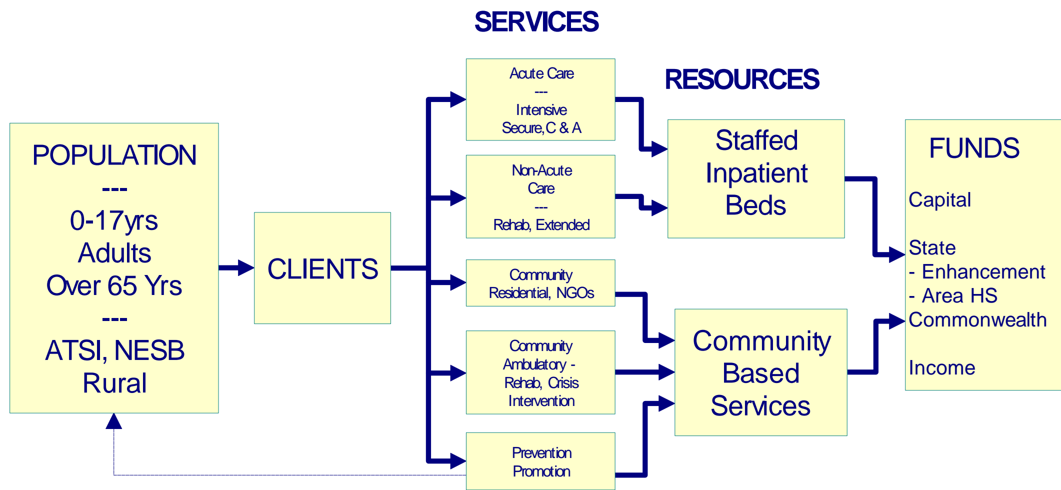
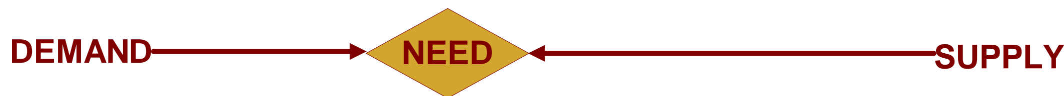
CHAPTER 7

Term of Reference G: The availability and mix of mental health services in New South Wales

MHS PLANNING MODEL





Mental Health Service Planning

Mental health service planning is based on the Population Health Model for Mental Health [1] a nationally accepted framework under the National Mental Health Strategy. This model identifies the patterns of morbidity and mortality in the population in terms of both population surveys and data from health service utilisation statistics. It also takes into account: the influence of social context; socio-economic and demographic patterns; risk and protective influences; and the service systems in terms of both public health and direct clinical personal health care.

It recognises the different levels of service delivery, primary, secondary and tertiary systems, as well as health and mental health needs across the life span. It also identifies the spectrum of interventions that may contribute to improved health of the population and impact on the disease burden. The model allows the identification of needs for mental health care, and the priorities for service delivery at different levels of need.

It is supported by an emphasis on the resources necessary to support service delivery and care that will achieve improved mental health outcomes; measure and evaluate these outcomes for individuals and in relation to the service systems that have delivered them; the effectiveness and efficiency of the programs delivered; and the nature, skills and resources for the workforce that will contribute to care.

Population Based Planning Model

- Conceptual
  - Population Based Planning
  - Measurement of Value
  - Resources (RDF)
  - Information (MHIDP)
- Need - Service Model (MH-CCP)
- Effectiveness - Outcomes (MH-OAT)
- Efficiency - Benchmarking

Planning processes for mental health services require a number of elements which are linked to this theoretical model and its interpretation in the Mental Health Clinical Care and Prevention Model .[2]

Planning process for mental health services

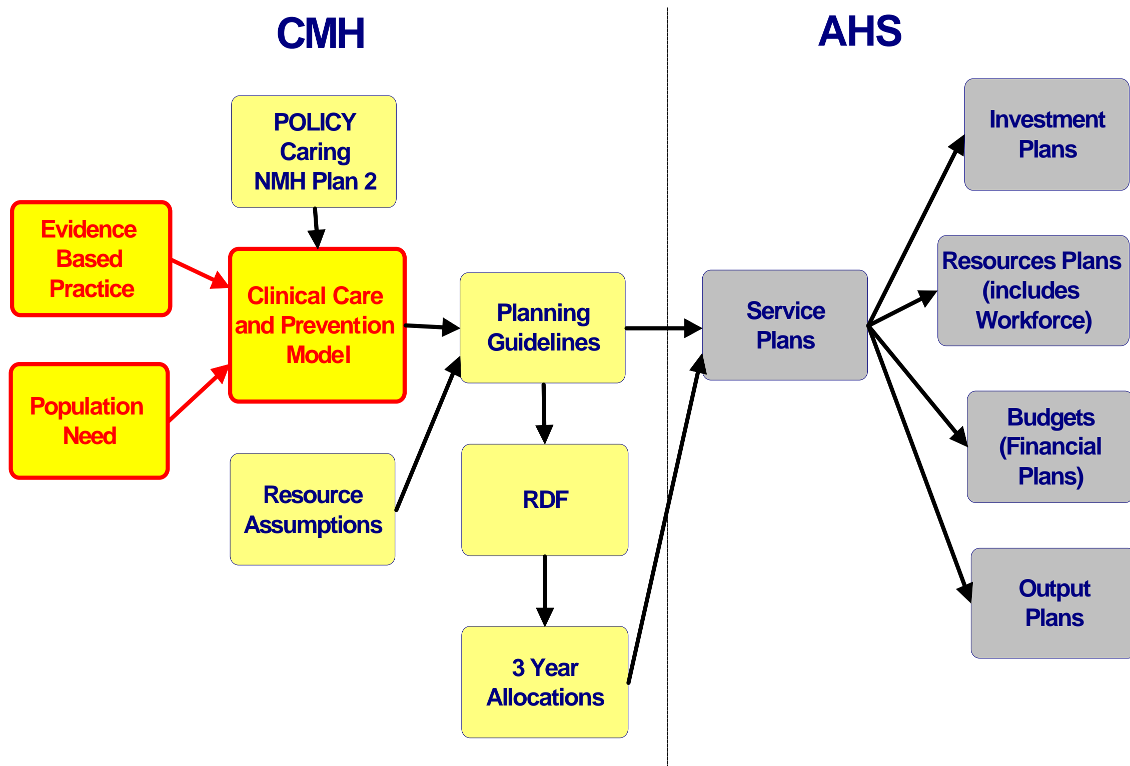
- Central Guidelines
- Devolved Planning
- Performance Indicators
- Evaluation of Plans
- Performance Review Action Plans
- Health Service Performance Agreements

