

Australia's Country Report

Asia-Pacific Community Mental Health Development Project

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Section 1: Country background and mental health system

Socio-economic and cultural context

Australia has a land mass of nearly 7.7 million square kilometres, making it the sixth largest country in area. It is the flattest and one of the driest of continents, yet it has extremes of climate and topography.

Australia is an independent Western democracy with a population of more than 20 million. It is one of the world's most urbanised countries, with about 70 per cent of the population living in the 10 largest cities. Most of the population is concentrated along the eastern seaboard and the south-eastern corner of the continent.

Australia's lifestyle reflects its mainly Western origins, but Australia is also a multicultural society which has been enriched by nearly five million settlers from almost 200 nations. Four out of 10 Australians are migrants or the first-generation children of migrants, half of them from non-English speaking backgrounds.

Mental Health Statistics

Mental health is identified as one of Australia's seven National Health Priority Areas.

Mental Health is one of the leading causes of non-fatal burden of disease and injury. In 2003, mental illnesses were among the ten leading causes of disease burden in Australia, accounting for 13% of the total burden of disease.

Mental illness is associated with increased exposure to health risk factors, poorer physical health, and higher rates of death from many causes including suicide. Mental health problems are responsible for a large proportion of disability cases, incur high direct and indirect costs, result in high numbers of hospitalisations and homelessness and impose a heavy burden of human suffering, including stigmatisation of people with mental disorders and their families.

One in five Australians will experience a mental illness during their life. One in four of these people suffer from more than one mental disorder. Anxiety related and affective disorders are the most prevalent with 9.7% and 5.8% respectively of the Australian population experiencing these conditions in the last 12 months.

Roles and responsibilities of government in mental health care

Australia has a federal system of government. Under the federal system, the power of government is constitutionally shared between the Commonwealth at the central level and the State and Territory Governments at the local or provincial level.

Using the federal system of government, the responsibility for health care is a partnership between the Commonwealth and State and Territory Governments. The Commonwealth

Government is responsible for a range of initiatives delivered through the private sector, in particular the primary care sector, and the non-government mental health sector.

Key areas of current responsibility include:

- primary care services through General Practitioners and other professionals;
- community based support programs administered by non-government organisations (NGO);
- medical and pharmaceutical benefits funding;
- funding to States and Territories for mental health services through the Australian Health Care Agreements;
- initiatives under the Council of Australian Governments (COAG) National Action Plan on Mental Health (2006-2011); and
- programs to support mental health consumers from special population groups, including veterans and Indigenous Australians.

Further, the Commonwealth Government administers a wide range of non-health specific mainstream programs and services that provide essential support for people with a mental illness. These include income support, social and community services, disability programs, and housing assistance programs.

State and Territory governments have primary responsibility for the management and delivery of public mental health hospital services, including those provided by corrective services. States and Territories also fund community health services, which include ambulatory care services and specialised residential services, and a range of NGO services including: accommodation; outreach support for people living in their own homes; residential rehabilitation units; recreational programs; carer respite services; self-help; mutual support; and system-wide advocacy.

Within the Australian health system, the private sector delivers a significant proportion of primary, specialist and allied health care through a medical workforce that includes psychiatrists, psychologists, general practitioners, specialists, pharmacists, physiotherapists and dentists. The private sector also operates private hospitals and, through health funds, offers private health insurance.

Overview of mental health in Australia prior to 1992

Prior to 1970, mental health was considered the responsibility of the States and Territories. The Commonwealth Government was not involved in the funding of public psychiatric hospitals, and each State and Territory was responsible for developing its own plans for services. The Commonwealth Government funded the private sector through national health insurance.

Bed numbers in stand alone psychiatric hospitals declined from 29,500 in the early 1960s, when Australia's population was 10.5 million (281 beds per 100,000) to 6750 beds for a population of 17 million in 1992 (40 beds per 100,000). The decline in psychiatric beds coincided with the development of the community mental health services sector, a process known as deinstitutionalisation. However, this process was largely uncoordinated and led to numbers of people with mental illness becoming homeless, living in unsatisfactory residential facilities in the community, or inappropriately placed in nursing homes or correctional facilities.

A national approach to mental health care 1992 onwards

In April 1992, Australian Health Ministers endorsed the National Mental Health Strategy as a framework to guide mental health reform over the period 1993 to 1998. The Strategy was reaffirmed and enhanced in 1998 and again in 2003.

The Strategy provides a framework for national reform from an institutionally based mental health system to one that is consumer focused with an emphasis on supporting the individual in their community. The Strategy is a commitment by the Commonwealth and State and Territory governments to improve the lives of people with a mental illness.

The National Mental Health Strategy aims to:

- promote the mental health of the Australian community;
- where possible, prevent the development of mental disorder;
- reduce the impact of mental disorders on individuals, families and the community; and
- assure the rights of people with mental illness.

