental health promotion, prevention and early intervention strategies to promote better mental health outcomes for older people.
- Developing models to support improved acute mental health and/or medical management of older people with a mental health condition and/or dementia, which may be complicated by delirium.
- Implementing appropriate transitional and long-term care and accommodation service models for older people with severe behavioural disturbance related to dementia and/or mental illness.

All jurisdictions will need to work together to develop coordinated approaches to addressing these issues, across program boundaries and service settings.

The 2005/2006 funding enhancement for community mental health services will target services for older people with a mental illness to improve access.

6.3.2 NSW Health Initiatives

NSW Health is responding to these issues and strategic priorities through a range of initiatives:

- The establishment of Area Clinical Coordinators for Specialist Mental Health Services for Older People (SMHSOP) to provide strategic and clinical leadership at the AHS level in developing SMHSOP and other partnership approaches to meet the complex mental health needs of the growing older population.
- The development of a 10-year NSW Service Plan for SMSHOP (currently being finalised) to guide the development of SMHSOP across NSW, with the aim of improving service access and health outcomes for older people with complex mental health problems.
- The development of an integrated model for the management and accommodation of older people with severely and persistently challenging behaviours associated with dementia and/or mental illness.
- The development of guidelines to assist staff in residential aged care facilities in the management of older people with challenging behaviours, entitled *Guidelines*

for Working with Challenging Behaviours in Residential Aged Care Facilities: Using Appropriate Interventions and Minimising Restraint.

- Development of partnership initiatives with supported accommodation and residential aged care providers such as the provision of top-up funding to Frederic House to ensure support for aged homeless men with mental health, drug and alcohol and age-related health problems.

6.3.3 Federal-State partnership issues

There are already examples of effective Federal-State partnerships for aged care in NSW, such as the Multi-Purpose Service (MPS) developments, the National Framework for Action on Dementia and a project to develop an integrated model for the management and accommodation of older people with severely and persistently challenging behaviours. However, at the national level, neither the *National Mental Health Plan* nor the aged care program has yet contained significant initiatives in this area.

A key issue is the difficult interface between aged care and mental health care for people with dementia complicated by emotional or behavioural problems, and services for people with mental illness who are aged. The recent Access Economics report[3] indicating an increased level of projected dementia makes this issue even more important to address.

As noted earlier, the community prevalence of severe mental illnesses in older people is lower than for younger people because many of the older group were relocated to residential aged care facilities, as identified in the RACF survey of 1996. It would be desirable to repeat this survey and establish an ongoing collection to monitor what is happening in this area. There is also a need to work on joint funding arrangements for the area, and criteria for access to the different levels of services. The work of Professor Henry Brodaty and his colleagues in estimating the different levels of mental health care needs in people with dementia[4] would provide a good starting point for such a development nationally.

NSW Health has worked cooperatively with the Commonwealth Department of Health and Ageing on a number of relevant initiatives. We believe that continuation and extension of this kind of work between jurisdictions in mental health and aged care programs needs to be supported by addressing the funding requirements and responsibilities in a formal way.

[3] Access Economics, 2005, Dementia Estimates and Projections: Australian States and Territories, Alzheimer's Australia, Canberra.

[4] Brodaty H, Draper B & Low L, 'Behavioural and Psychological Symptoms of Dementia: A seven tiered model of service delivery', MJA, 2003

6.4 Indigenous Australians

6.4.1 Summary

Aboriginal peoples and Torres Strait Islanders experience significant and severe socioeconomic and psychological disadvantage, higher levels of morbidity and premature mortality from physical illnesses, experiences of trauma and grief across generations; and demonstrated higher levels of psychological distress. In addition, the high death rate in the Aboriginal community places an increased burden on families, as does the high rate of incarceration of Aboriginal people.

The results of the NSW Health Surveys since 1997 and the recent Western Australian Aboriginal Child Health Survey indicate that the high levels of psychological distress identified in Aboriginal adults aged 16+ is also found in children 5-10 and adolescents 11-15. The result for young people is particularly concerning since it suggests that these problems will continue unless they are more effectively addressed than has been done so far.

Service provision needs to be guided by principles set out in the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Well-being 2004-2009. The principles of self-determination must underpin the management and service delivery to this cohort.

It will be important to implement and document best practice in clinical care and culturally appropriate rehabilitation programs and disability support across the life span for Aboriginal people and Torres Strait Islanders.

6.4.2 NSW Health Initiatives

The NSW Government has worked with Aboriginal communities and the Aboriginal Health & Medical Research Council of NSW to increase the number of Aboriginal Mental Health Workers across the state.

Aboriginal Mental Health Workers have been employed through Aboriginal Community Controlled Health Services to provide culturally appropriate support to indigenous communities, including access to mental health services. NSW Health is currently developing the NSW Aboriginal Mental Health and Wellbeing Policy under the NSW Aboriginal Health Partnership, an equal partnership between NSW Health and NSW Aboriginal Health and Medical Research Council (AH&MRC). This policy aligns with the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing (2004-09).

The School-Link Training program for school and TAFE counsellors and mental health workers is currently delivering and advanced module on adolescent depression and diversity issues, including Aboriginal mental health and wellbeing.

6.4.3 Federal-State partnership issues

Commonwealth and State funding models should be integrated or coordinated between all funding agencies for comprehensive programs and long-term sustainability of funding to enable users to adequately use services.

Innovative funding solutions to ensure equitable access to Medicare funded mental health services in rural and remote areas are particularly needed for Aboriginal people in NSW.

Services should be provided on an integrated basis wherever possible. Services should be seamless and culturally appropriate. Cooperation is needed between all relevant Local, State, and Commonwealth bodies to ensure that infrastructure support (eg housing) and services (eg dealing with employment or health) are coordinated.

