Introduction

The following notes have been prepared to assist in the interpretation of the data measuring each of the *Fourth National Mental Health Plan* indicators presented in Part 3 Monitoring progress and outcomes under the *Fourth National Mental Health Plan*.

Table A2-1 provides summary information about the data sources used, and which indicators are based on each source. Table A2-2 provides further explanatory detail regarding the derivation of each indicator. The table does not include information about indicators that cannot yet be reported.

Data sources and explanatory notes

Table A2-1
Overview of data sources, in alphabetical order

Data source	Description	Relevant indicators, figures and tables
Australian Bureau of Statistics Causes of Death, Australia, 2011, report	The official suicide rate in any given year is produced by the Australian Bureau of Statistics, using data from coroners' courts in all states and territories. Data covering the period 2003 to 2011 are published in the Causes of Death, Australia, 2011, report.[53] Unpublished data are also used. Information about deaths occurring in each state and territory is provided to the Australian Bureau of Statistics (ABS) by individual state and territory Registrars of Births, Deaths and Marriages for coding and compilation into aggregate statistics. In addition, the ABS supplements this data with information from the National Coronial Information System (NCIS).	Indicator 9 (Table 10, Figures 55-56)
Australian Government analyses of jurisdiction data	See Appendix 1, Table A1-1.	Indicators 13-16 (Figures 59-62)
Medicare Benefits Schedule data	See Appendix 1, Table A1-1.	Indicator 7 (Table 9) Indicator 13 (Figure 59)
National Drug Strategy Household Surveys conducted in 2010, 2007, 2004, 2001 and 1998	The National Drug and Alcohol Household Surveys are conducted by the Australian Institute of Health and Welfare every three years.[77] The surveys are designed to provide data on the level, patterns and trends of alcohol and other drug use in Australia, including licit and illicit drug use. The most recent survey – the tenth in the series – was conducted in 2010 and involved over 26,000 participants who were recruited via a household sampling strategy (a response rate of just over 50%).	Indicator 8 (Figures 52-54)
National Health Surveys conducted in 2011-12 and 2007-08	The 2011-12 National Health Survey (NHS)[34] was conducted from March 2011 to March 2012 by the Australian Bureau of Statistics. Previous surveys in this series were conducted in 1989-90, 1995, 2001, 2004-05 and 2007-08. The 2007-08 NHS[36] was conducted between August 2007 to June 2008. The surveys were designed to obtain national benchmarks on a wide range of health issues, and to enable changes in health to be monitored over time. The 2011-12 and 2007-08 NHSs each sampled more than 20,000 people across all age groups from private dwellings in all states and territories. Information was collected via personal interview. The surveys collected information about a broad range of health issues, include mental health status, as well as demographic and socio-economic information.	Indicator 1a (Figures 44-45) Indicator 2a (Figures 46-47)

Data source	Description	Relevant indicators, figures and tables
National Minimum Data Set (NMDS) – Mental Health Establishments (MHE) collection 2005–06 to 2010–11	See Appendix 1, Table A1-1.	Indicators 21-22 (Figures 65-66)
National Outcomes and Casemix Collection	Data on a range of outcomes for consumers of state and territory public sector mental health services are collected via the National Outcomes and Casemix Collection (NOCC).[78] The NOCC was endorsed by all States and Territories in 2003, and all jurisdictions have reported data since 2004-05. Analysis of this data is conducted by the Australian Mental Health Outcomes and Classification Network (AMHOCN), using data submitted annually by states and territories to the Australian Government Department of Health and Ageing. The NOCC protocol prescribes a set of measures to be collected at particular times in the clinical process. The measures are specific to three broad mental health service settings (Inpatient, Residential and Ambulatory) and also to three target populations (i.e., Children and Adolescents, Adults and Older Persons). It is difficult to ascertain definitively the 'coverage' of NOCC reporting, however AMHOCN has previously estimated Inpatient episode coverage at approximately 33% for Completed Episodes of at least 3 days duration and estimated ambulatory episode coverage at approximately 20% for 'Completed Episodes' and 33% for Ongoing Episodes.	Indicator 4 (Figures 49-50) Indicator 23 (Figure 67)
National Prisoner Health Census conducted in 2010	The National Prisoner Health Census[67 68] was conducted in 2010 by the Australian Institute of Health and Welfare. The Census was conducted in October and November 2010 in 44 of the 45 public and private adult correctional facilities from all jurisdictions except New South Wales and Victoria. The survey was developed to help monitor the health of prisoners, and to inform and evaluate the planning, delivery and quality of prisoner health services. Data were collected over a two week period. Individuals were asked a number of questions, including several about their mental health. Data were collected for 610 new prison entrants.	Indicator 20a (Figure 64)
National Survey of Mental Health and Wellbeing, surveys of adult population, conducted in 2007 and 1997	The 2007 National Survey of Mental Health and Wellbeing (NSMHWB)[65], survey of adult population, was conducted between August and December 2007 by the Australian Bureau of Statistics (ABS). The 2007 survey, and its precursor in 1997[4], were designed to provide reliable information about the prevalence of common mental disorders among Australian adults, and the impairment, severity, health care service use and unmet treatment needs associated with these disorders. In both surveys, participants were recruited by a household sampling strategy and interviewed in their homes. The 1997 survey involved 10,641 participants aged 16-85 years and the 2007 survey involved 8,841 participants aged 18-99 years. The response rate was 60% for the 2007 survey and 78% for the 1997 survey.	Indicator 12 (Figure 58) Indicator 13 (Table 11)
National Survey of Mental Health and Wellbeing, survey of children and adolescents, conducted in 1998	The Child and Adolescent Component of the National Survey of Mental Health and Wellbeing[6] was conducted in 1998. This survey recruited 4,509 children and adolescents aged 4-17 through a household sampling strategy. It elicited information from participants and their parents via interview.	Indicator 12 (Figure 58)
National Surveys of Mental Health Literacy and Stigma conducted in 2011, 2003-04 and 1995	The National Surveys of Mental Health Literacy and Stigma[46] are a series of general community surveys designed to assess aspects of the mental health literacy in the Australian population and to monitor trends over time. The surveys were conducted using computer-assisted telephone interviews. The surveys involved the presentation of vignettes describing males or females with symptoms of a mental illness, with subsequent questions eliciting information about respondents' ability to recognise specific mental disorders, their beliefs about treatment, and stigmatising attitudes. The 1995, 2003-04 and 2011 samples consisted of 2,164, 3,998 and 6,019 adults aged 18 years or older respectively. Response rates were 85% in 1995, 34% in 2003-04 and 44% in 2011.	Indicator 3 (Figure 48) Indicator 11 (Figure 57)

Data source	Description	Relevant indicators, figures and tables
Principals Australia's National Market Research Survey conducted in 2011	Australian Government funding was provided to expand the Principals Australia's National Market Research Survey[50] to collect specific information regarding the mental health literacy component of schools' curricula. The Market Research Survey was undertaken in April and May 2011 and included a range of mental health specific questions designed to gather information on the range of mental health related activities undertaken in Australian public and private schools. The survey captured data from a large sample of principals based in all states and territories of Australia, and from all school types, sectors and all locations and is believed to be representative of all schools. Analysis of data for the mental health specific questions was restricted to responses by school principals, numbering 1,285 and covering an estimated 14% of all Australian schools.	Indicator 6 (Figure 51)
Private Mental Health Alliance Centralised Data Management Service	Data on the number of people seen by private hospital-based psychiatric services, and their outcomes, are analysed by the Private Mental Health Alliance's Centralised Data Management Service.[80] Virtually all private hospitals with psychiatric beds in Australia have been routinely collecting and reporting a nationally agreed suite of clinical measures and related data since 2002. The clinical measures to be collected, and the timing of their collection, are guided by a protocol. Valid data for private hospitals in 2009-10 covered 76% of in-scope inpatient episodes.	Indicator 13 (Figure 59) Indicator 23 (Figure 67)
Supported Accommodation Assistance Program (SAAP) National Minimum Data Set 2005-06 to 2009-10	The Supported Accommodation Assistance Program (SAAP) National Minimum Data Set (NMDS) 2005-06 to 2009-10[81] includes information about all clients receiving SAAP support lasting more than one hour. The information is collected throughout the year. The SAAP NMDS is compiled by collating information provided by agencies across Australia and by State and Territory community service departments. Analysis of the SAAP NMDS is conducted by the Australian Institute of Health and Welfare.[81] The SAAP NMDS includes information from three collections: the client collection, the demand collection and the administrative collection. The client collection captures information on all clients receiving ongoing or substantial support under SAAP. It includes basic socio-demographic information and the services required by and provided to each client. Details about accompanying children are also obtained. Additionally, information is collected about the client circumstances before and after receiving SAAP support.	Indicator 19 (Figure 63)

Table A2-2
Explanatory notes to figures and tables presented Part 3.

Indicator(s)	Notes
Priority area 1: Social inclusion and recovery	
Indicator 1a: Participation rates by people with mental illness of working age in employment: General population	**(a)** This indicator estimates the proportion of the Australian population aged 16-64 years with a mental illness who are employed. Data for 2011-12 is derived from the 2011-12 National Health Survey.[34] Data for 2007-08 is derived from the 2007-08 National Health Survey.[36] The 2007-08 and 2011-12 National Health Surveys included questions about the respondent's mental health status and participation in employment. Mental illness was defined as self-reported mental or behavioural problems lasting six months or more, or which the respondent expects to last for six months or more. Persons were classified as employed according to the ABS quarterly Labour Force Survey definition, that is, if they reported in the preceding week that they had worked in a job, business or farm, or if they had a job but were absent during that week. The data collected from these surveys enables comparison between the employment rate for people with and without a mental illness. The data have been age-standardised to enable comparison between 2007-08 and 2011-12. **(b)** Given the relationship between employment and labour force participation and severity of mental illness, methodological aspects of the 2007-08 and 2011-12 National Health Surveys may influence the employment and labour force participation rates reported for people with mental illness. The six month duration criterion used to determine the presence of mental illness is likely to exclude people with milder forms of mental illness that resolve within this period. In addition, as with other household surveys, 2007-08 and 2011-12 National Health Survey samples may underrepresent people with more severe mental illnesses.
Indicator 2a: Participation rates by young people aged 16-30 with mental illness in education and employment: General population	**(c)** This indicator estimates the proportion of the Australian population aged 16-30 years with a mental illness who are employed and/or are enrolled for study towards a formal secondary or tertiary qualification. Data for 2011-12 is derived from the 2011-12 National Health Survey.[34] Data for 2007-08 is derived from the 2007-08 National Health Survey.[36] The 2007-08 and 2011-12 National Health Surveys included questions about the respondent's mental health status and participation in employment and education. Mental illness was defined as self-reported mental or behavioural problems lasting six months or more, or which the respondent expects to last for six months or more. Respondents were classified as employed if they had a job or business, or undertook work without pay in a family business for a minimum of one hour per week, or if they were absent from a job/business. Respondents were classified as participating in education if they were currently enrolled, whether full-time or part-time, in secondary school, university/ other higher education, TAFE/technical college, business college, industry skills centre, or other relevant educational institution. Enrolment in adult education courses, hobby and recreation courses were excluded. The data collected from these surveys enables comparison between the employment and education rates for people with and without a mental illness. The data have been age-standardised to enable comparison between 2007-08 and 2011-12. **(d)** As per note **(b)**.

Indicator(s)	Notes
Indicator 3: Rates of stigmatising attitudes within the community	**(e)** This indicator reports average scores on a measure of social distance. Social distance is the degree of closeness people are comfortable with in relation to particular groups, such as individuals with mental disorders. The desire for social distance is recognised as one component of the stigmatising attitudes and beliefs directed towards people with mental disorders.[82] Social distance has been measured in the National Surveys of Mental Health Literacy and Stigma conducted in 2003-04 and 2011. These surveys assessed rates of stigmatising attitudes in Australia using measures of social distance, which are indicators of the willingness of Australians to interact with people suffering from a range of mental disorders, in a variety of situations. In these surveys, respondents were read one of four vignettes describing a male ('John') or female ('Jenny') with depression, depression with suicidal thoughts, early schizophrenia and chronic schizophrenia. In 2011, social phobia and post-traumatic stress disorder were also included. Respondents were asked to rate their willingness to : (1) live next door to John/Jenny; (2) spend the evening socialising with John/Jenny; (3) make friends with John/Jenny; (4) work closely with John/Jenny; and (5) have John/Jenny marry into their family. Each of these five items was rated on a scale ranging 1 ('definitely willing') to 4 ('definitely unwilling'). A 'social distance' score was calculated by summing the ratings for each of the 5 items (maximum score 20).[45 46 83]
Indicator 4: Percentage of mental health consumers living in stable housing	**(f)** Data on a range of outcomes for consumers of state and territory public sector mental health services are collected via the National Outcomes and Casemix Collection (NOCC).[78] The majority of the instruments in the NOCC suite assess clinical outcomes like severity of symptoms and level of functioning, but a new measure of social inclusion is currently under development. Known as the Living in the Community Questionnaire (LCQ), this measure will be completed by consumers and will assess participation in various life domains. It will include an emphasis on stability of housing, which will ultimately inform this indicator. For now, proxy data on this indicator are taken from the Health of the Nation Outcome Scales (HoNOS) for adults (aged 15-64) and the HoNOS65+ for older adults (aged 65+). The HoNOS and HoNOS65+ are core clinician-rated instruments in the NOCC suite of measures. These measures are administered routinely at selected points during episodes of care in state and territory public sector mental health services. Item 11 on these instruments is concerned with problems with living conditions and is scored from 0 (no problem) to 4 (severe to very severe problem). The percentage of consumers scoring 0 on admission to episodes of inpatient, ambulatory and residential care is taken as a proxy for the percentage of consumers living in stable housing. These data provide an indicator of the housing status of consumers but should be interpreted with caution for several reasons. Item 11 on the HoNOS and HoNOS65+ relies on the clinician knowing the living circumstances of the consumer and is not optimally completed.
Priority area 2: Prevention and early intervention	
Indicator 6: Proportion of primary and secondary schools with mental health literacy component included in curriculum	**(g)** It was originally intended that data from Kidsmatter and MindMatters routinely collected by the Australian Government Department of Health and Ageing (DoHA) could be used to assess progress against this indicator. However, practical and conceptual issues prevented this. Firstly, only relatively basic data is captured on Kidsmatter and MindMatters. Secondly, these programs offer organising frameworks for mental health literacy rather than providing specific curriculum content, making it difficult for routinely collected data regarding these programs to gauge the extent and nature of curriculum developments. More importantly, while MindMatters and Kidsmatter are funded by the Australian Government, there are other mental health frameworks used by schools that would not be captured through DoHA's reporting arrangements. For this reason, Australian Government funding was provided to expand the Principals Australia's National Market Research Survey in 2011[50] to collect specific data to inform this indicator, at least as an interim measure. The mental health questions in the survey included the following filter question which forms the basis of this indicator: "Does your school currently: • Have mental health frameworks implemented and in use (for example, Kidsmatter, MindMatters etc.) – followed with a question on specific details • Provide mental health programs for staff, students or parents – followed with a question on specific details • Have mental health literacy resources that can be accessed by teachers and students (for example,specific printed material, web resources to online services, use computer programs etc.)".

Indicator(s)	Notes
Indicator 7: Rates of contact with primary mental health care by children and young people	**(h)** Data on the number of children and young people receiving relevant Medicare-funded services are provided by the Australian Government Department of Health and Ageing, based on Medicare Benefits Schedule data.[74] Relevant services relate to Medicare item numbers covering: consultations with private psychiatrists, consultations with GPs for mental health specific services (i.e., GP-related Better Access item numbers and a small number of other relevant item numbers, but not item numbers related to general consultations), and consultations with allied health professionals (i.e., Better Access and Enhanced Primary Care Strategy item numbers covering services provided by psychologists, social workers and occupational therapists). Data are based on the year in which the Medicare claim was processed, not the year in which the service was rendered.
Indicator 8: Rates of use of licit and illicit drugs that contribute to mental illness in young people	**(i)** Data for this indicator come from the National Drug Strategy Household Surveys.[77] These surveys provide insights into whether patterns of drug and alcohol misuse by young people have changed over time. The survey has undergone some methodological changes over time with, for example, a computer-assisted telephone interview being dropped in 2010 in favour of self-completion booklets. Data on alcohol use are presented here from all surveys from 2001 onwards, and data on cannabis and amphetamine use are presented from all surveys from 1998 onwards.
Indicator 9: Rates of suicide in the community	**(j)** The data for Figure 55 were sourced from the Australian Bureau of Statistics Causes of Death, Australia, 2011, report. Figure 56 is based on recent unpublished data provided by the Australian Bureau of Statistics. The 2007-11 figures vary slightly from those presented in Figure 55 due to a different upper age group being used in the calculation of each rate.[53] Until recently, the cause of death data for a given year were finalised by the ABS at a particular point in time, and cases that were still under investigation by the coroner in the relevant year were not reflected in the statistics for that year, even if they were subsequently judged by the coroner to be suicides. Recently, this anomaly has been rectified and now when cause-of-death determinations for a given year are forwarded from coroners, the ABS updates data from previous years. However, this improved method will only be applied to deaths registered after 1 January 2006, which means that data in very recent years and data from pre-2007 is likely to represent something of an undercount.[53] The causes of death data reported for 2006, 2007 and 2008 have undergone revisions and are now considered final. Causes of death data for 2009 and 2010 have been revised and are subject to further revisions. Causes of death data for 2011 are preliminary and subject to a revision process.[53]
Indicator 11: Rates of understanding of mental health problems and mental illness in the community	**(k)** This indicator reports the percentage of adults who accurately recognise a range of mental disorders. Accurate recognition of individual mental disorders is one indicator of mental health literacy.[57] Data for this indicator come from the National Surveys of Mental Health Literacy and Stigma, conducted in 1995, 2003-04 and 2011.[44] These surveys have used a vignette-based approach to investigate the ability of the Australian population to accurately identify a variety of mental disorders. Respondents were read one of several vignettes describing a male ('John') or female ('Jenny') with depression and early schizophrenia (assessed in all years), and depression with suicidal thoughts and chronic schizophrenia (assessed in 2003-04 and 2011), and social phobia and post-traumatic stress disorder (assessed in 2011). After being presented with the vignette, respondents were asked what, if anything, they thought was wrong with John/Jenny.[45 46 83]

Indicator(s)	Notes
Indicator 12: Prevalence of mental illness	**(l)** Information on the prevalence of common mental disorders among adults comes from the National Surveys of Mental Health and Wellbeing, conducted in 2007[8 9] and 1997.[4] There were several methodological differences between the two surveys which should be taken into account when comparing their findings: • The 1997 survey recruited people aged 18-99, whereas the 2007 survey recruited people aged 16-85. • The 1997 survey had a substantially higher response rate than its 2007 counterpart (78% versus 60%). • The 1997 survey focused on providing prevalence estimates over a 12 month timeframe, whereas the 2007 survey was designed to provide lifetime prevalence estimates and 12 month estimates were derived. • The two surveys used different algorithms to derive diagnoses. **(m)** Information on the prevalence of clinically significant mental health problems among children and adolescents comes from the Child and Adolescent Component of the National Survey of Mental Health and Wellbeing, conducted in 1998.[6] This survey recruited 4,509 children and adolescents aged 4-17 through a household sampling strategy. It elicited information from participants and their parents via interview. A second child and adolescent survey has been commissioned and will collect data from May to December 2013.
Priority area 3: Service access, coordination and continuity of care	
Indicator 13: Percentage of population receiving mental health care	**(n)** Data on the number of unique individuals seen by state and territory community mental health services are based on Department of Health and Ageing analyses of data submitted by jurisdictions. These data are provided by states and territories as person counts. Person counts are confined to those receiving one or more contacts with a community mental health service. This approach picks up most people seen in inpatient services too, since the majority of these would also be seen by a community team. The submitted service contacts are counted, including those delivered 'on behalf' of the consumer (i.e., where the consumer does not directly participate). This approach ensures that the role of state and territory mental health services in providing back-up specialist services to other health care providers is captured. It should be noted that states and territories differ in their capacity to provide accurate estimates of individuals receiving community mental health services because some (South Australia and Tasmania) do not have comprehensive unique identifier or data matching systems. In addition, jurisdictions differ in their approaches to counting individuals in receipt of services. Most record all individuals seen, but some – most notably Victoria – only count the individual once a clinical decision has been made to accept the person for treatment. **(o)** Data on the number of unique individuals receiving relevant Medicare-funded services are based on Department of Health and Ageing analyses of Medicare Benefits Schedule data.[74] Data are based on the year in which the Medicare claim was processed, not the year in which the service was rendered. **(p)** Data on the number of unique individuals seen by state and territory community mental health services and data on the number of unique individuals receiving relevant Medicare-funded services are converted to percentages using population denominator data taken from the 2006 Census. **(q)** Data on the number of people seen by private hospital-based psychiatric services were provided by the Private Mental Health Alliance Centralised Data Management Service. **(r)** Work is underway by the Australian Institute of Health and Welfare to use data linkage to more accurately identify the extent of duplication in consumer counts between state and territory services and MBS-subsidised mental health care. This work is progressing with the assistance of jurisdictions and in compliance with ethical requirements.

Indicator(s)	Notes
Indicator 14: Readmission to hospital within 28 days of discharge	**(s)** Data on 'in scope' separations from state and territory acute psychiatric inpatient units in each financial year are based on Department of Health and Ageing analyses of data submitted by jurisdictions. 'In scope' separations are defined as those for which it is meaningful to examine readmission rates, and exclude, for example, same day separations and overnight separations that occur through discharge/transfer to another hospital. Readmissions are defined as admissions to any public acute psychiatric unit within the given jurisdiction that occur within 28 days of the original discharge. In order to determine whether the same individual was discharged from one unit and readmitted to a different unit, it is necessary for a system of unique identifiers to be in place that allows individuals to be 'tracked' across sites. Such systems have been available in all states and territories for the full period (2005-06 to 2010-11), with the exception of Tasmania (which introduced such a system in 2007-08) and South Australia (which has not yet introduced such a system). The absence of such a system will lead to an undercount of the true readmission rate. Available data do not yet allow a distinction to be made between planned and unplanned readmissions.
Indicator 15: Rates of pre-admission community care	**(t)** Estimates for this indicator are based on Department of Health and Ageing analyses of data submitted by jurisdictions. Each jurisdiction provides data on 'in scope' separations from their acute psychiatric inpatient units in each financial year. 'In scope' separations are defined as those for which it is meaningful to examine rates of pre-admission community care, and exclude, for example, same day separations and overnight separations that occur through discharge/transfer to another hospital. Community mental health contacts are defined as contacts with any public community mental health team within the given jurisdiction that occur within the week before the inpatient admission. Except in the Northern Territory, these contacts are restricted to those in which the consumer participates directly. These may be face-to-face or indirect (for example, by telephone), but do not include those delivered 'on behalf of the consumer'. In order to determine whether the same individual was admitted to an acute inpatient unit and received pre-admission community care, it is necessary for a system of unique identifiers to be in place that allows individuals to be 'tracked' across service settings. Such systems were available in all states and territories for the full period (2005-06 to 2010-11), with the exception of Tasmania and South Australia. The absence of such a system may underestimate the true rate of pre-admission care. Only contacts with state and territory community mental health services are included here. Contacts with other community-based providers (for example, GPs and private psychiatrists) are excluded.
Indicator 16: Rates of post-discharge community care	**(u)** Estimates for this indicator are based on Department of Health and Ageing analyses of data submitted by jurisdictions. Each jurisdiction provides data on 'in scope' separations from their acute psychiatric inpatient units in each financial year. 'In scope' separations are defined as those for which it is meaningful to examine rates of post-discharge community care, and exclude, for example, same day separations and overnight separations that occur through discharge/transfer to another hospital. Community mental health contacts are defined as contacts with any public community mental health team within the given jurisdiction that occur within the week after discharge from the inpatient unit. Except in the Northern Territory, these contacts are restricted to those in which the consumer participates directly. These may be face-to-face or indirect (for example, by telephone), but do not include those delivered 'on behalf of the consumer'. In order to determine whether the same individual was admitted to an acute inpatient unit and received post-discharge community care, it is necessary for a system of unique identifiers to be in place that allows individuals to be 'tracked' across service settings. Such systems were available in all states/territories for the full period (2005-06 to 2010-11), with the exception of Tasmania and South Australia. The absence of such a system may underestimate the true rate of post-discharge care. Only contacts with state and territory community mental health services are included here. Contacts with other community-based providers (for example, GPs and private psychiatrists) are excluded.

Indicator(s)	Notes
Indicator 19: Prevalence of mental illness among homeless populations	**(v)** Data for this indicator is based on analysis of the Supported Accommodation Assistance Program (SAAP) National Minimum Data Set 2005-06 to 2009-10.[81] For the purpose of this indicator, SAAP clients are categorised into four mutually exclusive groups, based on their reasons for seeking assistance: • Those with mental health problems: This includes clients who were: referred from a psychiatric unit; reported psychiatric illness and/or mental health issues as reasons for seeking assistance; were in a psychiatric facility before or after receiving assistance; and/or needed, were provided with or were referred on for support in the form of psychological or psychiatric services. • Those with substance use problems: This includes clients who: reported problematic drug, alcohol and/or substance use as a reason for seeking assistance; and/or needed, were provided with or were referred on for support in the form of drug and/or alcohol support or intervention. • Those with comorbid mental health and substance use problems: This includes clients who reported at least one of the mental health criteria and at least one of the substance use criteria listed above in the same support period. • Other: This includes clients who reported none of the criteria listed above. A client may have more than one support period within a year and their circumstances might vary between support periods. Routinely collected SAAP data are likely to underestimate the true prevalence of mental illness among homeless populations because they focus on clients whose referral to SAAP was associated with these problems. They do not take into account clients who may have underlying conditions that are not directly responsible for the referral. SAAP data have now been replaced with the Specialist Homelessness Services Collection (SHSC). The SHSC is designed to provide more comprehensive data on clients of specialist homelessness services. Options for using the SHSC to assess the achievement of this indicator in future *National Mental Health Reports* are currently being explored.
Indicator 20a: Prevalence of mental illness among people who are remanded or newly sentenced to adult correctional facilities	**(w)** The data for this indicator come from the 2010 National Prisoner Health Census[67 68] which was conducted by the Australian Institute of Health and Welfare. The Census was conducted over a two week period in 44 adult correctional facilities from all jurisdictions except New South Wales and Victoria. Individuals who entered 44 adult correctional facilities from all jurisdictions except New South Wales and Victoria over a two week census period were asked a number of questions, including several about their mental health. Self-reported information on prison entrants' mental health status was sought across three domains: • Mental health history: This was assessed by a single question – 'Have you ever been told by a doctor, psychiatrist, psychologist or nurse that you have a mental health disorder (including drug and alcohol abuse)?' • Current mental health medication: This was also assessed by a single question – 'Are you currently on medication for a mental health disorder?' • Current psychological distress: This was assessed by the Kessler-10 (K-10), which measures non-specific psychological distress.[69] The K-10 comprises 10 items relating to symptoms of depression and anxiety in the past four weeks. Each item is rated from 1 (None of the time) to 5 (All of the time), resulting in a total score that ranges from 10 to 50. Standard cut-off scores for levels of psychological distress are as follows: 10-15 (Low); 16-21 (Moderate); 22-29 (High); ≥30 (Very high).

Indicator(s)	Notes
Priority area 4: Quality improvement and innovation	
Indicator 21: Proportion of total mental health workforce accounted for by consumer and carer workers	**(x)** This indicator measures the proportion of the state and territory mental health workforce who are consumer and carer workers. The data for this indicator are available through the National Minimum Data Set (NMDS) – Mental Health Establishments (MHE).[75] The NMDS-MHE captures information about the size and composition of the mental health workforce, including direct care staff. Direct care staff comprises Consultant psychiatrists and psychiatrists, Psychiatry registrars and trainees, Other medical officers, Registered nurses, Enrolled nurses, Psychologists, Social workers, Occupations therapists, Diagnostic and health professionals, Other personal care, Consumer workers, and Carer workers. FTE counts for consumer and carer workers are only available from 2002–03 onwards. The definition of these categories was modified from 'consultants' to 'mental health workers' for the 2010–11 collection, in order to capture a broader array of consumer and career roles, and this may impact on the figures reported. It is calculated as the number of full-time equivalent consumer and carer worker positions within Australian state and territory public mental health services, over the number of full-time equivalent clinical positions within Australian state and territory public mental health services. A revision of the current, nationally agreed definition of consumer and carer workers is currently being undertaken to improve consistency in how jurisdictions report the variety of arrangements that exist between organisations and consumer and carer workers. The current data collection does not include mental health services managed by non-government organisations. The development of a Mental Health Non-Government Organisation National Minimum Dataset is currently underway, and is it desirable that data to inform this indicator be included in that collection.
Indicator 22: Proportion of services reaching threshold standards of accreditation under the National Mental Health Standards	**(y)** The data for this indicator are available through the National Minimum Data Set (NMDS) – Mental Health Establishments (MHE).[75] The NMDS-MHE captures information about the extent of progress made by specialised mental health service units in implementing the National Standards for Mental Health Services, summarised into categories. The indicator grades services according to four categories: • Level 1—Services that have been reviewed by an external accreditation agency and judged to have met all National Standards for Mental Health Services. • Level 2—Services that have been reviewed by an external accreditation agency and judged to have met some but not all National Standards. • Level 3—Services that are either in the process of being reviewed by an external accreditation agency but the outcomes are not known; or are booked for review by an external accreditation agency. • Level 4—Services that do not meet the criteria detailed under levels 1 to 3. The indicator is based on the expenditure reported for each of the service units accredited at the various levels. This method takes account of the size of the service unit, and the number of service units per jurisdiction, and is therefore considered a more accurate reflection of the proportion of mental health services meeting each level. The current coverage of this indicator excludes service units that are non-government mental health service units and private hospital service units in receipt of government funding where the National Standards for Mental Health Services do not apply. It also excludes aged care residential services subject to Australian Government residential aged care reporting and service standards requirements.

Indicator(s)	Notes
Indicator 23: Mental health outcomes for people who receive treatment from state and territory services and the private hospital system	**(z)** Data for this indicator come from the National Outcomes and Casemix Collection (NOCC)[78] and the Private Mental Health Alliance.[80] For the purposes of this indicator, assessment of clinical outcomes is based on the clinician-rated Health of the Nation Outcome Scales (HoNOS), and its equivalents for children and adolescents (HoNOSCA) and older people (HoNOS65+). All three comprise items that collectively cover the sorts of problems that may be experienced by people with a mental illness. Each item is rated from 0 (no problem) to 4 (very severe problem), resulting in individual item scores, subscale scores and a total score. HoNOS/HoNOSCA/HoNOS65+ data for consumers of state and territory public sector mental health services are collected via the National Outcomes and Casemix Collection (NOCC) and analysed by the Australian Mental Health Outcomes and Classification Network (AMHOCN). Equivalent data for consumers seen in private psychiatric hospital units are collected and analysed by the Private Mental Health Alliance's Centralised Data Management Service. Outcomes according to the HoNOS family of measures are considered for four cohorts of consumers who received episodes of care during 2010-11. Outcome scores are calculated differently for these groups, depending on the setting and the duration of the episode of care: • Those discharged from hospital in both the public and private sector include people who had an inpatient admission that began and ended during the 2010-11 year and lasted at least three days. Outcome scores for these groups are calculated as the difference between the total HoNOS/HoNOSCA/HoNOS65+ scores recorded at admission to and discharge from inpatient care. • Those discharged from community care in the public sector include people who received an episode of community care that began and ended in 2010-11. Outcome scores for this group are calculated as the difference between the total HoNOS/HoNOSCA/HoNOS65+ scores recorded at admission to and discharge from community care. • Those in ongoing community care in the public sector include people who were receiving community care for the whole of 2010-11 and those who commenced community care some time after 1 July 2010 and continued to receive care for the rest of the year. The defining characteristic for this group is that all were still in ongoing care when the year ended (30 June 2011). Outcome scores for this group are calculated as the difference between the total HoNOS/HoNOSCA/HoNOS65+ scores recorded on the first and last occasions rated during the year. In each case, outcome scores are classified based on 'effect size'. 'Effect size' is a statistic used to measure the magnitude of a treatment effect. It is based on the ratio of the difference between pre- and post- scores to the standard deviation of the pre-score. As a rule of thumb, effect sizes of 0.2 are considered small, 0.5 are considered medium, and 0.8 are considered large. Based on this rule, a medium effect size of 0.5 is used to assign outcome scores to categories – an effect size of greater than or equal to +0.5 equates to 'significant improvement', an effect size of -0.5 to +0.5 equates to 'no change', and an effect size of less than or equal to -0.5 equates to 'significant deterioration'. The denominator in the analysis for each of the four cohorts is 'valid' episodes of care. To be considered valid, the episode had to have sufficiently complete HoNOS/HoNOSCA/HoNOS65+ data that total scores could be calculated at its beginning and end. It has been estimated that valid 2010-11 data were available for 34% of public sector inpatient episodes, 23% of public sector community episodes, and 80% of private sector inpatient episodes. It should be noted that, except in the case of ongoing community episodes, an individual may have had more than one episode during 2010-11 so the data represent episode-counts, rather than person-counts. This means that some individuals may appear more than once within a given group. Data coverage has been estimated at around one third of potential inpatient episodes and around one quarter of community care episodes. Coverage varies widely across jurisdictions. Changes in coverage may change the pattern of results.