Mental health funding

The major funders of mental health services in Australia are the Commonwealth Government, State and Territory governments and private health insurers. Total spending on mental health services in 2004-05 was \$3.9 billion, representing 7.3% of government health spending. The Commonwealth Government spending was \$1.38 billion, states and territories \$2.38 billion and private health insurers \$163 million. Subsidy of psychiatric medicines by the Commonwealth Government Pharmaceutical Benefits Scheme contributed 17% of total government funding on mental health services.

The Commonwealth Government is directly responsible for over 40 per cent of total health care spending and provides significant funds to States and Territories through the Australian Health Care Agreements (AHCAs). It does not manage these services directly.

The Commonwealth Government also provides \$331 million over 5 years (2003-2008) to States and Territories through the Australian Health Care Agreements (AHCAs) for mental health. The bilateral Agreements require States and Territories to facilitate health service reform and implement the National Mental Health Strategy. Under the AHCAs for the 2003-2008 period, a further \$66 million in Commonwealth Own Purpose Outlays funding has also been allocated to the Department for national mental health reform activities.

Recurrent government expenditure on mental health services has increased during the twelve-year period from 1993-2005 by 90% in real terms. Commonwealth Government spending has increased at a much greater rate than that of the States and Territories (149% compared with 67%). However, government spending on direct mental health services does not reflect the total resources going towards mental health. The cost of providing the income and support services needed to allow people affected by mental health illness to participate in community life is estimated to be over three times the outlays on specific mental health programs. This is equivalent to \$4.3 billion in 2005 prices.

Council of Australian Governments

On 14 July 2006, the Council of Australian Governments (COAG) endorsed a new *Council of Australian Governments' National Action Plan on Mental Health 2006-2011* (COAG Action Plan).

Approximately \$4 billion from Commonwealth and State and Territory governments was attached to the Plan.

This was the first time that a whole of government cross portfolio approach to mental health was adopted. It represents a partnership across governments, health, community, health services, education and employments sectors.

The COAG Action Plan has been designed to improve a number of areas of the mental health system, including access to a range of mental health professional services and care coordination. New measures also strengthen the emphasis on population wide approaches to the promotion of mental health, the prevention of mental health problems and disorders, and the supports available for those with mental health conditions, their carers and families (see section 2 for more detail).

Section 2: Country mental health strategy and principles

Concurrent with increasing national focus on mental health through the 1990s was a growing awareness that the mental health system needed further reform. There was also mounting evidence that the service systems had not been appropriately structured to respond to the impacts of deinstitutionalisation. In responding to these challenges, Australian Health Ministers in April 1992 endorsed the development of the National Mental Health Strategy to act as a national framework to guide mental health reform over the period 1992 to 1998.

The Strategy provided a framework to guide national reform agenda, with the focus being the transition from an institutionally based mental health system to one that is consumer focused, with an emphasis on supporting the individual in their community.

The National Mental Health Strategy is comprised of the following documents:

- *National Mental Health Policy* (1992);
- *Mental Health Statement of Rights and Responsibilities* (1991);
- *National Mental Health Plan 2003-2008*; and
- Australian Health Care Agreements 2003-2008.

Elements of the latest National Mental Health Strategy are currently under review.

National Mental Health Policy

The National Mental Health Policy (1992) 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.

The 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 also 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.

Mental Health Statement of Rights and Responsibilities

All people have certain fundamental human rights and membership in Australia society awards all Australian residents, including people with mental health problems or mental disorders, certain rights, roles and responsibilities.

In looking to redress inequities in the Australian society by way of social justice strategies, the Commonwealth and State and Territory governments believe people who suffer from mental health problems or mental disorders should be protected from abuse and neglect. It is essential

to ensure that their needs for care, protection and rights to treatment and rehabilitation are met. The *Mental Health Statement of Rights and Responsibilities* reflects these concerns and recognises the aspirations of all Australian residents to a dignified and secure way of life with equal access to health care, housing and education, and equal rights in civil, legal and industrial affairs.

National Mental Health Plan 2003-2008

The National Mental Health Plan (2003–2008) provides a national policy and implementation framework for a coordinated national approach to improving Australia’s mental health. It represents a commitment to this framework by all Health Ministers.

The Plan seeks to improve Australia’s mental health through linkages with other areas of public policy, including with areas aimed at promoting the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. The Plan also represents a commitment by the Commonwealth and State and Territory Governments to apply mental health funding to develop services in a manner consistent with the aims of the National Mental Health Strategy.

The current Plan builds on the priorities of both the First and Second National Mental Health Plans and it consolidates the existing reforms, begun under the first two Plans, which have been regarded as consistent with international best practice. Like its predecessors, the current Plan also encompasses the seminal principles contained in the Mental Health Statement of Rights and Responsibilities.

The 2003-08 Plan identifies four priority themes:

- mental health promotion and prevention;
- increasing responsiveness to consumers and carers across all mental health and related services;
- strengthening quality; and
- fostering research and innovation across the sector for sustainable programs and services.