Support is especially needed for research into mental health and social and emotional well-being of Aboriginal people. Research into these matters requires a partnership approach with Aboriginal people, the State and the Commonwealth Governments. To ensure that the research is used, the research needs to be supported through suitable forums and other mechanisms. The Indigenous Health Survey 2004 will provide the first national information on the social and emotional healthy and wellbeing of aboriginal people. It is important that maximum use be made of this information. However, since the IHS 2004 does not provide data on these issues in children and young people, and the Western Australian Aboriginal Child Health Survey is only in one state, a national survey of social and emotional wellbeing in Aboriginal children and young people is long overdue.

A health workforce that is appropriately skilled requires the training of Aboriginal people so that they develop suitable generalist skills (eg as Aboriginal Mental Health Workers or as mental health nurses), specialist skills and transferable skills (such as in psychology generally), together with support through scholarships or equipment support.

Information on planning and service activity for Aboriginal mental health has been identified as a limitation on quality improvement opportunities in NSW, and recent reviews by the Productivity Commission and the AIHW suggest that this is generally true. The current Service Development Reporting Framework (SDRF) collaboration between the Centre for Aboriginal Health in NSW Health and the Office of Aboriginal and Torres Strait Islander Heath (OATSIH) has potential to be further expanded to address these issues.

6.5 Comorbid Conditions

People with comorbid conditions, particularly comorbid substance use disorders, but also intellectual disability and physical illness and disability, often have complex needs that require a coordinated response from multiple service sectors.

6.5.2 NSW Health Initiatives

There are a number of local initiatives occurring in relation to dual mental illness and substance abuse. A working group of multi-agency senior officers is working to facilitate the establishment and monitoring of models of integrated supports, particularly for three high-risk groups (young people, Indigenous people and ex-offenders) with mental illness and substance abuse.

A major Systems Analysis of the mental health and drug and alcohol treatment services is currently underway to identify (1) the degree of coordination and

integration of the services in each Area Health Service; (2) the prevalence of various conditions in the cases presenting to each service; and (3) examples of best practice to provide a model for improvements in the system.

The Diploma of Case Management (Dual Diagnosis) with a focus on Aboriginal Health in partnership is currently being developed. The trial of a Mental Illness and Substance Use (MISU) Service Delivery Pilot, by a partnership of the peak NGO Councils for the Mental Health and Drug and Alcohol Sectors (The Network of Alcohol and Drug Agencies and the Mental Health Coordinating Council) should also be noted.

An advanced School-Link Training module on comorbidity – substance use and mental health problems – is currently under development. The School-Link training program is a collaborative training program for school and TAFE counsellors and mental health workers. Drug & alcohol workers will also attend the comorbidity module when it is implemented across NSW.

Other significant achievements include:

- The development of a manual and training resources on mental health issues for D&A workers. This resource will complement a new manual and resources on D&A issues for mental health workers.
- The development and delivery in statewide workshops of a Comorbidity Module for General Practitioners to promote the partnership of GPs with drug and alcohol services and mental health services.
- Two new cannabis clinics scheduled to open in the second half of 2005. Supporting the maintenance and potential expansion of an inpatient dual diagnosis residential rehabilitation facility.
- Implementation of a dual diagnosis family psycho-education project in Sydney South-West.
- The development of a Certificate IV Dual Diagnosis traineeship to be managed by the Community Services and Health Industry Training Advisory Body (ITAB).

The 2005/2006 enhancement funding for community mental health services will pilot dual substance abuse and mental illness pilots targeted at young people at risk of homelessness.

6.6 Transcultural Mental Health

6.6.1 Summary

The culturally and linguistically diverse (CALD) population is not identified in the Senate Inquiry's TOR as a special needs group, even though the Commonwealth has published the implementation of the National Mental Health Plan in Multicultural Australia. If not targeted at Commonwealth level the specific needs of this group will not be addressed.

It is well documented that people from CALD backgrounds have difficulty accessing mental health services, present late at the point of crisis, and have low mental health literacy. There is a need to increase evidence base and good practice in the effective assessment, diagnosis and management of people from CALD backgrounds.

Factors which may impact on the onset, recognition, management and course of mental health problems and mental illnesses for this population include: language; perceptions and meaning of mental illnesses and disability; migration; trauma; refugee status and other experiences related to traumatisation; nature and extent of social, cultural and family supports; and lack of cultural competency in health and/or mental services.

Delayed presentation, more difficult access, prolonged inpatient care have all been shown to be part of the experience of these populations on top of differing levels of vulnerability. People of culturally and linguistically diverse backgrounds require community support where cultural issues, differing patterns of need, issues of access and communication are recognised.

6.6.2 NSW Health Initiatives

NSW Health is currently developing the NSW Multicultural Mental Health Plan which is aligned to the Framework for Implementation of the National Mental Health Plan 2003-08 in Multicultural Australia. The NSW Multicultural Mental Health Plan will aim too provide guidance and direction to Area Health Services to enhance service delivery to people from CALD backgrounds, their families and carers.

NSW Health has funded specific pilots in the areas of: (1) Children and families from CALD backgrounds mental health program in partnership with the Transcultural Mental Health Centre, Children's Hospital at Westmead, and CAMHSNET, to provide a cultural consultancy role, policy development, and training and education of mainstream child and adolescent mental health workers (2) a 4 year rural outreach project by the Transcultural Mental Health Centre to develop service delivery models for the CALD population in geographically and socially isolated circumstances (3) A review of the cultural applicability of MH-OAT to ensure better assessment and outcomes for people with mental illness from CALD backgrounds, their families and carers (4) The Centre for Mental Health also funds cultural, clinical assessment services offered by the Transcultural Mental Health Centre and Services for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS).