Appendix 3: Highlights regarding progress of actions under the *Fourth National Mental Health Plan*

Table A3-1
Highlights of actions under Priority area 1 – Social inclusion and recovery

Action		Summary of highlights of progress
2	Coordinate the health, education and employment sectors to expand supported education, employment and vocational programs which are linked to mental health programs.	**Stocktake of supported employment and education activities:** A national stocktake of existing supported employment and education activities that are linked to mental health programs is being finalised.
4	Adopt a recovery oriented culture within mental health services, underpinned by appropriate values and service models.	**National Mental Health Recovery Framework:** A project to develop a National Mental Health Recovery Framework is being finalised. The Framework is intended to support implementation of recovery oriented culture in all mental health services. **National Recovery Forum:** An inaugural National Recovery Forum was held in June 2012. Three international experts gave keynote addresses. This enabled exchange about the implementation of a recovery oriented culture, and provided an opportunity to promote the development of the National Mental Health Recovery Framework.
5	Develop integrated programs between mental health support services and housing agencies to provide tailored assistance to people with mental illness and mental health problems living in the community.	**Intersectoral linkages:** The implementation of Actions 5 and 6 has been combined as a single process. An implementation approach has been endorsed and a Working Group was established in early 2013.
6	Develop integrated approaches between housing, justice, community and aged care sectors to facilitate access to mental health programs for people at risk of homelessness and other forms of disadvantage.	**Intersectoral linkages:** The implementation of Actions 5 and 6 has been combined as a single process. An implementation approach has been endorsed and a Working Group was established in early 2013.
7	Lead the development of coordinated actions to implement a renewed Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework.	**Renewal of the Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework:** A Working Group was established in March 2012 and a request for tender issued to engage a contractor to work with the Working Group to renew the Aboriginal and Torres Strait Islander Social Emotional Wellbeing Framework. The Working Group has begun to review the previous framework to identify gaps, achievements and changes that should be considered in renewing the Framework. A discussion paper will be developed and jurisdictional consultations will occur.

Table A3-2
Highlights of actions under Priority area 2 – Prevention and early intervention

Action		Summary of highlights of progress
9	Implement targeted prevention and early intervention programs for children and their families through partnerships between mental health, maternal and child health services, schools and other related organisations.	**Mapping child mental health services:** Work has commenced to progress the mapping of existing child mental health services and to identify existing links and possible gaps in the service provision.
10	Expand community based youth mental health services which are accessible and combine primary health care, mental health and alcohol and other drug services.	***headspace*:** Funding was provided in the 2011-12 Federal Budget for 90 fully sustainable headspace sites across Australia by 2014-15. 70 sites have been announced, and 40 are currently operational. When fully established, these sites will help up to 72,000 young people each year.
11	Implement evidence based and cost effective models of intervention for early psychosis in young people to provide broader national coverage.	**Early psychosis youth centres:** In addition to the expansion of the headspace program (see above), the 2011-12 Federal Budget also allocated $222.4 million over five years for up to 12 early psychosis youth centres across the country, based on the Early Psychosis Prevention and Intervention Centre model. This builds on a 2010-11 Budget measure that provided $25.5 million over four years to establish up to four sites, bringing the total number of sites to be funded to 16.

Action		Summary of highlights of progress
12	Provide education about mental health and suicide prevention to front line workers in emergency, welfare and associated sectors.	**Review of the National Suicide Prevention Working Group:** In May 2012, the Mental Health Standing Committee agreed to review the terms of reference, role and membership of the National Suicide Prevention Working Group, with a view to determining its capacity to progress this action and providing it with direction on priorities for the next 12 months. The National Suicide Prevention Working Group's last meeting was held in October 2012. This action now sits under the remit of the Mental Health Drug and Alcohol Principal Committee.
13	Coordinate state, territory and Australian Government suicide prevention activities through a nationally agreed suicide prevention framework to improve efforts to identify people at risk of suicide and improve the effectiveness of services and support available to them.	**Overarching framework for suicide prevention activity:** In September 2011, the Living Is For Everyone (LIFE) Framework was endorsed by the Australian Health Ministers Advisory Council as the national overarching framework for suicide prevention activity in Australia. The LIFE Framework provides evidence based priorities, actions and strategies for suicide prevention in Australia.

Table A3-3
Highlights of actions under Priority area 3 – Service access, coordination and continuity of care

Action		Summary of highlights of progress
16	Develop a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models.	**National Mental Health Service Planning Framework:** A project to develop a National Mental Health Service Planning Framework (NMHSPF) commenced in 2011 and is expected to be completed in 2013. Expert working groups comprising service providers, researchers, consumers, carers and people with service planning expertise are informing the development and refinement of a classification of mental health service elements and packages of care.
22	Better target services and address service gaps through cooperative and innovative service models for the delivery of primary mental health care.	**Resources for primary mental health care initiatives:** The 2011-12 Federal Budget allocated resources to address service gaps in the delivery of primary mental health care, including doubling funding for the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care program, and providing new funding for the Partners in Recovery program.

Table A3-4
Highlights of actions under Priority area 4 – Quality improvement and innovation

Action		Summary of highlights of progress
23	Review the Mental Health Statement of Rights and Responsibilities.	**Review of the Mental Health Statement of Rights and Responsibilities:** Led by the Safety and Quality Partnership Subcommittee, a project to review the Mental Health Statement of Rights and Responsibilities commenced in the first half of 2011. Following national consultation processes, the revised Draft Statement was endorsed by Health Ministers in late 2012 and publicly released in early 2013.
24	Review and where necessary amend mental health and related legislation to support cross-border agreements and transfers of people under civil and forensic orders, and scope requirements for the development of nationally consistent mental health legislation.	**Review of mental health and related legislation:** A working group was formed and an implementation approach and work plan were endorsed but unable to be progressed due to capacity issues.

Action		Summary of highlights of progress
25	Develop and commence implementation of a National Mental Health Workforce Strategy that defines standardised workforce competencies and roles in clinical, community and peer support areas.	**National Mental Health Workforce Strategy and Plan:** The Mental Health Workforce Advisory Committee (MHWAC) progressed the development of the National Mental Health Workforce Strategy and an accompanying National Mental Health Workforce Plan which were endorsed by Australian Health Ministers in September 2011. The Strategy and Plan provide an overarching framework for the ongoing development of the mental health workforce in Australia. A national implementation strategy is currently being developed. **National Practice Standards for the Mental Health Workforce:** MHWAC and Health Workforce Australia commenced a project in early 2012 to review the National Practice Standards for the Mental Health Workforce and to develop mental health core competencies. It is expected that the review of the Practice Standards will be completed in 2013, but that the work on standardised mental health competencies will continue.
27	Ensure accreditation and reporting systems in health and community sectors incorporate the National Standards for Mental Health Services.	**Mapping the National Safety and Quality Health Service Standards to the National Standards form Mental Health Services:** In 2011, the Australian Commission on Safety and Quality in Healthcare (ACSQHC) and the Safety and Quality Partnership Subcommittee mapped the draft National Safety and Quality Health Service Standards (NSQHSS) to the National Standards for Mental Health Services (NSMHS). The work explored ways to facilitate a single review process that avoids duplication and satisfactorily meets both the NSQHSS and the NSMHS accreditation standards. **Accreditation workbook:** Collaborative work continued in 2012 on an accreditation workbook to enable mental health service organisations to focus their quality improvement activities within the NSQHSS and NSMHS frameworks. The workbook was made available for trailing and consultation purposes via the ACSQHC website in January 2013.
28	Further develop and progress implementation of the National Mental Health Performance and Benchmarking Frameworks.	**Key Performance Indicators for Australian Mental Health Services:** Ongoing review of the National Key Performance Indicators for Australian Mental Health Services resulted in a second edition being published in May 2011. The technical specifications of this edition are currently being reviewed and it is anticipated that a third edition will be published in 2013. The focus will remain on public sector mental health services, however, it is envisaged that continued data development over time will enable the National Mental Health Performance Framework to be utilised in the broader mental health sector. ***Fourth National Mental Health Plan* Measurement Strategy:** Extensive collaborative work to describe the underlying technical details of the 25 *Fourth Plan* indicators resulted in the publication of the *Fourth National Mental Health Plan Measurement Strategy* in May 2011. The *Measurement Strategy* provides a high-level overview of the indicators and targets (where appropriate), details on indicator specifications and planned developments. **National support for benchmarking in Australian public mental health services:** A range of concepts for nationally-coordinated benchmarking activities for specialised mental health service organisations are being considered. These include developing a data repository for the reporting of national benchmarks; and establishing online benchmarking forums for unique mental health services (across Australia) that have insufficient critical mass to create relevant peer groups for reviewing and comparing performance. **Development of nationally consistent promotional material for use by states and territories:** A series of 'non-technical' fact sheets is being developed to promote the national key performance indicators and the range of performance measurement information available to the mental health sector. It is anticipated that the first set of fact sheets will be available in 2013.

Action		Summary of highlights of progress
29	Develop a national mental health research strategy to drive collaboration and inform the research agenda.	**Stocktake of mental health research efforts:** A stocktake on current mental health research efforts was completed in mid-2012. National Health and Medical Research Council investment: The National Health and Medical Research Council (NHMRC) held two workshops on 'developing a more evidence-based mental health system' which informed the 2011-12 Federal Budget allocation of $26.2 million over 5 years across three areas: (1) a targeted call for research focusing on prevention and early intervention in mental illness in children and young people; (2) three mental health centres of research excellence focusing on suicide prevention, substance abuse and better mental health planning; and (3) and the new John Cade Fellowship in Mental Health Research.
30	Expand and better utilise innovative approaches to service delivery including telephone and e-mental health services.	**Mental health portal:** The 2011-12 Federal Budget included funding for the development of a national mental health portal. Stage 1 of the portal – mindhealthconnect: your pathway to a healthy mind – was launched in July 2012 and provides access to a range of trusted, high quality online information and self-help programs from Australia's leading mental health organisations. The National Health Call Centre Network is hosting the portal. Continued development of the portal will examine the capability to refer to local services through the National Health Call Centre's services directory, along with other functionality. **Stocktake of e-mental health activities:** State and territory governments have also invested in e-mental health activities. A stocktake of e-mental health activities was undertaken in the first half of 2012, with the aim of informing decisions about further effective expansion and innovation of mental health services into the online environment.

Table A3-5
Highlights of actions under Priority area 5 – Accountability

Action		Summary of highlights of progress
31	Establish comprehensive, timely and regular national reporting on the progress of mental health reform which responds to the full range of stakeholder needs.	***Fourth National Mental Health Plan Measurement Strategy:*** In May 2011, the first edition of the *Fourth National Mental Health Plan Measurement Strategy* which proposed data sources, specifications and targets for the *Fourth Plan* progress indicators was released. ***COAG National Action Plan on Mental Health Annual Progress Report:*** The *Fourth Progress Report* – covering implementation to 2009-2010 – was published in July 2012. ***Mental Health Services in Australia:*** The Australian Institute of Health and Welfare has sought to make this publication and the data that underlie it more readily accessible. An online version of the report was launched in October 2011 and repeated in October 2012, as was a summary snapshot of the key findings. The data were presented via a range of media, including an interactive data portal. ***National Mental Health Report:*** In June 2012, the revised outline and structure of future *National Mental Health Reports* was endorsed and work began on the production of the current report.
32	Build an accountable service delivery system that monitors its performance on service quality indicators and makes this information available to consumers and other stakeholders.	**Public reporting:** The Mental Health Information Strategy Standing Committee (MHISSC) established a Public Reporting Working Group to develop recommendations on how to implement the *Fourth Plan's* commitment to public reporting. In May 2011, a report for this group was finalised. The report included a literature review, recommendations regarding the introduction of public performance reporting by state and territory mental health services, and a broader consultation strategy.

Action		Summary of highlights of progress
33	Further develop mental health information, including national mental health data collections, that provide the foundation for system accountability and reporting.	**Mental Health Non-Government Organisation Establishments National Minimum Data Set (MH NGOE NMDS) Project:** In February 2011, the Australian Institute of Health and Welfare (AIHW) commenced the MH NGOE NMDS Project, which aims to collect nationally consistent information about the mental health NGO sector. The AIHW, in collaboration with the MH NGOE NMDS Working Group, developed draft specifications and data collection manual which includes a mental health NGO service taxonomy and definitions of service types in the taxonomy. The AIHW is now consulting with relevant funders to confirm that the MH NGOE NMDS is 'fit for purpose' and that jurisdictions are able to map their MH NGO activities to the NGO service taxonomy. **Development of a carer (family inclusiveness) measure:** The Australian Mental Health Outcomes and Classification Network (AMHOCN) commenced work to develop a measure of carers' experiences of the family inclusiveness of mental health care. A literature review identified that the carer version of the Victorian Consumer and Carer Experiences Questionnaires (C&CEQ) was suitable for trialing but required some modification. AMHOCN's next step is to modify the C&CEQ and pilot the revised measure. **Development of the Living in the Community Questionnaire:** AMHOCN, in collaboration with a Technical Advisory Group, commenced work to develop a consumer self-report measure that focuses on the social inclusion aspects of recovery. A draft of instrument known as the Living in the Community Questionnaire (LCQ) was produced and underwent 'proof of concept' testing during 2011. Further development of the LCQ occurred on the basis of feedback in early 2012, and field trials of the latest instrument began in early 2013. **Measuring consumers' experiences of their care:** Under the auspices of the Mental Health Information Strategy Standing Committee (MHISSC), the Victorian Department of Health commenced work on a project to develop a national mental health Consumer Experiences of Care (CEoC) tool, to measure the degree to which consumers are involved and engaged in their care as well as the quality of that care. A draft CEoC tool has been completed and a national 'proof of concept' trial and an evaluation of the tool were completed in the second half of 2012. Further work to test the reliability of the instrument was completed in June 2013. **Mental Health Intervention Classification:** The AIHW developed and conducted a pilot study of a mental health interventions classification to be used in specialist mental health services. The classification was endorsed by MHISSC for voluntary implementation by jurisdictions. **Review of the National Outcomes and Casemix Collection (NOCC):** A review of the data collected by Australian public sector mental health services under NOCC commenced in 2012. Known as the NOCC Strategic Directions 2014-24 Project, this review will document the implementation of NOCC to date and develop recommendations for further development of NOCC.
34	Conduct a rigorous evaluation of the *Fourth National Mental Health Plan*.	**Evaluation Framework for the *Fourth National Mental Health Plan:*** An external contractor was funded to develop an evaluation framework for the evaluation of the *Fourth Plan.*

Appendix 4: Data sources and explanatory notes for Part 4

Introduction

The following notes have been prepared to assist in the interpretation of the tables and figures describing state and territory performance in Part 4 Profiles of state and territory reform progress (Tables NSW1 to NT1, and Figures NSW1 to NT18).

Information about the data sources used is provided in Table A4·1. Further explanatory detail regarding the derivation of each indicator is provided, where necessary, in Table A4·2. The majority of figures and data reported in the tables in Part 4 are derived from tables published in the Australian Institute of Health and Welfare's Mental Health Services in Australia (MHSiA)[22] series of annual mental health reports that describe the activity and characteristics of Australia's mental health care services. MHSiA presents analyses of data from a range of sources including, but not limited to, the Mental Health Care National Minimum Data Sets (NMDSs). These NMDSs cover specialised community and residential mental health care, mental health care for patients admitted to public and private hospitals, and the facilities providing these services. In many cases the data can be extracted directly from component tables of the MHSiA report. In some cases the data have been subject to additional analyses which may have been supplemented by unpublished data.

Data sources and explanatory notes

Table A4·1
Overview of data sources, in alphabetical order.

Data source	Description	Relevant figures and table rows
Australian Government analyses of jurisdiction data	See Appendix 1, Table A1-1.	Figures 1-12, 14, 16 Table sections A-E, G
Australian Government analyses of mental health program data	See Appendix 1, Table A1-1.	Figure 1 Tables sections A, H
Medicare Benefits Schedule data	See Appendix 1, Table A1-1.	Figure 13; Table section H
National Minimum Data Set (NMDS) – Mental Health Establishments (MHE) collection 2005–06 to 2010–11	See Appendix 1, Table A1-1.	Figures 1-7, 11, 16-17 Table sections A-G
National Outcomes and Casemix Collection	See Appendix 2, Table A2-1.	Figures 15, 18
Pharmaceutical Benefits Scheme and Repatriation Pharmaceutical Benefits Scheme data	Medicare Australia collects data on prescriptions funded through the Pharmaceutical Benefits Scheme (PBS) and Repatriation Pharmaceutical Benefits Scheme (RPBS).[86]	Table section I

Table A4-2
Explanatory notes to Tables NSW1 to NT1.

Indicator(s)	Notes
A. State and territory government expenditure	
State spending on mental health services State spending per capita Per capita spending rank	**(a)** Data source: MHSiA Table 14.30. State and territory expenditure estimates used for each of these indicators are based on overall spending by the state or territory government, which should be distinguished from spending in the state or territory. Spending by the state or territory is calculated as total spending on mental health services administered by the state or territory government, less Australian Government contributions made through National Mental Health Strategy grants and payments by the Department of Veterans' Affairs. As a result of these exclusions, total state or territory expenditure is in all cases less than the total actual amount spent on mental health services in the state or territory.
Average annual per capita spending growth since preceding milestone year	**(b)** Data source: MHSiA Table 14.30. As per the indicators described in note **(a)** above, average annual per capita spending growth indicators are based on overall spending by the state or territory government and exclude the specified Australian Government contributions. Spending growth is reported for two periods: • 2007-08: Average annual growth presented here refers to growth over the period of the *First, Second* and *Third National Mental Health Plans*, i.e., over the 15 year period 1993-94 to 2007-08. • 2010-11: Average annual growth presented here refers to growth over the period of the *Fourth National Mental Health Plan*, i.e., over the three years 2008-09 to 2010-11.
B. Service mix	
% total service expenditure - community services % total service expenditure – stand-alone psychiatric hospitals % total service expenditure - colocated general hospitals	**(c)** Data source: MHSiA Table 14.3. In contrast to the above indicators, these indicators are based on all recurrent amounts reported by the state or territory government in these service categories, regardless of funding source. The estimates therefore include Australian Government funds which are excluded in the indicators described at note **(a)** above. Calculation of percentages excludes from the denominator state and territory residual indirect expenditure (i.e., indirect expenditure that is not apportioned to services). Estimates of the percentage of service expenditure on community services include three categories of services: Ambulatory care, community residential and non-government services.
C. Inpatient services	
Total hospital beds	**(d)** Data source: MHSiA Table 12.13. Refers to total number of hospital-based psychiatric inpatient beds reported as available at 30 June of each of the respective years.
Per capita expenditure on inpatient care	**(e)** Data source: MHSiA Table 14.4. This indicator is based on total expenditure (constant 2010-11 prices) reported by state and territory-administered psychiatric inpatient services, regardless of source of funds.

Indicator(s)	Notes
Inpatient beds per 100,000 Acute inpatient beds per 100,000 Non-acute inpatient beds per 100,000	**(f)** Data source: MHSiA Table 12.14. Estimates of Acute inpatient beds include acute beds in Public psychiatric hospitals plus Specialised psychiatric units or wards in public acute hospitals. Estimates of Non-acute inpatient beds include non-acute beds in Public psychiatric hospitals plus Specialised psychiatric units or wards in public acute hospitals.
Stand-alone hospitals as % of total beds	**(g)** Data source: MHSiA Table 12.13.
Average cost per patient day	**(h)** Data source: MHSiA Table 14.7. All costs exclude depreciation.
D. Community services	
Ambulatory, NGO and Residential services - % total service expenditure	**(i)** Data sources: MHSiA Table 14.3, supplemented by Table 14.10 (expenditure on residential services used to calculated NGO expenditure). These indicators represent the ambulatory, NGO and residential components of expenditure on community services shown earlier in the table, and described in note **(c)** above. All expenditure reported by services is counted and includes Australian Government funds. Calculation of percentages excludes from the denominator state and territory residual indirect expenditure (i.e., indirect expenditure that is not apportioned to services). **(j)** 'NGO % total service expenditure' includes funding to staffed community residential services managed by non-government organisations, to give a more accurate estimate of non-government allocations by each jurisdiction and to ensure consistency in monitoring the 18 year spending trends. As these amounts are also included in the indicator 'Residential % total service expenditure', the total percentage of expenditure shown for residential, ambulatory and NGO services is greater than the amount shown in the indicator '% total service expenditure – community services' described in note **(c)** above.
Ambulatory, NGO and Residential services - per capita expenditure	**(k)** Data source: MHSiA Table 14.4 with the exception that NGO per capita expenditure includes staffed community residential services managed by non-government organisations (see MHSiA Table 14.10). These amounts are also counted in the indicator 'Residential services per capita expenditure'. As per note **(j)** above.
Residential services - Adult beds (24 hour staffed) per 100,000; Adult beds (non-24 hour) per 100,000 ; Older persons' beds (24 hour staffed) per 100,000; Adult beds (non-24 hour) per 100,000	**(l)** Data source: MHSiA Table 12.20. Estimates of per capita rates are based on age specific populations - Adult beds per 100,000 calculated using population aged 18-64 years; Older persons' beds calculated using population aged 65 years and over.
Supported public housing places per 100,000	**(m)** Data source: MHSiA Table 12.26. Per capita rates are calculated using total populations within each jurisdiction.

Indicator(s)	Notes
E. Direct care workforce	
Number Full-time Equivalent (FTE) staff FTE per 100,000 FTE per 100,000 - ambulatory services	**(n)** Data source: MHSiA Tables 12.40 and 12.41. FTE indicators presented in the state and territory tables are based on 'direct care' staff, covering the following occupational groups: Nursing, Medical, Diagnostic and Health Professionals and Other Personal Care Staff. FTE reported under the categories of Administrative and Clerical and Domestic and Other are excluded from the analysis. Data used for constructing these indicators are based only on staffing reported for each of the three service settings (inpatient, residential, ambulatory) and therefore exclude staff not reported against a specific service setting.
F. Implementation of National Service Standards	
% service expenditure covered by Level 1 services	**(o)** Data source: MHSiA Table 12.12.
G. Consumer and carer participation	
% services with Level 1 consumer committee representation	**(p)** Data source: MHSiA Table 12.8. As this information only commenced in 1993-94, data for that year is substituted in the 1992-93 column as an approximation of the pre-Strategy baseline.
% total mental health workforce account for by – consumers; carers	**(q)** Data source: MHSiA Table 12.36. Calculation of percentages excludes from the denominator non-direct care staff categories (i.e., Administrative and clerical staff, and Domestic and other staff).
H. Medicare-subsidised mental health services	
% population seen – all MBS funded providers (Psychiatrists, GPs, allied health)	**(r)** Data source: Medicare Benefits Schedule data. This indicator is based on a unique count of persons receiving one or more services provided under any of the Medicare-funded service streams described at (s) to (v) below. Persons seen by more than one provider stream are counted only once. All Medicare funded data are based on year of processing (i.e., date on which a Medicare claim was processed by Medicare Australia), not when the service was rendered. A significant component of the data includes services provided under the Australian Government Better Access to Mental Health Care initiative, which commenced on 1 November 2006. Comparable full year estimates are not available for years prior to 2007-08.
% population seen – GPs	**(s)** Data source: Medicare Benefits Schedule data. General practitioner data represents a unique count of people who received one or more general practitioner attendance items, billed to Medicare Australia, that are mental health specific. These are predominantly items under the Better Access to Mental Health Care initiative (available 1 November 2006 onwards) plus a small number of other items that were created in years preceding the introduction of the Better Access initiative. A small proportion of this latter group may also be provided by other medical practitioners. The count does not include people receiving GP-based mental health care that was billed as a general consultation.
% population seen – Consultant Psychiatrists	**(t)** Data source: Medicare Benefits Schedule data. Consultant psychiatrist data represents a unique count of people seen who received one or more consultant psychiatrist attendance items billed to Medicare Australia.

Indicator(s)	Notes
% population seen – Clinical Psychologists	**(u)** Data source: Medicare Benefits Schedule data. Clinical psychologist data represents a unique count of people who received one or more Clinical Psychologist attendance items, billed to Medicare Australia, as introduced under the Better Access to Mental Health Care initiative. As noted above, these commenced in 1 November 2006.
% population seen – Registered Psychologists and Other allied health professionals	**(v)** Data source: Medicare Benefits Schedule data. Registered Psychologists and Other allied health data represents a unique count of people who received one or more attendance items provided by Registered Psychologists, Social Workers or Occupational Therapists, billed to Medicare Australia, as introduced under the Better Access to Mental Health Care initiative. The person count also includes a small number of services provided by allied health professionals provided under the Enhanced Primary Care Strategy, introduced in the MBS in 2004.
Total MBS mental health related benefits paid per capita	**(w)** Data source: MHSiA Table 14.18. This indicator is based on total MBS rebates paid in relation to Medicare-funded service streams described at (s) to (v) above. 1992-93 is marked 'n.a.' because it is not possible to identify the GP component at state/territory level prior to 2006-07.
I. PBS-funded pharmaceuticals (including RPBS)	
Total PBS/RPBS benefits paid per capita	**(x)** Data source: MHSiA Table 14.27. Indicators of the utilisation of Australian Government-funded psychiatric medicines, subsidised through the Pharmaceutical Benefits Schemes, is included in each table to provide further context for interpreting differences between the states and territories. This indicator counts Australian Government benefits for psychiatric medication in each of the relevant years, in the following classes of the Anatomical Therapeutic Chemical Drug Classification system: antispychotics (except prochloperazine); anxiolytics; hypnotics and sedatives; psychostimulants; and antidepressants. In addition, expenditure on Clozapine, funded under the Highly Specialised Drugs program, has been included for all years, requiring adjustment to historical data. This indicator covers both the Pharmaceutical Benefits Scheme and the Repatriation Pharmaceutical Benefits Scheme.

Table A4-3
Explanatory notes to Figures NSW1 to NT18.

Indicator	Notes
Figure 1. Overall spending on mental health	**(y)** Data source: MHSiA Table 14.30.
Figure 2. Change in spending mix	**(z)** Data source: MHSiA Table 14.4.
Figure 3. Changes in inpatient services	**(aa)** Data sources: MHSiA Tables 12.13 (inpatient beds), 12.27 (inpatient days), 12.40 (clinical FTE) and 14.3 (expenditure). Growth in total inpatient services is calculated as the sum of Public psychiatric beds plus Specialised psychiatric units or wards in public acute hospitals (Table 14.3). FTE is for Hospital admitted patient services (Table 12.40).
Figure 4. Changes in ambulatory care	**(ab)** Data sources: MHSiA Tables 14.3 (expenditure) and 12.40 (clinical FTE).
Figure 5. Direct care workforce	**(ac)** Data source: MHSiA Table 12.41.
Figure 6. Inpatient and residential beds	**(ad)** Data sources: MHSiA Tables 12.14 (total acute and non-acute inpatient beds) and 12.20 (residential beds). **(ae)** Acute and non-acute bed totals are each calculated as the sum of Public psychiatric beds plus Specialised psychiatric units or wards in public acute hospitals. Residential beds includes 24 hour and Less than 24 hour staffed beds. Note: Queensland data as presented for 2002-03 is an artifact of changes in reporting by the Commonwealth and is not a reflection of closure of residential services in Queensland. Queensland's residential equivalent services are classified as non-acute inpatient in all other years presented.
Figure 7. Trends in provision of public sector specialised beds – acute and non-acute beds per 100,000	**(af)** Data source: MHSiA Table 12.14. As per note **(ae)** above.
Figure 8. Readmission to hospital within 28 days of discharge	**(ag)** Data source: Australian Government analyses of jurisdiction data provided by states and territories to Department of Health and Ageing for *National Mental Health Report* purposes.
Figure 9. Rates of pre-admission community care	**(ah)** Data source: Australian Government analyses of jurisdiction data provided by states and territories to Department of Health and Ageing for *National Mental Health Report* purposes.
Figure 10. Rates of post-discharge community care	**(ai)** Data source: Australian Government analyses of jurisdiction data provided by states and territories to Department of Health and Ageing for *National Mental Health Report* purposes.
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'AG-8'

Minister's Foreword

Mental Health is an area within the health sector that has suffered from considerable neglect. Proposals to improve the extent and quality of mental health services have tended, in the past, to be long on rhetoric and short on substance.

The Queensland Government has therefore determined it will address the historic problems in this state's mental health system. Recent budget initiatives have begun to expand community-based services and increase the number of hospital beds for people with mental illness. However, a long term, comprehensive strategy, over 10 years, is now released to ensure the planning and implementation of reform is sustained.

A Ten Year Mental Health Strategy for Queensland covering the period to 2006 has been developed. It is the result of a collaborative and cooperative planning process involving key stakeholders throughout the state and builds on Australia's National Mental Health Strategy. It provides a much brighter future for mentally ill people in our state.

The Strategy outlines the key directions and framework for the implementation of reforms which will make quality mental health care more accessible and less stigmatised. The detail provided in this document primarily relates to the development of mental health services. Other important initiatives, such as the development of the new Mental Health Act, Project 300, and nongovernment and other interagency initiatives have been announced separately.

I look forward to working with those in the mental health sector and the wider health community in implementing this 10 year strategy.

Mike Horan
Minister for Health

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Executive Summary

Numerous state and national reports and inquiries have documented the lack of services for mentally ill people in Australia. The most prominent of these has been the *1993 Human Rights and Equal Opportunities Commission Report on the Rights of People with Mental Illness.* This Report highlighted the fact that reforms, which have brought improvements in the quality of life and service provision for people with other illnesses and disabilities, largely bypassed people with mental illness and psychiatric disability.

In recognition of this, a National Mental Health Strategy was endorsed in 1992 by all Commonwealth, state and territory Health Ministers, and set the framework for the reform of mental health services in Australia.

Throughout Australia generally, and Queensland in particular, community-based services have been very underdeveloped, despite most people having their care delivered outside hospital. In addition, fragmentation of the community, acute and long-term hospital components has characterised mental health service delivery.

The Ten Year Mental Health Strategy for Queensland advances the directions identified in the Queensland Mental Health Policy (1993) and the Queensland Mental Health Plan (1994). It progresses the key directions and strategic framework for the implementation of service reform throughout the State and identifies the structural and service system reforms.

In Queensland, mental health treatment and rehabilitation services are provided by primary health care providers and specialised mental health services. Specialised mental health services are secondary and tertiary services, which are delivered by specialist mental health personnel. Under the National Mental Health Strategy and State policy directions these services are targeted particularly at those people with mental illness and serious mental health problems.

At the District level, services are delivered through community and hospital services and, in four Districts, extended inpatient services are provided on a supra-district basis from the psychiatric hospital facilities. Private psychiatric services are also key providers of secondary and tertiary mental health services.

The key directions for reform of mental health services in Queensland include significant enhancement of community mental health services, the reorganisation of the service delivery system, especially the psychiatric hospitals, the review of mental health legislation, and the improvement of intersectoral links particularly with housing and disability support agencies. The immediate priorities for Queensland include:

- establishing mainstreamed integrated services to promote continuity of care across service components
- providing locally available care through the more equitable distribution of mental health resources
- involving consumers and carers in the planning, operation and evaluation of services
- prioritising services to those most in need and ensuring services respond appropriately to the needs of priority groups
- progressing the reform of psychiatric hospitals
- establishing and maintaining links with the primary health care services
- implementing quality management systems, including the National Services Standards
- improving intersectoral links, particularly with housing and disability support agencies

The central principle for planning and delivering mental health services is that they must target the needs of consumers and demonstrate the effective use of resources in meeting

these needs. Formal consumer advisory processes and procedures for handling complaints are being established. The implementation of new mental health legislation will be consumer focused and provide for the special needs of people with mental illness by facilitating access to high quality treatment and care while, at the same time, ensuring the rights of individual patients and the community are protected.

An increased emphasis on intersectoral collaboration will occur to take account of the many factors which influence health status in terms of access to social and disability services, such as housing, employment, education and training, income security, transport, community support and recreation. The mental health service system will be responsible for ensuring continuity of care by providing coordination and linkage mechanisms across providers and agencies.

A number of groups have been identified by the National Mental Health Strategy and state policy directions as requiring specific strategies to ensure equitable access to appropriate mental health services. These include Aboriginal and Torres Strait Islander communities, people from non-English speaking backgrounds, older people, people from rural and remote communities, children and young people and mentally ill offenders.

Detailed mental health services planning for Queensland has been completed using population based planning guidelines. These guidelines have been based on existing service provision within Australia and overseas, and the population projections for 2006. The planning has concentrated on developing core mental health services to achieve a balance between hospital and community treatment based on the principles of integration of inpatient and community components and self sufficiency in service delivery for populations within geographically defined catchment areas.

The following service components and priorities for development have been identified for networks of District Health Services:

- referral, intake and assessment, including extended hours capacity
- continuing treatment, using a case management approach, including
  - community treatment services
  - outreach services
  - acute inpatient services, with provision for short to medium term treatment including acute inpatient secure treatment
  - psychiatric crisis response and treatment
  - specialist intensive treatment and support for identified “at risk” individuals (mobile intensive treatment)
  - extended inpatient treatment and rehabilitation services divided into five specialised clinical programs

For catchment area services whose population is not sufficient to support the full range of service components locally, formal arrangements for visiting from or access to District Health Services in major centres will be established.

The national and state directions for mental health services require significant reform in the structure and function of psychiatric hospitals. In Queensland, extended inpatient services are provided by Baillie Henderson Hospital, Wolston Park Hospital Complex, Mosman Hall Hospital, and Kirwan Rehabilitation Unit. These facilities will be restructured to provide services targeting five clinically identified programs.

To enable people to receive extended inpatient services as close to their homes as possible, new facilities are being planned for development in north Queensland, Sunshine Coast, Gold Coast, The Prince Charles Hospital and Bayside Districts. This will enable the decentralisation of extended inpatient services from the existing psychiatric hospitals. This process will be coordinated over the required time frame to allow human resource management and industrial relations issues to be dealt with. The rehabilitation and treatment focus of extended inpatient

services will be strengthened and transfer criteria will be used for people moving between District mental health services and supra-district extended inpatient services.

Resource implications for the implementation of the Ten Year Mental Health Strategy have been identified in terms of financial, human, and physical resources. They have been determined using indicative staffing profiles for each of the service components of mental health services and are based on the recurrent labour and non-labour costs to operate services. The financial implications for the implementation of the Ten Year Strategy will be considered within the context of a combination of Queensland Health growth funds and the allocation of new funds through the annual State Budget process.

A number of the statewide capital works required for the implementation of mental health reform are included in the general hospital redevelopment and expansion program of the Queensland Health's 10 year Hospital and Health Services Building Plan.

The reform of mental health service delivery involves significant changes to the size, location and skill mix of the mental health workforce. A Mental Health Workforce Steering Committee, comprising representatives from the major unions, three District Health Services, and the relevant Corporate Office areas, has identified a program of statewide workforce issues to be addressed.

To achieve the service outcomes identified in the National Mental Health Strategy, significant changes are needed in the delivery of mental health services in Queensland. The planning and service development necessary to achieve these changes is already in progress at both statewide and district levels. The Ten Year Mental Health Strategy for Queensland will ensure a coordinated and consistent approach to the implementation of mental health reform and that resources are allocated efficiently and effectively to best meet the needs of the population.