Australian Health Care Agreements 2003-2008

The Australian Health Care Agreements 2003-2008 (AHCA) are an important component within the Australian health care system as they are the Commonwealth Government’s financial commitment to the provision of free public hospital services in each State and Territory, and in return, the commitments and obligations of the States and Territories to provide these services

Under the current AHCA 2003-08, mental health is included in the main body of the Agreement and commits the Commonwealth Government and States and Territories to broadly implement the National Mental Health Strategy with a particular focus on continuum of care and mental health services reform. The aims of the Agreements as they relate to for mental health are to:

- improve the focus of public hospitals and mental health services on safety, quality and improved patient outcomes; and
- increase the responsiveness of services for people in need of mental health services.

Council of Australian Governments (COAG).

COAG is the peak intergovernmental forum in Australia which comprises the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government

Association (ALGA). The role of COAG is to initiate, develop and monitor the implementation of policy reforms that are of national significance and which require cooperative action by Australian governments.

In July 2006, the Council of Australian Governments (COAG) endorsed a *National Action Plan on Mental Health (2006 – 2011)*. All jurisdictions have committed funds to progress the aims of the Plan which include to improve mental health and facilitate recovery through a greater focus on promotion, prevention and early intervention; integrating and improving the care system; increasing participation in the community and education; addressing the accommodation and housing needs for people with a mental illness; better coordinating care; and increasing the capacity of the health workforce to deal with mental health issues.

The COAG Action Plan complemented and built on the existing programs and reforms that occur under the National Mental Health Strategy. The Action Plan is consistent with and expands upon the key policy directives of the National Mental Health Policy and the actions identified under the National Mental Health Plan 2003-2008.

Under the COAG Plan, the Commonwealth Government is implementing 18 new initiatives to improve services for people with a mental illness, their families and carers through:

- increasing clinical and health services available in the community and providing new team work arrangement for psychiatrists, GPs, psychologists and mental health nurses;
- providing new non-clinical and respite services for people with mental illness, their families and carers;
- increasing the mental health workforce; and
- providing new programs for community awareness.

The Commonwealth Government's component of the COAG Plan is being jointly implemented by the Department of Health and Ageing; the Department of Families, Housing, Community Services and Indigenous Affairs; and the Department of Education, Employment and Workplace Relations. The Department of Health and Ageing is the lead Commonwealth Government agency and has responsibility for implementing 13 of the 18 initiatives.

One of the flagship initiatives under the COAG Plan which all jurisdictions are currently progressing involves a new system of linking care for people with a severe and persistent mental illness with complex needs. This system will provide a more seamless and coordinated set of health and community services for these people who are most at risk of falling through the gaps. The aim is to ensure that people in this target group are better able to manage their recovery through better coordination of their care needs.

Further information on the initiatives the Commonwealth Government is progressing under the COAG Plan and other national mental health reform efforts is available from www.mentalhealth.gov.au

Indigenous Social and Emotional Well Being Framework

The National strategic framework for Aboriginal and Torres Strait Islander Peoples mental health and social and emotional well being 2004-2009 was endorsed by the Australian Health Minister's Advisory Council in December 2004.

The Framework provides a blueprint for action by all government and communities to improve the social and emotional well being and mental health of Indigenous Australians from 2004-2009. It sits within the context of the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* (2003-2013) and the *National Mental Health Plan* (2003-2008).

This Framework aims to respond to the high incidence of social and emotional well being problems and mental ill health, by providing a framework for national action. The Framework recognises the strengths, resilience, and diversity of Aboriginal and Torres Strait Islander communities. It acknowledges that Aboriginal and Torres Strait Islander peoples have different cultures and histories, and in many instances different needs which must be acknowledged and may need to be addressed by locally developed, specific strategies.

The Framework acknowledges the crucial role of the health sector in providing leadership and advocacy and in responding to health care needs. This Framework, therefore, has adopted a population health model to provide needs based care for Aboriginal and Torres Strait Islander communities. Aboriginal Community Controlled Health Services provide a unique structure for the delivery of accessible, holistic, and culturally appropriate care to communities.

Consumers and Carers

The Commonwealth Government is committed to consumer involvement in its activities related to mental health. The Department of Health and Ageing currently funds the Australian Mental Health Consumers Network (AMHCN) and the Mental Health Council of Australia (MHCA) to inform the development of government policy and programs.

One of the primary purposes of Commonwealth Government funding to consumers and carers is to strengthen consumer involvement in mental health service delivery and development processes.

The funding provided to AMHCN supports the participation of consumers in the development of mental health policy. The AMHCN provides a national voice in mental health service planning, delivery and evaluation, and in particular, represents people with severe mental illness. The AMHCN also develops and provides information to inform consumers and service providers of consumer mental health issues and promotes consumer-based feedback and research.

The MHCA is funded by the Commonwealth and State and Territory Governments to auspice the National Mental Health Consumer and Carer Forum (NMHCCF), which is the primary vehicle supporting consumer and carer participation at a national level. Specifically, the MHCA develops and disseminates resources to educate members about committee functions, government process and advocacy skills.