The School-Link Training program for school and TAFE counsellors and mental health workers is currently delivering and advanced module on adolescent depression and diversity issues, including young people from CALD backgrounds.

7.0 Support for Primary Carers

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

7.1 Summary of Issues

The need for improved services and supports for families and carers of people with mental health problems is recognised in a range of federal and state policy documents and reports, including the National Mental Health Plan 2003 – 2008 and the NSW Government Carers Statement.

A significant evidence base exists within mental health research outlining effective family and carer supports and interventions. Support for families and carers is extremely cost effective. Research recent studies indicate that services and supports provided to families and carers result in improved health outcomes for people with mental health problems and reduce demand on clinical mental health services, especially hospitalisations.

An Access Economics Report (2002) analysing the cost burden of schizophrenia and related suicide in Australia quotes an American study that demonstrated a cost-benefit ratio of 1:34 for an education and training program for families and carers. That is, for every dollar spent, $34 dollars were saved in mental health costs overall.

Carers from CALD and Aboriginal backgrounds are not well integrated into mainstream carer advocacy bodies, which further impede their access to training and support services. This further exacerbates levels of isolation, stigma and 'hidden carers' syndrome

7.2 NSW Health Initiatives

- The *carer engagement model* was one of the state's 12 demonstration programs aimed to provide support for the families and carers of people with mental illness. The program operates on the principles that families, carers and communities add genuine value to health service delivery, by providing support and education (increasing knowledge) to families, carers and communities, their health and well being will be improved and by providing education and information to communities, the stigma directed at people with mental illness will be reduced.
- The review of the NSW Mental Health Act 1990 includes a major discussion paper on carers and their involvement in treatment, recovery and support of people with a mental illness.
- NSW Health has further developed this evidence base by funding ($1million recurrent since 2001) a number of projects and evaluations, which identify needs of families and carers of people with mental illness n NSW and effective intervention and support strategies.
- In partnership with ARAFMI NSW, has developed a draft service model for the Family and Carer Mental Health Program. The Service model identifies a comprehensive suite of supports and services to be delivered across the mental health, and non government organisation sectors, which complements other supports and services available for all carers (eg via Australian Government Programs). This innovative program will provide a range of supports and services to families and carers that address their education, information needs such as skilled family oriented mental health services, support groups. Underpinned by carer life-course framework developed in partnership between carers, NGOs and mental health services.
- Consultation on the draft service model, conducted with service providers and families and carers, has validated the proposed model. The Government is providing further funding of up to $2.8 million to implement this comprehensive program and it will be implemented over 2005/2006 and will be reviewed and evaluated.

8.0 Role of Primary Health Care

The role of primary health care in promotion, prevention, early detection and chronic care management.

8.1 Summary of Issues

The NSW Government is committed to improve support for general practitioners and other primary mental health providers, especially in rural and remote areas. This includes ongoing support for existing programs in which general practitioners and other primary care clinicians (including, for example, community nurses, psychologists, social workers, occupational therapists, and other allied health providers) provide mental health care to the community.

8.2 NSW Health Initiatives

- A CD-Rom and training package for general practitioners, to assist in the recognition of postnatal depression and the provision of appropriate response is available.
- The Alliance of NSW Divisions of General Practice has received funding to develop and support Teams of Two: a joint learning initiative. The project builds on work previously undertaken to enhance partnerships between general practice and mental health services and uses learning as a tool for collaboration. The Alliance of NSW Divisions is coordinating the project in conjunction with the Centre for Mental Health and the NSW Institute of Psychiatry. The primary aim of the modules is to facilitate greater collaboration between general practitioners and mental health professionals at the local level through interactive joint learning activities. Participants engage in challenging and creative problem solving activities that sharpen their clinical skills and examine the GP/mental health service interface in the provision of mental health care. Three modules have been developed for the Teams of Two initiative: (1) physical health/mental health (2) acute mental health presentations (3) depression in older people. A total of 1,400 GP's, mental health workers and others have participated in the program to date.
- The Centre for Mental Health has also supported the NSW Institute of Psychiatry with funding for a range of courses targeting medical practitioners, including Studies in Mental Health for General Practitioners. This one year, part-time course equips the General Practitioner with assessment and management skills for common mental health problems as they present in general practice. The four units studied are: Mental Health Assessment in General Practice (Theory and Clinically Applied) and Mental Health Management in General Practice (Theory and Clinically Applied). Topics include: the GP-Patient relationship, the biopsychosocial approach to mental health assessment, physical health and mental health, crisis assessment and response, the realities of General Practice, and pharmacological interventions.
- For additional strategies, refer responses to Terms of Reference 3 and 4.

8.3 Federal-State partnership issues

As noted in relation to the first Term of Reference, the main opportunity for collaboration is to ensure that State funded health services and specialist mental health services operate in a complementary way with Medicare funded services for people with mild and moderate mental illnesses. Within that, the issue of rural-urban disparities in access to private psychiatric care is a critical one. In addition, although General Practitioners are more evenly distributed than psychiatrists, it is frequently the case that those in rural towns do not bulk-bill. This creates a cost differential for everyone in rural areas, even if it does not limit access. In addition, it acts as a barrier for provision of primary health services to people with severe mental illness whose main income is from Disability Support pensions.

Development of mechanisms for joint Commonwealth-State funding of mental health services in non-metropolitan regions need to be developed as a matter of urgency.

9.0 Promoting Recovery Focus

> *Opportunities for reducing the effects of iatrogenesis and promoting recovery-focused care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated.*

9.1 Summary of Issues

All health services should have a strong emphasis on recovery with hopeful attitudes and engagement of the patient, family and carers. This should build on identified strengths, support resilience and utilise resources such as those provided under the National planning strategies for Promotion, Prevention and Early Intervention, and Relapse Prevention.