1 Introduction

1.1 Queensland Health System

Queensland Health is currently moving to a new structure. It is refocussing to concentrate on delivering high quality and accessible health services through self-management. The new structure of Queensland Health has two major divisions; the Planning and Systems Division and the Health Service Division.

The primary function of the Planning and Systems Division is to set statewide broad health priorities, and identify and develop services which improve health status and achieve identified health outcomes, and provide corporate infrastructure support.

The Health Services Division is responsible for direct health service delivery issues in the 39 District Health Services, which are responsible for the delivery of health services to their communities. Health Councils have been established for each District to facilitate community input into the planning, monitoring and evaluation of hospital and community health services.

This structure aims to give greater autonomy and responsibility to Managers of health services and keep decisions or service delivery as close as possible to the local level. This is especially important given the size of Queensland and the different characteristics of each District.

1.2 The Queensland Mental Health System

Mental Health, Corporate Office is responsible for progressing the development of mental health services in Queensland. This includes coordinating the statewide policy directions and strategic framework for service development, review of mental health legislation, supporting the development of the non-government sector, and the administration of the Mental Health Act and Regulations.

Public mental health services will be delivered by District Health Services. These will include services provided by primary health care providers as well as specialised mental health services. Specialised services are secondary and tertiary services delivered by specialist mental health personnel.

Under National and State directions for mental health reform, these services are particularly targeted to those people with mental disorders and serious mental health problems. This is to ensure that the people most at risk receive the treatment they need. This does not exclude access to treatment for people with a range of mental health problems which are serious in terms of their impact on quality of life or have adverse social consequences.

Consultation and liaison services are provided by the specialist mental health services to other health and welfare services dealing with people who have mental health problems. Early intervention for people developing mental disorder and adequate mental health promotion and prevention activities are important components of the mental health service system.

Primary health care services

This level of service is provided through locally available services such as general practitioners, community health services, pharmacists, and domiciliary nursing. Queensland Health's Primary Health Care Policy seeks to strengthen the role of these services in the health system. The aim is to develop a coordinated network of health services and other social and disability support services in both the government and non-government sectors to provide comprehensive support for people with mental disorders and their carers.

Primary health care providers will usually be the first point of contact for people with mental

disorder and will also play an important role in ongoing clinical care. The Third National Mental Health Report (1996) identified that 33 per cent of people with serious mental disorder receiving any form of treatment are being managed by general practitioners. In rural and remote Queensland, primary health care workers are the key providers of mental health services, supported by limited specialised mental health services.

Public and private mental health services provide a consultation and liaison service to primary health care providers which enhances and supports their work.

Secondary and tertiary mental health services

Secondary and tertiary mental health services are delivered by mental health professionals to a geographically defined population of a District and/or network of Districts. Services are provided to address the needs of children, young people, adults and older people with serious mental illness.

Comprehensive services are provided which encompass integrated processes of referral, intake and assessment, and continuing treatment using a case management approach.

These services should be provided in a way that makes them accessible to people with special needs. Mental health non-government community organisations provide a range of complementary specialised support services. Private psychiatric services provide a significant proportion of the specialised mental health services.

The Ten Year Mental Health Strategy for Queensland focuses on the provision of mental health services through the public system while acknowledging the need to link these with private sector services. The development of a strong partnership between public mental health services, private sector services and non-government community sector services is an integral component of providing better mental health services in Queensland.

1.3 Program Management

Within the new Queensland Health program structure a discrete Mental Health Program has been identified as the framework for the provision of mental health services by Queensland Health.

The goal of the Program is *'to improve the quality of life of people with mental disorders and serious mental health problems through the provision of consumer focussed services'* .

The scope of the Mental Health Program includes:

- services funded by Queensland Health for the specific purpose of providing intake and assessment, continuing treatment, and community support services to people with mental disorders, serious mental health problems and associated disabilities
- services normally delivered from a service or facility which is readily identifiable as both specialised and mental health in focus
- services provided by dedicated personnel employed or contracted by state-funded services

The Program is accountable for:

- services being delivered in accordance with social justice principles
- services targeting the core business of the Program
- services being delivered efficiently
- services being consumer focussed and delivered effectively

Services are organised around catchment area populations within networks of District Health Services. Within each network there will be an identified principal service centre. This will be generally defined as one with a minimum size catchment population of 100,000 with an acute mental health inpatient unit located in the general hospital. Using the role delineation model for adult catchment area mental health services this will be a Level 4 service. In many cases the principal service centre will provide direct service delivery and clinical and

professional support services to surrounding Districts which may or may not have a satellite mental health service staffed by locally-based mental health professionals.

In some instances the Mental Health Program budget may be provided to one District to manage and provide mental health services in a surrounding District/s within the network. This arrangement will be clearly articulated in the Service Agreement between Corporate Office and relevant Districts.

Mental health services provided within the Mental Health Program include:

- community mental health services for children, youth and adults, including specialist outpatient services in general and psychiatric hospitals, and day centre, community outreach and other ambulatory mental health services
- dedicated acute inpatient services for children, youth and adults
- consultation and liaison mental health services
- extended inpatient services for the five specialised clinical programs
- any of the above services provided by a private or non-government sector specialist mental health service provider as part of a contractual arrangement with a state funded service
- services provided by community organisations funded under the Community Organisations Funding Program, currently administered by the Mental Health Branch, Queensland Health

These are described in more detail in Section 3 — Service Framework.

1.4 Evaluation

Evaluation of the Ten Year Strategy will occur within the context of Program Management in accordance with Public Finance Standard 310. Performance standards and indicators relevant for mental health are included in the 1996/2001 Corporate Plan. These will be further refined in subsequent Corporate Plans. Mental Health will continue to work on the development of performance standards and indicators for all mental health activities within the Program to form the basis for regular evaluation and review.

2 *Policy and Planning Context*

A National Mental Health Strategy was endorsed by all Commonwealth, State and Territory Health Ministers in 1992 and set the framework for the reform of mental health services in Australia.

The National Strategy reflects national and international recognition that the majority of mental health care can be delivered by community-based services, that acute inpatient care should be delivered in general hospitals, along with other acute health care, and that a small proportion of people with very severe mental illness do need care for extended periods in psychiatric hospitals.

The agenda for mental health reform in Queensland has been set by a number of international, national and state initiatives. These include:

- United Nations Resolution 98B on the Protection of Rights of People with Mental Disorders and the Improvement of Mental Health Care endorsed by Australia in December 1991.
- The Mental Health Statement of Rights and Responsibilities accepted by all Australian Health Ministers in March 1991.
- The National Mental Health Policy, adopted by all Australian Health Ministers in April 1992, which clearly outlines the need and priorities for the reform of mental health service delivery in Australia.
- The National Mental Health Plan, supported by all Australian Health Ministers in April 1992, which sets the time frame and priorities for the implementation of the National Policy.
- The Medicare Agreement (1993 - 1998), signed by the Commonwealth and Queensland in February 1993, which provides additional Commonwealth funding to support the initiatives outlined in the National Plan.
- The National Health Strategy Issues Paper, "*Help Where Help is Needed: Continuity of Care for People with Chronic Mental Illness*" (February 1993), which proposes directions for the reform of mental health services to ensure continuity of care and recommends change at many levels of service delivery for people with long-term mental disorders and disability.
- The annual National Mental Health Report, which compares Queensland's progress toward the implementation of the National Mental Health Policy and Plan with the other States and Territories.
- The National Health Goals and Targets, which identifies mental health as a priority area in the process to improve the health of all Australians.
- The Queensland Disability Services Act (1992) and the Queensland Anti-Discrimination Act (1991), which assists people with mental disorders to gain access to disability services in a non-discriminatory manner.
- The Report of the National Inquiry into the Human Rights of People with Mental Illness (Human Rights and Equal Opportunity Commission 1993), which highlighted the vulnerability and poor quality of life of people with serious mental illness and provided recommendations for the improvement of services.

2.1 Priorities for Action

The current planning context provided by the National Mental Health Strategy and the policy directions for Queensland set the directions to reshape the mental health service system to be more appropriate and responsive to the needs of the population. This Ten Year Mental Health Strategy for Queensland provides the framework for progressing mental health services reform in Queensland. The reform process has a long-term focus, and it is anticipated that subsequent strategies will address new and emerging issues and include innovative service reforms as they evolve over the next 10 years.

Based on the agreed national approach, the key directions and priorities for mental health service reform in Queensland include:

- The planning and delivery of high quality mental health services targeting those mentally ill people most in need and demonstrating the effective use of resources in meeting these needs.
- The mainstreaming of mental health services as part of the total network of general health system, rather than as an organisationally separate system. This involves the delivery of mental health services as part of the total health service network.
- The integration of inpatient and community specialised mental health services as a single service to promote continuity of care for a defined catchment population.
- The provision of mental health services as close as possible to where people live.
- The establishment of links between mental health services and other sectors to ensure access to the range of support services by people with mental illness.
- Progressing the reform of the psychiatric hospitals in Queensland by improving local mental health and disability support services to provide alternative systems of extended treatment and care, supporting current residents of these facilities to return to live in the community or more appropriate settings, and improving and decentralising the extended treatment and rehabilitation focus of these facilities for those people who do need to be admitted.
- The development of new mental health legislation for Queensland. The *Mental Health Act 1974* is being reviewed as an essential part of the reform of mental health services. A major review is continuing and will result in new legislation which will take account of new policies in mental health, the broader context of established Government policies, and other legislative reform.

2.2 Policy Directions

2.2.1 Consumer focussed service approach

The central principle for planning and delivering mental health services is that they must target the needs of consumers and demonstrate the effective use of resources in meeting these needs.

The strategies to achieve this include:

- establishing adequately resourced and effective, formal consumer advisory processes at state, district, or facility levels to ensure the participation of consumers and carers in mental health service development, planning and review
- establishing consistent methods of service evaluation for Queensland which focus on consumer outcomes
- fully linking mental health services to each District's Quality Assurance Program
- implementing service standards for Mental Health Services
- establishing clearly outlined and publicly available procedures for handling complaints and grievances for consumers and providers

- having in place a clear structure and mechanisms which ensure there is accountability for mental health services at all levels of the system
- ensuring that mental health legislation meets the international principles contained in United Nations Resolution 98B relating to the rights of people with mental illness and the improvement of mental health care

Formal consumer advisory processes and procedures for handling complaints and grievances for consumers and providers are being established. Amendments to mental health legislation to better protect the rights of people with mental illness will further assist in the adoption of a consumer focussed service program.

2.2.2 Organisation of services

Specialised mental health services will be delivered at a District and/or network of Districts level based on the principles established in the National Mental Health Strategy and State policy directions of mainstreaming, integration and self sufficiency.

Mainstreaming

Mental health services will be delivered and administered as part of the mainstream District health system to provide better access to a wider range of quality services for people with mental disorder, and to improve coordination with other health services.

The strategies to functionally mainstream Queensland's acute inpatient and community mental health services include:

- locating all acute inpatient services in general hospitals by 1999. This will involve the transfer of acute beds from Barrett Psychiatry Centre, Wolston Park Hospital, and Baillie Henderson Hospital, Toowoomba, to the appropriate District services.
- ensuring that specialised community mental health services have defined links with other community health services including, where appropriate, the co-location of community mental health services with other community health services.

Integration

Inpatient and community components of specialised mental health services will function as a single service for a defined catchment population.

The development of organisational structures and funding arrangements to support this and improve continuity of care for consumers is a priority. Strategies adopted include establishing a single point of accountability and an identified program budget covering all service components. The re-organisation into integrated mental health services does not require additional resources. Industrial relations issues are being addressed to enable greater flexibility in deployment of mental health staff between the community and inpatient components.

Systems of service coordination will be implemented to ensure continuity of care across all components of the services. These will focus on ensuring:

- a single process of entry into each district mental health service which can be activated from a number of entry points
- a case management approach for the coordination of clinical and support services for an individual
- implementation of information systems that support continuity of care across service sites
- day-to-day coordination between different components of the mental health service
- "barrier free" access to the necessary range of services according to individual needs

The reform of mental health services involves a reorientation of the way mental health services are delivered and includes mental health staff working in new ways. It is important that this is acknowledged and that appropriate training and support is provided for all staff.

Self sufficiency

Consistent with Queensland Health's corporate direction, the key planning principle under this policy direction is that mental health services will be provided as close as possible to where people live.

Districts and/or networks of Districts will be self-sufficient for specialised mental health services, including both acute inpatient and community components, at a level and mix determined by the specific needs of their defined catchment populations. Services will be provided in the least restrictive, most facilitative setting. The majority of treatment will be provided in the community with inpatient services only being used when necessary. Provision of locally available care ensures improved access and better outcomes for people with mental illness, limiting the dislocation from family and support networks.

This involves planning around catchment area populations, at a level and mix determined by the specific needs of the defined population. It also involves the development of appropriate services for rural and remote communities and establishing consultation and liaison services to link with general hospital, private and other health service providers.

2.2.3 Intersectoral links

An increased emphasis on intersectoral collaboration will occur to take account of the many factors which influence health status such as housing, employment, education and training, income security, transport, community support and recreation. These services fall outside the responsibility of health departments and links must be made with responsible agencies to ensure the needs of consumers are met. Effective planning can facilitate good health and, therefore, forging intersectoral links is a fundamental principle in the National Mental Health Strategy.

Many of the services needed by people with mental disorder are available in the private sector. For individuals who cannot or do not want to access these services, three key public sector service components will be available. Clinical treatment and rehabilitation will be provided by mental health services. Public housing and accommodation and disability and social support will be provided through the relevant government agencies or non-government organisations. The mental health service will be responsible to ensure that continuity of care is provided by facilitating access to the necessary range of health, housing and support services.

2.3 Priority Groups

A number of groups have been identified by the National Mental Health Strategy and state policy directions as requiring specific strategies to ensure equitable access to appropriate mental health services and to improve that standard of treatment provided.

Specific mental health policy statements and directions for service delivery for a number of groups have recently been finalised and the strategic framework for their implementation have been incorporated in the Ten Year Mental Health Strategy for Queensland.

2.3.1 Future directions for child and youth mental health services

The policy statement recognises that children and youth present different patterns and types of mental health problems and disorders, and require special consideration of their developmental context and legal status. Contemporary treatment for children and youth needs to be individualised and drawn from a range of therapeutic approaches which are appropriate for different ages, developmental stages, conditions and situations. The policy also recognises the importance of developing close links with other agencies such as education, paediatric, juvenile justice and child protection services in meeting the needs of children and young people with mental health problems.

The following key directions for services are specific to children and youth mental health

services. Services will:

- target those with severe, complex problems which require specialised mental health intervention
- provide assessments, brief, clinically appropriate interventions and crisis response
- improve service responsiveness to youth
- develop and maintain intersectoral links in service planning and, where appropriate, collaborative case management

2.3.2 Aboriginal and Torres Strait Islander people mental health policy statement

The policy statement outlines clear directions for change in the planning and delivery of health services to better meet the mental health needs of Aboriginal and Torres Strait Islander people. The service model promoted under this policy statement requires strengthening the response provided by primary health care services and by specialist mental health services. This is to ensure that access to a culturally appropriate service is available at all levels for people with mental health problems or mental disorders, family and friends. This policy directions require specialist mental health services to become more responsive to the specific cultural needs of Aboriginal and Torres Strait Islander people.

The key directions to improve the capacity to meet the needs of Aboriginal and Torres Strait Islander people include:

- the provision of services based on need
- the creation of Aboriginal and Torres Strait Islander mental health worker positions in specialist mental health services and at the primary health care level
- action to ensure that Aboriginal and Torres Strait Islander people have opportunities to obtain qualifications at all levels
- cross-cultural awareness training of mental health and other health professionals
- the development of culturally appropriate assessment, diagnosis and treatment tools

Primary health care services and specialist mental health services will work in partnership to ensure that assessment, diagnosis, treatment and rehabilitation is available; to facilitate access to more intensive levels of care such as hospital based acute and extended treatment and rehabilitation services; to be involved in discharge planning and follow up care to ensure continuity of care for the individual across hospital and community settings.

2.3.3 Non-English speaking background mental health policy statement

The policy statement sets the directions for change in the planning and operation of mental health services to improve their quality, accessibility and appropriateness to people from non-English speaking background. Strategies to improve outcomes for this particular group are not complex and rest primarily on recognition of the impact of cultural differences and language needs.

The key directions of the policy statement include:

- ensuring cultural differences are acknowledged and addressed at all stages of diagnosis, assessment and treatment
- pro-active recruiting bilingual mental health professionals, where appropriate
- using accredited, trained and gender appropriate interpreters in mental health care settings
- developing information about mental health, mental illness, mental health services and the *Mental Health Act* available in the major community languages

- involving people from non-English speaking backgrounds in community education strategies
- involving consumers and carers from non-English speaking backgrounds in the development, monitoring and evaluation of services
- improving the quality of data available on the use of mental health services by people from non-English speaking backgrounds
- establishing a community-based torture and trauma service in Queensland

2.3.4 Mental health services for older people

The policy statement addresses the needs of all older people with mental illness within a range of service settings, from community-based services to acute inpatient and extended inpatient services.

While many older people will continue to access adult mental health and mainstream services, special expertise is required in the assessment of people with mental illness when it is complicated by problems and illnesses related to ageing. For this group of people, psychogeriatric services are necessary.

The key directions of the policy statement include:

- targeting people aged over 65 who suffer from a mental disorder complicating an underlying disorder related to ageing or a disorder related to ageing complicating a pre-existing mental disorder
- providing psychogeriatric services as an integral component of mental health services across hospital and community settings
- strengthening linkages and developing collaborative approaches to service planning and delivery between primary health, aged care and mental health services
- specific training or supervised experience for mental health professionals in both dedicated psychogeriatric services and mainstream mental health services

2.3.5 Mental health services for rural and remote communities

Mental health services which cover rural and remote communities will develop services to ensure access to specialised services for people living outside the large rural towns and provide appropriate support to the mental health service providers.

The key directions for service development include:

- provision of outreach services from principal service centres to key rural centres in same or neighbouring Districts on a visiting basis
- establishment of satellite services in key rural centres through the employment of locally based mental health professionals. The satellite services will be linked to and supported by visiting outreach services from a principal mental health service centre located in a neighbouring major District Health Service
- establishing collaborative networks with other local health services for the provision of ongoing management and support, between visits by specialised mental health professionals
- access to acute inpatient services located in the principal service centre of a District network
- development of special care suites in a number of rural general hospital settings to provide short term specialised treatment for people experiencing an acute episode of mental illness
- developing strategies to improve the capacity for recruitment and retention, including training, professional development, and clinical supervision for the rural and remote mental health workforce

- improving the availability of communication technology to support the delivery of mental health services to rural and remote areas, including telemedicine technology to assist in the delivery of mental health services, and the provision of professional support, and training
- supporting the primary health sector in addressing mental health issues in rural and remote areas including training, and the development of mental health referral and support networks within this sector

2.3.6 Mental health services for people involved in the criminal justice system

A policy is being developed to ensure that mental health services are available to people with mental illness who are involved in the criminal justice system. These will encompass services to children, young people and adults. Services to children who are before the court on care and protection applications will also be included.

People with mental illness are disproportionately represented in prisons, with prevalence rates of seven to 10 per cent reported. This includes people who develop mental disorders while in prison, and those who have a mental illness at the time of entering the criminal justice system. These people may also be discriminated against when accessing treatment and support services in the community.

The forensic mental health services policy statement is being developed by Queensland Health, in conjunction with Queensland Corrective Services Commission, Queensland Police Services, Department of Justice and Department of Families, Youth and Community Care.

Proposed policy principles state that the majority of mental health services to people who are involved in the criminal justice system will be provided by District mental health services. Queensland Health forensic mental health services will be responsible for providing services to those people who are assessed as requiring more specialised forensic intervention, and will provide consultation and liaison services to support District mental health services.

The Mental Health Act provides a mechanism for people with a mental illness who are subject to a custodial order to be treated within an inpatient mental health service. The policy will facilitate this process through ensuring that the clinical needs of the person are considered in determining the most appropriate setting for treatment to occur. Further discussion of this area is in Section 5 — Service Planning and Development.

The provision of forensic mental health services to other Government facilities and Departments (eg. the Courts; Queensland Corrective Services Commission) will be considered within the development of the policy.

The planning guidelines for the acute and extended inpatient service requirements for this target group have been included within the statewide detailed planning.

3 *Service Framework*

Under national and state mental health directions, specialised mental health services are particularly targeted to those people with mental disorders and serious mental health problems. This includes people suffering from psychoses, both acute and persistent, mood, anxiety, or eating disorders, and those with situational crises which may lead to self-harm or inappropriate behaviour directed towards others. People with personality disorder whose behaviour places themselves or others at risk of harm are included in the target group.

Service components are planned and organised around age groups — children, youth and adults including older people. However, they will not be segmented within the rigid age criteria. The delivery of mental health services will focus on providing a continuum of care based on individual needs and will take account of the specific needs of priority groups. The continuum of care begins at the point of entry into a mental health service and proceeds through all phases of assessment and continuing treatment, and across hospital and community service settings.

A range of service components are provided as part of a District and/or network of Districts mental health services. To enable a continuum of care for the individual the following service components and priorities for development have been identified:

- referral, intake and assessment, including an extended hours capacity
- continuing treatment using a case management approach. This includes the following components:
  - community treatment services
  - outreach services
  - acute inpatient services, with provision for short to medium-term treatment, including secure treatment
  - psychiatric crisis response and treatment
  - specialist intensive treatment and support for identified “at risk” individuals (mobile intensive treatment)
  - extended inpatient services for treatment and rehabilitation, with services organised around the five specialised clinical programs.

The framework for the development of mental health services will be established for children, youth and adult mental health services taking into account the special needs of priority groups ie. older people, Aboriginal and Torres Strait Islander people, people from non-English speaking background, and people involved in the criminal justice system.

The following section defines the scope of specialised mental health service delivery and describes the service components of a core District and/or network of Districts, mental health service.

3.1 Intake and Assessment

Intake and assessment is the process which occurs during initial contact by a clinical staff member with a person referred to a mental health service. It includes the collection of information to assess the appropriateness of the referral and enables the person to be directed to the most appropriate service, within or outside the mental health service. Where intervention from the mental health service is indicated it enables appropriate and timely specialised assessment and identifies the type and level of service response required.

Intake and assessment will form the single process of entry into a mental health service and will ensure a person receives appropriate and timely assessment and treatment. It will also provide the process for triaging/gatekeeping for admission to the acute inpatient service component.

Where entry to the service operates from more than one service point within a specific catchment area of the mental health service it is essential that:

- common processes be established for standardised collection of information
- intake and assessment be available at least during normal working hours, Monday to Friday, and include the capacity for a mobile response within a specific catchment area of the mental health service
- formal mechanisms be established for all referrals, intake and assessments to be reviewed on a daily basis for the purpose of determining plans of action or validation of action taken
- a mental health professional is nominated at the time a person enters a service delivery stage and has the responsibility for ensuring continuity of care
- the nominated mental health professional (case manager or principal contact) ensures the relevant action is taken and initiates the development of an individual management plan.
- formal mechanisms be established for referrals from the Court or for people in custody, and liaison with police

Extended hours intake and assessment

As increasing resources are made available to the mental health service, intake and assessment will be expanded, or developed, with the capacity for extended working hours. In major centres this will be the extension of the normal working hours within a specific catchment area of the mental health service to a minimum of 12 hours per day, (Monday to Friday), and at times appropriate to the needs of the catchment population on Saturdays and Sundays. This includes an after-hours on-call mobile response capacity, beyond the extended hours, to provide intake and assessment, and limited case management.

In a number of Districts, child and youth mental health services will establish processes for an extended hours capacity in arrangements with the adult mental health services.

In rural centres where there are local mental health professionals, mechanisms will be developed to provide extended hours for intake and assessment, and may include on-call beyond normal working hours, and general practitioner and local general hospital liaison.

Consultation and liaison intake and assessment

Consultation and liaison within a general hospital is also included within this service component and is another point of entry to the mental health service. It includes the provision of specialised and expert psychiatric assessment and advice for management, or collaborative management, of a patient to accident and emergency and other inpatient areas of the hospital. In large general hospitals this service component may be an identified group of mental health professionals. Referral and assessments conducted within this component of intake and assessment will be included in the common process for standardised collection of information, and the review of all intake and referrals on a daily basis. This will enable the capacity to determine plans of action or to validate the action taken and where appropriate nominate a case manager or principal contact.

3.2 Continuing Treatment and Case Management Services

Mental illness is often episodic in nature and associated with varying degrees of ongoing disability. Continuity of care is a critical component of effective service provision for many people with mental illness. It requires that the provision of the range of services to a person

with mental illness is coordinated across service settings, whether hospital or community based, and across a range of clinical and support services.

The range of service components provided by specialised mental health professionals includes an individualised and multidisciplinary focus for the provision and coordination of clinical treatment, rehabilitation, and assistance in accessing housing, disability support, income support and vocational training for a person with a mental illness. Linking and networking with relevant government and nongovernment agencies is essential to ensure coordination and appropriate service responses occur.

The role of the mental health professional is to provide a comprehensive assessment of the individual's clinical and social needs, specialised intervention when required, and the formulation and documentation of a management plan developed with the consumer and focused on that person's requirements and needs.

Continuing treatment and case management is the establishment of formal processes, which follow the intake and assessment process, to ensure continuity of care for people with a mental disorder or serious mental health problem requiring acute and ongoing treatment. It comprises a number of mental health service components and these are described in more detail below.

Case management is well established as an effective way of ensuring continuity of care for people with mental illness. It does not refer to the management of the person with the mental illness but to the management of the provision of services. A person with a mental disorder or serious mental health problem will be assigned a case manager or principal contact at entry to the service delivery stage of the mental health service.

Case management is a clinical service response which draws on the case manager's professional skills in engaging with a person with a mental illness and responding to his or her clinical and support needs. The case manager or principal contact is responsible for coordinating the range of services to meet the individual needs of a person with a mental illness and will include:

- the development of an individual management plan in collaboration with the person with the mental illness
- the provision of education and support for illness, treatment and medication management
- the provision of direct clinical and treatment services where appropriate, including individual, group and/or family treatment
- the provision of support and education for families and carers
- the coordination and facilitation of access to interventions from the range of specialist mental health disciplines within the mental health service
- the facilitation of access to the range of support services where appropriate. Integral to this role is the linking with disability support key workers in centres where these positions exist, or the individual community support agencies, to facilitate access to these services to meet the needs of the person with mental illness
- the provision of consultation and liaison with primary health care providers, and private sector service providers with a focus on specialised assessment and a collaborative approach to individual management
- the regular monitoring and review of individual management plans

3.2.1 Community treatment services

Community treatment is the provision of multidisciplinary, specialised treatment and support services, in a variety of community settings, to people with mental disorders and serious mental health problems. These include clinic based services, outpatient services, domiciliary and other visiting services, and consultation and liaison services to general practitioners,

primary health care and private sector providers.

Child and youth mental health services

In addition to the above, child and youth mental health services will establish their own specific service responses within the community treatment component, to meet the specific needs of children and young people accessing mental health services. These include:

- outreach to children and youth within the context of their everyday environment eg. schools, youth services, day programs
- specialist individualised programs for specific disorders
- interagency liaison and joint case management
- input into interagency program planning and delivery, and community development activities.

Service responses specific to the needs of children and young people will be further developed as part of the implementation of the policy statement *"Future Directions for Child and Youth Mental Health Services"*. These will include specialised programs for young people with early onset psychosis, or severe functional impairments from mental illness, and their families.

The existing forensic community mental health service for young people will maintain its current role as a supra-district service. The further development of this service component will be considered within the development of the forensic mental health service policy statement.

Psychogeriatric mental health service

Older people with a mental disorder who are otherwise fit and well should remain the concern of adult mental health services. Psychogeriatric services are primarily aimed at people over 65 years of age who suffer from:

- a mental disorder complicating an underlying disorder related to ageing; or
- a disorder related to ageing complicating a pre-existing mental disorder.

In a District mental health service with sufficient catchment population it will be possible to create a significant focus of expertise in this area. This will allow a discrete psychogeriatric assessment and treatment (PAT) service component to be developed. The psychogeriatric service component, whether provided by a discrete PAT or as part of the general mental health service, will provide assessment and continuing treatment using a case management approach. In addition, the psychogeriatric service component will have a key role in providing advice and support to carers, other primary health and aged care services.

3.2.2 Outreach services

A mental health outreach service provides visiting specialised mental health services to people who are unable to access these services close to their own community. This service includes regular visits to rural and remote areas by a multidisciplinary team of a mental health service based in a provincial or metropolitan centre. It also includes establishing formal mechanisms for the provision of a point of contact for advice, support and education between visits.

This component is provided to rural and remote areas where there are no mental health services or where there is a satellite mental health service.

Outreach services also include the development of mechanisms in conjunction with local primary health care and/or local mental health service providers to provide intake and assessment, and continuing treatment and case management.

3.2.3 Acute inpatient services

Acute treatment refers to mental health service responses that provide psychiatric treatment and intervention for people who are in an acute phase of their illness with the aim of reducing symptoms and promoting recovery. This service component involves the provision of short-

term intensive treatment with medical management and includes clinical staff on duty 24 hours per day. Acute inpatient services may be provided in a variety of facilities and/or settings, these are described below.

General hospital acute inpatient unit

Hospital-based acute inpatient units will be located in and be an integral part of the public general hospital system. These units will provide assessment and treatment for people suffering acute episodes of mental illness who cannot be treated more appropriately in a community setting, and is seen as only one of many treatment options. To ensure continuity of care across hospital and community settings, management and discharge planning must be in collaboration with case managers, other service providers and carers.

General hospital acute inpatient units in major centres will have the capacity to provide:

- flexible high dependency or acute inpatient secure options
- special purpose rooms which can be used for special needs patients (including mothers with babies; older people with severe cognitive impairment; Aboriginal and Torres Strait Islander people)
- domestic-style open ward accommodation

Child and youth mental health inpatient services

Acute treatment services for children and youth will be established in general inpatient settings as discrete units where bed numbers are of a sufficient size or special purpose areas within adult mental health inpatient units for youth, or as day treatment services attached to community mental health services. Acute treatment services will be developed to provide specialised clinical interventions using best practice models for children and youth with mental disorders, eg. major depression, suicidal behaviour, severe obsessive compulsive disorders, eating disorders.

Special care suites

A special care suite is a small dedicated self-contained facility, about two to four beds, located within a rural general hospital setting. It provides short-term medical management and treatment for people experiencing acute episodes of mental illness. The suite must have the capacity for high dependency options if necessary.

The special care suite is staffed by mental health professionals drawn from the local mental health service as required. In the smaller rural areas, a pool of nurses from the general medical wards who are interested in mental health may be used as a back-up to the mental health professionals. Extra training will be provided to this pool of staff. The service must have access to consultation with a psychiatrist on a regular basis.

When the suite is not occupied by anyone who requires acute inpatient services it is closed, or used for other purposes, eg. accommodation for families or carers of inpatients.

Non-hospital based acute inpatient units

It is proposed to pilot this service model, which will substitute for general hospital acute inpatient beds in some Districts. These facilities will be sited in the community, generally provide the same services as a hospital-based acute inpatient unit (clinical staff on duty 24 hours per day), and be seen as an equivalent treatment facility by public sector mental health services.

The non-hospital based inpatient facility will be developed as a large house consistent with local residential configuration, accommodating eight to 10 people in single and twin room accommodation, and be near to a community-based component of the mental service.

This type of facility will generally provide inpatient treatment services for most people suffering from acute mental disorders, including involuntary patients, within an open environment. It may include an intensive care area for observation of people at risk of self harm. Admission to this facility would be based on clinical assessment and judgement.

Clinical staffing for these facilities are considered to have the same profile as for a hospital

based acute inpatient unit.

3.2.4 Psychiatric crisis response and treatment services

This is a mobile acute treatment response that is available 24 hours per day, seven days per week. The service provides ongoing assessment, short-term clinical treatment and interventions for psychiatric crisis resolution, and the management of people experiencing an acute episode of illness. The mental health service will have the capacity to provide varying levels of intensive treatment, and/or back-up support for carers, families and service providers involved in the management of the person. It ensures access to treatment options in a variety of community-based settings to prevent admission to an acute inpatient unit.

These settings will be considered within the context of alternatives to admission and may include the person's home, host family programs, respite facilities, and supervised accommodation facilities. Alternatives to admission represent a range of options which reduce the need for admission to a general hospital or non-hospital based acute inpatient unit. It is proposed that mental health services in Queensland continue to collaborate with other government and non-government agencies to progress the development of a range of options that reduce the need for admission to general hospital and non-hospital acute inpatient units, and which are not necessarily health-owned facilities.

As resources are made available for the development of this component within the mental health service, formal mechanisms within intake and assessment need to be established. This will ensure that all persons considered for hospital admission are assessed and a decision made as to whether the person can be treated in a less restrictive environment. Once the person no longer requires the short-term acute treatment, ongoing management within the continuing treatment service component and the provision of consultation to other service providers is essential.

3.2.5 Mobile Intensive Treatment services

The Mobile Intensive Treatment (MIT) capacity is a component of continuing treatment and case management services. The target group is the small number of very vulnerable and disabled people with severe mental illness and enduring disability, who are the most difficult to maintain in the community. Without the MIT service this group of people have frequent admissions to an acute inpatient facility or are at risk of future multiple admissions. The service is mobile and focuses on providing assertive and intensive community-based treatment, rehabilitation and support services, using a case management approach to ensure continuity of care. Input is continued until the person is functioning at a level where she or he can be provided ongoing treatment within the less intensive community treatment component of the mental health service.

3.2.6 Extended inpatient services

Adult mental health services

Extended inpatient services are a component of a District mental health service and will be developed to enable people to receive long-term treatment and rehabilitation as close to their homes as possible. In some districts these services are provided on a supra-district basis as economies of scale require a population of sufficient size to sustain the level of clinical expertise necessary for the provision of high quality care.

Significant reform is called for at both a state and national level in the structure and function of the psychiatric hospitals which presently provide these services. Queensland's psychiatric hospitals currently use almost 50 per cent of the State's mental health budget. This is discussed in more detail in Section 4.