In recognition of the increasing demand on a small number of consumer and carer representatives to provide advice to governments developing mental health policies and programs, the Department of Health and Ageing has recently provided funding to the Mental Health Council of Australia to trial a Consumer and Carer Advocacy Project.

The project aims to build and strengthen mental health consumers' and carers' capacity to represent their sectors in the development of mental health services, including at the national level.

Section 3: Country examples of best practice models of community based services or care

There have been significant improvements in the delivery of community based services by implementing strategies and initiatives that have improved service responsiveness; access to services; promotion and prevention; and strengthened the quality of the carer and consumer sector.

Governments have implemented evidence based prevention and early intervention programs and have also put significant effort into developing priority strategies in suicide prevention and intervention. Significant gains have also been achieved with States and Territories focusing on emergency mental health access as a key area of priority.

Both levels of Government have introduced a range of initiatives to better integrate mental health services and drug and alcohol services to meet the complex needs of people with coexisting mental health and substance use disorders.

The following examples demonstrate models of community based care undertaken by the Commonwealth Government and the States of Victoria, New South Wales and Queensland.

Commonwealth Government

Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative

One of the key initiatives under the COAG Action Plan is the Commonwealth Government's *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative*.

The *Better Access* initiative provides better access to mental health care by general practitioners, psychiatrists, clinical psychologists and appropriately trained social workers and occupational therapists. The *Better Access* initiative encourages a team-based, multidisciplinary approach to mental health care in the community with psychologists working alongside general practitioners, psychiatrists, social workers and occupational therapists.

The initiative is aimed at eligible patients with a clinically diagnosed mental disorder who would benefit from a structured approach to the management of their care needs, using the short-to-medium term treatment available under the Better Access Medicare items. Mental health services that can be provided under this initiative include Psychological Therapy services provided by eligible clinical psychologists, and Focussed Psychological Strategies services provided by eligible psychologists, social workers and occupational therapists. Focussed Psychological Strategies services can also be provided by GPs with mental health training.

In the first 12 months of the initiative, more than 2.2 million mental health care services were subsidised under Medicare, with the total value of claims paid in this period exceeding AU\$225 million. Approximately one-quarter of all services claimed were provided to people in rural and remote areas of Australia.

To access the *Better Access* initiative patients must be eligible for Medicare services and have an assessed mental disorder. Medicare is Australia's universal health care system to provide eligible Australian residents with affordable, accessible and high-quality health care.

Victoria

Prevention and Recovery Care services (PARC)

Victoria has an area based mental health system which provides both bed based and community mental health services. It also has a strong community support system provided through the non-government psychiatric disability rehabilitation and support (PDRSS) sector. Over the past several years, a number of service initiatives have been developed to support these two systems working more collaboratively, such that they complement each other in the support and treatment provided to clients of the mental health service. While the service system is a comprehensive one, it was recognised that there was a gap between the level of supervision and care provided in an inpatient unit, and that provided to people in the community. In 2005, funds were obtained to develop a new service component – Prevention and Recovery Care services. These have been welcomed by the service sector, consumers and carers. They provide an example of hybrid services which provide both clinical and rehabilitation and support services.

PARC services form part of the acute end of the mental health service continuum. The term ‘prevention’ refers to intervening early in the relapse process while ‘recovery’ refers to maximising people’s well-being through providing post-acute support and interventions to lay a foundation for self-management, relapse prevention and rehabilitation.

PARC services are often referred to as a ‘step up step down’ service. They are intended to reduce admissions and avoidable readmissions to inpatient services. This is achieved by providing an option for assisting people in the community with a mental illness who are becoming acutely unwell (step up), and providing an early discharge alternative from inpatient units (step down). While the service model is still being refined, those models developed to-date provide 10 beds in a community residential setting.

PARC services aim to improve people’s mental health before full onset of an acute episode or in the end stages of an acute episode by providing:

- appropriate types and levels of clinical treatment and support to improve the person’s symptom control, along with
- an appropriate range of types and levels of psycho-social treatment and support to encourage the person’s use of their functional abilities and to facilitate a return to their usual residence.

Entry into the PARC is subject to an assessment and the service is not a suitable option for all clients. Considerations include the person’s and community safety, the person’s behaviour or capacity to engage with service providers and comply with treatment. PARC services are able to accept patients who are on a Community Treatment Order.

Typically, the clinical services concentrate on the management and treatment of the person’s mental illness including risk assessment, psycho-education and monitoring of any prescribed medication. The PDRSS staff engage with residents to provide support and guidance in relation to employment, family relationships, living skills, and socialisation. During their stay in the PARC, clients set goals with the staff in some or all of these areas. These activities introduce clients to psycho-social rehabilitation and prepare them to connect with services when they leave the PARC service. The average length of stay in a PARC is approximately 15 days with a maximum of 28 days.