A recovery and strengths focus should be in place with support from consumer and family and carer organisations in moving this forward.

Mental health services and partner agencies need to deliver care that optimises recovery processes and achieve the best possible clinical, social, functional and general health outcomes, including hopeful and positive life views. This care should include promotion, prevention, early intervention, relapse prevention, treatment and rehabilitation, community support and where necessary, disability support.

Individual care plans and service delivery protocols (including community and inpatient – acute and non acute) should include goals and targets to optimise fullest possible recovery and the person's capacity for this and social inclusion, and affirmative equity of access to community support agencies. It should include mental health, physical health, strategies to improve functioning and staged goals with the person affected and significant others to reach these. This management plan should be formulated and should have cross agency and NGO community support strategies that should be available to the consumer and the carer; all roles should be identified in terms of an agency's involvement and their contribution to community support.

This can provide the basis for monitoring of ongoing care. It should include the recovery focus and relapse prevention strategies.

Mental health services also have the expertise to contribute to building the capacity of government agencies and community organisations to manage mental health issues. Consumers and families and carers (across the life span) need to be more engaged in individual care planning, program development and program implementation to contribute to positive mental health outcomes.

Mental health literacy programs and other programs aimed at providing mental health will be particularly relevant to improving mental health outcomes for all consumers.

We need to deliver the most effective, efficient, accessible, acceptable and compassionate systems of care in partnership with those affected, their families and carers, and the clinicians who provide for them as well as the full range of community support agencies.

- Workforce issues in regard to the further development of recovery-oriented services and resource development are being identified. Strategies to address these will be progressively put in place, particularly educational skill building as part of workforce development.
- Self care and educational resources for clients/patients, and their families and carers and the wider community are being drawn together as a resource base and further developed in partnership with these groups.
- Strategies for early intervention to prevent chronicity and relapse and to optimise outcomes should be incorporated in service delivery.

"My Health Record" has been a successful initiative for those with physical health problems, which are chronic. It is strongly supported by consumers, as is the "smart card" concept of a personally held record. It provides record of mental health, personal functional, issues care plans, treatment and relapse prevention information and physical health and mental health needs.

NSW Health calls these range of stakeholders - consumers, families and carers. This is to ensure the "family" maintains a central place in policy and program development and recognises the wider nature of the carer role and also the impact of mental health problems on the wider family group.

NSW Health maintains close links with peak consumer and family and carer organisations. These peak bodies are represented on the range of state level task forces and working groups set up to review services or to develop programs etc. Examples include:

- Consumer Advisory Group (CAG) – Official Visitors Advisory Committee; Joint Guarantee of Service Implementation Group (with Housing and other stakeholders);
- ARAFMI – Family and Carers Strategic Planning Group and the Sentinel Events Review Committee;
- Mental Health Coordinating Council (MHCC: peak NG MH body) – Housing and Supported Accommodation Steering Group;

- Aboriginal Consumer Rep (CAG) - Aboriginal MH Policy Review Group.

NSW Health works closely with a number of consumer and family and carer groups to assist them to review their service profile and their target or core business. A recent project set up is to scope with relevant NGOs and representative bodies how they can best contribute to family and carers projects, what range of services or self help or participation services they can do best, and how to better target their services to cut down on duplication and improve integration and effectiveness across the state.

Mental Health First Aid is one approach to educating a wide range of people (including families of people with mental illness) about to identify the most common mental disorders, how to recognise signs and symptoms, where and how to get help and what sort of help has been shown to be effective. There have been three major evaluations which have shown that the training has changed knowledge, attitudes and helping behaviours. These benefits continue 5-6 months after the training. There has not yet been an evaluation of the effects on those who are recipients of the first aid although there is some evidence that there may be a positive effect.

Human service agencies and non-government agencies have shown considerable interest in obtaining Mental Health First Aid training for their workers. At least one non-government agency, Mental Illness Education – Australia (NSW) is able to provide training in Mental Health First Aid.

10.0 Mental Illness in the Criminal Justice System

> *The overrepresentation 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.*

10.1 Summary of Issues

Prisoner populations are comprised of some of the most disadvantaged and stigmatised individuals in the community. People from disadvantaged backgrounds, poor educational attainment, histories of unemployment, and indigenous populations are over-represented among prisoner populations in Australia.

There is good evidence to suggest a high prevalence of mental illness among the prisoner population. This was further confirmed by the NSW Health Inmate Mental Health Survey, with key findings as follows:

- The prevalence of mental illness in the NSW correctional system is substantial and consistent with international findings.
- The twelve-month prevalence of ‘any psychiatric disorder’ (psychosis, anxiety disorder, affective disorder, substance use disorder, personality disorder, or

neurasthenia) identified in the NSW inmate population is substantially higher than in the general community (74% vs. 22%).

- Almost half of reception (46%) and over one-third (38%) of sentenced inmates had suffered a mental disorder (psychosis, affective disorder, or anxiety disorder) in the previous twelve months.
- Female prisoners have a higher prevalence of psychiatric disorder than male prisoners.
- Two-thirds of reception prisoners had a twelve-month diagnosis of substance use disorder.
- The high rate of mental disorder 40% of reception prisoners had a twelve-month diagnosis of opioid use disorder.
- An estimated 4% to 7% of reception inmates suffer from a functional psychotic mental illness.
- The most common group of mental disorders were anxiety disorders with over one-third of those screened experiencing an anxiety disorder in the previous twelve months.
- Post-traumatic stress disorder (PTSD) was the most common anxiety disorder (24%).
- Females were more likely than males to utilise health services for mental health problems.
- Prisoners with a psychiatric diagnosis had higher levels of disability.