Extended inpatient services are organised into five specialised clinical programs for:

- people who are sufficiently ill or disabled by their mental disorder to be unable to be

cared for adequately by their local community and acute inpatient services

- people who cannot function in more independent settings
- people who may pose a serious and/or long term danger to themselves or to the community

Extended inpatient services will provide ongoing assessment, long-term treatment and rehabilitation with the goal for the person to return to management by District mental health services. It includes service provision which extends into the community to facilitate movement of the person back to the referring mental health service when this is clinically indicated.

The focus of services is inclusion in the local community and individual planning to enable enhancement of community living skills, independence and maximising the quality of life. Individual service plans will be collaboratively developed with consumers which recognise people's needs, goals and strengths to ensure that services are appropriate and flexible and that people have access to a range of services and resources in the community. The continuing treatment and case management services of the referring district mental health service will be involved in ongoing case management where appropriate.

3.2.6.1 Criteria for admission/discharge to extended inpatient mental health services

The following principles and criteria for transfer of people from a District mental health service to supra-district extended inpatient services have been developed by Mental Health in consultation with the supra-district facilities and the mental health services.

Principles

- Supra-district facilities will provide services to patients referred by District mental health services based on clinical need.
- District mental health services will give priority to patients transferring back to their District from the supra-district extended inpatient services.
- Procedures for discharge from the extended inpatient facility will be developed at the time of admission in consultation with the referring District mental health service, and including families and carers.
- All referrals must include full documentation from a multidisciplinary team.
- Patients will be referred to extended inpatient services from District mental health services only after all appropriate management options within the referring District have been tried.
- People will only be referred if a length of hospital stay greater than three months is anticipated.
- People to be admitted will be 16 years of age or over.
- Departures from these principles will only occur in exceptional circumstances.

Clinical programs and admission criteria

1. ***Services for people with severe mental disorder and associated severe disability requiring extended treatment and rehabilitation.***

   This service targets people with a chronic mental disorder, usually schizophrenia or affective disorder, who have been unable to maintain themselves in the community with the support of existing local services. It includes those who are vulnerable to exploitation and/or who exhibit behaviours which are unacceptable to the local community to a point where repeated admissions to acute inpatient units have been required.

2. ***Services for people with a mental disorder and concomitant intellectual disability.***

   This service targets those people with a mental disorder who are also intellectually disabled

and who exhibit aggressive or violent behaviour, which makes them unmanageable in an integrated mental health service.

The program offers specialist assessment, treatment and rehabilitation on a medium to long-term basis in an environment where these behaviours can be more appropriately managed. The referring service retains responsibility for ongoing care subsequent to successful treatment and rehabilitation. Those people who are assessed as having an intellectual disability and an associated behaviour problem but no mental disorder will not be eligible for this program.

3. ***Services for people with acquired brain damage and associated mental disorder and/or severe behaviour problems.***

   This service targets those people with a serious loss of impulse control due to acquired brain damage, including alcohol and drug-related causes, who cannot be managed in other residential or community settings.

4. ***Services for people who suffer a mental disorder and require treatment in a specialised secure facility.***

   This service targets people who have a mental disorder characterised by persistent assaultative behaviour or self harm which has failed to respond to treatment to a point where continued treatment in an acute inpatient unit is no longer clinically desirable. It includes forensic patients, who are not required to be in a Security Patients' Hospital, and non-forensic patients.

   All people referred to this program will be regulated under the Mental Health Act at the time of referral. Mechanisms for transfer of people into and out of Security Patients Hospitals is provided by the Mental Health Act. Treatment aims to discharge or transfer of these patients back to district mental health services when this level of security is no longer required based, on clinical assessment of ongoing needs.

5. ***Psychogeriatric services for people with associated marked behaviour problems.***

   This service targets those people primarily aged over 65 years who suffer from: a mental disorder complicating an underlying disorder related to ageing; or a disorder related to ageing complicating a pre-existing mental disorder; and who, because of the nature of their behaviour, which make their management in an acute inpatient unit or in a nursing home inappropriate. Access to such a facility will only be through the continuing treatment service components of the mental health service.

   The program offers residential, specialist assessment, treatment and rehabilitation services over an extended period of time to people meeting the criteria for psychogeriatric services who cannot be managed in any other setting due to their behaviour requiring both psychiatric and aged care. These facilities will be collocated with aged care facilities wherever possible to enable access to generic aged care services when required.

Hospital based extended inpatient unit

A number of extended inpatient units will be provided within a hospital-based facility and be an integral part of the public sector mental health services. These facilities will provide inpatient services for the five clinical programs. To ensure continuity of care across extended inpatient and District mental health service settings, management and discharge planning must be in collaboration with the referring District mental health services. Extended inpatient services will be better distributed in Queensland as discussed in Section 4, Reform of Psychiatric Hospitals.

Non-hospital based extended inpatient unit

It is proposed to develop facilities in some Districts which substitute for hospital extended inpatient units for the dual diagnosis and extended treatment and rehabilitation clinical programs, and the collocation of psychogeriatric units with aged care residential facilities.

These will be considered within the context of non-hospital based extended inpatient units. These facilities will be sited in the community, generally provide the same services as a hospital-based dual diagnosis, and extended treatment and rehabilitation inpatient units (clinical staff on duty 24 hours per day), and be seen as an equivalent treatment facility by public sector mental health services.

The non-hospital based inpatient unit will be developed as cluster housing and consistent with a local residential configuration. It will be able to accommodate up to 20 people in single and twin room accommodation, and be near proximity to a community-based component of the district mental service.

This type of facility will generally be able to provide extended inpatient treatment and rehabilitation for people with a chronic mental disorder and associated disability requiring extended treatment and rehabilitation, and people with dual diagnosis who have been unable to maintain themselves in the community with the support of existing services. Admission to this facility would be based on clinical assessment and judgement. Clinical staffing for these facilities will have the same profile as for an extended treatment and rehabilitation, and dual diagnosis inpatient units.

4 *Reform of Psychiatric Hospitals*

The national and state directions for mental health services require significant reform in the structure and function of psychiatric hospitals. Strategies to implement reform include:

- the development of specific programs in each of the supra-district extended inpatient services targeting clinically identified groups
- the reduction of the size of the facilities by mainstreaming existing acute beds from psychiatric hospital facilities to general hospitals
- the transfer of services for older people, people with alcohol and drug problems, and those with intellectual disability who do not have a mental disorder to more appropriate service settings
- the relocation to the community of those people who are able to live more independently given adequate treatment and support services

In Queensland, extended inpatient services are provided by Baillie Henderson Hospital, Toowoomba District; Wolston Park Hospital Complex, West Moreton District; Mosman Hall Hospital, Charters Towers District; and Kirwan Rehabilitation Unit, Townsville District. These facilities will be restructured to provide services for the five clinical programs, outlined in Section 3.

Historically, due to a lack of community-based mental health and disability support services, there has been a tendency for people to spend many years in psychiatric hospitals with little or no contact maintained with the referring District after admission. Current reforms will strengthen the rehabilitation focus of the extended inpatient facilities and establish a two-way transfer process. Close links will be developed between supra-district and district services to enable admission and discharge planning. Rehabilitation programs will be extended into the community to facilitate movement of the person back to the referring integrated mental health service when this is clinically indicated.

The specialised services needed for this group of people are often provided on a supra-district basis because economies of scale require a service of sufficient size to sustain the level of clinical expertise necessary for the provision of high quality care.

It is critical that the decentralisation of extended inpatient services is coordinated over the required time frame to allow the human resource management and industrial relations issues to be dealt with.

The planning for adult extended inpatient services has been undertaken for 2001 and 2006 within three geographical zones which relate in part to the historical catchment areas of the psychiatric hospitals. These zones are:

- the northern zone (Torres, Cape York, Tablelands, Innisfail, Cairns, Townsville, Charters Towers, Mount Isa, Bowen, Mackay and Moranbah Districts);
- the south-east zone (Gympie, Sunshine Coast, Redcliffe/Caboolture, The Prince Charles Hospital, Royal Brisbane Hospital, Princess Alexandra Hospital, Mater Hospital, Queen Elizabeth II Hospital, West Moreton, Bayside, Logan/Beaudesert, Gold Coast Districts); and
- the central-downs zone (Rockhampton, Banana, Central Highlands, Gladstone, North Burnett, South Burnett, Bundaberg, Hervey Bay/Maryborough, Central West, Toowoomba, Northern Downs, Southern Downs, Roma, and Charleville Districts).

Consultations were held with key stakeholders in each of these Districts, principally to determine the viability of achieving self-sufficiency. Limiting factors included a perceived inability to recruit senior specialist staff, the lack of existence of core mental health service

components, which were seen as an important prerequisite to the development of extended inpatient services, and most obviously the loss of economies of scale associated with the development of very small inpatient units. It became evident that it is difficult to justify extended inpatient service development for populations of fewer than 500,000 people.

There are approximately 1100 inpatient beds in the psychiatric hospitals. Of these, approximately 600 beds are currently dedicated to providing extended inpatient services for the five specialised clinical programs.

In addition, it is estimated that there are currently 250 beds being used for the provision of geriatric and nursing home type residential care services. The remaining beds are currently being used to provide adult acute inpatient and medium term youth inpatient services, and services for people with drug and alcohol problems or intellectual disability. It is anticipated that these services will be relocated within the next five years.

As a component of the reform of psychiatric hospitals, Queensland Health is working with the Department of Public Works and Housing and the community sector in a joint project to assist people currently living in hospital to return to live in the community. Project 300 will provide packages of support, including mental health services, disability support services and housing to 300 people over the next three years and specifically targets those people who no longer require 24-hour clinical care in a hospital environment. This strategy will assist in achieving the reorientation of psychiatric hospitals from custodial to rehabilitative care, improve the quality of life for those people participating, and increase the infrastructure in the community for the provision of disability support for people with psychiatric disability.

By 2001 it is envisaged that the total number of beds required for extended inpatient services for the five clinical programs will be 824 (this includes 107 beds which may be required for geriatric services continued to be provided in an extended inpatient setting). This number will decrease to 717 beds by 2006 as the use of beds in extended inpatient settings for geriatric services reduces to zero.

The development of extended inpatient services in north Queensland, and The Prince Charles Hospital, Sunshine Coast, Bayside and Gold Coast Districts over the next three to five years will enable the downsizing and decentralisation of Wolston Park Hospital, West Moreton District. Table 1 outlines the planned location of extended inpatient beds by district.

As new extended inpatient services are established, services at the existing psychiatric hospitals will be decreased. By 2001, Mosman Hall Hospital will reduce from 111 beds to 27 beds, Wolston Park Hospital will reduce from 586 beds to 275 beds, and Baillie Henderson Hospital will reduce from 401 beds to 154 beds. Subsequent to this, by 2006 Wolston Park Hospital will further reduce to 177 beds, and Baillie Henderson Hospital to 122 beds.

Table 1 *Location of extended inpatient beds by District, 2006*

District Health Service	**Clinical Programs**

Table 1 *Location of extended inpatient beds by District, 2006*

District Health Service	Clinical Programs						
	Extended treatment and rehabilitation	Dual diagnosis	Acquired brain injury	Extended secure	High security	Psycho-geriatrics	TOTAL
Northern Zone						*19	19
Townsville	24	-	10	21	10	-	65
Charters Towers	8	19	-	-	-	-	27
Central-Downs Zone							
Toowoomba	38	23	13	25	-	16	115
Rockhampton	-	-	-	-	-	7	7
South-east Zone							
West Moreton	51	31	-	34	61	-	177
Gold Coast	27	16	-	19	-	16	78
Bayside	-	-	23	-	-	31	54
For Prince Charles Hospital/Sunshine Coast/ Redcliffe-Caboolture	55	33	16	38	-	33	**175
TOTAL	**203**	**122**	**62**	**137**	**71**	**122**	**717**

* *The site/s for the psychogeriatric places are yet to be finalised — proposed sites are Townsville and/or Charters Towers.*

** *This is the total extended inpatient bed requirements to meet the population catchment areas of The Prince Charles Hospital and District, Redcliffe/Caboolture, Sunshine Coast and Gympie Districts. The sites for the inpatient facilities has yet to be determined.*

The downsizing of the psychiatric hospitals and decentralisation of extended inpatient services, as described in this section, will be coordinated over the required time frame, within the context of the overall implementation of the Ten Year Strategy. This will include a significant number of human resource management and industrial relations issues to be dealt with which will principally involve the redeployment, retraining and redundancy of some staff.

5 Service Planning and Development

5.1 Objectives for Service Planning

To achieve the development of the identified core mental health services detailed mental health services planning has been undertaken. This has been aimed at:

- establishing planning guidelines using per capita estimates of resource needs
- identifying the skill mix required for the provision of services
- developing detailed plans for the development of core District mental health services which aim to achieve identified planning guidelines and priorities by 2006
- developing detailed plans which aim to achieve self-sufficiency for mental health extended inpatient services by 2006

5.2 Planning Principles

The planning to achieve these priorities for action in the delivery of mental health services in Queensland is guided by the following principles.

1. ***Services should be equitably distributed across the State and developed in the context of networks of health services.***
2. ***The community should have access to the full range of services required across both service and program areas.***
3. ***Communities' special needs, such as those of rural communities, will be recognised.***
4. ***The primary health care approach should be accommodated, and primary health care services should be strengthened.***
5. ***New models for service delivery will be assessed and pursued where appropriate.***
6. ***Regional self-sufficiency will be promoted as far as practical to optimise local access to services.***
7. ***Ensuring quality of care in provision of highly specialist services will require cooperation between Districts.***

Ten Year Health Services Plan for Queensland, 1994 - 2003, Queensland Health

As previously stated mental health services have been planned for development around three target groups of children, youth and adults (including services for older people).

In undertaking the planning for mental health services for these groups the following additional factors have been taken into account:

- population projections for 2006 have been used, which may change depending on future population censuses
- the excess morbidity experienced in some catchment areas such as the inner northern areas of Brisbane
- the need for formal arrangement where significant cross-district flows occur
- the particular needs of Aboriginal and Torres Strait Islander people
- the particular needs of people from non-English speaking backgrounds
- the particular needs of rural and remote areas

- the cost effectiveness of the provision of adult extended inpatient services for populations of fewer than 500,000 people balanced against the need for self sufficiency
- the use of existing services by people who live in northern New South Wales
- the development of appropriate and adequately resourced adult acute inpatient and community services as an important pre-requisite to the development of adult extended inpatient services
- the consideration that planning guidelines for adult extended inpatient services need to remain flexible at this time. The impact of community service development, effectiveness of particular service models and other advances in clinical practice (eg. Clozapine) need to be assessed over time

5.3 Planning Guidelines

Based on the emerging consensus from the National Mental Health Strategy, model services in Australia and overseas, and findings of national and international research Queensland has adopted population based planning guidelines for the provision of the specific mental health service components. Table 2 identifies the adopted planning guidelines for Queensland mental health services.

Table 2 *Adopted planning guidelines for Queensland mental health services*

Target Group	**Service Component**	**Type**	**Allocation per 100,000 population**	
			Target population	***Proposed***
Children (age to 13)	Inpatient Community	Beds FTEs	(population 0-13 yrs) (population 0-13 years)	7 25
Youth (age 14-18)	Inpatient Community	Beds FTEs	(population 14-18 yrs) (population 14-18 yrs)	15 25
Adult	Acute inpatient	Beds	(population 15-64 yrs) (population 65yrs +)	15-20 45
	Community	FTEs	(total population) (population 65yrs +)	30 10
	Extended inpatients: *Five clinical programs*	Beds	(total population)	17.7
	- Acquired brain injury	Beds	(total population)	1.5
	- Psychogeriatric	Beds	(total population)	3.0
	- Extended treatment and rehabilitation	Beds	(total population)	5.0
	- Dual Diagnosis	Beds	(total population)	3.0
	- Secure: extended secure high security	 Beds Beds	 (population > 15 yrs) (population > 15 yrs)	 4.3 2.2

The planning guidelines adopted for Aboriginal and Torres Strait Islander mental health services, based on the higher level of need, has been set at twice the level for the general adult and children and youth services. These are outlined in Table 3.

Table 3 *Adopted planning guidelines for Queensland indigenous mental health services*

Target group	Service component	Type	Allocation per 10,000 Aboriginal and Torres Strait Islander population
Children and youth	Community	FTEs	5 (population 1-18 yrs)
Adult	Community	FTEs	6 (total population)
Older people	Community	FTEs	2 (population over 55 yrs)

5.4 Child and Youth Mental Health Services

Target group

Children's mental health services will provide services for children under 14 years of age, but mainly target primary school children between five and 13 who are most at risk of severe disturbance.

Youth mental health services will provide services for 14 to 18 year olds, with a specific focus on those within secondary school age groups who are severely disturbed or have a mental disorder.

It is estimated that by the year 2006, Queensland's population of children under 14 will be 830,000, with 500,000 between five and 13 years. The population of youth 14 to 18 years by the same time, is estimated to be 280,000.

Planning guidelines

The acute treatment service component for children's mental health services will require the equivalent of seven beds per 100,000 under 14 population, and youth mental health services will require the equivalent of 15 beds per 100,000 population 14 to 18 years. On this basis Queensland will require the equivalent of 64 beds for children, and the equivalent of 48 beds for youth (including a weighting for specific need areas for children and youth mental health inpatient services). It is proposed that these be established as discrete units where bed numbers are sufficient, or as day treatment services attached to community mental health services.

Currently there are only 10 mental health inpatient beds for children in Queensland, located at the Royal Children's Hospital. In early 1997 the 12 bed youth acute inpatient unit, located at the Royal Brisbane Hospital, will be operational and provide the only dedicated acute mental health inpatient beds for youth in Queensland. The Barrett Adolescent Unit at the Wolston Park Hospital complex has 15 places to accommodate young people with serious mental disorders for medium lengths of stay.

The community service component for child and youth mental health services require 25 full-time equivalent clinical staff per 100,000 population under 19 years. On this basis Queensland will require 213 full-time equivalent clinical staff for children, and 76 full-time equivalent clinical staff for youth mental health services plus administrative support by the year 2006.

An additional 20 full-time equivalent clinical staff are required to enhance community mental health services with mental health staff dedicated to meeting the needs of Aboriginal and Torres Strait Islander children and young people. This has been determined at the level of five clinical full-time equivalent staff per 10,000 indigenous population one to 18 years. This guideline will be reviewed as services are monitored and evaluated.

Service Development

The development of, and access to, acute treatment services for children and young people will be progressed as a priority within the implementation of the *"Future Directions for Child*

and Youth Mental Health Services" policy statement. It is proposed that acute treatment services be established in general hospital settings as discrete units where bed numbers are of a sufficient size, or special purpose areas of adult mental health inpatient units for youth, including partial hospitalisation programs; or as day treatment services attached to community mental health services.

Dedicated mental health inpatient services for children are planned to be provided in the Royal Childrens Hospital, Mater Hospital, Gold Coast, Toowoomba and Cairns Districts. These units will be established in general paediatric inpatient settings either as part of a paediatric unit or, where the bed numbers are sufficient, as a discrete inpatient unit. It is planned that the children's mental health inpatient units will be developed by 2001.

Dedicated mental health inpatient services for young people are planned to be provided in Royal Brisbane Hospital, Logan/Beaudesert, Gold Coast, and Toowoomba Districts. These services will be established as part of the adult inpatient unit or, where the bed numbers are sufficient, as a discrete inpatient unit. It is planned that the youth mental health inpatient units will be developed by 2001.

Formal mechanisms will need to be established between the relevant Districts regarding access to child and youth mental health inpatient services.

In Districts and/or networks of Districts where there are no dedicated inpatient units for children or youth, and where short-term inpatient treatment is required, services can be accessed within a general paediatric unit for children, and special purpose areas within the adult mental health inpatient unit for young people. Child and youth mental health services will be resourced to provide the necessary specialist mental health treatment and management for this service response as a component of the district child and youth mental health service.

Staffing establishment of child and youth community mental health services will be expanded to consolidate service provision to these target groups. Additional clinical staff will be required to provide services for children and youth from northern New South Wales. Based upon the current use of existing services, it is estimated mental health services will require an additional six full-time equivalent clinical staff for mental health services for children and an additional 2.5 full-time equivalent for youth by 2006.

5.5 Adult Mental Health Services

Target group

Adult mental health services will provide services for people aged 15 and over with a mental disorder or serious mental health problem.

It is estimated that by the year 2006, Queensland's population aged 15 and over will be 3.2 million, with 11.7 percent of the total population over the age of 65 years.

Planning Guidelines

The acute inpatient service component for adult mental health services will require: 15 to 20 dedicated beds per 100,000 population aged between 15 and 65 years; and 45 dedicated beds per 100,000 population aged 65 years and over. Where the catchment population is of sufficient size, a separate unit or part of a unit could be dedicated for acute psychogeriatric inpatient services. However, in Queensland the majority of acute units are, and will continue to be, too small for this degree of specialisation.

On this basis, Queensland will require between 622 and 758 acute inpatient beds. The higher figure of 758 takes into account recognised excess morbidity of mental illness in the inner city of the Brisbane north area. Currently there are 643 adult acute mental health inpatient beds in Queensland. Of these 643 adult acute beds, 104 acute beds are located at psychiatric hospitals.

The community service component for adult mental health services will require 30 full-time equivalent clinical staff per 100,000 total population. On this basis Queensland will require

1114 full-time equivalent clinical staff for community mental health services plus administrative support.

An additional 46 full-time equivalent clinical staff is required to enhance the capacity of community mental health services to provide psychogeriatric services. This has been determined at the level of one per 10,000 population aged 65 and over. The established mental health planning guideline for adult community mental health services (30 clinical FTE per 100,000 total population) includes the capacity to provide intake, assessment, continuing treatment and case management services to all adults including older people (at the level of at least one worker per 10,000 population 65 and over). This guideline will be reviewed as services are monitored and evaluated.

An additional 49 full-time equivalent clinical staff are required to enhance community mental health services with mental health staff dedicated to meeting the needs of Aboriginal and Torres Strait Islander people. This has been determined at the level of six clinical full-time equivalent staff per 10,000 total indigenous population for adults up to 55 years, and two clinical full-time equivalent staff per 10,000 indigenous population over 55 years. These guidelines will be reviewed as services are monitored and evaluated.

Service development

Most of the planned redevelopment of the adult acute inpatient units and some special care suites in general hospitals will be completed by 2001. This will provide 16 beds per 100,000 of the population aged 15 years and over. Acute beds in special care suites and non-hospital based acute inpatient units will provide the additional beds for population growth, by 2006, up to 20 beds per 100,000 of the population aged 15 years and over.

The planning for adult acute inpatient units redistributes the existing resources more equitably. For example, in some instances resources will need to be transferred from one District to another to provide inpatient services closer to where people live. This process may require additional funding to establish new services before existing services are reduced or closed.

It is envisaged adult community mental health service development across Queensland will achieve 20 clinical staff per 100,000 total population by 2001. This will have the capacity to provide core mental health service components of routine referral, intake, assessment on an extended hours basis, and some continuing treatment and case management service components (including outreach to rural and remote areas). These service components are the priority for service development.

Additional clinical staffing is required for psychiatric crisis response and treatment, and mobile intensive treatment service components, and will need to be developed when the service components identified above are functioning.

The additional clinical staffing required to enhance the capacity of mental health services to address the specific needs of the priority groups will be incorporated in the development of all service components.

Additional clinical staff will be required to provide services for people from northern New South Wales. Based upon the current use of existing services, it is estimated an additional 32.5 full-time equivalent clinical staff are required by 2006.

5.5.1 Extended inpatient services

Target group

Adult extended inpatient services are planned for the identified five specialised clinical programs for people who are sufficiently ill or disabled by their mental disorder to be unable

to be cared for adequately by local community based and acute inpatient services.

Planning guidelines

The extended inpatient service component for adult mental health services will require the following bed allocations per 100,000 of the specified population.

Acquired brain injury	1.5 (total population)
Psychogeriatric	3.0 (total population)
Extended treatment & rehabilitation	5.0 (total population)
Dual diagnosis	3.0 (total population)
Secure — Extended secure	4.3 (population > 15 yrs)
— High security	2.2 (population > 15 yrs)

Currently these services in Queensland are provided in four facilities: Mosman Hall Hospital, Charters Towers District; Kirwan Rehabilitation Complex, Townsville District; Baillie Henderson Hospital, Toowoomba District; and Wolston Park Hospital, West Moreton District.

Service development

The adult extended inpatient services within Queensland have been planned in three zones based around the five clinical programs, and will be provided on a supra-district basis. As previously stated these zones are:

- the northern zone (Torres, Cape York, Tablelands, Innisfail, Cairns, Townsville, Charters Towers, Mount Isa, Bowen, Mackay and Moranbah Districts);
- the south-east zone (Gympie, Sunshine Coast, Redcliffe/Caboolture, The Prince Charles Hospital, Royal Brisbane Hospital, Princess Alexandra Hospital, Mater Hospital, Queen Elizabeth II Hospital, West Moreton, Bayside, Logan/Beaudesert, Gold Coast Districts); and
- the central-downs zone (Rockhampton, Banana, Central Highlands, Gladstone, North Burnett, South Burnett, Bundaberg, Hervey Bay/Maryborough, Central West, Toowoomba, Northern Downs, Southern Downs, Roma, and Charleville Districts).

Services for the component of the extended secure clinical program for high security inpatient treatment will only be developed in the northern and south-east zones.

Development of extended inpatient services within these zones will occur in the context of the reform of the psychiatric hospitals, as outlined in Section 4 — Reform of Psychiatric Hospitals.

6 Resource Implications

Resource implications for the implementation of the Ten Year Mental Health Strategy have been identified, and are significant in terms of financial, human, and physical resources. They have been determined using indicative staffing profiles for each of the service components of mental health services and are based on the recurrent labour and non-labour costs to operate services.

6.1 Financial implications

In 1995/96, Queensland Health spent an estimated $170 million on mental health services. To provide mental health services to the level described in the Ten Year Mental Health Strategy for Queensland, the annual mental health budget will need to be increased. A strategic framework for mental health service development in each District Health Service has been completed and determines when the financial resources are required.

The directions of the National Mental Health Strategy and the Queensland mental health policy directions require fundamental changes to the way in which mental health resources are used. These changes will involve a number of key strategies:

- identify and monitor statewide and district mental health expenditure
- identify the Mental Health Program budget in the service agreements between Corporate Office of Queensland Health and District Health Services
- increasing the Mental Health Program budget to ensure that service effort is enhanced
- appropriate cost centre accounting and reporting through a specific schedule of the Queensland Government Financial Management System (QGFMS) established to allow monitoring of mental health expenditure
- allocation of resources to priority areas and the transfer of resources from one District Health Service to another
- establish district organisational structures to support mental health reform, this includes the deployment of a single accountable officer for the integrated mental health services within all relevant District Health Services
- inclusion of mental health capital implications within Queensland Health's 10 year Hospital and Health Services Building Plan.

Approximately 68 per cent of the additional funds are required to provide mental health services to the level determined in the detailed mental health service planning. The remaining 32 per cent represents resources required to meet the population growth to 2006. On this basis the financial implications for the implementation of the Ten Year Strategy will be considered within the context of a combination of Queensland Health funds and the allocation of new funds through the annual State Budget process.

6.2 Capital implications

A proposed framework for the statewide capital works required for the implementation of mental health reform in Queensland has been completed. A number of the required capital implications for adult, youth and children's acute inpatient services are included in the general hospital redevelopment and expansion program of the Queensland Health's 10 year Hospital and Health Services Building Plan.

In addition, this program includes the provision of approximately $100 million for mental health capital works as a component of the Ten Year Strategy. In the first instance this will primarily

focus on the decentralisation of existing inpatient services in the psychiatric hospitals. This is discussed in the previous section, Reform of psychiatric hospitals.

The identified priorities within the Building Plan will enable the decentralisation of acute and extended inpatient services closer to where people live and improve progress towards self-sufficiency for catchment area populations. Table 4 outlines the indicative mental health capital works program.

Table 4 *Indicative mental health capital works program*

- Bed numbers and sites for acute and extended inpatient services have been planned on the basis of population projections for 2006, based on 1994 census data.

- Development will need to take into account functional unit sizes and optimum location of facilities.

District	**Service Type**	**Year** *Indicative only*
Cairns	- Acute inpatient (39 adult and youth, 6 child)	1997/98
Townsville	- Acquired brain injury (10) - Extended secure (21) - High security (10) - Psychogeriatric (19)[1] - Extended treatment and rehabilitation (refurbishment — Kirwan, 24)	1998/99
Mackay	- Acute inpatient — Mackay Hospital (refurbishment) - Special care suite — Proserpine Hospital	1997/98 1998/99
Sunshine Coast	- Adult acute — Nambour Hospital (refurbishment 24) - Extended treatment and rehabilitation (24)[2] - Psychogeriatric (17) [2]	1996/97 2000 1999/2000
Redcliffe/Caboolture	- Adult acute — Caboolture Hospital (24)	1999/2000
The Prince Charles Hospital and District	- Adult Acute — The Prince Charles Hospital (60) - Extended treatment and rehabilitation (31)[3] - Acquired brain injury (16) - Dual diagnosis (33)[3] - Extended secure (40) - Psychogeriatric (16)	1998/99 1999 1999 1999 1999
Bayside	- Adult acute — Redlands Hospital (24) - Acquired brain injury (23) - Psychogeriatric (31)	1999/2000 2000/01 2000/01
Princess Alexandra Hospital	- Clinical Studies Unit (refurbishment, 10)	1998
Logan/Beaudesert	- Adult acute — Logan Hospital (17) - Youth acute — Logan Hospital (10)	1999 1999
Gold Coast	- Adult acute (35) [4] - Extended treatment and rehabilitation (27)[4] - Extended secure (19)[4] - Dual diagnosis (16)[4] - Psychogeriatric (16)[4]	1998/99 1998/99 1998/99 1998/99 1998/99
Toowoomba	- Adult acute — Toowoomba Hospital (20, relocate from Baillie Henderson Hospital)	1998/99
West Moreton	- Adult acute — Ipswich Hospital (32) - Extended inpatient — Wolston Park Hospital: - Extended treatment and rehabilitation (51) - Dual diagnosis (28) - Extended secure (28) - High security (64)	1997/98 2000/01 2000/01 2000/01 2000/01

1. The location of these beds is still to be determined. Options include Townsville and/or Charters Towers Districts.

2. The location and number of these beds is still to be determined in collaboration with The Prince Charles Hospital and District.

3. The location and number of these beds is still to be determined in collaboration with the Sunshine Coast District.

4. The location of these beds is still to be determined.

The remaining identified capital works required for the reform are primarily the community health capital development, and the development of additional acute inpatient services required to meet population growth by 2006. The recurrent costs for leasing premises for community mental health services has been included in the overall financial strategy for the reform, rather than delay the establishment of key community services.

The additional acute inpatient services required are the development of two to three bed dedicated mental health inpatient suites in rural general hospitals and the proposed model of non-hospital based inpatient services. It is envisaged that the capital costs for a number of these projects could be met from within minor capital works allocations.

The capital works implications to support mental health reform in Queensland will be coordinated within the framework for overall implementation of the Ten Year Strategy.

6.3 Workforce implications

Queensland mental health services currently employ 3094 full-time equivalent staff, with nurses representing 49 per cent, allied health 12 per cent, medical practitioners 8 per cent, and operational support and administrative staff 31 per cent. Significant increases in staffing are required to implement mental health reform in Queensland. Using the planning guidelines, a total of 4064 clinical and 372 administrative support staff are required by 2006.

The reform of mental health service delivery involves significant changes to the size, location and skill mix of the mental health workforce. An essential component of the implementation of the Ten Year Strategy is ensuring there is a coordinated strategy to achieve a consistent statewide approach to changes in work practice and organisational structure, and a framework for resolving industrial relations and other human resource management issues arising from the reform process.

A Mental Health Workforce Steering Committee, comprising representatives from the major unions, three District Health Services, and the relevant Corporate Office areas, has identified a program of statewide workforce issues to be addressed.

7 Glossary

Acute: recent onset of severe clinical symptoms of mental illness, with potential for prolonged dysfunction or risk to self or others. Treatment efforts are focussed upon symptom reduction, with an expectation of substantial improvement.

Acute inpatient service: provides assessment and short- term intensive treatment, as a part of the continuum of care, for people experiencing acute episodes of mental illness who cannot be treated more appropriately in other community settings.

***Case management*:** the mechanism for ensuring continuity of care, across inpatient and community settings, for access to and coordination of the range of services necessary to meet the individual and identified needs of a person within and outside the mental health service. People with mental disorders and severe mental health problems have ongoing needs necessitating access to health and other relevant community services. This will vary in intensity according to the person's needs and also involve some delivery of clinical services.

Community treatment: is the provision of routine treatment and support services, in a variety of community settings, to people with mental disorders and serious mental health problems. These include clinic-based services, outpatient services, domiciliary and other visiting services, and consultation and liaison services to general practitioners, primary health care and private sector providers.

Continuing treatment and case management: formal processes which follow the intake and assessment process, to ensure continuity of care for a person with a mental disorder or serious mental health problem requiring acute and ongoing treatment. It comprises a number of specialised mental health service components which include the provision of community treatment, outreach services, acute inpatient services in a variety of settings, psychiatric crisis response and treatment, mobile intensive treatment, and extended inpatient services in a variety of settings.

Continuity of care: is the provision of barrier-free access to the necessary range of health care services, across hospital, community and other support agencies, over any given period of time with the level of support and care varying according to individual needs.

Disability Support Services: are a range of service responses which enable the individual to live as independently as possible and be included in the ordinary life of their community.

District Mental Health Service: provides a range of specialised mental health service components, delivered by specialist mental health professionals, to a geographically defined population. Service components provide integrated and coordinated treatment options for people with mental disorders or severe mental health problems, are mainstreamed with general health services, and have well developed relationships with other government and non-government sector service providers. A district (or network) mental health service includes the core service responses required for the treatment of a person with serious mental illness, which comprise the entry into the mental health service delivery system (intake and assessment) and continuing treatment using a case management approach.

Extended hours: is an extension of the normal working hours of the mental health service to a minimum of 12 hours per day (Monday to Friday), and at times appropriate to the needs of catchment populations on Saturdays and Sundays. This includes

an after-hours on-call mobile response capacity (when resources permit), beyond the extended hours, to provide the intake and assessment service component, and limited case management.