PARC services operate 24 hours per day, 7 days per week. Generally, the PDRSS provides the 24 hour coverage with at least daily in-reach by clinical mental health staff. Up until now PARC

services have been developed on existing residential properties. The first seven PARC services were established by refurbishing housing accommodation and eight more are either in-development or are being planned. Most of the planned PARCs will be purpose-built. The location of a PARC services need to be easily accessible to specialist community teams and within reasonable proximity to an acute inpatient unit. PARC services also need to provide a suitable environment for different adult age groups, mixed gender and with due consideration to issues of privacy, personal space and safety.

An evaluation of PARC services is being conducted by consultants for the Department of Human Services. The outcome of the evaluation will be available in the second half of 2008.

New South Wales (NSW)

Housing and Accommodation Support Initiative (HASI)

Commencing in 2003, HASI was designed to assist people with mental illness requiring accommodation support to participate in community life, maintain successful tenancies and improve their quality of life.

In this context, the program's key objectives are to:

- Improve housing stability for individual participants;
- Reduce impact demand on acute sector and non-acute sector in patient services;
- Reduce impact on crisis calls to emergency services;
- Reduce hospital bed stays in a psychiatric unit;
- Demonstrate an independent living, community based model of psychosocial rehabilitation, support and case management service;
- Improve quality of life for individual participants activated through social, vocational, educational, life skills development and family connections; and
- Integrate across all existing HASI stages and other proposed expansions of HASI to allow for a continuum of service delivery that is flexible and responsive in meeting individual needs.

The HASI partnership

To deliver outcomes against these objectives, the HASI model has been developed in stages to provide a continuum of support from low outreach to high support services, which are targeted to individual needs, are recovery focused and linked with existing community services. These are:

- HASI 1 – High support (4 – 5 hours a day, 7 days a week)
- HASI 2 - Lower support (up to 5 hours a week)
- HASI 3 – High Support
- HASI 3B - Very high support (8 hours a day, 7 days a week)
- HASI 4A – High support and
- HASI in the Home - Medium support (2 –3 hours per day and lower support)

From 2008, the new HASI in the Home stage will increase places to over 1,000 across NSW.

This is delivered in a three-way partnership:

- tailored accommodation support and psychosocial rehabilitation associated with disability provided by specialist mental health non government organisations which are funded by NSW Health;
- clinical mental health care and rehabilitation provided by specialist local mental health services through the Area Health Services;

- long-term, secure, and affordable housing, and property and tenancy management provided by public and community housing and funded by NSW Housing.

The purpose of the HASI partnership is to:

- More efficiently and effectively co-ordinate care for consumers (all HASI partners)
- Explore and enhance the interface between specialist mental health services (both acute and rehabilitative), the General Practitioner and the non-government sector in NSW
- Enable and facilitate stable housing outcomes for all HASI clients, and
- Facilitate consumer, family and carer participation (all HASI partners).

Program configuration

A range of accommodation options are provided:

1. Individual self-contained accommodation
2. One or two bedroom places (bed-sitters are too confined when receiving daily support, sometimes for long periods of time, as this increases the potential for support to become intrusive)
3. “Salt and pepper” approach, i.e. HASI properties to be sprinkled amongst the community
4. Small clusters (up to 4 HASI places in one site) are acceptable when deemed to be clinically viable. Virtual clusters are the preferred options, e.g. several HASI places within a few streets. HASI does not support “asylums in the community” or congregate care
5. Range of choice in type of housing and location of housing where possible, and
6. Area Health Services are considered to be the experts when considering specific locations as they have the long-term local knowledge required in ensuring location of housing is appropriate (eg near shops and not near a known outlet for illegal sale of drugs etc). NGOs are also consulted before accepting particular housing stock into the HASI program.

In conjunction with the local Area Mental Health Service, the non-government support services:

- Provide comprehensive, client centred, strengths based assessment, care planning and intervention which target self maintenance, productivity levels including education and employment and leisure needs;
- Provide services based on a philosophy that promotes consumer recovery through fostering hope, supporting consumer empowerment and supporting self-determination;
- Ensure intervention strategies utilise mainstream community services networks and resources to encourage community inclusion.
- *Target group*

Eligibility criteria for HASI, include those clients:

- 16 years of age or more until age related frailty is determined to inhibit ongoing involvement in the program;
- Diagnosed with a mental illness; or in the case of a young person where formal diagnosis is absent, functional impairment due to psychological disturbance that has been identified by a mental health professional;
- Eligible for social housing;

- Have high levels of psychiatric disability and low level of functioning;
- Have the capacity to benefit from the provision of accommodation support services; and
- Give informed consent to participate in the program.

Achievements and outcomes

To assess the effectiveness of the HASI program, the New South Wales Government contracted the Social Policy Research Centre from the University of NSW to undertake a two-year longitudinal evaluation of the initial stage of the Housing and Accommodation Support Initiative – HASI Stage One. This stage of the Initiative provided 100 high support places across NSW.