The recent survey of young people in custody found that the rate of mental health problems of young people in the juvenile justice system was significantly higher than the general population. NSW Health is working with other government agencies to investigate how best to support young people in the Juvenile Justice system who present with a mental illness, to improve their life outcomes and reduce recidivism.

10.2 NSW Health Initiatives

- A new 135-bed forensic mental health hospital is currently being constructed in outer Sydney.
- A Statewide court liaison program was established in 2002, and now provides mental health assessment and referral services to magistrates and other court personnel in 21 local courts across metropolitan and rural NSW. This is a whole of government initiative, under the auspice of NSW Health.
- In the 12 months to July 2004, 18,902 clients were screened for mental health problems under the Court Liaison program. 1,945 people, or just over 10 per cent, were referred for a comprehensive mental health assessment. 1,413 of these people were assessed as having a severe mental illness or disorder; as a result:
    - 204 people were diverted to hospital for mental health treatment;
    - 702 people were diverted to community care;
    - 507 were referred to custodial mental health services as per the Magistrates orders.
- NSW Health continues to provide high quality prison in-reach mental health programs across all correctional facilities in NSW, in partnership with the Department of Corrective Services, to meet the mental health care needs of inmates.
- A Community Forensic Mental Health Service was established in 2004 to provide consultation liaison and case management services for the forensic mental health population.
- An interagency working party is currently exploring the evidence for models of prevention and early intervention with young people in contact with the criminal justice system.
- Cross Border agreements under the Mental Health Act 1990: A series of agreements between NSW and other States have been developed to allow the cross-border transfer of persons covered by mental health legislation. There are currently 4 such agreements in operation.
    - NSW –Victoria Agreement for the return of Absconding Forensic Patients
    - NSW-Queensland Interstate Apprehension Order
    - NSW Australian Capital Territory Agreement for the transfer of Civil Patients between NSW and the Australian capital Territory.
    - NSW Victoria Agreement for the transfer of Civil Patients between NSW and Victoria

11.0 Detention and Seclusion in Mental Health Facilities

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.

11.1 Summary of Issues

Issues of good practice, skilled workforce and policies and protocols that provide guidance in the management of people with severe and challenging behaviours pose a challenge to the mental health system. NSW Health is undertaking a number of initiatives to inform the practice of physical and chemical restraint in mental health facilities and the residential aged care sector. These initiatives aim to improve quality of care for residents and consumers, inform responsive development of policy and protocols and increase the capacity of the mental health sector to provide appropriate assessment and care.

11.3 NSW Health Initiatives

- The NSW Health Department issued a policy in 1994, guiding the use of seclusion practices in NSW mental health services.
- NSW Health currently collects and monitors seclusion rates in inpatient units.
- NSW Health is developing Restraint, Seclusion and Transport Guidelines for Patients with Behavioural Disturbance. The Guidelines suggest that restraint, sedation or seclusion can be avoided given appropriate resources, skills and attitudes of health services. These interventions certainly have a place in the management of patients with severe behavioural disturbances, but should be seen as part of a spectrum of responses to disturbed behaviour, supported by appropriate physical and human resources, training, education, monitoring and quality improvement. The Guidelines emphasise that there is much that can be done to prepare a service to minimise the need for seclusion or restraint.
- NSW Health is developing Guidelines for Working with People with Challenging Behaviours in residential aged Care facilities – using appropriate interventions and minimizing restraint. This document aims to improve practice to optimize the prevention of restraint free care in the least restrictive environment for residents with challenging behaviours

12.0 Stigma

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.

12.1 Summary of Issues

People with mental illness, their families and carers not only have to contend with the pressures of living and coping with, managing the illness and negotiating the complex array of services but are also subjected to the stigma in the community, by families and friends around mental illness.

This exacerbates the levels of isolation, loneliness and alienation experienced by people in our community with mental illness. Access to education, information about mental illness and access to support services are vital tools to increase the level of knowledge on mental illness and sense of empowerment in their roles as carers.

Education based on the specific needs of consumers and carers and through mediums accessible to them is required to empower people and reduce stigma and fear previously associated with their circumstances. There is a need to also build capacity of NGO sector to work with people with mental illness and their families.

NSW Health Initiatives

- Mental Illness Education –Australia (NSW) has an interactive program about mental illness for secondary school students, which is presented by people who have been affected by mental illness.
- NSW Health also funds a number of other consumer and carer groups that target the need for de-stigmatising. These include the NSW Mental Health Association, NSW Clinical Advisory Group (CAG) and the Mental Health Coordinating Council, NISAD and the Schizophrenia Fellowship.
- Providing core and specific program funding statewide to NGO to build their capacity to work with people with mental illness and their families and carers eg Mapping project for ARAFMI
- The Mental Health Association NSW is a non-government organisation and registered charity funded by NSW Health. Members are people who are interested in mental health issues. The Association's major activities include provision of the Mental Health Information Service, support groups (including training and establishment of new groups), mental health promotion and advocacy, including reducing stigma.

13. Role of Other Agencies

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.

13.1 Summary of Issues

There is strong awareness of mental health issues within the health sector and across government agencies. It is recognised that some of the most vulnerable population groups receiving services and supports from a range of agencies will have a mental illness and these agencies need to be able to respond appropriately.

Training is an important mechanism for improving the capacity of all agencies to meet the needs of people affected by mental illness. Specific training initiatives have been developed within a number of agencies and to support the funded services provided by the NGO sector. Specific examples of training initiatives have been provided throughout this submission.

Similarly, the development of partnerships and service agreements for the coordination of support across services also plays a significant role in improving agency skills and awareness and the appropriateness of referrals. Such partnerships at the state level include HASI, JGOS, School-Link and the Memorandum of Understanding between Health, Police and Ambulance services. Just as important is the array of partnerships that have been developed at the local level, including collaboration with the primary health, VET and disability support sectors.