Extended inpatient services: provides ongoing assessment, longer-term treatment and rehabilitation, on an inpatient basis, where a severe level of impairment exists. Treatment is focussed on prevention of deterioration and reduction in impairment. The expectation is for improvement over a longer period than in an acute setting and returning to community living in an area of the person's choice. Extended inpatient services are organised into five specialised clinical programs for people who are sufficiently ill or disabled by their mental disorder to be unable to be cared for adequately by community-based and acute inpatient services. The five clinical programs are acquired brain injury, psychogeriatric, dual diagnosis, extended treatment and rehabilitation, and secure services.

Intake: is the initial contact by clinical staff for a person referred to a mental health service. It involves the collection of information to assess the appropriateness of a referral, and enables a person to be directed to the most appropriate service response within or outside the mental health service.

Integration: refers to the process whereby a mental health service becomes coordinated as a single specialist network, and includes mechanisms which link intake and assessment, and continuing treatment and case management to ensure continuity of care. One single accountable officer has management and budgetary responsibilities for all service components within a District and/or network mental health service.

Mental Health Program: is the framework for the provision of mental health services by Queensland Health and its scope is defined by the following:

- services funded by Queensland Health for the specific purpose of providing intake and assessment, continuing treatment, community support services to people with mental disorders, serious mental health problems and associated disabilities
- services normally delivered from a service or facility which is readily identifiable as both specialised and mental health in focus
- services provided by dedicated personnel employed or contracted by state funded services

Mobile intensive treatment services: provides long-term case management and assertive outreach to very vulnerable and disabled people, living in the community, with severe mental illness, enduring disability and complex needs. Without the provision of this service response the person would be likely to have recurring admissions to acute inpatient services.

Network: mental health networks are groups of district health services based on geographic catchment areas to ensure access to a more comprehensive range of service components within the Mental Health Program. A network has an identified principal service centre.

Non-hospital based acute inpatient unit: provides acute inpatient services in a facility that is located on a non-hospital campus. Non-hospital based acute inpatient units can have approximately eight to 10 beds, are sited in the community, and provide the same service with equivalent clinical staffing profile as a hospital-based acute inpatient unit. Criteria for admission are the same as those for admission to a hospital-based acute inpatient unit.

Non-hospital based extended inpatient unit: provides extended inpatient services in a facility that is located on a non-hospital campus. Non-hospital based extended inpatient units can have about

20 beds, are sited in the community, and provide the same services with equivalent clinical staffing profile as hospital-based extended inpatient units for dual diagnosis and extended treatment and rehabilitation inpatient services. Criteria for admission are the same as those for admission to hospital-based dual diagnosis, and extended treatment and rehabilitation inpatient units.

Outreach services: provides visiting specialised mental health services to people who are unable to access such services close to their own community. It includes regular visits from a mental health service, located in a major population area, to rural and remote areas, and the establishment of formal mechanisms for clinical consultation and support between visits. This is generally provided to rural and remote areas where there are no local mental health services or those areas with satellite mental health services.

Principal service centre: is within a mental health network of districts and is defined as one with a minimum size catchment population of 100,000 with a mental health acute inpatient unit located in the general hospital. A principal service centre is responsible for providing acute inpatient services, community treatment, outreach and clinical and professional support services to satellite services within its own and other districts in the network. Using the role delineation for adult catchment area mental health services this will be Level 4 services.

Psychiatric crisis response and treatment: provides ongoing assessment, short-term interventions and treatment in the community for psychiatric crisis resolution. It includes the management of a person in an acute episode of mental illness with access to treatment options in a variety of settings to prevent admission to an acute inpatient unit.

Psychogeriatric services: is a component of the mental health service which targets older people with mental illness who require both specialised mental health and aged care expertise.

Rehabilitation: is focussed on the disability dimension and the promotion of personal recovery, across inpatient and community settings, with an expectation of substantial improvement over short to mid term. The key requirement is reduction of functional impairments that limit independence. There is a relatively stable pattern of clinical symptoms and an emphasis on prevention of illness relapse.

Satellite mental health service: provides intake and assessment, continuing treatment and case management, and consultation and liaison from a small number of mental health professionals based in rural or non-provincial centres. These services are supported clinically and professionally by outreach mental health services from provincial and metropolitan mental health services (from within the district or from another district).

Secure treatment service: provides services for people with mental disorders or serious mental health problems who, based on clinical assessment, require treatment in a closed setting to ensure the safety of the person, the staff and the community. Three levels of inpatient secure treatment are provided: acute inpatient secure treatment, extended secure treatment and high security treatment.

Single point accountability: within the program management structure, the Mental Health Program necessitates that one accountable officer be able to link all service components both administratively and operationally.

Special care suite: provides short-term specialised treatment for a person experiencing an acute episode of mental illness. It is a small dedicated self-contained facility, about two to four beds, located within a rural general hospital setting.

Specialised mental health service: are specifically designed health services for individualised assessment, continuing treatment and rehabilitation for people with mental disorders and

serious mental health problems. They also provide specialised consultation and liaison services to other agencies and include a component offering expert advice to facilitate rehabilitation and promotion programs.

Council of Australian Governments (COAG)

National Action Plan on Mental Health 2006 – 2011

14 July 2006

Leaders' Foreword

The effects of mental illness are felt across our nation. Recent reports from Parliamentary inquiries and independent reviews have presented strong evidence for change in the way governments respond to mental illness. In February 2006, Australian leaders recognised that mental health is a major problem for the Australian community and committed to reform the mental health system in Australia.

The Council of Australian Governments (COAG) has agreed to a National Action Plan on Mental Health. The Plan provides a strategic framework that emphasises coordination and collaboration between government, private and non-government providers in order to deliver a more seamless and connected care system, so that people with mental illness are able to participate in the community.

All governments have invested significantly in mental health services in recent years, with the National Mental Health Report 2005 finding that Australian governments spent a total of $3.2 billion in 2002-03. However we all acknowledge that more needs to be done.

This National Action Plan presents a unique opportunity to support people to manage their mental illness and make best use of services that will work for them, their families and carers in a more integrated way. This will require collaboration between Commonwealth, State, and Territory governments, and between the government and non-government sectors. Governments have committed to a new model of community care for people with severe mental illness and complex needs, who are most at risk of falling through the gaps in the system.

COAG recognises that it will take time to strengthen the capacity of our mental health services. This National Action Plan outlines a series of initiatives that will be implemented over the five-year period, comprising a significant investment from all governments. The value of measures covered in the Individual Implementation Plans totals approximately $4 billion over five years. All governments have agreed to continued investment in the area after this time.

The Plan aims to improve mental health and facilitate recovery from illness through a greater focus on promotion, prevention and early intervention; improved access to mental health services, including in Indigenous and rural communities; more stable accommodation and support; and meaningful participation in recreational, social, employment and other activities in the community. Improving the care system will involve a focus on better coordinated care and building workforce capacity.

The success of the Plan will require continuing effort by all governments. COAG has therefore agreed to new arrangements for the Commonwealth and States and Territories to work together to implement our commitments in the most effective way.

The Plan is an historic step towards governments working together to achieve better outcomes for people with mental illness. Together these reforms will significantly contribute to the wellbeing of people with mental illness, and their families and communities.

Contents

Introduction

Mental illness is a term used to describe a number of diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities. These include depression, bipolar disorder and schizophrenia.

Mental illness can impair a person's development, education and career and diminish quality of life. Nearly one in five, or more than three million Australians are affected by a mental illness in any one year. Severe mental illnesses are less prevalent and affect around two and a half per cent of the population at any one time.

It is estimated that the annual cost of mental illness in Australia is approximately $20 billion, which includes the costs from loss of productivity and participation in the workforce. It follows that improving mental health can lead to social and economic benefits to the Australian community (Victorian Government, 2006).

Outcomes of this Plan

The National Action Plan is directed at achieving four outcomes:

1. reducing the prevalence and severity of mental illness in Australia;
2. reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery;
3. increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention; and
4. increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

Governments are committed to actions that are directed at achieving these outcomes, and have identified indicators of progress against each of these that will be measured and reported on over the life of the Plan.

Roles and Responsibility for Action

Both the Commonwealth and State and Territory governments, the private sector and non-government organisations provide care and support for people with mental illness. Governments have made significant investments in services over the past years, however from a consumer perspective, the responsibilities for action are not always clear, services can overlap and result in fragmentation and poor connections between them. This has a detrimental impact on individuals who need to access services and is costly and inefficient.

The Plan outlines where Commonwealth, State and Territory governments will significantly expand and improve their mental health services, and access to them. It also defines opportunities where better connections will be made between services provided by different governments, and where greater collaboration and joint action will occur between governments, so that people with a mental illness are better supported to participate in the community.

The Commonwealth Government will significantly expand its funding in key areas of responsibility, such as:

- services delivered by private psychiatrists in the community, general practitioners (GPs), psychologists, mental health nurses and other allied health professionals;
- labour market programmes associated with assisting people with mental illness find and stay in employment; and
- tertiary education including funding training places and scholarships, and enhancements to course content.

States and Territories will be enhancing services in their key areas of responsibility including the provision of emergency and crisis responses; mental health treatment services by public hospitals and community-based teams; mental health services for people in contact with the justice system; and supported accommodation.

In addition, the Commonwealth, States and Territories are investing in areas of common action, along with a strong commitment to work together more closely to ensure that investment is coordinated, efficient and effective. These areas of common action include:

- promotion and prevention programmes including suicide prevention;
- school-based early intervention programmes targeting children and young people;
- community-based mental health treatment services particularly for people with mental illness and drug and alcohol issues;
- mental health services in rural and remote areas;
- support for people with more severe mental illness to gain living skills and work-readiness;
- clinical rehabilitation services;
- telephone counselling and advisory services, including through the National Health Call Centre Network; and
- support for families and carers including respite care.

In light of the range of services for people with mental illness delivered by all governments, COAG has committed to two flagship initiatives to better integrate and connect services on the ground. The first is joint action to coordinate the provision of health and community support services for people with severe mental illness and complex needs across Australia. The second is to establish institutional arrangements to ensure that new investment under this Plan by each level of government is delivered in the most effective way within each State and Territory. These initiatives are outlined in the section titled *Coordinating Care*.

Structure of this Plan

This Plan comprises two major parts. The first part describes the overarching outcomes, indicators, and five areas for action with specific policy directions agreed between governments.

The second part of the Plan contains Individual Implementation Plans that have been prepared by each government. These set out the additional investment that each government will be making to achieve the outcomes and policy directions that are agreed at the national level and set out in the first part of this Plan.

This framework complements the approach being taken by COAG in developing a National Reform Agenda that is aimed at enhancing productivity and participation and the wellbeing of all Australians.

Promotion, Prevention and Early Intervention

COAG agrees that promotion, prevention and early intervention are critical to enabling the community to better recognise the risk factors and early signs of mental illness and to find appropriate treatment. Growing evidence suggests that when identified and treated early, mental illnesses are less severe and of shorter duration, and are less likely to recur. Early intervention is therefore critical to promote recovery and reduce the incidence in the community and chronic disability. In this Plan, recovery means people reach their optimal capacity to live independent and fulfilling lives.

This Plan identifies several specific policy directions necessary to achieve effective promotion, prevention and early intervention, specifically: building resilience and coping skills of children, young people and families; raising community awareness; improving capacity for early identification and referral to appropriate services; improving treatment services to better respond to the early onset of mental illness, particularly for children and young people; and investing in mental health research to better understand the onset and treatment of mental illnesses.

Consistent with these policy directions, governments will be investing extra funds on top of their existing programmes and services to support promotion, prevention and early intervention. Each government is undertaking different actions as part of their Individual Implementation Plan. This diversity reflects the differences in the range and scale of services that are already in place in each State and Territory. Some examples of the types of actions that are included in the Individual Implementation Plans include:

- expanding suicide prevention programmes under the National Suicide Prevention Strategy;
- public information and education activities that improve community awareness of mental health risk factors and promote social inclusion and support;
- investing in support groups for children of parents with mental illness;
- investing in health services for young people that focus on early intervention;
- investing in health services that focus on early intervention, including counselling services, primary care and maternal and child health;
- expanding mental health research through research centres or bodies, universities and various initiatives, including *beyondblue*;
- specialist youth mental health services such as early psychosis programmes and conduct disorder programmes;
- specialist mental health services for older people; and
- statewide 24-hour 7 days a week mental health service access by telephone, which would be linked to the National Health Call Centre Network.

In each of these areas, the needs of Aboriginal and Torres Strait Islander people will be subject to particular attention.

Details on the actions being funded in each jurisdiction are set out in each government's Individual Implementation Plan.

Integrating and Improving the Care System

People with mental illness often require access to a range of human services provided by Commonwealth, State and Territory governments and the private and non-government sector. Better coordination of all these services can help to prevent people who are experiencing acute mental illness from slipping through the care 'net' and reduce their chances of readmission to hospital, homelessness, incarceration or suicide. Better coordinated services will also mean that people can better manage their own recovery.

An effective care system will provide timely and high-quality health and community services to people with a mental illness that assists them to live, work and participate in the community. An effective, integrated care system has several parts working well together:

- psychiatrists in the community and a primary health care sector of GPs, psychologists, mental health nurses, and other allied health workers that provide clinical services to people with mild, moderate and severe mental illness, including early identification, assessment, continuous care and case management;
- emergency, acute and community-based mental health services assisting people who are experiencing acute episodes of mental illness to prevent crisis and promote rehabilitation and recovery;
- community support services such as accommodation, personal support, vocational education and training, and employment services that enable people with mental illness to live stable and productive lives in the community; and
- effective assessment and triage within all parts of the system to ensure care needs are properly identified early, and that people with mental illness are referred to the services from which they will benefit most.

Achieving such an integrated care system requires governments to focus on two specific policy directions: to resource adequately health and community support services to meet the level of need; and to develop ways of coordinating and linking the range of care that is provided across

the continuum of primary, acute and community services by public, non-government and private sector providers.

Each jurisdiction is undertaking different actions to strengthen their mental health services as part of their Individual Implementation Plan. This diversity reflects the differences in the range and scale of services that are already in place in each State and Territory. Some examples of the actions include:

- implementing new Medical Benefits Schedule items for psychology and other allied health providers, psychiatry and GPs;
- improving access to acute and community-based clinical services through enhancing emergency departments, providing additional acute and non-acute beds and expanding community treatment services across the lifespan;
- providing additional step-up and step-down community-based treatment facilities;
- more services in rural and remote areas and providing a more flexible approach to service delivery in these areas;
- providing additional care coordination services through the public, private and non-government sector;
- improving services for people with mental illness in the criminal justice system, including community-based forensic mental health services;
- integrating mental health and drug and alcohol services, including in Indigenous communities; and
- improving mental health clinical information and accountability.

Additional investment is also being made to expand capacity in community support services for people with mental illness, as outlined in the section titled *Participation in the Community and Employment*.

Importantly, as part of the Plan, governments have committed to two flagship initiatives consistent with the specific policy strategic direction of coordinating and linking the range of care that is provided across the continuum of primary, acute and community services by public, non-government and private sector providers. These are described in the section entitled *Coordinating Care.*

Participation in the Community and Employment, including Accommodation

People with mental illness are amongst the most socially disadvantaged and economically marginalised in our communities. Three quarters of the 360,000 people of working age in Australia diagnosed with a severe mental illness are not in the labour force.

COAG recognises the importance of ensuring that people experiencing severe mental illness are better connected with services and supports that will allow them to live independently in the community and lead productive and satisfying lives. For the majority of people with mental illness, effective community-based support will reduce their need for acute hospital services, leading to improved health outcomes and reduced costs of care. Carers also provide a vital role in the recovery process for people with mental illness, and supporting carers is an essential component of this Plan.

Governments have agreed to a number of specific policy directions to achieve positive change in this area, including: enhancing support services for people with mental illness to participate in the community, education and employment; enabling people with mental illness to have stable housing by linking them with other personal support services; improving referral pathways and links between clinical, accommodation, personal and vocational support programmes; and expanding support for families and carers including respite care.

Each jurisdiction is undertaking different actions as part of their Individual Implementation Plan. This diversity reflects the range and scale of services that are already in place in each State and Territory. Some examples of the types of actions within governments' Individual Implementation Plans include:

- increasing the number of places in programmes that assist people with severe mental illness with daily living including additional home-based outreach, day programmes and residential rehabilitation services;
- providing more one-on-one assistance to young people to help them stay in education, such as programmes delivered in partnership with schools;
- additional places in support programmes to help people with a mental illness obtain and stay in employment;
- supporting families and carers of people with mental illness to continue to care for people with a severe mental illness, including peer support, and respite programmes through the non-government sector; and
- increasing housing options and support in accommodation for people with a mental illness.

This Plan also includes an initiative to ensure that people with severe mental illness and complex needs receive community support services that are better connected with their clinical care. This initiative is outlined in the following section.

Coordinating Care

This Plan contains two flagship national initiatives directed at providing more seamless and coordinated health and community services for people with a mental illness.

Coordinating Care

COAG is committed to ensuring coordinated care for people with severe mental illness and complex needs who are most at risk of falling through the gaps in the system. This will have an initial focus on those people with serious illness who are most likely to benefit. This group of people have persistent symptoms and significant disability, have lost social or family support networks and rely extensively on multiple health and community services for assistance to maintain their lives within the community.

Governments have agreed to introduce a new system of linking care. People within the target group will be offered a clinical provider and a community coordinator from Commonwealth and/or State and Territory government funded services.

The clinical provider, who may be a GP, a mental health nurse, a treating doctor in hospital, or where appropriate an Aboriginal Health Worker, will be responsible for the clinical management of the person.

The community coordinators could be Commonwealth-funded personal helpers and mentors or coordinators from State and Territory government funded services. The community coordinator will be responsible for ensuring the person is connected to the non-clinical services they need, for example accommodation, employment, education, or rehabilitation.

This new way of linking services for people with a mental illness is aimed at giving them the ability to better manage their recovery by giving them clear information on who is providing their care, including information on how to access 24-hour support, and who can help link them into the range of services they need. Regular communication will also empower professionals to work across Commonwealth and State and Territory boundaries, and across clinical and non-clinical services. Clinicians and community coordinators would ensure continuity of care is maintained when they are relinquishing their role to a new clinician or community coordinator.

This new system will build on any existing coordination arrangements. This system will be progressively developed over the next six months in consultation with key stakeholders.

Governments Working Together

To ensure the full effectiveness of the Plan, COAG has agreed that the Premier or Chief Minister's department in each State and Territory will convene a COAG Mental Health Group. These groups will involve Commonwealth and State and Territory representatives and engage with non-government organisations, the private sector and consumer and carer representatives.

These groups will provide a forum for oversight and collaboration on how the different initiatives from the Commonwealth and State and Territory governments will be coordinated and delivered in a seamless way. The groups represent a commitment to collaborate on improving the responsiveness of the mental health system for the benefit of individuals with a mental illness, their families and carers, and the wider community.

These groups will ensure that all relevant Commonwealth, State or Territory government agencies work with each other at a State and Territory level, and consult with the non-government and private sectors as well as consumer and carer representatives, in order to deliver the best possible system of care. The groups should comprise representatives with responsibility for, and expertise in, mental health policy and service delivery.

The first task of these groups will be to consider how the new community coordinators for severely mentally ill people will be implemented in each jurisdiction. Implementation in each jurisdiction needs to be flexible reflecting local systems and their capacity.

Each of these groups will report back to COAG Senior Officials on their progress after six months and then at regular intervals.

Increasing Workforce Capacity

There are serious workforce shortages across all mental health professional groups, including mental health nurses and psychiatrists. This shortage hinders the ability of government and non-government providers to meet the increasing demand for services. A major focus of the Plan is to build the capacity of the public, private and non-government workforce to deliver services.

The Plan includes the specific policy directions to: increase the mental health workforce; improve its ability to meet patient needs across Australia, particularly in rural and regional areas and for Aboriginal and Torres Strait Islander people; and support the non-government and private sector to provide quality services to people with mental illness.

Each government is undertaking different actions as part of their Individual Implementation Plan. This reflects the differences in the range and scale of services that are already in place in each State and Territory. Some examples of the types of actions include:

- increasing the number of training places for mental health nurses and clinical psychologists;
- improving mental health tertiary training in health-related university courses;
- training front-line workers to better respond to mental illness;
- providing education and employment support programmes that target Aboriginal and Torres Strait Islander workers; and
- workforce development, including education, training and support for new and more experienced staff, recruitment and retention initiatives, and piloting new/expanded roles.

Details on the actions being funded in each jurisdiction are set out in each government's Individual Implementation Plan.

Measuring the Progress of the National Action Plan

All governments are committed to working together to achieve the four defined outcomes over the life of the Plan and beyond. A series of measures have been identified to track progress against the outcomes. Australian Health Ministers will report annually to COAG on implementation of the Plan, and on progress against the agreed outcomes. Governments have also agreed to an independent evaluation and review of the Plan after five years.

Outcome	Progress Measures[1]
Reducing the prevalence and severity of mental illness in Australia	The prevalence of mental illness in the community[2]
	The rate of suicide in the community
Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery	Rates of use of illicit drugs that contribute to mental illness in young people
	Rates of substance abuse
Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention	Percentage of people with a mental illness who receive mental health care
	Mental health outcomes of people who receive treatment from State and Territory services and the private hospital system
	The rates of community follow up for people within the first seven days of discharge from hospital
	Readmissions to hospital within 28 days of discharge
Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation	Participation rates by people with mental illness of working age in employment
	Participation rates by young people aged 16-30 with mental illness in education and employment
	Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities
	Prevalence of mental illness among homeless populations

[1] These progress measures may be enhanced through work under way in the Australian Health Ministers' Conference, Productivity Commission and other entities.

[2] The prevalence of mental illness in the community may in fact appear to increase at first, if the Plan is successful in helping to identify a greater number of people with mental health issues who should be treated. The increase in people seeking treatment is a positive first step towards reducing the real prevalence throughout society. There should be a similar trend identified in the percentage of people with a mental illness who receive mental health care.

Individual Implementation Plans

INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

COMMONWEALTH

The Prime Minister announced new Commonwealth funding of $1.9 billion over five years as part of the COAG package on 5 April 2006. These funds were included in the Commonwealth Budget for 2006-07. These new funds are in addition to existing Commonwealth funding and measures previously announced.

***Promotion, Prevention and Early Intervention* ($158.3 million)**

Expanding Suicide Prevention Programmes ($62.4 million)

Funding will be provided to expand and enhance national and community-based projects under the National Suicide Prevention Strategy. National research and development projects to increase understanding of suicide and how to prevent it will also be funded. *Implementation arrangements:* through the National Suicide Prevention Strategy. *Implementation commencement date:* July 2006

Alerting the Community to Links between Illicit Drugs and Mental Illness ($21.6 million)

Funding will be provided to help people better understand the links between drug use and the development of mental illness, and to encourage individuals and families to seek help or treatment. *Implementation arrangements:* through public information and education activities targeting the general population. *Implementation commencement date:* July 2006

New Early Intervention Services for Parents, Children and Young People ($28.1 million)

Assistance will be provided to parents and schools to allow them to identify better children at risk of mental illness and to offer early referral for appropriate treatment. Resources, information and training for parents and schools will be provided to promote the availability of new mental health services for children and young people with complex mental health conditions. *Implementation arrangements:* through programmes such as the MindMatters programme, and through funding to education providers and other relevant organisations. *Implementation commencement date:* September 2006

Community Based Programmes to help Families Coping with Mental Illness ($45.2 million)

Local, community-based projects will be funded to support families, children and young people affected by mental illness. Projects will target prevention and early intervention, with a particular focus on Indigenous families and those from a culturally and linguistically diverse background. *Implementation arrangements:* through non-government organisations (NGOs) and community-based organisations. *Implementation commencement date:* July 2006

Increased Funding for the Mental Health Council of Australia ($1.0 million)

The Mental Health Council of Australia secretariat will receive additional funding to assist the Council to respond to an increased focus on mental health issues in the broader community. *Implementation arrangements:* funding will be provided under the Department of Health and Ageing's Community Sector Support Scheme. *Implementation commencement date:* July 2006

***Integrating and Improving the Care System* ($1,196.9 million)**

Better Access to Psychiatrists, Psychologists and General Practitioners (GPs) through the Medical Benefits Schedule (MBS) ($538.0 million)

Reforms to the MBS will improve access to, and better teamwork between, psychiatrists, clinical psychologists, GPs and other allied health professionals. Reforms will allow private psychiatrists to refer patients to psychologists and GPs, encourage early assessment and management of people with

a mental illness by GPs, and allow GPs to refer patients to psychologists and allied health professionals. *Implementation arrangements:* through changes to the MBS and training delivered through organisations such as Divisions of General Practice. *Implementation commencement date:* November 2006

New Funding for Mental Health Nurses ($191.6 million)

New mental health nurses in private psychiatry practice, general practice and other appropriate organisations will assist people with serious mental illness to receive better coordinated treatment and care. They will work closely with the patient's psychiatrist or GP and provide services such as home visiting, medication management, and improving links to other health professionals. *Implementation arrangements*: through a range of payment mechanisms. *Implementation commencement date:* July 2007

Mental Health Services in Rural and Remote Areas ($51.7 million)

Access to mental health services for people in rural and remote areas will be improved through funding for treatment services provided by appropriately trained allied mental health professionals such as psychologists, social workers, occupational therapists, and mental health nurses. *Implementation arrangements:* through flexible funding to a Division of General Practice or alternative organisations such as an Aboriginal and Torres Strait Islander primary health care service. *Implementation commencement date:* November 2006

Improved Services for People with Drug and Alcohol Problems and Mental Illness ($73.9 million)

The non-government drug and alcohol sector will be funded to provide treatment for clients who also have a mental health problem. Best-practice models for intervention for clients with substance use and mental health co-morbidities will be identified and training will be provided for the drug and alcohol workforce. *Implementation arrangements:* through Non-Government Organisations (NGOs), and through the National Comorbidity Initiative and National Illicit Drug Strategy. *Implementation commencement date:* July 2006

Funding for Telephone Counselling, Self-Help and Web-based Support Programmes ($56.9 million)

Non-government organisations currently providing telephone counselling services will be provided with more funding to further enhance the services they currently provide. New web-based counselling services will also be developed. *Implementation arrangements:* through NGOs currently funded to provide similar services. *Implementation commencement date:* July 2006

New Personal Helpers and Mentors ($284.8 million)

Funding will be provided to the non-government sector to engage 900 personal helpers and mentors to assist people with a mental illness who are living in the community to better manage their daily activities. People with a severe mental illness will be assisted in accessing the range of treatment, income support, employment and accommodation services they need. *Implementation arrangements:* through NGOs. *Implementation commencement date:* July 2006

Participation in the Community and Employment, including Accommodation ($370.0 million)

Helping People with a Mental Illness enter and remain in Employment ($39.8 million)

Funding will provide 2,500 additional places in the Personal Support Programme to help people with a mental illness who are not yet ready to benefit from the Job Network. Funding will also support people with a mental illness at risk of losing or leaving their jobs, and help evaluate and disseminate information on effective ways of providing employment assistance for people with mental illness. *Implementation arrangements:* through the Department of Employment and Workplace Relations. *Implementation commencement date:* July 2006

Support for Day-to-Day living in the Community ($46.0 million)

7,000 additional places will be created in programmes that assist people with severe mental illness to provide access to structured activities such as cooking, shopping and social outings, and help improve social participation through independent living skills and social rehabilitation activities. *Implementation arrangements:* through NGOs. *Implementation commencement date:* July 2007

Helping Young People stay in Education ($59.5 million)

The Youth Pathways programme will be increased to help young people who are experiencing a mental health problem and who are at risk of dropping out of school, including the provision of one-on-one assistance to identify services and professional support to help individual young people with their specific needs (for example, counselling, support to find housing or remain at home). This initiative, in conjunction with the Partnership Outreach Education Model, will assist an estimated 6,000 young people who are experiencing mental health issues. *Implementation arrangements:* through Youth Pathways providers. *Implementation commencement date:* January 2007

More Respite Care Places to help Families and Carers ($224.7 million)

Funding will be provided for approximately 650 new respite care places to help families and carers of people with a mental illness or an intellectual disability. Overnight respite and day respite services will be provided for up to 15,000 families a year, and priority access will be given to elderly parents who live with, and care for, a son and daughter with a severe mental illness or an intellectual disability. *Implementation arrangements:* through NGOs. *Implementation commencement date:* July 2006

***Increasing Workforce Capacity* ($129.9 million)**

Additional Education Places, Scholarships and Clinical Training in Mental Health ($103.5 million)

Funding will be provided to increase the supply and quality of the mental health workforce. An additional 420 mental health nursing places and 200 post-graduate psychology places each year will be provided, as well as 25 full-time and 50 part-time post-graduate scholarships to nurses and psychologists. Mental health competencies and mental health clinical training will be increased across the health workforce, including medicine, psychiatry, nursing, psychology, occupational therapy and social work. *Implementation arrangements:* universities will provide student places and scholarships. *Implementation commencement date:* components of this initiative will start from November 2006

Mental Health in Tertiary Curricula ($5.6 million)

Funding will be provided to increase the mental health content in tertiary curricula through the development of mental health training modules for registered nurses, including the culturally appropriate management of Indigenous patients, and will provide students with clinical training in multi-disciplinary teams that include allied health, medical and nursing students. *Implementation arrangements:* through funding to education service providers, such as universities. *Implementation commencement date:* July 2006

Improving the Capacity of Health Workers in Indigenous Communities ($20.8 million)

Five new scholarships will be provided for Indigenous students undertaking studies in a mental health discipline, and 10 additional mental health worker positions will be created in Indigenous communities. A range of mental health training programmes and resources will be provided for the existing Indigenous health workforce to enable them to identify better mental illness and assist people to access appropriate treatment. *Implementation arrangements:* scholarships will be provided through the Puggy Hunter Memorial Scholarship Scheme. *Implementation commencement date:* July 2006

INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

NEW SOUTH WALES

The New South Wales Government will deliver a $938.9 million programme of additional expenditure in mental health services over the next five years, commencing with $148.8 million in the 2006-07 financial year. This five-year programme comprises:

- $337.7 million in new additional recurrent funding commencing in the 2006-07 Budget;
- $263.3 million in additional recurrent funding for the expansion of programmes and services which has been previously announced; and
- $337.9 million in capital works, including additional funding for new capital works, works-in-progress, and privately-financed projects.

***Promotion, Prevention and Early Intervention* ($102.2 million)**

Expanding University Based Research ($10.0 million)

Funding of $6.0 million will be provided to the Brain and Mind Research Institute to conduct research and clinical outreach services and $4.0 million to the University of New South Wales to further its research into schizophrenia, depression and anxiety disorders. *Implementation arrangements:* through the university sector. *Implementation commencement date:* May 2006

Expanding Early Intervention Services for Youth ($28.6 million)

Tertiary mental health treatment services will be expanded for young people 14-24 years of age. These services will focus on intervention at the early stages of their serious mental illness and effective evidence-based treatment, bringing together specialist youth mental health treatment services, general practitioners (GPs), drug and alcohol workers and other relevant services in a one-stop shop. *Implementation arrangements:* through Area Health Services in collaboration with the non-government and primary care sector. *Implementation commencement date:* July 2006

Specialist Assessment of the Needs of Older People ($37.3 million)

Funding will be provided to expand specialist community mental health teams to provide assessment and treatment for older people with mental illness and age-related mental health problems. This programme will build on 2005-06 Budget enhancements for older peoples' mental health community teams and community-based programmes. *Implementation arrangements:* through Area Health Services in partnership with aged care services. *Implementation commencement date:* July 2006

Statewide 24-hour Mental Health Access by Telephone ($26.3 million)

Funding will be provided for a New South Wales mental health telephone advice, triage and referral service, staffed by mental health clinicians. This will link into the National Health Call Centre agreed to by the COAG. *Implementation arrangements:* through the roll-out of a statewide 1800 number linked to Area Health Services. *Implementation commencement date:* July 2006

***Integrating and Improving the Care System* ($699.7 million)**

Enhancing Community Mental Health Emergency Care ($51.4 million)

An additional 65 specially-trained professionals will be funded to respond to out of hours emergency and acute community responses across the State by 2007-08, and doubling by 2009-10. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

Expansion of Community Forensic Mental Health Services ($6.5 million)

Specialist community forensic mental health services will provide assessment, support court diversion, discharge planning from custody and case management of difficult adults and adolescents with a mental illness in contact with the criminal justice system. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

Better Integration of Mental Health Services with Drug and Alcohol Services ($17.6 million)

This includes specialist support for offenders and young people, and the trial of methamphetamine treatments. In 2006-07, 20 new graduates will be placed with drug and alcohol and mental health services to strengthen the workforce and build relationships across the two areas. Funding will support new positions that provide specialist drug and alcohol advice and assistance to mental health services and emergency departments. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

Supporting People with Mental Illness in the Prison System ($5.0 million)

Enhancement funding will be provided for programmes to assist people with mental illness in correctional centres who are exhibiting challenging behaviours, including through stronger case management. *Implementation arrangements:* through Department of Corrective Services. *Implementation commencement date:* July 2006

Further increasing the Number of Acute and Non-acute Mental Health Beds ($151.7 million)

An additional 300 mental health beds in public hospitals have been planned and will be opened over the next three years. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

Building and Operating New Forensic Facility at Long Bay Prison ($171.6 million)

Implementation arrangements: through public/private partnership. *Implementation commencement date:* July 2006

Expansion of Community-based Professional Mental Health Services including Child and Adolescent Services ($14.3 million)

Implementation arrangements: through Area Health Services. *Implementation commencement date:* July 2006

Specialist Mental Health Services for Older People ($10.8 million)

Funding is being provided to reconfigure seven 16-bed units across New South Wales to operate as short-medium stay specialist assessment and treatment facilities for older people with severely and persistently challenging behaviours associated with dementia and/or mental illness. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

Improving Mental Health Clinical Information and Accountability ($7.6 million)

Implementation arrangements: through Area Health Services. *Implementation commencement date:* July 2006

Building New Facilities to Accommodate New Mental Health Beds including Works at Lismore, Illawarra and Bloomfield Hospital ($117.0 million)

Implementation arrangements: through Area Health Services. *Implementation commencement date:* July 2006

Redevelop and Integrate Mental Health Services with Drug and Alcohol Services at St Vincent's Hospital ($23.0 million)

Implementation arrangements: through Area Health Services. *Implementation commencement date:* July 2006

Refurbishing and relocating Mental Health Facilities at Concord, Gosford, Newcastle and Orange hospitals ($117.4 million)

Implementation arrangements: through Area Health Services. *Implementation commencement date:* July 2006

Establishing Psychiatric Emergency Care Centres ($5.8 million)

Funding is to be provided for continuing the roll-out of Psychiatric Emergency Care Centres at Major Metropolitan Hospitals such as Blacktown, Liverpool, Nepean, Campbelltown, Wollongong, Hornsby, Wyong, St. George and St Vincent's. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

Participation in the Community and Employment, including Accommodation ($113.8 million)

Housing Accommodation and Support Initiative ($58.8 million)

This initiative is in partnership with the Department of Housing and the non-government sector. This funding will provide an additional 234 support packages to the 736 already funded. A significant proportion of this funding will be for individualised support packages for people requiring ongoing monitoring after in-patient care. In partnership with the NGO sector, this will help people re-settle in the community and prevent re-admission. In 2006-07, 100 of these support packages will be available. The Department of Housing will spend $5.0 million of these funds on the leasing of properties to accommodate people participating in the Housing Accommodation and Support Initiative. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

Community Rehabilitation Services ($41.5 million)

This initiative includes extra clinical rehabilitation specialists that will provide assessments and options for people at the earliest stages of their disorder. This includes individualised plans for intervention, transition to community care and specialist psychosocial rehabilitation in the community. This initiative will introduce Vocational Education Training and Employment (VETE) clinicians to provide individual assessments and intervention; preparation and support of VETE plans; linkages and advice on mental health issues for the client as required to Vocational Rehabilitation providers (CRS), employment services and educational providers; and development of local service networks to facilitate referral and management options. It will also include the introduction of Recovery and Resource Services to increase the capacity of NGOs to provide quality social and leisure opportunities for people with a mental illness, based on best practices. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

Enhance New South Wales Family and Carer Mental Health Programme ($13.5 million)

Funding will be made available to provide: specialist clinical advice and a comprehensive range of support services for families and carers education and training for families and carers; information for new carers about their rights and responsibilities; involvement of families and carers in assessment, care planning and discharge planning of a loved one; and better access and referrals for families and carers to other community support services. *Implementation arrangements:* through Area Health Services and NGOs. *Implementation commencement date:* July 2006

***Increasing Workforce Capacity* ($23.2 million)**

Mental Health Workforce Programme ($11.0 million)

This programme comprises a variety of initiatives to improve the capacity of the health workforce to deliver mental health services. These include training of extra doctors in psychiatry, new graduate and transition training programmes for nurses and allied health, 600 undergraduate and postgraduate scholarships for mental health nurses, guaranteed employment for up to 50 New South Wales psychologists while undertaking the Clinical Masters course, and expanding uptake of GPs in the GP Procedural Training Programme in Mental Health. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

Aboriginal Mental Health Workforce Programme ($12.2 million)

This initiative will place local Aboriginal mental health trainees in mainstream community mental health teams to address the high and complex needs of Aboriginal people, and for Aboriginal people to engage better with mental health services. This programme is being expanded following a pilot in the Greater Western Area Health Service, which won the Premier's Public Service Award in 2005. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

VICTORIA

The Victorian Government will deliver at least $472.4 million under the five-year COAG Plan, as part of an ongoing comprehensive strategy for significant and sustained growth and reform.