The final report has now been published (www.health.nsw.gov.au/pubs/2007/hasi_evaluation) with findings including:

- HASI achieves its objective of providing secure, affordable housing with 85% of all participants remaining with the same housing provider;
- HASI results in people having increased community participation;
- 94% of people had established friendships by the end of the evaluation;
- 73% of participants were participating in social and community activities; and
- 43% of participants were working and/or studying at the end of the two year evaluation.

Both, in terms of frequency and duration:

- Hospitalisation rates were reduced for 84% of participants;
- Time spent in hospital and emergency departments decreased by 81%;
- Over 50% of participants reported improved physical health from regular access to general practitioners, specialists, improved diet and increased physical exercise; and
- 68% of participants described an improvement in symptoms, social and living skills and a decrease in psychological distress.

Queensland

Mental Health Intervention Project

The Mental Health Intervention Program (MHIP) is a tri-agency partnership between Queensland Health (QH), the Queensland Police Service (QPS) and the Queensland Ambulance Service (QAS). The program is aimed at the prevention and safe resolution of mental health crisis situations. It was developed in response to a number of deaths of people with mental illness in crisis, during police interventions. Under the lead of the QPS, funding was obtained in 2005 to develop a collaborative program to establish an infrastructure, governance process and knowledge base across the three departments which would support better outcomes for consumers and service providers.

The MHIP recognises the need to develop improved safety for individuals, mental health staff, police, ambulance and the community through improved collaboration and integration between the services. The program focuses on establishing meaningful communication and sharing of information between the stakeholders as a foundation for providing timely responses to

individuals experiencing mental health crises and the development of collaborative responses to these crises. The MHIP also facilitates access to a range of services and responses for those who are experiencing a mental health crisis.

Implementation of the MHIP has focused on two major areas of activity: roll-out of a governance and operational infrastructure in the network of Mental Health Intervention Coordinators, and the delivery of complementary training to police officers, mental health clinicians, and ambulance officers.

Mental Health Intervention Coordinators (MHICs) have been established within police, ambulance and mental health services across the state, to implement protocols and procedures to support collaborative responses across the three agencies and facilitate development of local solutions to specific mental health issues. MHIC positions have been established in 17 Health Service Districts to directly liaise with QPS and QAS staff, and support collaboration through a consultation and liaison model. Corresponding MHIC positions have been appointed within the QPS, in locations which align with the 17 Health Service Districts. The Queensland Ambulance Service has also appointed Mental Health Intervention Coordinators to the 17 Health Service Districts to liaise and cooperate with the coordinators from the QPS and Queensland Health.

Governance processes have been established in each District to ensure continued development and monitoring of the program and effective linkages to broader processes of collaboration and service improvement between the agencies. Under a formal Memorandum of Agreement, an Operational Liaison Committee has been established in each Health Service District, which provides a forum for discussion and resolution of issues arising in responding to the needs of people with mental illness in the community, including both day-to-day and crisis situations. This forum has been of significant value in supporting improved processes and understanding of shared responsibilities and information needs, and is supported by the MHICs from each of the three agencies.

To assist in the collaborative work of the three agencies, guidelines have been established relating to information sharing. In balancing the legislative requirements relating to confidentiality and duty of care, the guidelines provide a framework for the development and implementation of local policy and procedure to promote safety and to improve coordinated response to mental health crisis situations.

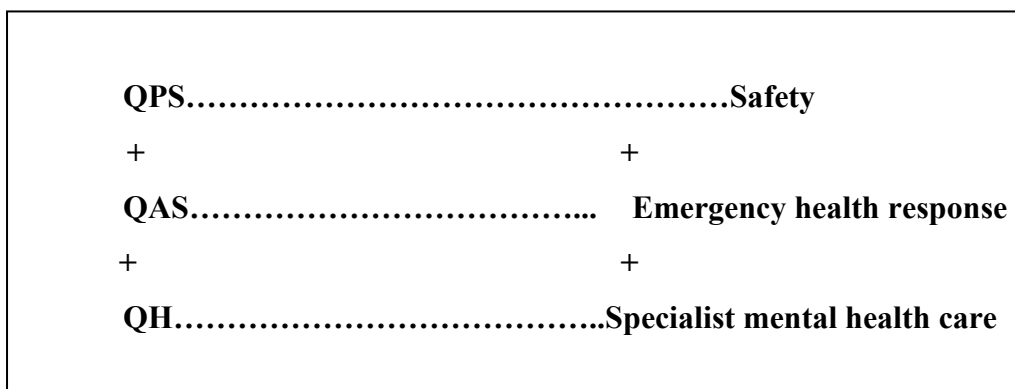
An extensive program of delivery of complementary mental health intervention training to QPS, QAS and mental health service officers has been undertaken within the MHIP. Within the QPS, training has been provided to key staff, including first response officers, first response supervisors, district coordinators, regional coordinators and communications room operators. Training has focused on improving recognition and understanding of mental illness and enhancing skills in de-escalation of situations involving people with a mental disorder. Training for Queensland Health staff, including both mental health and emergency staff, has been aimed at providing an enhanced understanding of the operations and work practices of the QPS and QAS. QPS first response officers have been provided with an intensive one day training session primarily focused on enhancing tactical communication skills through practical role-play scenarios.