13.2 Specific Initiatives

The Senior Officers Group on Mental Health brings together all human and justice service agencies. These agencies are working on a range of activities where roles and responsibilities are shared, including in the areas of vocational training and employment, emergency responses, housing and community support. . A major activity area that is currently being progressed is the identification, dissemination and facilitation of training and mental health awareness within agencies.

NSW Health has facilitated the funding and access to Mental Health First Aid training for some Aboriginal front line organisations such as Link-Up. Some Areas such as FWAHS have facilitated and funded training for organisations such as Lifeline and drought counsellors. Further development of awareness raising programs including Mental Health First Aid and other such programs will be done in partnership with NGOs, specialist mental health and other agencies.

14.0 Mental Health Research

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

14.1 Summary of Issues

Limited financial resources inhibit the need and demand for evidence based practice. Funds are required for research which will in turn generate, trial and document evidence based practice. Additional funding will be required to map gaps in research which will inform clinical practice, planning and policy development.

Some of the key issues to address:

- Lack of evidence based best practice research on mental health issues and culturally and linguistically appropriate models of care
- Lack of documentation on pilot projects that have proven successful
- Need for Commonwealth and state initiatives and support for funding for research on transcultural mental health

Need to identify a research agenda that addresses priority issues of concern in the mental health field.

14.2 NSW Health Initiatives

- The NSW Government recognises the importance of research and evaluation for the continued improvement of mental health services. Funding to the value of more than $25 million over 4 years has now been allocated to a range of mental health research, education and training programs, undertaken by universities, non-government organisations and professional colleges.
- Initiatives target mental illnesses such as Schizophrenia and mood disorders, training and development support for mental health staff, post-graduate education grants for nurses and doctors, and service delivery in rural and remote areas. Funded organisations include NISAD, Schizophrenia Fellowship, the Black Dog Institute and universities across NSW.
- The NSW Government has committed an additional $500,000 per annum to the Neuroscience Institute of Schizophrenia and Allied Disorders (NISAD) to establish Australia's first Chair of Schizophrenia Research. A host university will be selected by May and a Chair recruited by the end of this year.
- $3.2 million in additional funding has been provided to *The Black Dog Institute* for a new standalone facility at Prince of Wales Hospital. The Black Dog Institute conducts research into depression, provides education and training for clinicians in treating Depression, provides clinical services, including tele-psychiatry and satellite services for rural patients, and provides an information resource for consumers. The NSW Government will continue to provide $1 million in recurrent funding to assist the Black Dog Institute's important depression initiatives.
- The Centre for Mental Health Studies is a marriage between the University of Newcastle and the Hunter/New England Health Service. The specific focus of the Centre is to promote evidence based clinical practice and cooperation between both academic and clinical services areas.

15.0 Information Management

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.

15.1 Summary of Issues

The National Mental Health Information Strategy has achieved considerable success in the area of service related information and has a 12 year time series of nationally comparable data to evaluate spending by service type and mode of delivery. It has also introduced the recording of client outcome measures for all clients of mental health services across the nation. This process is still in its infancy and requires further work in the areas of data analysis, linkage, reporting and special attention to enabling clinicians to use the information generated to effect better client treatment options and better service planning and delivery.

15.2 NSW Health Initiatives

NSW has followed a strategy of integration of mental health information with mainstream health information processes but at present has gone ahead of the mainstream and is finding it difficult to get adequate support for some of the necessary processes. As a result NSW has several interim solutions in place till the mainstream catches up.

As required by the National Mental Health Information Strategy, the National Health Information Agreement and the Australian Health Care Agreements, NSW since 1999 has developed and maintains a number of major data collections about mental health services and the clients who use them. In addition, mental health items are included in regular NSW population surveys and school surveys:

- Data is collected about every client contact with inpatient services as part of the mainstream inpatient statistics collection.
- The mental health ambulatory collection is the only statewide unit record data collection about non-admitted clients in NSW.
- Client based data will be collected for the first time in 2004/05 for clients in 24hr staffed government operated residential services. This collection will be extended to less than 24 hr staffed services and possibly to NGOs.
- Consumer outcome measures are collected at admission, review and discharge for all clients of mental health services across inpatient, ambulatory and community residential settings.

These client data are collected by a wide variety of systems in Areas but are aggregated in a series of Area and State data warehouses where they will be linked by unique client identifiers at Area and State level by December 2005. This will enable the patient journey for any particular client to be tracked across all data in the warehouse for all settings and over time and to be linked to clinical outcome measures.

To ensure that outcome measures are based on a quality assessment, NSW has introduced mandatory standard clinical documentation across all mental health services so that all assessments include a core set of domains.

The major gaps in client based clinical data relate to the type and amount of treatment/intervention received by the client and to the type and qualifications of the provider who delivers such treatment. The national codes for recording mental health interventions in inpatient care require revision and coding standards need to mandate recording of what happened during the episode using currently available codes until better ones are developed. The development of such codes is a priority project under the Information Priorities and strategies for the third NMH Plan. There is a need to improve the collection of ethnicity data in existing data sets to track utilisation rates of mental health services, prevalence of mental health, and access to services by people with mental illness from CALD backgrounds.

The interpretation of client outcomes must be able to include the type and amount of treatment received. Ideally this treatment would be related to the goals of a care plan based on measures such as the K10 and HoNOS at admission. Intervention codes therefore should be able to reflect programs of treatment and their components which are tailored to the patient needs at that time and which follow a best practice model.

Knowledge of the provider/s delivering such a care program may also indicate its likelihood of success.