This five-year programme comprises:

- $222.7 million in new initiatives announced since February 2006, including $178.8 million announced in the 2006-07 State budget. Of this, $20.5 million is to fund capital works at three sites;
- $161.9 million in additional recurrent funding from 2006-07 to 2010-11 announced as part of the landmark investment in mental health services in April 2005; and
- $87.8 million to provide for cost growth in existing services over the same period.

Victoria will carry through reforms begun in previous years and make new investments that are aimed at:

- strengthening our prevention and early intervention efforts;
- expanding the available range of community based treatment and support options;
- improving hospital based mental health services and providing alternatives to inpatient care; and
- providing for the wider support needs of people with a serious psychiatric disability, particularly for supported accommodation.

Promotion, Prevention and Early Intervention ($80.4 million)

Victoria's commitment to promotion, prevention and early intervention in mental health has been progressed over the past several years. Victoria is a leader in early psychosis programmes, including ORYGEN Youth Health and the Early Psychosis Prevention and Intervention Centre (EPPIC). Victoria has been involved in the establishment of *beyondblue*, including the Victorian Centre for Excellence in Depression.

Other initiatives include Vic Health's Mental Health Promotion Strategy, the employment of Mental Health Promotion Officers in child and adolescent mental health services; and the establishment of Primary Mental Health Teams to support general practitioners (GPs) and other primary care providers across the State.

Expanding Early Psychosis Programmes ($16.9 million)

Funding will be provided to expand further early psychosis programmes for young people 16 to 25 years as part of a progressive statewide rollout of these services. Early psychosis programmes target young people who are experiencing a first episode of psychosis, with a view to reducing the impact of the illness and improving engagement with the health and education systems. Two early psychosis programmes were funded in 2005 and three more will be funded in 2006. It is anticipated that by the end of 2006-07 approximately 70 per cent of the State will have access to these services. *Implementation arrangements*: through adult clinical community services. *Implementation commencement date:* progressively from July 2005

Expanding Conduct Disorder Programmes ($8.4 million)

Funding will be provided to further expand conduct disorder programmes for primary school children as part of a progressive statewide rollout of these services. Two conduct disorder programmes were funded in 2005 and two more will be funded in 2006. These programmes are delivered in partnership with schools and target children with severe behavioural and emerging conduct disorder problems with a view to improving behaviour and educational engagement. *Implementation arrangements:* through child and adolescent clinical community services. *Implementation commencement date:* progressively from July 2005

Support for Children of Parents with a Mental Illness ($2.4 million)

Funding will be provided to support families with children where a parent has a mental illness. Family support for children in these circumstances will help improve their educational attainment, and reduces their likelihood of long-term mental illness and contact with the protective and criminal justice systems. This initiative will be coordinated between seven area mental health services to maximise access to the programme. *Implementation arrangements:* through area mental health services. *Implementation commencement date:* July 2006

Postnatal Depression Support Services ($4.9 million)

Funding will be provided for additional treatment and support for women with mental illness in the post-partum period and their babies, as well as training, advice and support to primary health and adult mental health services. These services will be funded through the three specialist mother/baby units and will promote attachment and bonding known to be associated with better health and wellbeing outcomes for mothers and babies. *Implementation arrangements:* through specialist mother/baby services. *Implementation commencement date:* July 2005

New Centre for Women's Mental Health ($1.1 million)

New funding will be provided to the Royal Women's Hospital (RWH) in 2006 to strengthen the hospital's capacity to identify better, diagnose and treat mental illness. This funding will also help establish a telephone-based secondary consultation service on women's mental health for specialist and generalist clinicians. *Implementation arrangements:* through the hospital. *Implementation commencement date:* October 2006

Expanding Counselling in Community Health Services ($2.6 million)

Funding will be provided for up to five additional counselling positions in community health centres to support people with primary mental health problems. *Implementation arrangements:* through community health centres. *Implementation commencement date:* October 2006

Expanding Primary Prevention and Promotion Programmes ($36.0 million)

Vic Health will provide a focus on mental health primary prevention and promotion through its mental health strategy and research programme. *Implementation arrangements:* through Vic Health. *Implementation commencement date:* from July 2006

Mental Health Research ($8.0 million)

Funding will be provided to relocate the Mental Health Research Institute (MHRI) to the Australian Centre for Neuroscience and Mental Health Research. This will strengthen Victoria's medical research into the causes and treatment of mental illness. *Implementation arrangements:* through the new Centre. *Implementation commencement date:* from July 2005

Integrating and Improving the Care System ($284.9 million)

Victoria's early investment in mainstreaming hospital-based services and providing community-based care, has meant that it now provides the highest number of total beds (acute and community) per capita nationally. In recent years, Victoria has built on this reform and diversified through, for example, Prevention and Recovery Care (PARC) services to provide new options for step-up/step-down care.

Victoria has also responded to the needs of key target groups through, for example, Dual Diagnosis Services, the Victorian Centre for Excellence in Eating Disorders and the Victorian Institute for Forensic Mental Health Care.

Additional funding includes $79.6 million allowed for cost growth in forward estimates over the five years of the Plan.

Expand community mental health services

Expanding Child and Adolescent, Adult and Aged Specialist Community Services ($47.3 million)

Funding will be provided to expand the intensive community treatment capacity of adult, aged and child and adolescent clinical mental health services. In 2005, 57 additional positions were funded and 24 more positions will be funded in 2006. This funding forms part of an ongoing statewide strategy to strengthen the core capacity of clinical ambulatory services to reduce demand for bed-based services and more assertively manage and treat consumers with complex needs. *Implementation arrangements:* through adult, aged and child and adolescent clinical community services. *Implementation commencement date:* progressively from July 2005

In addition a new specialised eating disorder day programme will be established for young people up to 24 years of age with eating disorders who do not require hospitalisation but require a higher level of care than can be provided in the community by specialist mental health services. *Implementation arrangements:* through an area mental health service in partnership with the Butterfly Foundation. *Implementation commencement date:* October 2006

Expanding Dual Diagnosis Services ($8.9 million)

Funding will be provided for a range of workforce initiatives that will improve the quality of services provided to people experiencing both mental health and drug and alcohol problems, and encourage greater collaboration between mental health and drug and alcohol treatment services. *Implementation arrangements:* through adult clinical community services in collaboration with alcohol and drug treatment services. *Implementation commencement date:* July 2005

Improve hospital care and alternatives

Expansion of Mental Health Teams in Hospital Emergency Departments ($15.6 million)

Funding will be provided for an enhanced mental health response at hospital emergency departments (EDs) to assist staff in addressing demand pressures within the ED. Five hospitals received funding in 2005 and nine more hospitals will receive funding in 2006. This initiative is part of an ongoing strategy to reduce waiting times in EDs and improve outcomes for consumers, and builds on existing crisis assessment and treatment capacity to enable 24-hour, seven day a week coverage. *Implementation arrangements:* through hospitals. *Implementation commencement date:* progressively from July 2005

Supporting Transition to the Community for Long-term Residents of Extended Care Facilities ($6.6 million)

Funding will be provided for a new initiative to support the transition of long stay residents from bed-based extended clinical care services to the community. The 12 intensive psychosocial support packages will be augmented by intensive clinical outreach support. *Implementation arrangements*: through selected Psychiatric Disability Rehabilitation and Support Services (PDRSS), in partnership with adult clinical community services. *Implementation commencement date:* October 2006

Expanding Capacity in Bed-based Forensic Mental Health Services ($21.1 million)

Funding will be provided for an additional 18 interim forensic mental health beds at Thomas Embling Hospital. This investment will provide the service system with greater capacity in the immediate term to manage the complex mental health problems of the prison and forensic population while the long-term expansion of forensic mental health capacity is planned. *Implementation arrangements*: through Forensicare. *Implementation commencement date:* late 2006

Additional Step-up/Step-down PARC Sub-acute Places ($25.1 million)

Funding will be provided for additional Prevention and Recovery Care (PARC) places for people who need short-term sub-acute care. In 2005, two new PARC services were funded and in 2006 another full service and one extended service will be funded. These services will avert inpatient admissions for consumers who would otherwise require acute inpatient care and provide post-acute treatment and

support to facilitate discharge from this service setting. *Implementation arrangements*: through PDRSS, in partnership with adult clinical community services. *Implementation commencement date*: progressively from July 2005

Hospital Demand Management ($17.4 million)

Funding will be provided to support hospitals to manage mental health ED presentations, increase the capacity of community-based services to reduce avoidable admissions by consumers with chronic and complex needs (HARP), and provide additional acute inpatient beds and diversionary services. *Implementation arrangements*: through hospitals and area mental health services. *Implementation commencement date*: July 2005

Increasing the Acute Mental Health Bed Capacity ($39.9 million)

Funding will be provided to support the expansion of adult acute inpatient capacity. This includes full year funding for 26 new beds and the purchase of private beds on an interim basis, while new/replacement beds are constructed in the future. *Implementation arrangements*: through hospitals. *Implementation commencement date*: July 2005

Improve information flow

Improving Triage Practice ($2.8 million)

Funding has been provided to improve service information and effective triage and intake assessment, especially for people in crisis, to improve client flow through the service system. These are linked to broader developments across key service interfaces with acute hospitals, primary care and community health. *Implementation arrangements*: through hospitals and adult clinical community services. *Implementation commencement date*: July 2005

Building Better Mental Health Facilities ($20.5 million)

Funding will be provided to support the efficient use of acute inpatient beds and provide alternative discharge options and diversion from inpatient services. The initiatives include:

- **Heidelberg Repatriation Hospital Mental Health ($9.0 million)** Developmental works for a secure extended care beds facility on the Heidelberg Repatriation Hospital site will be advanced. This funding will also enable the construction of the Kokoda gymnasium and pool for the Heidelberg Repatriation Hospital site;
- **Shepparton Mental Health – Ambermere ($6.5 million)** Facilities in the former Ambermere psychiatric hospital will be redeveloped for mental health services that will provide opportunities for both recovery and rehabilitation for 20 patients. This development includes facilities for the Centre for Older Person's Health, which operates from the Ambermere site; and
- **Brunswick Human Services Precinct: Bouverie Centre Relocation ($5.0 million)** The Bouverie Centre will be relocated to the new Brunswick Human Services precinct. The move to Brunswick will co-locate the Bouverie Centre with the Victorian Foundation for Survivors of Torture to provide an accessible location for family intervention services.

Implementation arrangements: through the hospitals and Bouverie Centre. *Implementation commencement date*: from October 2006

Participation in the Community and Employment, including Accommodation ($102.7 million)

Over the past several years, Victoria has invested in a comprehensive network of clinical and non-clinical community-based services. This has seen the growth of a robust PDRSS sector to promote recovery, primarily delivered through non-government agencies. These services include housing support, day programmes, residential rehabilitation services, and respite care.

Victoria's investment in clinical and non-clinical mental health services has increased the capacity to provide a range of supported accommodation options for people with a mental illness and their carers

living in the community. In addition, the Victorian Homelessness Strategy has provided new pathways out of homelessness for people with mental illness.

Additional funding includes $8.2 million allowed for cost growth in forward estimates over the five years of the Plan.

Growing Psychiatric Disability Rehabilitation Support Services ($38.6 million)

Funding will be provided for the progressive statewide expansion of PDRSS living support services for people with a psychiatric disability, and to improve service sustainability by addressing cost pressures. In 2005 services received a nine per cent increase in funding with further growth funding provided in 2006. This funding will also improve links between homelessness support services and the mental health system. *Implementation arrangements*: through the PDRSS sector. *Implementation commencement date*: progressively from July 2005

Expanding Community Care Units ($7.5 million)

Funding will be provided to expand community care unit capacity for people who need extended clinical care by the equivalent of 14 additional beds. *Implementation arrangements*: through metropolitan and rural health services. *Implementation commencement date*: October 2006

Supported Accommodation for Vulnerable People ($40.4 million)

Funding will be provided to assist pension-level Supported Residential Services to improve accommodation and personal support for residents with psychiatric and other disabilities. *Implementation arrangements*: through pension-level Supported Residential Services. *Implementation commencement date*: July 2006

Homelessness and Mental Health Initiatives ($8.0 million)

Funding will be provided to create stable and affordable housing pathways for people with a mental illness post their discharge from adult acute inpatient and extended care facilities through the provision of proactive tenancy support. *Implementation arrangements*: through homelessness support agencies. *Implementation commencement date*: July 2006

Increasing Workforce Capacity ($4.4 million)

Victoria's commitment to delivering high-quality services has been paralleled by a focus on workforce development.

Victoria will continue to invest in clinical training and a range of graduate and postgraduate supports for students, as well as ongoing education and training for mental health professionals. This will be complemented by additional training for frontline workers in health and non-health sectors to improve early recognition and intervention of mental health problems, and facilitate integrated service responses.

Victoria will continue to fund Consumer and Carer Consultants within mental health services who provide a range of peer support services and contribute to service development.

As part of a broader health workforce strategy, Victoria will pilot new or expanded roles and service/workforce models to improve the quality and safety of care.

Enhancing Workforce Capacity ($4.4 million)

Funding is being provided for specialist graduate nurse positions and post graduate nursing scholarships. In 2005, 81 post graduate scholarships and 10 graduate positions were funded. In 2006, another 37 post graduate scholarships and six graduate positions will be funded. These initiatives form part of a strategy to provide new starters and early career staff with a structured package of peer supports and professional opportunities, and to support the implementation of education and training initiatives to improve workforce quality in the specialist mental health sector. *Implementation arrangements*: through area mental health services. *Implementation commencement date*: progressively from July 2005

INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

QUEENSLAND

From 2006-07 the Queensland Government is committing new funding of $366.2 million over five years to improve the quality of, and access to, mental health services. This includes:

- $189.0 million announced in the October 2005 Special Fiscal and Economic Statement, with the first full year of funding to commence in 2006-07;
- $109.6 million additional recurrent funding for the expansion of initiatives previously announced;
- $35.7 million in new additional recurrent funding commencing in the 2006-07 State Budget; and
- $32.0 million for capital works, including additional funding for new capital works and works-in-progress.

In addition to the above initiatives, more than $250.0 million has been provided to address wages growth over the next three years to attract and retain skilled mental health staff. Initiatives have been split between the four below areas, where appropriate.

***Promotion, Prevention and Early Intervention* ($6.9 million)**

To complement existing investment targeting depression, suicide, resilience in school children and wellness in rural and remote communities, Queensland has funded the following initiatives.

Early Years Service Centres ($4.9 million)

Queensland is establishing four early years service centres to improve services and support for families with children from 0–8 years of age. The services will integrate universal child care and family support with early childhood education and health services and provide targeted support to vulnerable families in a non-stigmatising way. Mental health-related prevention and early intervention strategies will include parenting resources and programmes, emotional well-being and developmental programmes, a range of play therapy and counselling initiatives, health screening and assessment and mental health promotion. Specialist early childhood teams will provide home visits for high need families, outreach services to early childhood settings and broker specialist support as required. *Implementation arrangements:* through the Department of Communities. *Implementation commencement date:* the centres will be phased in from 2006 to 2009

Prevention Strategies in Schools

New strategies are also being developed to assist schools in supporting students with a mental illness. Strategies will include: regional contact officers; a statewide senior guidance officer; on-line materials; and staff professional development. *Implementation arrangements:* through the Department of Education and the Arts. *Implementation commencement date:* Queensland is reprioritising its existing budget commitments to allow for these to be developed as soon as possible.

Dual Diagnosis Positions ($0.8 million)

Thirteen new dual diagnosis positions will be created across Queensland to respond to people showing early symptoms of mental health and/or drug and alcohol problems. The positions will enhance service capacity in both the mental health and drug and alcohol sectors by: integrating assessment, intervention and care processes; implementing workforce development and training initiatives; and formalising collaboration and leadership development. The positions will have a strong early intervention focus. Part of the funding package is to improve the care system and is represented in that section. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2006

Transcultural Mental Health Workforce ($1.2 million)

Eleven transcultural mental health workers will be employed across thirteen District Health Services to support mental health services working with people from culturally and linguistically diverse backgrounds. Staff will dedicate a proportion of their time to work with local multicultural groups to initiate mental health promotion, illness prevention and early intervention strategies. The Queensland Transcultural Mental Health Centre will engage a range of bilingual mental health promoters, who will implement community activities that promote mental wellness. Part of the funding package is to improve the care system and is represented in that section. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2006

Integrating and Improving the Care System ($289.0 million)

Queensland will enhance mental health service delivery across a range of sectors. It will target both the general population and specific population sub-groups, including children and young people in care; Indigenous people; people from culturally and linguistically diverse backgrounds; the homeless; people who come into contact with police and the criminal justice system; and those in correctional facilities. Queensland will supplement its existing investment through the following initiatives.

Blueprint for the Bush Service Delivery Hubs ($1.8 million)

Under the auspices of Blueprint for the Bush, Queensland will establish three multi-tenant service hubs in rural and remote areas. The hubs will co-locate a range of services including family support workers; support services to vulnerable families with children from 10 to 14 years of age; and suicide prevention initiatives for older men at risk of suicide and self-harming behaviour and to promote social inclusion for isolated older people. *Implementation arrangements:* through the non-government sector. *Implementation commencement date:* from July 2007

Indigenous Domestic and Family Violence Counselling ($1.2 million)

Domestic and family violence counselling services will be piloted in three rural communities (the Torres Strait, Cooktown and Cherbourg) to provide support to Indigenous victims and child witnesses of domestic and family violence. The services will also provide outreach support to surrounding Indigenous communities. These counselling services can assist clients to overcome anxiety and depression, often associated with being a victim of violence, and reduce the likelihood of more serious mental illness developing. *Implementation arrangements:* through the non-government sector. *Implementation commencement date:* from March 2007

Child Safety Therapeutic and Behaviour Support Services ($17.6 million)

Queensland will provide capital and operational funding to establish two new therapeutic residential facilities in South East Queensland. The facilities will each provide placement options for four to six children and young people with complex to extreme needs at any point in time. It is part of a statewide roll-out of therapeutic services established to provide professional treatment for complex emotional, mental and behavioural problems in children. *Implementation arrangements:* to be operated under service agreements by the non-government sector. *Implementation commencement date:* July 2007

Health Action Plan - Existing Service Pressures ($58.1 million)

The pressure on acute mental health inpatient services and emergency departments has increased over the years as a result of approximately twice the national average population growth and increases in the level of acuity in people presenting with mental health problems. Additional funding will be targeted specifically at these services components to deal with high levels of bed occupancy and the high volume of mental health presentations in Emergency Departments. *Implementation arrangements:* through District Health Services. *Implementation commencement date:* from January 2006

Community Mental Health Services – Enhancement ($114.5 million)

Queensland will improve specialist community mental health services to provide acute care, crisis assessment, mobile intensive treatment, continuing care and intake and assessment services in

community settings. More people with mental illness will be able to access services and receive treatment in the community and in settings closer to their natural support networks. *Implementation arrangements:* through District Community Mental Health Services. *Implementation commencement date:* from 1 July 2006

Dual Diagnosis Positions ($4.7 million)

Thirteen new dual diagnosis positions will be created across Queensland to respond to people showing early symptoms of mental health and/or drug and alcohol problems. The positions will enhance service capacity in both the mental health and drug and alcohol sectors by: integrating assessment, intervention and care processes; implementing workforce development and training initiatives; and formalising collaboration and leadership development. Part of the funding package is for promotion and prevention activities and is represented in that section. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2006

Mental Health Intervention Teams ($4.1 million)

Funding will be provided to improve responses to mental health incidents that require police or ambulance officers. This initiative aims to prevent and resolve mental health crisis situations by establishing collaborative responses between Queensland Health, the Queensland Police Service and the Queensland Ambulance Service. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* 1 January 2006

Forensic Mental Health Services ($14.8 million)

Additional funding will be provided to enhance service responses to high-risk forensic patients in Queensland. This will include the provision of support services to people with mental illness transitioning through the criminal justice system and the provision of support, advice and education to district mental health staff to manage high-risk patients. *Implementation arrangements:* through Community Forensic Mental Health Services. *Implementation commencement date:* from 1 July 2006

Transcultural Mental Health Positions ($6.8 million)

Eleven transcultural mental health workers will be employed across 13 District Health Services to support mental health services working with people from culturally and linguistically diverse backgrounds. Staff will dedicate a proportion of their time to work with local multicultural groups to initiate mental health promotion, illness prevention and early intervention strategies. At the statewide level, the Queensland Transcultural Mental Health Centre will engage a range of bilingual mental health promoters who will implement community activities that promote mental wellness. Part of the funding package is for promotion and prevention activities and is represented in that section. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2006

Area Clinical Mental Health Networks ($7.7 million)

In recognition of ongoing pressures on mental health services, Queensland will allocate funding to Area Mental Health Clinical Networks to address priority service capacity issues and to initiate innovative responses to area-wide service delivery issues. *Implementation arrangements:* through Area Mental Health Clinical Networks. *Implementation commencement date:* from 1 July 2006

Alternatives to Admission ($17.5 million)

Nine District Health Services have been funded to develop and implement a range of alternatives to acute admission, in collaboration with the non-government sector, consumers and carers. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2007

Responding to Homelessness ($19.7 million)

As part of the Responding to Homelessness Strategy 2005-2009, Queensland will establish homeless outreach teams in Brisbane, the Gold Coast, Townsville, Cairns, and Mount Isa as part of a commitment to address homelessness and public intoxication. In addition, 36 transitional housing places will be established in Brisbane and Townsville. This will assertively tackle the high prevalence of mental illness amongst homeless people in high-need areas and reduce the number of people with mental illness being discharged into homelessness. *Implementation arrangements:* through District Mental Health Services; Department of Housing and the non-government sector. *Implementation commencement date:* this project has been underway since 1 July 2005

Mental Health Services in Prisons ($8.6 million)

Queensland will enhance clinical mental health services to people in correctional facilities across the state, including in-reach assessment and treatment services. *Implementation arrangements:* through Community Forensic Mental Health Services and District Mental Health Services. *Implementation commencement date:* from 1 July 2006

Mental Health Capital ($12.0 million)

Queensland has committed capital funding of $5.8 million over five years for the construction and redevelopment of designated mental health facilities to support enhanced access to services. In 2006-07, the Cairns Mental Health Community Rehabilitation and Recovery Service and the Rockhampton Child and Youth Mental Health community clinic will be completed. An investment of $41.0 million over five years in a number of community health and primary health care centres including Gladstone, Nundah, and Yarrabah will also result in enhanced access to community-based health and mental health services. This $41.0 million investment includes $6.1 million which will be specifically for access to community mental health services. *Implementation arrangements:* through District Health Services. *Implementation commencement date:* from 1 July 2006

Participation in the Community and Employment, including Accommodation ($64.3 million)

Queensland will supplement its existing investment through the following initiatives.

Housing Capital ($20.0 million)

A mix of accommodation to best meet the needs of individual clients will be procured for adults with a mental illness and moderate to high support needs (clinical and non-clinical) who are currently housed inappropriately, and who are assessed as being able to live independently in the community, with appropriate support. Housing for about 80 people will be provided in 2006-07 in accordance with social housing eligibility guidelines. Planning is currently under way with Queensland Health and Disability Services Queensland to link identified clients with support arrangements who are ready to live independently with suitable accommodation arrangements. *Implementation arrangements:* through the Department of Housing. *Implementation commencement date:* from 1 July 2006

Health Action Plan Non-Government Organisation Funding ($25.0 million)

Funding will be provided to Queensland non-government organisations to support people with a mental illness living in the community, including people living in housing provided by the $20.0 million capital investment identified above. This will ensure that people living in the community have access to adequate clinical and non-clinical support to assist them in their recovery process. *Implementation arrangements:* through the non-government sector. *Implementation commencement date:* 1 July 2006

To further complement the $20.0 million housing capital, the Queensland Government will support clients through the Special Fiscal and Economic Statement funding announced in October 2005, specifically the Mental Health Community Organisation Funding Programme; and growth funding to Disability Services Queensland for accommodation support services. The housing capital investment will also enable some acceleration of Project 300 clients to access appropriate accommodation.

Disability Services Respite and Sector Capacity Building ($12.0 million)

Additional funding will be provided for the establishment of new, and enhancement of existing, respite and day services. Additional services under the Resident Support Programme will be funded to assist people living in private residential facilities, while people inappropriately housed in hostels and boarding houses will be supported to relocate to alternative accommodation through Hostels Response funding. Funding through both the Family Support and Adult Lifestyle Support Programmes will enable people with a psychiatric disability to maintain their community living either independently or with their families. *Implementation arrangements:* mostly through the non-government sector. *Implementation commencement date:* from August 2006

Employment and Training ($5.0 million)

Financial assistance will be provided to the non-government sector as part of the 'Breaking the Unemployment Cycle' initiative, to provide job and training opportunities to people with a mental illness who experience disadvantage in the labour market. Funding will initially be provided under the Community Jobs Programme to community and public sector organisations to provide job search assistance and training to people with a mental illness and/or employment for three to six months on projects that will enhance skills development and future employment prospects. It is proposed that approximately $1.0 million will be directed towards projects during 2006-07 to assist 130 people with a mental illness. From 2007-08 onwards, it is proposed that about 100 people with a mental illness will be assisted each year for the following four years. *Implementation arrangements:* predominantly through the non-government sector. *Implementation commencement date:* from August 2006

Mental Health Services in Prisons ($2.3 million)

Funding will be provided to the non-government sector to support the enhanced prison mental health services, particularly to provide post-release support to people with mental illness returning to the community. *Implementation arrangements:* through the non-government sector. *Implementation commencement date:* 1 July 2006

***Increasing Workforce Capacity* ($6.1 million)**

Queensland is the most decentralised state in Australia, and as such, needs a workforce for the large, urban specialist inpatient and community mental health services, and a workforce for its small rural and remote communities. This requires a range of different skill sets to meet differing needs and appropriate remuneration and conditions of employment to ensure that Queenslanders have access to high-quality health care. Queensland will supplement its existing investment through the initiatives outlined below.

Increased Workforce Remuneration ($5.8 million)

As a result of this overall increased investment in mental health, remuneration and conditions of employment have improved for all mental health staff which will assist in attracting and retaining the required workforce. This will particularly assist in the areas of community mental health services ($3.6 million), community forensic mental health services ($1.0 million), services to correctional facilities ($1.0 million) and services designed to assist situations where the first response is by police or ambulance officers ($0.2 million). *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2006

Mental Health Transition to Practice Nurse Education Programme ($0.3 million)

Queensland Health will establish a Mental Health Transition to Practice Nurse Educator Programme to provide adequate practical clinical experience for inexperienced nurses before they enter the mental health sector. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* 1 July 2006

INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

WESTERN AUSTRALIA

In September 2004 the Western Australian Government announced the *Mental Health Strategy 2004-07*. The strategy is targeted to:

- expand statewide mental health emergency services within emergency departments;
- increase access to adult in-patient beds for people with severe mental illness;
- promote recovery for people with mental illness through provision of accessible community services, which encourage early identification, intervention and rehabilitation, and to enhance service coverage and accountability and provide a whole of service/government approach to promote mental health and recovery from mental illness for young people; and
- expand the range and amount of community supported accommodation services for people with severe and persistent mental illness.

The strategy contains increases in both capital and operating funding and covers expenditures within the Department of Health and other agencies, including the Department of Housing and Works.

The table below provides summary information on the budgeted increases in funding for mental health initiatives provided since the commencement of the strategy.

	2004-05	2005-06	2006-07	2007-08	2008-09	2009-10	
	Actual $'000	Estimated Actual $'000	Budget $'000	Budget $'000	Budget $'000	Budget $'000	Total $'000
Operating	11,000	32,484	47,268	30,000	30,000	30,000	**180,752**
Capital	516	4,200	20,584	19,000	15,500	12,000	**71,800**
Total	11,516	36,684	67,852	49,000	45,500	42,000	**252,552**

Western Australia's contribution to the National Action Plan is therefore not a one-off effort, but rather a continuation of the State's deliberate *Mental Health Strategy* of growth and reform. In total, this lifts overall spending on mental health funding by the Western Australian Government to more than $300 million a year. Further information on the additional funding allocated under the *Mental Health Strategy* is provided below.