By early 2008, MHIP training had been provided to in excess of 3,500 Queensland Police Service first response officers, more than 600 QAS officers, paramedics and paramedic students within Queensland Ambulance Service, and more than 550 Queensland Health staff.

Within participating districts, the benefits of the MHIP have been demonstrated in supporting appropriate responses to people with a mental health disorder in times of crisis, which has resulted in safer outcomes for the individual and the public, along with a safer work environment for the QPS and QAS officers. It is seen as facilitating timely and accessible mental health responses for a person experiencing a mental health crisis and improved relationships and cooperation between QPS, Queensland Health and QAS. The project has also enhanced communication skills and knowledge levels for staff within the police, ambulance and mental health services and increased and improved community support networks and crisis prevention capacity.

The evidence that has been provided thus far, indicates a significant reduction of crisis presentations and better management of people with dual mental illness and substance use presentations over a three month period. Positive changes in the attitude of the QPS and QAS officers and an overall better understanding of people with a mental illness have also been reported. A formal evaluation will be undertaken in the future.

Overview of MHIP



Co-ordinated approach to prevent and/or safely resolve mental health crisis

Section 4: Extending the current capacity of community care

The Government has laid out a new platform for health care reform which involves a stronger approach to preventative health care. This new approach brings a greater focus to prevention and early intervention in the health system and the establishment of a National Preventative Healthcare Strategy to be driven by a Taskforce, and commissioning the Treasury Department to produce a series of reports detailing the impact of chronic disease on the Australian economy.

The key principles which underpin the new Government's approach to health care reform will also underpin the Government's principles to mental health. These principles are:

- Prevention of chronic disease;
- Early intervention and systems for management of chronic illness where prevention is not possible;
- Co-operative reform to improve services; and
- National leadership to drive changes.

More specifically, these new priorities will drive reforms to improve mental health services through:

- Putting mental health firmly back on the COAG agenda and working collaboratively with the States and Territories on an integrated national approach to mental health service delivery;
- Using an evidence based approach to reorient mental health policy towards prevention and early intervention;
- Ensuring mental health services are well integrated with primary care and specialist services;
- Investing in programs that can ensure resources are used to fill gaps in existing service delivery, particularly in the rural and remote parts of Australia; and
- The development of open, transparent system of evaluation and accountability of existing mental health services to ensure investment is well targeted.

Monitoring and evaluation

Evaluation and accountability have been central to the National Mental Health Strategy from the outset.

In agreeing to the Strategy, Health Ministers recognised that an important aspect of the reform process was to ensure that progress is monitored and publicly reported on a regular basis. This has been achieved through two key mechanisms:

- independent evaluations of each five year National Plan; and
- the development of nationally agreed measures of performance in relation to the objectives of the Strategy and regular reporting of progress against these in the National Mental Health Report series.

Few national policy areas in Australia have been subject to an equivalent level of reporting and accountability as required under the National Mental Health Strategy. The first National

Mental Health Report covered the 1992-93 financial year and presented 'baseline' data against which progress of the Strategy could be evaluated.

Mental health is reported in a range of other broader health reports, including annually through the Australian Institute of Health and Welfare and the Report on Government Services.

Mental health services and the outcomes of care are monitored through a number of mechanisms including:

- National Minimum Data Sets that gather information about care provided in hospitals, residential settings and the community;
- routine measurement of the outcomes of care, mandated in the public sector and being undertaken in the private sector, through the Australian Mental Health Outcomes and Classification Network; and
- the publication of data in the National Mental Health Report. This report monitors the mental health reform progress of each jurisdiction and places a wide range of information in the public domain.

The National Mental Health Report

The National Mental Health Report series is a key accountability mechanism for monitoring shifts in the way in which mental health services are funded and delivered. The 2007 Report was released on 18 April 2008 and provides updated information to 2004-05.

The National Mental Health Report was set up as a central feature of the monitoring requirements under the National Mental Health Strategy. It has been prepared by the Department of Health and Ageing to:

- provide the most recent available data on mental health services provision;
- monitor changes that have taken place in the provision of specialised mental health services;
- act as an information resource on the state of mental health services in Australia, for use by a range of interested parties; and
- inform and improve community understanding of the reform of Australia's mental health services.

The current report is the tenth in the National Mental Health Report series and tracks changes over the 12 years since the inception of the National Mental Health Strategy. The information provided includes expenditure, service mix, workforce, activity levels including patients treated, and arrangements for consumer and carer participation. The Report also collates data on private mental health services and from the Commonwealth Government through the Medicare Benefits Schedule, Pharmaceutical Benefits Schedule and the Department of Veteran's Affairs.