A comprehensive service based National Survey of Mental Health services is conducted annually to measure activity, staffing and costs of mental health services. The NSW version of the NSMHS provides extra information specifically for NSW in addition to that mandated by the Commonwealth to inform the National Mental Health report. These client and service based data are used to formulate performance indicators and targets for services such as:

- % need met
- % provider time spent on ambulatory client care
- Acute separations
- Non acute bed days

These data sources are being evaluated against the newly released National Key Performance Indicators for mental health services to establish the need for any further development.

The Government recognises that funding of mental health services in NSW needs to be based on proper evaluation of the effectiveness and efficiency of programs. Evaluation of mental health programs is now a regular part of funding allocations for Area Health Services, to ensure quality standards and outcomes of service provision, and to establish consumer and carer characteristics in relation to the resources needed to provide effective care.

The exploration of novel funding mechanisms should be explored, with a focus on those which support access to effective services. However the linkage of funding with compliance with national standards should be strongly opposed. The standards are an important foundation document, but do not adequately support the full range of contemporary mental health care service models. Most jurisdictions indicate support for the standards, but also identify a need for them to be updated and reviewed. The process for accreditation of services against these standards is a slow and intensive one, and the impact of this on service quality or outcomes is as yet untested. Funding based on standards compliance therefore risks:

- lack of sensitivity
- discouragement of service development

16.0 New Modes of Delivery of Mental Health Care

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

16.1 Summary of Issues

E-technology - technology supplies the NSW Health Department and Area Health Services with opportunities for improving access to health care, including information sharing and the ability to execute projects successfully, on time and within budget.

16.2 NSW Health Initiatives

- The NSW Telehealth Initiative commenced operations in 1996 with 12 pilot projects connecting 16 sites. It is now an extensive network to over 257 facilities, which supports 35 clinical services. The Telehealth Initiative has the support of clinicians and clients and is a proven enhancement to providing quality healthcare. Providers of mental health services are frequent users of this technology, for the purpose of clinical assessment and management.
- The Child and Adolescent Psychiatry Telemedicine Outreach Service (CAPTOS) has been improving access to effective assessment and treatment options for young people with mental health problems in NSW since 1996. The initial service from Dubbo and Bourke pioneered paediatric telepsychiatry in NSW. These seven years of collaboration have led to new skills, long term clinical relationships and a statewide service between the Department of Psychological Medicine at The Children's Hospital at Westmead and regional clinicians.
- There have been a number of local initiatives developed based on e-technology. The *MoodSwell* CD-ROM, developed by Mid North Coast Area Health Service, is an interactive environment where young people can explore their feelings, develop stress management and life skills, be inspired by others and identify avenues for support. OutaSite, an intergalactic guide to high school is an interactive CD-Rom developed in the Central Coast Area Health Service as part of the School-Link initiative to help children cope with the transition from primary to secondary school.
- The Centre for Rural and Remote Mental Health is developing a number of programs using new modes of delivery of education and mental health care applicable to rural areas. This includes education based on distance-learning modalities, and the provision of support and information to mental health workers in rural areas through internet based programs and networks. The Centre for Rural and Remote Mental Health's work with NSW Centre for Mental Health on a Rural Mental Health Emergency and Critical Care Plan involves identifying new models for improved emergency care, based on a successful pilot program of NSW Health, the Rural Critical Care Pilot. This planning involves addressing the potential role for videoconference support and outreach services.

Part C
Best Practice Examples of Mental Health Services in NSW and Suggestions for Visits by the Committee

1.0 Early Intervention and Prevention Programs

- Programs for children whose parents have a mental illness (COPMI): Gaining Ground Program, South Western Sydney AHS (Liverpool).
- School-Link (prevention, early intervention, evidence-based treatment – Centre for Mental Health and various Area Health Services).
- Southern Area First Episode (SAFE) early psychosis program in (former) Southern Area Health Service.
- Integrated Perinatal and Infant Care (IPC): Central Coast Area Health Service IPC Team.
- Illawarra Area Health Service adolescent mental health services, including service for young people with comorbid drug and alcohol and mental health issues.
- Central Coast Area Health Service – Bong Off (problematic drug use in young people with psychosis).
- Western Sydney Area Health Service – Stop Using Stuff (problematic drug use in young people with psychosis).
- Development of the Older People Suicide Prevention Training Module

2.0 Special Needs Programs

- A new primary health care approach to the mental health needs of indigenous communities. The Fifth Hub Team has been established in partnership with Maari Ma Health Aboriginal Corporation and the Broken Hill Mental Health and Counselling Team. It provides culturally appropriate Mental Health Promotion, Prevention and Early Intervention services to the communities of Broken Hill, Wilcannia and Menindee. Underpinning this initiative is the Aboriginal Mental Health Workforce Development Program. This program currently has 8 Aboriginal Mental Health Trainees, (5 in Adult Mental Health and 3 in Child and Family Mental Health – in partnership with CAMSHNET) who are completing the degree in Mental Health at Charles Sturt University. These trainees are supported through a comprehensive program of placements, supervision and mentoring.
- Sydney South West operates, with substantial funding from the Centre for Mental Health, a statewide service, NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) which offers specialist individual and family counselling, psychiatric clinical assessments and follow up and physiotherapy. STARTTS also offers clinical sessional services in regional and rural areas. STARTTS facilitates the healing process of survivors of torture and refugee trauma and assists and resources individuals and organisations who work with them to provide appropriate, effective and culturally sensitive services.