***Promotion, Prevention and Early Intervention* ($60.7 million over six years)**

Multi-systemic Therapy for Adolescents ($10.5 million)

This initiative will provide two Multi-systemic Therapy (MST) Teams for young people aged 12 - 16 years at risk of developing mental illness in the south and north metropolitan areas. *Implementation arrangements:* establishment of clinical teams through Area Mental Health Services. *Implementation commencement date:* September 2005

Post-natal Depression Services ($2.0 million)

Statewide Post-natal Depression (PND) Service for mothers with babies will be expanded through non-government community services, including areas with a high growth of young families. Research will be undertaken to develop PND services for culturally and linguistically diverse and Aboriginal groups. *Implementation arrangements:* statewide service provision through a non-government service. *Implementation commencement date*: July 2006

Assertive Case Management Systems (including Increased Access to In-patient Care) ($45.2 million)

Based on national benchmarks to meet the increase in population, community mental health team staffing levels will be increased to introduce the Assertive Community Care (ACC) model. This model will be embedded within existing community mental health services to provide intensive intervention to people with severe and persistent mental illness. *Implementation arrangements:* through Area Mental Health Services to existing community mental health services. *Implementation commencement date:* July 2006

Homeless Clinical Services ($1.0 million)

This service will provide transitional supported accommodation services in the metropolitan area for homeless adults and young people with a mental illness, including 24-hour on site supported residential accommodation, access on site to specialist mental health, substance abuse and psychosocial support services and access on site to employment, income support and educational services. *Implementation arrangements:* through non-government services. *Implementation commencement date:* May 2008

Intensive Community Youth Services ($2.0 million)

This service will provide intensive counselling, access to stable accommodation, education and employment access for homeless youth at risk of mental illness, with little family or guardian support, in the south metropolitan area. *Implementation arrangements:* establishment of a clinical community service through the South Metropolitan Area Mental Health Service. *Implementation commencement date:* services operational with permanent offices to be completed by November 2007

***Integrating and Improving the Care System* ($53.6 million over six years)**

Emergency Department Mental Health Liaison Nurses and On-duty Registrars ($24.5 million)

Additional mental health nurses will provide 24-hour 7-day a week specialised mental health triaging and clinical support within Emergency Departments across the metropolitan area. The number of On-Duty Psychiatric Registrars for after hours cover across the metropolitan area will also be increased to provide psychiatric assessment, treatment and support for mental health patients in the Emergency Department. *Implementation arrangements:* through Area Mental Health Services. *Implementation commencement date:* July 2006

Acute Observation Emergency Department Beds ($20.1 million)

Observation mental health beds will be established three main metropolitan hospitals (Joondalup, Fremantle Hospital and Royal Perth Hospital) and a four-bed admissions unit will be established at the main psychiatric hospital, Graylands. These units will provide a safe and secure environment for both patients and staff during assessment and triage. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* March 2007

Rural and Remote Medical Cover ($9.0 million)

Additional psychiatrist and medical officer cover in rural and regional Western Australia. *Implementation arrangements:* recruitment through Area Health Services. *Implementation commencement date:* September 2006

***Participation in the Community and Employment, including Accommodation* ($129.4 million over six years)**

Intermediate Care Units ($25.0 million)

These units will be established in the metropolitan and regional areas to provide a central role in the progressive move towards more community based rehabilitation and recovery services. The units will be available for consumers who are no longer in the most acute phase of their illness, but who are not

yet ready for discharge to supported accommodation or independent living. Consumers will be engaged in a multi-disciplinary therapeutic programme, tailored to their individual needs and strengths, to prepare them for entry into either independent living or supported community accommodation. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2008

Day Treatment Programme ($29.0 million)

This initiative will establish Day Therapy services in metropolitan locations. Art Therapy Services will also be established in Joondalup and Northbridge and an adult transition unit at Sir Charles Gairdner Hospital. Day Therapy Units will be intermediate level services based on a recovery model, using multi-disciplinary teams, and including a range of rehabilitative interventions following inpatient care, intensive therapy for individuals with long-term severe mental disorders following a relapse and ensure rehabilitation and maintenance, early intensive treatment options for those severely affected by the high prevalence disorders (anxiety, panic disorder and depression) and for some services, low prevalence disorders (eating disorders, and obsessive compulsive disorders). *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* November 2006

Supported Community Residential Units ($27.2 million)

Community Supported Residential Units will be established in key metropolitan and rural locations. This cluster style accommodation will provide 24-hour non-clinical support in permanent, home-like accommodation to support community integration and participation including access to generic mainstream services, facilities and recreational pursuits, along with access to a mix of services including clinical, case management, GP and non-clinical community support. *Implementation arrangements:* through non-government services, in collaboration with Area Mental Health Services. *Implementation commencement date:* August 2007

Licensed Psychiatric Support Expansion ($10.0 million)

Psychosocial support services to people with severe and persistent mental illness living in psychiatric hostels will be expanded, including an increase in the Personal Care Subsidy payment. *Implementation arrangements:* increased service delivery through psychiatric hostels. *Implementation commencement date:* July 2006

NGO Psychosocial Support Expansion ($10.0 million)

This initiative will expand non-clinical psychosocial support services to assist people to live in their own homes, including purchasing personal care services to provide assistance for each resident with activities for daily living and communal living. It will also establish 60 housing units for the Independent Living Programme per year. *Implementation arrangements:* increased service delivery through non-government services. *Implementation commencement date:* July 2006

Clinical Rehabilitation Teams ($28.2 million)

This service will establish two Mobile Clinical Rehabilitation Teams (CRT) to maintain people with chronic mental illness and disability, who have been long-term inpatients, in supported community-based residential environments. These multidisciplinary teams will provide ongoing clinical and rehabilitation services to residents. The model will be one of intensive and assertive case management where each team is responsible for all aspects of clinical mental health care and rehabilitation. The CRTs will develop strong partnerships and will collaborate with the non-government accommodation provider on the best way to relocate individuals and provide the ongoing clinical, rehabilitation and disability support. *Implementation arrangements:* through Area Mental Health Services in collaboration with a non-government service provider. *Implementation commencement date:* December 2008

***Increasing Workforce Capacity* ($8.8 million over six years)**

Workforce and Safety Initiatives ($2.3 million)

A statewide mental health safety group has been convened to provide a sector-wide response to major safety issues for staff and patients in mental health services. The safety group will produce guidelines on areas such as design of mental health facilities, training and safe transportation of patients, the use and availability of duress alarms, communication (including mobile telephones) and safe flexible working environments. In addition to the work of this group, guidelines on the management of inpatient violence are also being developed, in collaboration with clinicians and consumers. *Implementation arrangements:* statewide in collaboration with Area Mental Health Services. *Implementation commencement date:* October 2006

Workforce Development and Expansion ($5.5 million)

The Department of Health will embark on a major recruitment drive in Australia and overseas to recruit and retain staff. The Department will also work in collaboration with Western Australian universities to attract graduates and post-graduates to mental health nursing. *Implementation arrangements:* through Area Mental Health Services and in collaboration with universities. *Implementation commencement date*: July 2006

Standards and Implementation Monitoring ($1.0 million)

The following programmes will be delivered to implement the National Practice Standards:

- a statewide orientation programme for all staff new to Western Australia;
- the development and implementation of a framework and training package for clinical supervision, along with a supervision database;
- the facilitation of a Mental Health Management and Leadership programme for senior mental health staff;
- the development of a cultural competency training package that includes cultural competency standards and a self-assessment audit tool for mental health services;
- the transfer of $2.0 million to Health Services to procure duress systems across the State;
- the progressive implementation of the Mental Health Clinical Information System (PSOLIS);
- a project to develop a policy and clinical practice framework in Clinical Risk Assessment and Management, including the implementation of these standards in Health Services, through training; and
- development of training programmes for nursing professions and NGO sector development.

Implementation arrangements: through the Office of Mental Health, in collaboration with Area Mental Health Services. *Implementation commencement date:* January 2006

INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

SOUTH AUSTRALIA

Over the past four years South Australia has increased spending on mental health service programmes by 24 per cent, from a base of $145.8 million in 2001-02 to $181.0 million in 2005-06. In addition, a one off allocation of $25.0 million was made for the provision of non-government mental health services in 2005-2006 and 2006-07. Additionally, the South Australian Government has made new commitments with relevance to this Plan. Over four years South Australia will deliver a $116.2 million programme of additional expenditure in mental health services:

- $50.1 million in new additional recurrent funding commencing in the 2006-07;
- $53.1 million in recurrent funding for programmes and services which have been previously announced; and
- $13.0 million in one off funding for programmes and services which have been previously announced.

The 2006-07 South Australian Budget will be brought down on 21 September 2006. Further information on the programmes below concerning implementation arrangements, implementation dates and final funding commitments and their impact over five years will be available after the 2006 Budget.

Promotion, Prevention and Early Intervention ***($39.5 million over four years)***

Promoting Mental Health ($1.1 million)

A new five year agreement with *beyondblue* commences on 1 July 2006. Funding will be provided to *beyondblue* to develop promotion and prevention strategies, enhance professional training, commission and support research and promote partnerships across health and other sectors. *Implementation commencement date*: 1 July 2006

Preventing Mental Illness by Building Resilience ($29.6 million)

The *Every Chance Every Child* home visiting programme will be expanded with an additional $6.5 million over four years to provide families in need with up to 34 visits in the first two years of their baby's life. South Australia's network of Early Childhood Development Centres will be expanded to 20 with the establishment of a further 10 centres. They will provide education services for children and their parents, and will help children in the transition from the early years to junior primary school. Health services will include: immunisation and health checks; child and youth health; parenting networks; child and adolescent mental health; speech pathology; and health promotion ($13.0 million capital funding and $10.0 million recurrent over four years). These initiatives give increased capacity to programmes focusing on building resilience and coping skills of children, young people and families.

Early Intervention with Young People ($8.8 million)

The *Healthy Young Minds* programme will provide 20 additional community outreach workers in Child and Adolescent Mental Health Services, plus three psychiatrists to improve and expand services in areas where there is high demand for therapy.

Integrating and Improving Care Systems ***($75.7 million over four years)***

Shared Care with General Practitioners (GPs) ($10.0 million)

This initiative will provide 30 allied health professionals such as psychologists, occupational therapists, nurse practitioners and social workers to work with GPs in private practice. GPs are at the frontline in the delivery of primary health care services. This shared care initiative will increase their capacity to provide appropriate services to people with mental illness who have complex needs.

Improving Services to People with Mental Illness and Drug and Alcohol Issues ($3.5 million)

Through the *Healthy Young Minds* funding, two specialist mental health workers and a consulting psychiatrist will provide an outreach service for adolescents with both mental illness and substance abuse problems ($1.2 million over four years). This builds on the 2005 allocation of $578,000 per year for coordinated care between mental health and drug and alcohol services.

24-hour Mental Health Access by Telephone ($8.0 million)

A 1800 number service will provide South Australia with a mental health telephone advice, triage and referral service, staffed by mental health clinicians. This will link into the National Health Call Centre agreed to by COAG.

Enhancing Emergency Department Responses ($6.7 million)

Mental health cover in the Emergency Department of the Women's and Children's Hospital will be extended to provide 24-hour seven day a week help for children and adolescents in crisis ($480,000) through *Healthy Young Minds* funding. This builds on the annual allocation of $1.4 million for 15.4 additional, full-time mental health liaison nurses in metropolitan emergency departments to enhance patient services and the $156,000 per year to expand the Mental Health Emergency Response Service for Children and Young People, based at the Women's and Children's Hospital, announced in 2005.

Improving Access to Acute and Community-based Clinical Services ($22.7 million)

Acute and community-based mental health services have been given increased capacity to assist people who are experiencing acute episodes of mental illness to prevent crisis and promote rehabilitation and recovery. Ten new nurse practitioners will be placed in metropolitan and country regions, working in areas such as Glenside Hospital, emergency departments, aged care, and the child and adolescent sector ($1.1 million per year). The programme includes: 20 extra nurses or allied health professionals to enhance assertive care of those with severe and complex illnesses ($1.0 million per year); increasing mental health 'hospital at home' services ($1.2 million per year): more social workers to provide and evaluate discharge follow-up for each patient leaving hospital ($740,000 per year); the Central Northern Adelaide's Peer Support Programme will employ mental health consumers to provide support, education and advocacy for fellow consumers in our mental health system ($500,000 per year); a youth mobile outreach service focused on reducing the rate of relapse in young people through timely emergency intervention ($265,000 per year); and community support and expansion of Assessment and Crisis Intervention team capacity to improve emergency mobile response ($830,000 per year).

Increased Services for People in Country Areas ($7.6 million)

More services are being provided in rural and remote areas and a more flexible approach to service delivery in these areas. This has been made possible through: six additional workers in country-based Child and Adolescent Mental Health Services ($475,000 per year); enhanced treatment and support of people experiencing acute mental illness in country areas ($600,000 per year); additional psychosocial rehabilitation programmes ($496,000 per year); and expanded emergency triage and liaison services for country South Australians ($330,000 per year).

Extra Support for Aboriginal and Torres Strait Islander People ($5.1 million)

This is being done by enhancing the Northern Assessment and Crisis Intervention Team's emergency response for Aboriginal and Torres Strait Islanders ($180,000 per year) and development of a peer-support programme for Aboriginal and Torres Strait Islanders run by Central Northern Adelaide Health Service ($100,000 per year). A substance abuse treatment centre and outreach programme will provide assessment, referral to hospital if intensive medical support is required for detoxification, and residential rehabilitation programmes for up to three months on the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands ($1.0 million per year).

Community Support ($12.0 million one-off)

Community based psycho-social support services to enable consumers with mental illness to reside safely in the community with packages of support delivered through community organisations. Support packages include home-based support, social skill development, assistance with medication management, support to engage with recreation, training education and employment. Funding is also included for building capacity with General Practice to work with primary care networks and provide shared care mental health specialist services.

Increasing Workforce Capacity ($1.0 million one-off)

Peer Support Workers ($1.0 million)

Training and employment of peer support workers to work alongside mental health workers has been provided with one-off funding. These peer workers will provide support, education, and advocacy for fellow consumers of the mental health system.

INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

TASMANIA

The Tasmanian Government committed to significant reform and investment in service delivery for mental health services following the 2004 *Bridging the Gap* review. This was in recognition that Tasmanians suffering mental illness are entitled to expect high quality, professional mental health care in a safe environment.

The approach to reform will see the Mental Health Services budget increase from $55.5 million in 2003-04 to $92.5 million in 2006-07. The reforms and growth to Tasmania's mental health system will be based on the *Tasmanian Mental Health Services Strategic Plan 2006-2011*. The Strategic Plan aligns closely with the directions of the COAG Plan.

The Tasmanian Government understands that improvement of mental health services is not static and requires consistent and constant attention to ensure best practice, transparency and accountability. Following implementation of the *Bridging the Gap* reforms an evaluation of this strategy will result in recommendations for future effort for the period 2008-2011.

***Promotion, Prevention and Early Intervention* ($2.0 million)**

Kids in Mind Tasmania ($2.0 million)

The Kids in Mind Tasmania (KIMT) initiative focuses on the needs of and support for children and young people in families where a parent has a mental illness. Services are delivered by non-government organisations (NGOs) funded to conduct specific interventions (Taz Kidz Clubs, Champs Camps) and by staff employed within Mental Health Services. The programme commenced as a two-year trial in 2004. This allocation of at least $400,000 per annum will build upon and extend the KIMT trial as part of ongoing mental health services.

***Improving and Integration the Care System* ($21.1 million)**

Improved Alcohol and Drugs Programmes ($2.0 million)

Funding will be provided to Tasmania's Alcohol and Drug Services, including NGOs, to provide better support and further development for people with drug and alcohol problems, especially through the shared care model for pharmacotherapy.

Secure Mental Health Unit ($12.5 million)

The Wilfred Lopes Centre is a secure hospital, primarily for patients from the criminal justice system who are in need of psychiatric assessment and/or care and treatment. The hospital has been purpose-designed and built to further the delivery of advanced clinical programmes. An allocation of $2.5 million per year ($12.5 million over five years) has been made. Patients will be provided with modern, professional and highly specialised psychiatric care and treatment. Treatment will be based on individually tailored programmes designed to support independence and dignity, and minimise the ill effects of long-term care.

Improved Access to Acute Psychiatric Care, including Emergency, Crisis, Acute Inpatient and Community Services ($1.5 million)

Additional clinical positions to assist people experiencing serious mental illness to receive better coordinated treatment and care will be allocated following a review of existing positions, and the needs of the Tasmanian population. Implementation of the Tasmanian model of care will result in a statewide triage process, commencing in September 2006, to provide a standardised user-friendly access point for all consumers, carers, and supporting organisations to refer people experiencing mental illness to Mental Health Services.

Improved Youth Health Services - Child and Adolescent Mental Health Services (CAMHS) ($5.1 million)

Additional clinical positions will be added to CAMHS to provide assistance to young people experiencing serious mental illness, and act as a resource to services that also work with young people.

Participation in the Community and Employment, including Accommodation ($11.3 million)

Additional Accommodation for People with Mental Illness ($6.3 million)

A total of $5.3 million will be invested in a Launceston facility and accommodation clusters in the North West and South to provide supported accommodation for people experiencing serious mental illness. Further funding has also been allocated to provide an expansion of level one and two packages of care.

Support to the Non-Government Sector to Provide Quality Services to People with Mental Illness ($5.0 million)

Additional support to the non-government sector will be provided for recovery services for people experiencing serious mental illness ($2.2 million), more packages of care ($2.9 million) and the upgrading of services ($500,000).

Increasing Workforce Capacity ($8.6 million)

Improve the Working Conditions and Remuneration for Doctors and Allied Health Professionals ($8.6 million)

In an environment of serious workforce shortages across all disciplines within mental health services there is strong demand for professionals. Funding to improve the working conditions and remuneration for doctors and allied health professionals will assist Tasmania to successfully fill additional places in its expanded mental health workforce.

INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

AUSTRALIAN CAPITAL TERRITORY

Mental health service delivery and prevention activity in the Australian Capital Territory (ACT) is guided by the population mental health framework of the *ACT Mental Health Strategy* and *Action Plan*. The strategy describes the local service picture and priorities for the Territory. The prioritising of mental health by COAG has enabled a number of ACT priorities to be brought forward. The actions described in this Individual Implementation Plan emerge from the alignment of local priorities with the areas identified for action in the COAG Plan.

The ACT will work collaboratively with the Commonwealth and other jurisdictions to achieve the best outcome from the national reform of mental health, including effective interaction of government and newly-funded community services.

The ACT Government has allocated a total of $20.6 million over five years for new mental health initiatives. The specific initiatives are outlined below, with funding amounts over five years unless otherwise stated.

***Promotion, Prevention and Early Intervention* ($3.2 million)**

Funding will be provided to begin implementation of the ACT Action Plan for Mental Health Promotion, Prevention and Early Intervention 2006 – 2008 as outlined below.

Perinatal and Infant Mental Health Services ($0.9 million)

This initiative will enhance mental health services capacity to participate in an integrated model of early childhood health care, and provide an early intervention approach to service delivery. This model will build on the successful *beyondblue* perinatal project previously undertaken in the ACT as part of the national project.

Community Education ($0.4 million)

This initiative will increase the capacity of community agencies to provide mental illness education to the ACT community through schools and other agencies. Services will be based on a 'consumers and carers as educators' model.

Children of Parents with a Mental Illness ($0.3 million)

This initiative will provide for the development and delivery of a training programme for professionals and community workers across sectors to enhance skills in working with children of parents with a mental illness (COPMI).

Workplace Mental Health Promotion ($0.7 million)

This initiative will facilitate the ACT working in partnership with *beyondblue* and other agencies to support the development of mental health promotion in workplaces throughout the ACT. This programme will not only help to raise awareness of mental illness but will also provide training and education about how to maintain a mentally health workplace and reduce the risk of mental illness.

Early Recovery Support ($1.0 million)

Additional funding will provide intensive early recovery support for people who have experienced an episode of mental illness and hospitalisation, to overcome the barriers to re-engagement with the community and rehabilitation programmes.

***Integrating and Improving the Care System* ($11.5 million)**

Improving the General Health of People with a Mental Illness ($0.8 million)

This funding will embed and expand the ACT Better General Health for People with Mental Illness pilot programme. This programme improves the physical health outcomes for persons with serious mental illness through improved referral and access for clients of Mental Health ACT to GP practices. There may be future capacity to utilise this programme as a model for collaborative service delivery between specialist mental health services and GPs.

Increase Capacity for Carer and Consumer Participation in Service Planning ($0.4 million)

The ACT Government will allocate additional funding to provide additional part-time carer and consumer consultant positions to improve the level of consumer and carer contribution to the development of mental health services that better meet their needs.

Mental Health Legislation Review ($0.2 million over two years)

The ACT Government is funding a full review of the *ACT Mental Health (Treatment and Care) Act* to ensure compatibility with the *ACT Human Rights Act* and consistency with current best practice for mental health. The review will be conducted in full consultation with consumers, carers and all other key stakeholders.

Mental Health Services Plan ($0.08 million in 2006-07)

Funding has been allocated to develop a comprehensive Mental Health Services Plan for the ACT to guide the future development and operation of government and community agency mental health services, including redevelopment of inpatient services to meet the special needs of groups such as women and adolescents and culturally and linguistically diverse communities. The Plan will be developed in consultation with the ACT community and will consider the range of services required for good mental health including specialist clinical services, primary care, step-up/step-down services, rehabilitation, employment and accommodation. This Plan will guide future funding decisions for mental health based on those service needs identified in the Plan.

Intensive Treatment and Support Programme for People with a Dual Disability ($10.0 million)

Funding has been allocated for the ACT Department of Disability, Housing and Community Services to establish the Intensive Treatment and Support Initiative for People with Dual Disabilities. The service is expected to commence in July 2006 and will provide a comprehensive additional service for an identified group of clients aged 17 and over who have an intellectual disability and a mental disorder with complex behavioural problems and who are at significant risk of entering the criminal justice system. The programme includes a step-up short-term purpose-built accommodation to be used for some within this client group requiring intense support.

***Participation in the Community and Employment, including Accommodation* ($2.8 million)**

Youth Supported Accommodation ($2.8 million)

This initiative will increase capacity to provide 24-hour supported accommodation and outreach services to youth with mental illnesses, which is an identified area of need in the ACT. This service will be developed in collaboration with the community sector and will provide a safe, supportive environment to facilitate early intervention and access to education and employment opportunities for this client group.

***Increasing Workforce Capacity* ($3.1 million)**

Additional Medical Workforce Positions ($3.1 million)

This funding has been allocated to provide medical officer positions for the ACT public mental health system. These additional positions will help to improve access to specialist mental health services in the ACT.

INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

NORTHERN TERRITORY

The following is a summary of the Northern Territory initiatives that commenced in 2006 or that are planned to commence in 2007. Funding for these initiatives is committed for the full five years of the Plan.

***Promotion, Prevention and Early Intervention* ($1.0 million)**

Suicide Prevention and Response ($1.0 million)

Increased suicide prevention and response activities including creation of a Suicide Prevention Coordinator position. *Implementation commencement date:* 2006

***Integrating and Improving the Care System* ($13.0 million)**

Sub-acute Beds ($5.5 million)

24-hour supported community based services as an alternative to hospital admission or to facilitate intensive support following discharge from hospital. *Implementation commencement date:* facilities planning underway, service expected to commence January 2007

Rural and Remote Services ($4.0 million)

Increased services to rural and remote communities, including additional child and adolescent clinical positions for rural and remote areas, increased funding to Aboriginal Mental Health Worker Programmes and Visiting Psychiatrist Services (in addition to Medical Specialist Outreach Assistance Program funding). *Implementation commencement date:* 2006

Prison In-reach Services ($3.5 million)

Increased forensic mental health clinical, behavioural and Aboriginal Mental Health Worker positions to provide in-reach services to people in Alice Springs and Darwin prisons who have a mental illness, intellectual disability or acquired brain injury. *Implementation commencement date:* 2006

***Participation in the Community and Employment, including Accommodation* ($0.5 million)**

Rehabilitation and Recovery Services ($0.5 million)

Increased funding for rehabilitation and recovery and carer support services provided by the non-government sector. *Implementation commencement date:* 2006

QUEENSLAND HEALTH

CHILD AND YOUTH MENTAL HEALTH PLAN

2006-2011

EXECUTIVE SUMMARY

The Queensland Health Child and Youth Mental Health Plan 2006-2011 ("the Plan") has been developed in the context of the broader Queensland Health Mental Health Plan 2006-2011. It represents a balance between maintaining the objectives towards which the Queensland child and youth mental health system has been striving under previous Plans and other strategic documents, and a new emphasis on innovative solutions to address persistent gaps in service delivery.

Enhancements required to implement the Plan are as follows. A summary table (Attachment 1) suggests a phased roll-out for these enhancements.

Workforce Enhancements

- Traineeships (entry level/PO1) x 30
- Nurse Educators (NO3) x 8.5
- CYMHS Educators (PO4) x 3
- Training Officers (PO3) x 13
- Allied Health Upgrades and Enhancements (PO5 to PO6 x 3, PO4 to PO6 x 2,
- PO4 to PO5 x 3)
- Team Leader Upgrades (up to 35 expected from PO4 to PO5)
- New Professional Senior PO5 x 3
- New Professional Senior PO4 x 5
- Administrative Support (AO2) x 14
- Leave relief/backfill enhancements (PO3) x 0.5 FTE x 17
- Service Development Officers (AO6) x 10.0
- Consumer Consultants x 19
- Advanced Health Worker (007)
- New Workforce Project $487 197

Intensive Treatment Enhancements

- Redevelopment of inpatient units – CAFTU, Mater, RBWH
- Modifications to paediatric wards – quarantined fund of $1.3m
- Staffing enhancement – CAFTU, Mater
- Day programs – Townsville, Toowoomba, Logan, Gold Coast, Sunshine Coast, Brisbane North
- Expansion of day program - Mater
- Full staffing, Gold Coast Adolescent Unit – 2 x NO1, 2 x PO3
- Redevelopment of Barrett Adolescent Centre - $17m capital works, 44 FTEs
- 20% loading on bed day costs for child and adolescent inpatient facilities
- Increase in Patient Transit Scheme to facilitate admissions to day programs

Continuing Care Enhancements

- e-CYMHS – full-year recurrent costs by Year 5 - $863 450 + $770 656
- Community staff – to minimum ratio of 40:100 000 child and youth population
- Speech pathology enhancements – 20.0 FTE x PO3, 1.0 FTE x TO2/OO4
- Young adult outreach services – 16.0 FTE x PO3/NO2

Infant and Early Childhood Mental Health Enhancements

- Capital Works $5,200,000
- Recurrent Staffing Costs $7,745,522 or 7,602,332

Emergency Psychiatry Enhancements

- Emergency Psychiatry Teams – Stage 1 = 48 x PO3/NO2, Stage 2 = 48.5 x PO3/NO2
- Acute Care Teams – Stage 1 = 47 x PO3/NO2, Stage 2 = 37 x PO3/NO2
- Resourcing to establish 24-hour phone line
- Resourcing to establish new accommodation options

Intersectoral Collaboration Enhancements

- 16 x FTE (PO3/NO3) Partnerships Facilitators
- 6 Joint Assessment Clinics – 6.0 x FTE Psychologist (PO3), 1.8 x FTE Administrative Officer (AO2), 1.2 x FTE Psychiatrist
- Special Assessment Unit – 0.5 x FTE Psychiatrist, 1.0 x FTE Registrar, running costs equal to approximately 1/3 Mater inpatient unit's current budget

Eating Disorders Enhancements

- Stage 1 – 8.0 FTE x PO4 Care Co-ordinator positions
- Stage 2 – Intensive outpatient treatment - 4 x teams of 6 FTEs + Psychiatrist + Registrar, plus 2.0 FTE x PO3/NO2 for regional enhancement
- Stage 3 – 6.0 FTE x PO4 Care Co-ordinator positions

Promotion, Prevention, Early Intervention Enhancements

- Services for Children of Parents with Mental Illness (COPMI): 8.5 x FTE PO3/NO2
- Consultation/Liaison Services: 12.5 x FTE PO3/NO2 + 0.5 FTE Registrar
- Resourcing for mental health policy and infrastructure, mental health promotion, mental illness prevention, and early intervention, as outlined in the Mental Health Promotion. Illness Prevention and Early Intervention Subgroup Report 2006

Forensic Mental Health Enhancements

- Southern/Central Child and Youth Forensic Outreach Service – 7 x FTEs
- Northern Child and Youth Forensic Outreach Service – 4 x FTEs
- Southern and Central Area MHATODS – 6.5 x FTEs + 0.5 FTE psychiatrist
- Northern Area MHATODS – 3.5 x FTEs + 0.5 FTE psychiatrist
- Statewide Child and Adolescent Forensic Psychiatrist – MO2
- MST Teams ($1m) x 3
- 12-bed unit for adolescents with mental health issues and high risk behaviours, involved in the juvenile justice system

Dual Diagnosis Enhancements

- 2.0 x FTE for ADAWS service (Mater CYMHS)
- 60.0 x FTE to establish ADAWS-type services in Townsville, Royal Children's Hospital, Sunshine Coast, and Gold Coast
- 2.0 x FTE to enhance the capacity of the CYMHS team in Cairns to provide an aftercare service for adolescents who have been treated for drug and alcohol issues

Indigenous Mental Health Enhancements:

- 1.0 FTE x AO2
- 2.0 FTE x PO3/NO2
- 3. 0 FTE x TO2/004 Indigenous Mental Health Workers

Capital Works Requirements

- Office Accommodation for Community Mental Health Staff
- Accommodation for rural and remote staff
- Redevelopment of inpatient units – CAFTU, Mater, RBWH
- Modifications to paediatric wards
- Day programs
- Future inpatient facilities
- Redevelopment of Barrett Adolescent Centre
- 12-bed unit for adolescents with mental health issues involved in juvenile justice system

Corporate Governance Enhancements

- AO6 Senior Project Officer
- AO7 Principal Project Officer Child & Youth Mental Health – permanently fund

INTRODUCTION

There are two complementary ways to conceptualize mental health services for children and young people. The Child and Youth Mental Health system as a whole can be viewed as a form of "early intervention". There is evidence that positive intervention in a child's early development can prevent or ameliorate the impact of mental health problems in later life. On the other hand, considering the present rather than the future, children and young people suffer a range of severe and complex mental health problems which require a service system incorporating early intervention, treatment, and rehabilitation. Child and youth mental health services are seeing a rise in the severity and complexity of mental health problems, at younger ages. The current service system is overstretched and cannot provide the continuum of care to deal with this rising acuity. Unless the current service system is expanded to fill the gaps and provide safe, quality care for children and young people with serious mental health issues, the negative impacts on individuals, families, and the community, will only increase.

The Queensland Health Child and Youth Mental Health Plan 2006-2011 ("the Plan") has been developed in the context of the broader Queensland Health Mental Health Plan 2006-2011. It represents a balance between maintaining the objectives towards which the Queensland child and youth mental health system has been striving under previous Plans and other strategic documents, and a new emphasis on innovative solutions to address persistent gaps in service delivery.

The Queensland Health Child and Youth Mental Health Plan 2006-2011 is predicated on a number of existing strategic documents:

- National Mental Health Plan 2003-2008
- Future Directions for Child and Youth Mental Health (1996)
- Mental Health Unit Strategic Plan 2003-2008
- Ten Year Mental Health Strategy (1996)
- Child and Youth Mental Health Beds Report (2003)

In addition to an extensive consultation process, the Plan has also been informed by recent reference materials. Key documents will be noted at the end of relevant sections.

The Queensland Health Child and Youth Mental Health Plan 2006-2011 is a practical document. It is not about aspirations: it is about outcomes. To make a real difference to the mental health of children, young people, and families in Queensland, it is necessary to invest significant new resources in a comprehensive system of mental health care. This system must address the spectrum of mental health needs, from promotion, prevention and early intervention, through treatment, to relapse prevention and rehabilitation. The initiatives outlined in this Plan represent expansion where components of service are shown to be working effectively in a limited context, and evidence-based innovations to fill the gaps where it has been identified that consumers do not currently receive the service necessary to promote recovery. Each component of the enhanced system is dependent on the others.

The four major new emphases of the Queensland Health Child and Youth Mental Health Plan 2006-2011 are:

1. **Emphasis on developing the child and youth mental health workforce.**

Work in child and youth mental health services is difficult, stressful, and complex. It requires a range of knowledge and skills, from understanding the physical, cognitive, behavioural, emotional and social development of children and young people, to understanding family systems and how to work with the young person's community context, to collaborating with other agencies and service systems (eg. schools, Child Safety, juvenile justice) in the interests of desired outcomes. This Plan proposes a comprehensive system for recruiting, deploying and training the CYMHS workforce, providing practice supervision and professional development, and ensuring workers are appropriately supported to provide safe, quality mental health services for children, young people, and families, wherever they may live in Queensland.

An identified challenge to recruitment and retention in the CYMHS workforce is the lack of a defined career progression for certain groups of staff, notably allied health professionals and indigenous mental health workers. This Plan proposes a number of strategies to establish career pathways, including the introduction of entry level training positions, rotational positions, greater support for CYMHS staff seeking to pursue further study, Team Leader upgrades, and an expanded tier of allied health professional senior positions in larger services.

In CYMHS, as in adult mental health services, there are a number of "gaps" in service delivery which cannot be efficiently and effectively filled using the existing workforce. Two major categories of "other professions" have been identified as requiring development. One is the group of therapeutic specialists which includes art therapists, music therapists, leisure therapists, exercise therapists, adventure therapists, and some highly specialized family therapists. The other is the group of non-clinical support workers, who are referred to by titles such as recovery support workers or rehabilitation therapy aides. This Plan outlines a pilot project to evaluate the use of youth/family support workers in a CYMHS service.

2. **Emphasis on a statewide system of care for children, young people and families, with sufficient resources in individual Districts to provide general mental health services, proactively supported by centres of specialist expertise at Area and state levels.**

It is recognized that the principle of providing services close to where people live is especially important for children and young people, who are usually more dependent than adults on their social support systems including family of origin, extended family or community, and school.

At the same time, it is recognized that the sustainability of safe, quality health services is a major issue in regional, rural and remote centres. Consultation suggests that the type, duration, complexity and severity of mental health problems are similar in rural

areas to metropolitan areas; the differences concern service provision (existence of other support services, isolation from inpatient options, access to staff training and supervision) and total numbers of presentations. Where populations are small, presentations will be fewer than in larger centres, but will require at least the same levels of time and skill to treat when they do occur. Some disorders with low prevalence but high morbidity, such as eating disorders, pose a particular challenge in terms of building and maintaining specialist skills across the state.

To ensure an appropriate continuum of treatment options is available to every child or adolescent presenting with mental health issues, to ensure staff have access to the expertise and support required to effectively treat these issues, and to deal realistically with the difficulties of recruitment and retention in rural centres, a number of service components will operate on a "hub and spoke" model. Queensland already has two tertiary centres of child and youth mental health expertise (Royal Children's Hospital and Mater CYMHS), which are associated with tertiary paediatric hospitals, large maternity hospitals, and major universities. These tertiary centres will expand their role in providing intensive treatment, particularly specialist treatment for low prevalence disorders, highly complex presentations, and sub-specialties such as infant mental health. The tertiary hubs will also expand their role in supporting other centres through consultation/liaison, professional development, and supervision.

The Plan aims to develop a third major hub to service Northern Area, based in Townsville, and also recognizes the potential for Gold Coast to develop as a fourth major hub over the period 2006-2011 and beyond. It is likely that, by 2016, Sunshine Coast will also be emerging as a major population centre, and its potential as a future hub of child and youth mental health services should inform current planning.

Hub services must be sustainable over time, with a critical mass of experienced CYMHS staff and a demonstrated capacity to attract and retain senior professionals. They must have established and growing relationships with tertiary services and with tertiary research and education institutions. They must have the capacity to support "spokes", through the provision of clinical services (including inpatient services), consultation/liaison, and workforce support such as professional development opportunities and practice supervision.

It is acknowledged that although some larger services are not designated hubs under the Plan, specialist expertise in areas of child and youth mental health have developed and will develop in individual services. Queensland CYMHS services have a tradition of sharing their strengths, through formal and informal pathways. It is expected that some relationships among tertiary hubs, regional hubs, and spokes, will be formalized as enhancements are made, and service agreements will be established outlining service pathways and the respective responsibilities of each service level.

3. Emphasis on a continuum of treatment options, to which consumers can be matched according to clinical needs, and among which consumers can transition as their needs change, rather than a focus on "beds" and "case management".

Child and youth mental health practitioners have an increasingly sophisticated understanding of the groups of consumers who currently fall through gaps in service provision, or receive treatment in settings which are not well-matched to their needs but currently represent the only options available. The Plan emphasizes the development of new and expanded components of mental health service delivery, which will enable consumers, carers, and treating teams, to make more effective treatment decisions.

4. Emphasis on partnerships and collaborative practice, to ensure an holistic response to mental health needs including determinants of health.