Information Development

Information development has been central to the National Mental Health Strategy since it began in 1992 and the Commonwealth Government is continuing its work with State and Territory governments to build the information base.

Driving the collection of information within the public sector has been the:

- regular assessment of consumer outcomes using standardised assessment tools;
- introduction of minimum data sets reporting on community care; and

- development of key performance indicators for monitoring public sector performance and using for benchmarking purposes.

A range of recent initiatives are providing the basis for the collection, monitoring and reporting of a broader range of information, which will in turn ensure better accountability, for example:

- a scoping study to examine issues with the coding of Mental Health Interventions and counting methods for the reappraisal of the development of a Mental Health Interventions Classification;
- the development of instruments to collect consumers' perceptions of care and to obtain better information on the implementation of National Standards for Mental Health Services under review;
- the Second National Survey of Mental Health and Wellbeing in 2007 will provide a picture of levels of disablement, service utilisation and prevalence of mental health problems in the Australian population;
- agreed National Key Performance Indicators for Public Mental Health Services and further work on the development of national indicators;
- benchmarking of mental health services nationally, which has begun with 23 organisations participating in adult, older persons, child and adolescent, and forensic forums over the coming year; and
- National Seclusion and Restraint projects, developed in collaboration with the States and Territories, will develop and test resources that can be used to change workforce culture and practice leading to the reduced use of seclusion and restraint.

Council of Australian Governments (COAG) *National Action Plan on Mental Health 2006-2011*

The COAG *National Action Plan* (the Plan) includes a requirement that Australian Ministers report annually to COAG on the implementation and progress against the agreed outcomes of the Plan.

The Annual Progress Report 2006-07 is the first report in the series of annual reports stipulated by COAG as a requirement for monitoring implementation of the Plan. These reports will chart progress made under the Plan, and monitor the extent to which the agreed initiatives are taking place to address the commitments made by all governments under the Plan.

Australian Health Ministers endorsed the Annual Progress Report 2006-07 in January 2008 and have lodged the report with the COAG Secretariat.

Section 5: Conclusions

Significant progress in reforming mental health services has been made throughout Australia since the inception of the Mental Health Strategy and the National Mental Health Policy in the early 1990s.

Prior to 1992, mental health in Australia was traditionally considered the responsibility of the States and Territories. Each State and Territory was responsible for developing their own plans for services and the Commonwealth Government funded the private sector through national health insurance.

During this period, declines were seen for bed numbers in stand alone psychiatric hospitals and this decline coincided with the development of the community mental health services sector, a process which became known as deinstitutionalisation. This process was largely uncoordinated and led to numbers of people with mental illness becoming homeless, living in unsatisfactory residential facilities in the community, or inappropriately placed in nursing homes or correctional facilities.

Through the 1990s and concurrent with increasing national focus on mental health, was a growing awareness that the mental health system needed further reform. There was also mounting evidence that the mental health service systems had not been appropriately structured to respond to the impacts of deinstitutionalisation. In responding to these challenges, Australian Health Ministers in April 1992 endorsed the development of the National Mental Health Strategy to guide mental health reform over the period 1992 to 1998.

The Strategy provided a framework for national reform, with the focus being the transition from an institutionally based mental health system to one that is consumer focused, with an emphasis on supporting the individual in their community. The Strategy was accompanied by a series of National five year Mental Health Plans; 1993-1998, 1998-2003, 2003-2008). The Strategy was reaffirmed in 1998 and again in 2003.

In July 2006, the Council of Australian Governments endorsed a *National Action Plan on Mental Health (2006 – 2011)*. The Plan complements and builds on existing programs and reforms that are occurring under the National Mental Health Strategy. The measures contained within the Action Plan are designed to improve a number of areas of the mental health system, including access to a range of mental health professional services and care coordination. The measures also strengthen the emphasis on population wide approaches to the promotion of mental health, the prevention of mental health problems and disorders, and the supports available for those with mental health conditions, their carers and families

Both the Commonwealth and States and Territories Governments have made significant progress in the delivery of community based services through the implementation of strategies and initiatives that have improved service responsiveness; access to services; promotion and prevention; and strengthened the quality of the carer and consumer sector. All States and Territories have implemented evidence based prevention and early intervention programs and have also placed significant effort into developing priority strategies in suicide prevention and intervention.

Central to the National Mental Health Strategy has been the development of a comprehensive evaluation and accountability Framework. Few national policy areas in Australia have been

subject to an equivalent level of monitoring, evaluation, reporting and accountability as required under the National Mental Health Strategy.

The Commonwealth Government priorities for mental health include working in partnership with States and Territories on an integrated national approach to service delivery; developing an open, transparent system of evaluation and accountability of existing mental health services; and ensuring that mental health services are well integrated with other primary care and specialist services.

The Commonwealth Government recognises the vital need for initiatives to prevent or delay the onset of mental illness, to intervene early, and to ensure access to and continuity of appropriate treatment and care for people with mental health problems.