- Sydney West Area Mental Health Service operates a number of innovative programs, including the Riverview Ward, Cumberland Hospital; a new service model which allocates patients according to diagnostic group (first episode psychosis and mood disorders), reflecting overseas evidence of improved outcomes compared to mixed diagnostic wards.
- Sydney West Area operates, with funding provided by the CMH, a specialist transcultural mental health service by the Transcultural Mental Health Centre (TMHC) that provides a statewide clinical cultural assessment service to other organisations and practitioners working in the health and mental health sector. TMHC contracts bilingual mental health clinicians who offer an initial assessment and referral service. It also offers a cultural consultancy service to AMHS and other health related agencies who deal with people from CALD backgrounds with mental health problems, their families and carers.
- Sydney West Area Health Service also operates a range of important, best practice programs, including:
    - Early Psychosis Team, Western Cluster, Penrith: a small team implementing best practice guidelines in first episode psychosis.
    - Nepean Anxiety Disorders Clinic, Penrith: outpatient treatment service providing evidence based individual and group programs.
    - Development of clinical pathways and whole of health service training strategy for roll out of suicide prevention guidelines (Western Sector).
    - Development of Psychiatric Emergency Care Service at Nepean Emergency Department which has improved the mental health care of patients in the Emergency Departments.
    - CHIPS program, Eastern Sector: community housing preparation program that facilitates movement of patients from inpatient to community living.

3.0 Mainstream Mental Health Services

- The Wyong Mental Health Centre, situated within northern Sydney/Central Coast Area Health Service, is a 50-bed state-of-the-art facility located at Wyong Hospital. Its co-location with other essential hospital services, including Drug and Alcohol, is vital in providing a total care plan for patients. The Centre has tripled the number of mental health beds available on the Central Coast. Within the Centre there are three specialist patient care areas: a 15 bed Older Person unit, a 25 bed Adult acute mental health unit, and 10 bed High-level observation unit. Wyong Mental Health Centre will open in stages commencing with ten Older Persons mental health beds in the dedicated Older Persons unit.

4.0 The Housing and Supported Accommodation Initiative (HASI)

- Many patients with continuing care issues/ disability related to their mental illness have great difficulty in retaining a secure home, shelter or place of residence and sustaining tenancy. This group may be either at risk of homelessness or homeless and require both community mental health assistance to provide clinical

care for their illness and specialist disability and accommodation support to assist them towards recovery and independent living in the community.

- The Housing and Supported Accommodation Initiative (HASI) aims to strengthen the partnership with the Department of Housing and NGOs in delivering accommodation support to people with mental illness to live successfully in the community.
- The initiative is underpinned by policy, by statewide tender programs to ensure standard levels of care and by evaluation and review mechanisms. The development of the HASI program for NSW is a staged process:
  - o Stage One - 100 Medium to High Support places in the community;
    - NSW Health is funding $5m/year recurrently to mental health non-government organisations (NGOs) for high-level accommodation support.
    - The Department of Housing has provided housing stock of approximately $7.8m (one-off and recurrent).
  - o Stage Two - 460 Low outreach support places to people in public and community housing.

    NSW Health is funding $15m over 4 years to mental health NGOs for low-level disability outreach support for people with mental illness and disability associated with that illness who live in social housing.

    The NSW Health contribution to HASI Stage Two is a major acknowledgement and commitment to HASI and to the interagency approach required to meet the needs of people with a mental illness currently residing in public and community housing.

Stage Three - 126 places in medium to high support:

NSW Health is to fund $6.3m/year recurrently for moderate to high-level accommodation support. These places will be allocated across all Area Health Services. This program is due to go to statewide tender processes within the next two months for the NGO support component. Services should be implemented during 2005/06.

5.0 MH-COPES (Mental Health Consumer Perception and Experience of Services)

- This project is being conducted by the NSW Consumer Advisory Group – Mental Health Inc. in partnership with the Centre for Mental Health, NSW Health. It commenced in January 2004 and is due to report to NSW Health in mid-2005. MH- CoPES aims to develop a state wide approach for mental health services in NSW to hear and respond to consumers' views about services as part of their continuing improvement processes.
- The vision of the project is:

- To develop a formal mechanism for consumers' voices to be recognised in practice – and recognised as essential to guiding services;
- To develop tools and processes which assist services to become more responsive and accountable to consumers;
- To augment existing quality processes in NSW by developing a mechanism whereby consumers' views contribute to continuous service improvement; and
- To establish a formal mechanism that builds dialogue and partnership within NSW Mental Health services around issues that are important to consumers.
- Mental Health First Aid courses

As at April 2005, a process of consumer involvement and a tool has been developed. This project has been proposed for National development by the National Mental Health Information Strategy Committee.

6.0 NSW Statewide Community & Court Liaison Service

The NSW Statewide Community & Court Liaison Service provides court- based diversion for the mentally ill and mentally disordered from the criminal justice system towards treatment in mental health facilities based in hospitals, community mental health clinics and in goal.

The Service provides psychiatric assessment and court reports to assist the judiciary in making timely and better-informed decisions about mental health matters. Contrary to the belief of many, court diversion does not equate with discontinuation of criminal

prosecution but allows for the two systems to co-exist in a collaborative manner.

The NSW Statewide Community & Court Liaison Service is presently provided in 21 metropolitan and rural courts in NSW and is available to those who are charged with relatively minor (summary) offences at the local Magistrate's Court.

The NSW Court & Community Liaison Service, Corrections Health is a w hole-of-

Government initiative, which provides court based diversion. It is funded by NSW Health and supported by Department of Corrective Service, Police, DPP, Magistrates and Legal services. Court diversion means diversion from the criminal justice system towards treatment in mental health facilities. Diversion of persons with mental health problems and disorders is available to those w ho face charges for a minor summary) offence, and w here the process of prosecution has begun.

The service provides psychiatric expertise and advice to magistrates w hen mentally ill people in court. The aim is to divert this target group of people to appropriate treatment programs and to prevent unnecessary incarceration. Clinical Nurse Consultants supervise by forensic psychiatrists are available in courts to make an immediate psychiatric assessment and provide a report on options for further psychiatric treatment.