Child and youth mental health professionals traditionally reject a reductionistic view of "mental illness" as a biological illness only happening to the individual. Rather, these professionals embrace a systems-based view, striving to work with the young person's family and support system to address underlying developmental needs, environmental stressors, and other factors which impact on the young person's wellness. However, in the context of limited resources, service rationing often occurs as staff find themselves under tremendous pressure attempting to meet the needs of all young people who present to the service.

A persistent theme arising through the consultation process for this Plan was the need for "FTEs, not MOUs" (full-time equivalents/positions, not Memoranda of Understanding). This statement expresses that while a number of strategic plans and other documents have outlined aspirations for partnerships between Queensland Health and other agencies, to achieve desired outcomes for consumers, these aspirations cannot be implemented without additional resources. The key is to invest a level of resourcing in the right places, in the right ways, to achieve maximum impact on consumer outcomes.

The current Plan emphasizes additional investment in aspects of mental health service delivery which the evidence-base clearly supports as repaying investment over the life-time of the young person in terms of improved quality of life, contribution to society, and cost savings to the community. Since service contexts, including the capacities of non-government organizations and private providers, differ greatly from one District to another, a principle is to provide Partnership Facilitator positions within mental health service teams to liaise and collaborate with partner organizations, and play a role in co-ordinating aspects of care from the individual to the community level.

The implementation of a dedicated resource would enable Queensland Health to leverage off the investments made in other core departments, paediatric services, and non-government community services. For example, Education Queensland has embarked on the development of a departmental Mental Health Plan, which provides significant new opportunities for partnership between Education Queensland and Queensland Health in the area of child and youth mental health. This represents an unprecedented opportunity for a well-planned collaboration to build resilience and enhance mental health literacy, promote help-seeking behaviours, and improve early detection and referral.

Understanding the "new morbidities in paediatrics" (presentations that affect speech, language, learning, and emotional and behavioural health) suggest that the relationship between mental health and child health will continue to increase in relevance. Within Queensland Health and the private health sector, linkages between CYMHS, child health, child development services, paediatricians and private practitioners need to be strengthened.

The new Mental Health – Child Safety Support Teams, the Multi-Systemic Therapy trial, and the development of therapeutic residential facilities, represent an innovative partnership between the Department of Child Safety and Queensland Health, to address the mental health needs of children and young people in care. This relationship can be expected to develop and expand over time, and with further funding to provide early intervention services to prevent young people needing to be taken into care.

MODEL OF SERVICE DELIVERY

Public mental health services for children, young people and families are generally referred to as Child and Youth Mental Health Services (CYMHS). As specialist services, they target direct service delivery to that portion of the child and youth population whose disorders are severe and complex, or at risk of becoming so, and whose needs cannot be met by other services. A significant number of adults (particularly parents/carers) receive mental health interventions through CYMHS services, in relation to the presentation of an identified child or young person.

CYMHS services also provide a lead role in addressing mental health issues across the spectrum of interventions, through the input of specialist knowledge and assisting other service systems in the areas of mental health promotion, illness prevention, identification of mental health issues, and early intervention.

Access to a specialist service is determined by a clinical decision, taking into the account the psychiatric nature of the disorder, the severity of disturbance, the complexity of the issues (including comorbidity), the extent of functional impairment, and the level of child, young person's and/or family distress.

CYMHS services are delivered by multi-disciplinary teams, typically involving the disciplines of psychiatry, psychology, nursing, social work, occupational therapy, speech therapy, and dietetics, with an increasing number of other disciplines providing input either as part of a CYMHS team or through the provision of brokered services (eg. leisure therapists, exercise physiologists, art therapists, support workers). CYMHS services aim to co-ordinate the provision of care with other providers of service to the child or young person and their family (eg. General Practitioner). CYMHS services are primarily community-based, with inpatient and day program components, and a developing number of step-up/step-down treatment options which can prevent the need for hospital admission or facilitate earlier discharge from hospital. The majority of CYMHS clientele are school-aged children, young people, and their families.

CYMHS operates in a complex, multi-system environment including crucial interactions with Education Queensland, Department of Communities, Department of Child Safety, Juvenile Justice, Disability Services Queensland, Alcohol Tobacco and Other Drug Services, Child and Youth Health, private providers, non-government organisations, and others. There are service provision implications associated with this complexity.

The Queensland Health Child and Youth Mental Health Plan 2006-2011 builds on the foundation of the existing CYMHS service, to describe a system of care which will be safe, sustainable, and capable of providing quality services to all Queensland children, young people and families in need of mental health care over the next five to ten years.

Age Range:

- Infant and Early Years (0-8 years) – specialist focus on Infant and Early Childhood Mental Health services, including adverse perinatal outcomes and the prevention of subsequent pathology, and services for young Children of Parents with Mental Illness
- Children (0-13 years) – triage, assessment, referral, treatment, outreach, continuing care and rehabilitation services for children, including emergency psychiatry, acute care teams, community Child and Youth Mental Health (CYMHS) teams, inpatient and family admissions to tertiary centres, alternative inpatient management for children in regional areas, day programs
- Adolescents (13-18 years) – triage, assessment, referral, treatment, outreach, continuing care and rehabilitation services for adolescents, including emergency psychiatry, acute care teams, community Child and Youth Mental Health (CYMHS) teams, acute inpatient units with high dependency capacity, extended inpatient treatment facility, step-up and step-down alternatives to hospitalisation, day programs
- Young Adults (18-25 years) – mental health services to young adults are provided by adult mental health services, with some specialist foci across the state, but consultation/liaison, support, and "up-reach" services may be provided by child and youth mental health services on a needs basis

Services

- Triage, assessment, referral – triage of cases according to clinical need, bio-psycho-social assessment, systemic assessment (eg. parental psychopathology), referral to other more appropriate services where CYMHS service is not appropriate, provision of advice and support to other services and families to manage issues and meet needs
- Acute care – short-term intervention as required to resolve crises, achieve stabilisation of mental health problems
- Continuing care, case management and rehabilitation – longer term treatment, service co-ordination to meet the needs of the child or young person and family, rehabilitation activities eg. school reintegration, linking with vocational readiness

There are three aspects to the model of mental health service delivery for children and young people in Queensland. Firstly, there is a set of principles which guide policy and implementation. Secondly, there is a tiered structure of services based on population and need for service. Thirdly, there are identified components of service delivery ranging from core components to specialist services to inter-sectoral linkages. These three aspects considered together constitute a service capability framework.

Currently, there is widespread agreement among stakeholders regarding the policy principles, and the components required for effective child and youth mental health service delivery. There is also general agreement that the current structure of services provides an appropriate foundation, but requires enhancement to existing core components, and considerable attention to "gaps" in service delivery.

1. Principles of Child and Youth Mental Health Service Delivery in Queensland

The Model of Service Delivery for child and youth mental health in Queensland can be contextualized within the "Spectrum of Interventions for Mental Health" outlined in the National Mental Health Plan 2003-2008.

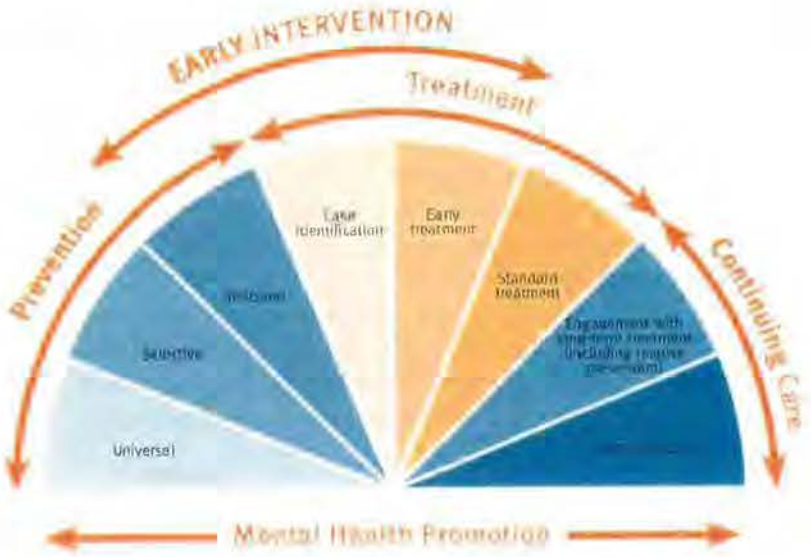

Figure 1: The spectrum of interventions for mental health problems and mental disorders
(Adapted from the Mrazek & Haggerty 1994 Mental Health Intervention Spectrum for Mental Disorders)

The "indicated prevention", "symptom identification", and "early treatment" phases fall within the scope of early intervention, and are considered part of the core business of mental health services. If sufficiently well-resourced, mental health services may also play a role in mental health promotion, universal prevention measures, and selected prevention, although this is usually undertaken in partnership with other agencies such as public health, other government agencies, the education sector, private providers, and/or non-government organizations.

A set of Principles to guide the delivery of mental health services for children and youth was articulated in Future Directions for Child and Youth Mental Health Services (1996):

1. Timely Access to Safe, Quality Service: Each child or young person with serious levels of disturbance, or at risk, should have timely access to safe, high quality mental health services, which take account of family and social circumstances, and cultural and language differences

2. Early Intervention: Service provision should include the development of strategies for identification and early intervention targeting those with known risk factors

3. Consumer-Centred: Mental health services for children, young people and families/carers must be flexible and individually tailored, taking into account developmental and social contexts as well as clinical need

4. Consumer Empowerment: Children, young people and families/carers need to be able to make informed decisions and be involved in the processes affecting them

5. Consumer and Carer Participation: Services should be developed, delivered and evaluated with the involvement of consumers and carers.

6. Inter-Sectoral Collaboration: Mental health services for children and youth will be led by Queensland Health Child and Youth Mental Health Services, and co-ordinated among adult mental health, general health, welfare and education services (including government, non-government, and private providers) in ways that ensure responsive service provision to meet the the specific needs of individual children, young people, and families/carers

7. Environmental Enhancement: The service approach will maximize the support given to the child's caring network, including parents, and build on existing strengths and opportunities within their environment

8. Evidence-based Practice: Mental health interventions will be based on the best available evidence for effectiveness, and outcomes will be monitored and reported in order to continuously improve the evidence base

9. Strengths-based Interventions: Mental health interventions will build on the existing strengths of the child, young person, and family, to improve resilience to cope with demands and stressors

10. Commitment to Workforce: Child and Youth Mental Health Services are committed to developing and maintaining a highly-skilled, well-supported workforce, consisting of the right people with the right skills in the right place at the right time to provide effective mental health services to children, young people and families/carers

2. Tiered Structure of Child and Youth Mental Health Services Across Queensland

DISTRICT	AHS	PRINCIPAL SERVICE CENTRE/NETWORK	OTHER LINKAGES/ HUBS
REMOTE TEAMS			
Cape York	N	Cairns	Remote Area Outreach Team *e-CYMHS
Central West	C	Rockhampton	*e-CYMHS
Charleville	S	Toowoomba	e-CYMHS
Torres Strait & Northern Peninsula Area	N	Cairns	Remote Area Outreach Team *e-CYMHS
COMBINED ADULT / CHILD AND YOUTH TEAMS			
Bowen	N	Townsville	
Central Highlands	C	Rockhampton	
Charters Towers	N	Townsville	*e-CYMHS
Gladstone + Banana	C	Rockhampton	
Gympie	C	Sunshine Coast	
Innisfail	N	Cairns	
Moranbah	N	Mackay	*e-CYMHS
Mt Isa	N	Townsville	*e-CYMHS
North Burnett	C	Bundaberg	
Northern Downs	S	Toowoomba	
Roma	S	Toowoomba	
South Burnett	S	Toowoomba	e-CYMHS
Southern Downs	S	Toowoomba	
Tablelands	N	Cairns	e-CYMHS
CYMHS STAND-ALONE TEAMS			
Bundaberg	C		
Fraser Coast	C		
Bayside	S		
CYMHS REGIONAL TEAMS			
Redcliffe-Caboolture	C		MH-CSST
Sunshine Coast	C		MH-CSST
Rockhampton	C		MH-CSST?
Gold Coast	S		MH-CSST, Beds
Logan-Beaudesert	S		MH-CSST, Beds
Toowoomba	S		Beds
West Moreton	S		MH-CSST?, Beds
Cairns	N		MH-CSST
Townsville	N		MH-CSST
Mackay	N		
METROPOLITAN BRISBANE STATEWIDE HUBS			
Royal Children's Hospital and Health	C		MH-CSST, Beds + Royal Brisbane &

DISTRICT	AHS	PRINCIPAL SERVICE CENTRE/NETWORK	OTHER LINKAGES/ HUBS
Service District			Women's Hospital
Mater	S		MH-CSST. Beds

AHS = Area Health Service; N = Northern AHS; C=Central AHS; S = Southern AHS
*e-CYMHS = *permanent/temporary funded RCH&HSD e-CYMHS
MH-CSST = Mental Health Child Safety Support Teams ?=possible hubs for future teams
RA Outreach Team = CYMHS Remote Area Outreach Team

3. Components of Service Delivery

For the purposes of this Plan, the components of CYMHS service delivery in Queensland can be conceptualized in terms of the following framework:

1. Promotion, Prevention, Early Intervention (including Early Treatment)
    a. Social Promotion
    b. Primary Mental Health Promotion and Prevention
    c. Infant and Early Childhood Mental Health (prevention and early intervention aspects)
    d. Children of Parents with a Mental Illness
    e. Universal, Selected, and Indicated Interventions
    f. Consultation/Liaison Services

2. Acute Care – currently a component of community CYMHS care, proposed to expand under the current plan to include:
    a. Emergency Psychiatry
    b. Mobile Acute Care Teams

3. Intensive Treatment
    a. Acute Inpatient Treatment
    b. Mental Health Admissions to Paediatric Wards
    c. Day Programs
    d. Extended Inpatient Treatment

4. Continuing Care
    a. Community Mental Health Services
    b. E-CYMHS

5. Specialist Services
    a. Infant and Early Childhood Mental Health (treatment aspects)
    b. Eating Disorders
    c. Dual Diagnosis (Mental Health/Substance Abuse Issues)
    d. Forensic Issues
    e. Transcultural Mental Health
    f. Indigenous Mental Health
    g. Child Safety Therapeutic Support

Vital "enablers" for CYMHS service delivery include:

1. Workforce Development and Support (Section 6)
2. Intersectoral Collaboration (Section 7)
3. Information Management (Section 8)
4. Research (Section 9)
5. Capital Works Infrastructure (Section 10)
6. Corporate Governance (Section 11)

SERVICE ENHANCEMENT AND EXPANSION

1. Promotion, Prevention, Early Intervention

1.1 Social Promotion

Mental health promotion, increasing mental health literacy, and reducing stigma associated with mental illness, are roles which currently fall within the jurisdiction of Public Health, through a small number of Mental Health Promotion Officers in Districts. Additional resourcing is needed in this area, to provide a broad social foundation which facilitates prevention, early intervention, and treatment. While there is evidence that large-scale media campaigns can assist in raising mental health awareness, some sections of the community require more targeted efforts – for example there is potential to partner with School of the Air, and the Royal Flying Doctor Service, to reach rural and remote families with mental health promotion messages and materials.

As has been noted in the Mental Health Promotion, Illness Prevention & Early Intervention Subgroup Report 2006 (Attachment 1), to enable these developments there is a need for social policy development, strategic development of infrastructure resources, and the kind of statewide leadership that could be provided by a Centre tasked with promoting mental health promotion, mental illness prevention, and early intervention throughout Queensland.

1.2 Primary Mental Health Promotion and Prevention

For children, young people, and families, mental health primary prevention is addressed through Child and Youth Health, General Practitioners, Paediatricians and a range of other agencies and services. Again, additional resourcing is required to adapt strategies which have proven to be effective, to the unique needs of a geographically dispersed and culturally diverse state. Home visiting programs, for example, are a proven strategy for primary prevention and promoting child wellness, however many indigenous families prefer outreach programs to centres in local communities rather than having government workers visit their homes. Parent training (eg. Triple P) is an evidence-based intervention, but may require adaptation to the needs of indigenous families, to CALD families, and in the context of various types of disability. Pre-conception counseling, perinatal screening of both parents for psychopathology, and screening children in kindergarten and the early years of primary school, are increasingly recommended as primary prevention strategies.

References:

1.3 Infant and Early Childhood Mental Health

Research indicates that the quality of relationships in the early years of life can have far-reaching effects on human development across the lifespan and that good mental health outcomes have a basis around secure parent-child attachments (*Hay, 2003*). The early years of development from conception to age six, particularly the first three years, set the base for competence and coping skills that will affect learning, behaviour and health throughout life" (*Mustard, 1999*).

Future Families received funding from Second National Mental Health Plan, Promotion, Prevention and Early Intervention – February 2002 to develop, implement and evaluate the effectiveness of a pilot program in Infant Mental Health for implementation in sites across Queensland.

The Future Families Framework has been developed in response to identified service needs and national and state directives. In line with the *Queensland Health Prevention, Promotion and Early Intervention Framework for Mental Health (2001)*, the model uses a community capacity-building framework, and aims to address the priority mental health targets: enhancing parenting skills, child development and family functioning, and promoting strong positive attachment between parent and child. The intended outcomes are to improve maternal and infant health, increase early identification and management of individuals and families at risk of mental health problems in the antenatal and post-natal periods, and improve positive nurturing learning environments.

References:

Infant and Early Years Mental Health Plan (Attachment 2)

1.4 Children of Parents with Mental Illness

Over one million children in Australia live in households where a parent has a mental illness (VIC Health Resarch Report, November 2005). Studies have found that 25-50% of children in this situation will experience some psychological disorder during childhood, adolescence or adulthood, and 10-14% will be diagnosed with a psychotic illness at some point in their lives (Farrell et al., 1999). The literature indicates that successful interventions with these families involve work with both the parents and the children. Collaboration between adult and child and youth mental health services, and across agencies, is required to improve the engagement of these families in effective treatment and prevention programs.

Targeted investment in programs for Children of Parents with Mental Illness (COPMI) is likely to be realized in improved current functioning of the family, adults, and children, and in the future mental health of the children (and, ultimately, the next generation). For this reason, Children of Parents with Mental Illness were identified as a priority group within the Second National Mental Health Plan (1995) and the National Mental Health Plan 2003-2008, and the Australian Infant, Child, Adolescent, Family Mental Health Association has developed National guidelines to address the needs of this population.

Currently, Royal Children's Hospital offers a KOPING program for young people aged 12-18 years, which aims to increase peer support and build coping capacity. The program also offers resources, consultation liaison and support for service providers working with families affected by mental illness and/or drug and alcohol concerns.

Mater CYMHS operates a Kidz Club for primary school children of parents with mental illness, and offers resources to other services and organizations wishing to provide similar programs. Two positions have recently been funded to improve service co-ordination between the adult mental health service at Princess Alexandra Hospital, and the Mater CYMHS service.

Sunshine Coast CYMHS has developed the Sunshine Coast KOPING (SCKOPING) Network, and operates a group program (Kids Club for 8-12 year olds, Gaining Grounds for adolescents, Peer Support for graduates of these groups). Sunshine Coast has also run 2 camps in the past two years, using peer support and adventure therapy, Some 150 children have received active interventions through the direct service program, which is facilitated by 0.5 FTE. Sunshine Coast requires an additional 0.5 FTE Network Facilitator, and 1.0 FTE Program Facilitator, to make the KOPING program sustainable.

Gold Coast has a COPMI Management Committee and runs programs as a collaborative undertaking between CYMHS, the adult mental health service, and a non-government organization. Gold Coast requires a dedicated 1.0 FTE to improve sustainability.

Bayside has established a COPMI program for children and adolescents.

An enhancement of 1.0 FTE x PO3/NO2 is required to commence COPMI initiatives in Districts with substantial numbers of Children of Parents with Mental Illness, where interest in COPMI has already developed:

- Cairns
- Toowoomba
- Gladstone
- West Moreton
- Logan-Beaudesert
- Redcliffe-Caboolture

There is a need for a statewide co-ordination function for COPMI initiatives. Enhancement to establish this function is outlined in Section 9, Corporate Governance.

References:

Child and Youth Health Update December 2004
Royal Children's Hospital Website

1.5 Universal, Selected, and Indicated Interventions

Evidence is available from numerous studies at international, national, and local levels (eg. Durlak & Wells, 1997; MindMatters; Aussie Optimism; Bayside Integrated Case Management project) that a tiered promotion-prevention-early intervention approach to an identified population can curtail the development of mental health problems in that population on a number of dimensions (prevalence, severity, complexity, duration). A universal mental health promotion approach can incorporate a screening component, which enables selective intervention, which in turn enables the identification of individuals requiring indicated intervention. Such approaches are cost-effective, can be implemented with a small number of dedicated resources engaged in co-ordinating efforts across a number of agencies, and have demonstrated long-term benefits.

References:

Mental Health Promotion, Illness Prevention & Early Intervention Subgroup Report 2006
Durlak, J.A., & Wells, A.M. (1997) Primary prevention mental health programs for children and adolescents: A meta-analytic review. American Journal of Community Psychology, 25, 115-152.

1.6 Consultation/Liaison Services

Although consultation/liaison services are not restricted to early intervention, they are included under this heading in recognition that mental health issues can often be managed by general health services and other providers within the child or adolescent's environment, if appropriate consultation/liaison support is available.

Currently, the major hubs of consultation/liaison services are Mater CYMHS and Royal Children's Hospital. To provide more capacity and effective service coverage across the state, augmentation is required of:

- 2 x FTE PO3/NO2 Mater CYMHS
- 2 x FTE PO3/NO2 Royal Children's Hospital
- 2 x FTE PO3/NO2 Gold Coast
- 1 x FTE PO3/NO2 Toowoomba
- 1 x FTE PO3/NO2 Cairns
- 1 x FTE PO3/NO2 Rockhampton
- 1 x FTE PO3/NO2 Gladstone
- 1 x FTE PO3/NO2 Townsville
- 1 x FTE PO3/NO2 Logan-Beaudesert
- 0.5 x FTE Registrar and 0.5 x FTE PO3/NO2 Sunshine Coast

1.7 Cross-Agency Promotion, Prevention, Early Intervention

Many government agencies and non-government organizations invest resources in "prevention" and "early intervention", attempting to divert an individual's trajectory away from undesirable outcomes including unemployment, involvement in crime, becoming a victim or perpetrator of domestic violence or sexual assault, substance abuse, homelessness or marginal homelessness, mental illness. An effective early intervention strategy may help protect the individual from a number of these undesirable outcomes, with resulting benefits to the individual, their family, their children, and society. It is therefore logical for mental health services to combine

resources and efforts with other government departments and non-government agencies, at the level of local communities, to implement effective prevention and early intervention strategies. However, the building of partnerships and the implementation of joint strategies usually cannot be undertaken by busy services without a dedicated resource to drive this work.

Developing partnerships to address the spectrum of mental health promotion, prevention, and early intervention for children, young people and families, is a large part of the role proposed for Partnership Facilitators, to be established in CYMHS service centres. The role of these positions will be to progress partnerships between Queensland Health and other government departments, private providers or non-government agencies, which improve services to CYMHS clients and their families. These positions will play a role in communication and negotiation which occurs in relation to specific young people and their families from time to time, but the main purpose of the role is strategic development of local service networks so as to improve access, timeliness and appropriateness of interventions, safety and quality of service, and continuity of care. Supporting interagency forums will be a key responsibility. Additional detail regarding these positions is provided in section 7.1 **Partnership Facilitators**.

References:

Infant and Early Years Mental Health Plan (Attachment 1)
Mental Health Promotion, Illness Prevention & Early Intervention Subgroup Report 2006

Promotion, Prevention, Early Intervention Enhancements

COPMI: 8.5 x FTE PO3/NO2
Consultation/Liaison Services: 12.5 x FTE PO3/NO2 + 0.5 FTE Registrar
Resourcing for mental health policy and infrastructure, mental health promotion, mental illness prevention, and early intervention, as outlined in the Mental Health Promotion, Illness Prevention and Early Intervention Subgroup Report 2006

2. Emergency Psychiatry and Acute Care

The proposed model of service delivery for Emergency Psychiatry in Queensland consists of:

- Statewide name for emergency mental health teams
- Statewide 24-hour phone line to divert to local service providers
- 24 hour Department of Emergency Mental Health Staff in Principal Service Provision centres
- Enhancement to staffing in the community component of emergency mental health services
- Access to short-term crisis accommodation

Each of these components is required to respond to children, young people and families.

2.1 Emergency Psychiatry

The following benchmarks have been proposed for Emergency Psychiatry Services for the total population serviced by an emergency department:

Service Size	Hospital Beds	Shifts to cover 24 hr/ 7 day service	FTEs Required
Large	>450 beds	42	10
Medium/Small	<450 beds	21	5

These staff will be based in the Emergency Department and will also staff the 24-hour phone line, responding to calls and making scheduled calls on behalf of the acute care team and community mental health service as required (eg. for follow-up care). Based on the experience of Kids Helpline and Parentline, it can be expected that the 24-hour phone line will be accessed by children, young people and parents out of hours, and that there will be similar needs for proactive telephone support (eg. scheduled follow-up calls).

Enhancements required for Emergency Psychiatry Teams, for child and youth presentations, are as follows:

District	Staffing
RCH (Covers RCH, RBWH & TPCH)	10
Mater (Covers Mater, PAH, QEII)	10
Redcliffe-Caboolture (2 DEMS)	8.5
Gold Coast (2 DEMS)	8.5
Fraser Coast (2 DEMS)	8.5
Cairns	5
Sunshine Coast	5
Rockhampton	5
Logan-Beaudesert	6
Toowoomba	5
West Moreton	5
Townsville	5
Mackay	5
Bundaberg	5
Bayside	5

* Using Medium/Small Staffing Shifts with additions to cover services with >1 DEM
Considers that RCH, Mater & possibly eventually Townsville would be Hubs to support other services that do not operate 24 hours/7 days.
These allocations are based on PO3/NO2 FTEs. Child psychiatry and registrar input are included in these allocations.

Usage data and demand should be monitored, with a view to increasing these enhancements in the later years of the Plan.

2.2 Mobile Acute Care Teams

For child and youth mental health, mobile acute care teams are proposed to fulfill a number of functions, in the interests of a continuum of care. Mobile acute care teams:

- may provide an alternative to acute inpatient admission
- have the capacity to facilitate early discharge from acute inpatient treatment
- can provide intensive support for clients who are marginalized and hard to access, for example homeless youth, young people with concurrent early psychosis and substance abuse issues
- can intensively treat such conditions as agoraphobia, social phobia, and school refusal, which must be addressed in situ (eg. the young person's home, school, and other local environments)

For adult Mobile Acute Care Teams, a benchmark of 10 FTE per 100 000 adult population has been suggested, based on services in Victoria (10:100 000) and UK (14:150 000). For child and youth, a figure of 8 FTE per 100 000 child and youth population has been suggested. It is anticipated that fewer children and young people than adults will require a mobile acute care response, but treatment will be more complex (as the effective treatment of children and young people generally involves family therapy and work with significant others including school personnel). Again, it is expected that Mobile Acute Care Teams in Principal Service Provider centres will provide consultation/liaison services to mental health staff, general health staff, GPs, schools, and other stakeholders in Districts which do not have Mobile Acute Care Teams.

Due to the need to develop services over time, and the difficulties associated with recruiting large numbers of new staff at once, it is suggested that Mobile Acute Care Teams, like Emergency Psychiatry teams, should be established through a staged implementation with monitoring of usage rates and patterns of demand. Districts may choose to deploy Emergency Psychiatry staff and Mobile Acute Care staff flexibly in order to meet specific District patterns of need.

District	**C&Y Population 2006**	**C&Y Population Estimated Projection 2011**	**Staffing (4 FTE/ 100 000)**
RCH (Covers RCH, RBWH & TPCH)	150 001	153186	12
Mater (Covers Mater, PAH, QEII)	116 138	120476	10
Gold Coast (2 DEMS)	104 892	109485	9
Logan-Beaudesert	97 547	104399	8
Sunshine Coast	74 214	80367	6
West Moreton	54 810	57177	5
Bayside	54 851	56971	5
Townsville	52 304	54711	4
Redcliffe-Caboolture (2 DEMS)	51 346	51073	4
Cairns	42 940	44802	4
Toowoomba	42 958	43336	3
Mackay	32 190	33119	3
Rockhampton	31 473	31565	3

District	C&Y Population 2006	C&Y Population Estimated Projection 2011	Staffing (4 FTE/ 100 000)
Bundaberg	25086	25854	2
Fraser Coast (2 DEMS)	21 825	22358	2

There are 17 Health Service Districts which provide community mental health services but do not have inpatient mental health services. The general model for these services involves extending service delivery to seven days per week (one shift for Saturday and Sunday). However, it is proposed that in rural and remote centres where the child and youth population is less than 10 000, no specific additional allocation should be made for child and youth specialist weekend response. Many of these services already work with a "cradle-to-grave" model, expecting staff to be multi-skilled to see people across the age range, and to seek appropriate consultation/liaison support from the Principal Service Centre as required. These services will have access to the 24 hour phone line for support. Therefore, enhancements are requested for Mobile Acute Care responses only for CYMHS teams in Districts where the child and youth population is over 10 000. These two services are:

- Gladstone & Banana 1.0 FTE
- Southern Downs 1.0 FTE

References:

Emergency Mental Health Subgroup Report 2006

2.3 Accommodation Network

Children and young people presenting with mental health issues may require crisis accommodation because they are homeless, marginally housed, or at risk in their usual living situation. Crisis accommodation for children, young people, and families, is generally scarce and difficult to access, particularly outside business hours. Transitional accommodation, such as an older adolescent may require on discharge from inpatient care, is also difficult to source and may be even less accessible to an adolescent than to an adult. A major criticism of those crisis and transitional programs that do exist is the lack of long-term affordable accommodation available for people to transition to, particularly those who require some level of ongoing support.

There is an overwhelming need to expand the system of crisis, transitional, and long-term accommodation options, particularly for families and unaccompanied young people. Evidence shows that the provision of a range of options is necessary, to allow safe and beneficial placement based on such factors as whether the accommodation is for a family or an unaccompanied young person, children or young people's ages, the length of time accommodation is likely to be needed, and the level of supervision and support required. The range and quantum of accommodation options may vary from one District to another, but a high priority should be placed on ensuring that some options are available in every regional centre with an Emergency Department.

It is essential that Queensland Health engage with other government departments and the non-government sector to seek significant expansion in the accommodation options available for children, young people and families with identified mental health issues. Consideration should be given to addressing factors which may present barriers to young people with mental health issues accessing existing accommodation options, including substance abuse, positive symptoms of psychosis, self-harm, lack of income, and challenging behaviours.

There is a concurrent need to improve the efficiency with which mental health staff can refer clients to accommodation options. The introduction of two Information and Referral Hubs for homeless people in Brisbane, under the whole-of-government Responding to Homelessness strategy, may be an initiative that could be expanded to include mental health service providers as a partner in and user of the Information and Referral services. It is expected that Partnership Facilitators will play a role in developing these links.

It may be possible, with careful design of the model, for crisis accommodation places in the Accommodation Network to double as respite accommodation, to be used on a more planned and proactive basis by existing clients of child and youth mental health services. Consumer and carer representatives have emphasized a need for this component of care, which may be conceptualized in part as an early intervention for other members of the young person's family.

In order to progress the development of the Accommodation Network, support should be enlisted from the Statewide Co-ordinator, Homelessness Initiatives (AO7) and Senior Project Officer, Housing (AO6), based in Southern Area Health Service.

References

Emergency Mental Health Subgroup Report, 2006
Alternatives to Admission Subgroup Report, 2006
Children in Homeless Services, Australian Federation of Homelessness Organisations (2006)

Emergency Psychiatry Enhancements

Emergency Psychiatry Teams – 96.5 x PO3/NO2
Acute Care Teams – 84.0 x PO3/NO2
Resourcing to establish 24-hour phone line
Resourcing to establish new accommodation options

3. Intensive Treatment

3.1 Acute Inpatient Treatment

Inpatient treatment is sometimes the most effective way to provide intensive therapeutic intervention and monitoring for a child, adolescent or family, particularly where the environment is contributing to the mental health problems, or where a complete break is required to establish new and more functional patterns of

behaviour. However, because inpatient admission may be experienced by the young person and family as disruptive, restrictive, and potentially stigmatizing, alternative treatment settings and modalities are preferred where possible.

This Plan outlines a number of enhancements to aspects of the child and youth mental health service system, which will improve the system's capacity to treat mental health issues in the community. Providing these enhancements are put in place, there is an agreed position that no *additional* acute inpatient beds for children and young people in Queensland are required within the life of the current Plan (2006-2011). The major enhancements which will allow the system to function without building additional acute beds are:

- enhancements to community CYMHS services
- development/enhancement of Emergency Psychiatry Teams and Mobile Acute Care Teams
- development/expansion of day programs
- family admissions to tertiary hubs
- admission of children to paediatric wards with mental health support
- operation of existing adolescent units at full capacity (with the exception of Toowoomba)
- expansion of statewide system of care for eating disorders
- development/expansion of drug and alcohol treatment services for adolescents
- development/expansion of Outreach teams for marginalized adolescents and young adults
- development/expansion of joint assessment services

There are currently no designated beds for child and youth mental health north of Brisbane. There are currently acute inpatient beds designated for:

- children – Child and Family Therapy Unit, Royal Children's Hospital (10 beds); Mater Hospital (8 beds - nominal); Gold Coast (4 beds - nominal)
- adolescents – Mater Hospital (4 beds – nominal); Royal Brisbane Hospital (12 beds); Gold Coast (4 beds - nominal); Logan (10 beds – 3 currently closed); Toowoomba (6 beds – currently closed)

Treating children and adolescents within the same unit is generally not an effective model, due to:

- the difficulties of providing appropriate programs for a wide range of ages and developmental levels
- safety concerns for vulnerable children, including (potentially) mothers and babies, in the same environment as severely disturbed adolescents
- different skill sets, knowledge and approaches required by staff working with children vis a vis staff working with adolescents

Historical admission patterns show that beds designated for children, in units planned to provide both child and adolescent inpatient care, have tended to be used for adolescents (Mater inpatient unit, Gold Coast) as there is much higher demand for adolescent admissions, and a wider range of options available for managing children.