Area mental health service plans

- For Area population based services
- By age groups
- Plans for:
  - Activity
  - Resources
  - Workforce
  - Finance

These planning processes and plans are specified in detail below They provide a structured framework which links response to illness patterns and need to services which deliver interventions through the relevant clinical and other processes, to outcomes achieved.

STRATEGIC PLANNING FRAMEWORK FOR MENTAL HEALTH SERVICES



Strategic and Annual Mental Health Service Planning

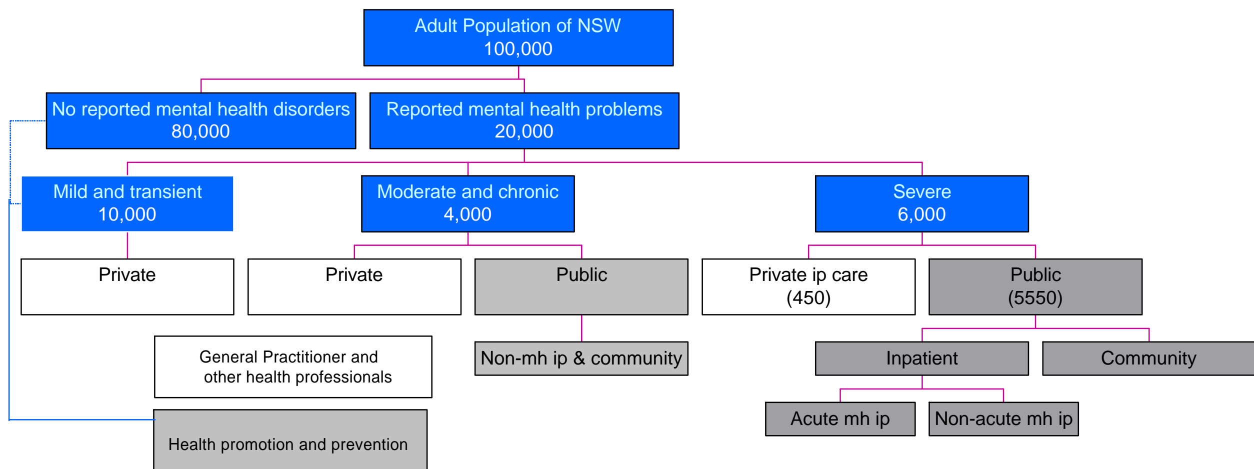
- Strategic and Annual Plans integrated
- Areas provided with Planning Guidelines
- Strategic Plans led by
  - National and State policies for MHS development
  - The MH Clinical Care and Prevention Model
  - Local Area characteristics, needs, priorities and opportunities
- Annual Plans led by
  - The framework provided by approved Area Strategic Plans
  - The need to demonstrate the implementation of service realignment in priority directions leading to more efficient and effective services
- Forward planning and accountability

The Mental Health Clinical Care and Prevention Model

This model interprets population need and potential for service system response to this need. It identifies the epidemiology of mental health problems and builds on Australian and relevant international data and what these would mean in terms of a population base of 100,000 people representative of the NSW population in terms of age and illness patterns.

The best available evidence is then drawn on to determine the service packages necessary to manage the highest priority of need for specialised mental health care, and the necessary partnerships / primary care and other potential components that will require support from mental health expertise. This is then translated into a planning framework. Community, inpatient and other services components as well as the private sector that respond to meet these needs at different stages of the life-span, are identified below

MH-CCP - assessment of need



MH-CCP Planning Model - Step 1: Epidemiological estimates of need for ALL ages

ALL AGES, NSW

Population 1996: 6,204,728 100%

Universal Prevention

Population
100,000

Reported mental health problems

No Reported mental health problems
83,439

16,561

EI/MILD
9,551

MODERATE
4,504

SEVERE
2,506

Selective Prevention

Indicated Prevention

AMB
1,647

PRIV IP
45

IP & AMB
719

CONT IP
17

NH
123

ED
516

GEN IP
174

MH Ac IP
433

MH NAc IP
67

COM RES
5

VLS
12

Best estimates of NSW Epidemiology per 100,000 (Summary)

- 16.6 % have some level of need for specialist MH care, within which:
  - 9.6% can be treated in primary general care with specialist support
  - 4.5% need moderate amounts of community-based MH care
  - 2.5% have severe illnesses and impairment, including 1% who may need MH inpatient care and 0.02% who may need continuous 365-day inpatient care.

- NSW currently provides specialist MH care to about 1% of the population

MH-CCP Planning Model:

Prioritise

- Set initial treatment priorities for each age-specific clinical group as the percentage of the defined number in need who can be treated.

Calculate

- Calculate resource predictions (FTE, Beds) and outputs (OOS, separations, bed-days)
- Calculate total costs using standard unit costs, or local costs, for resources and/or outputs

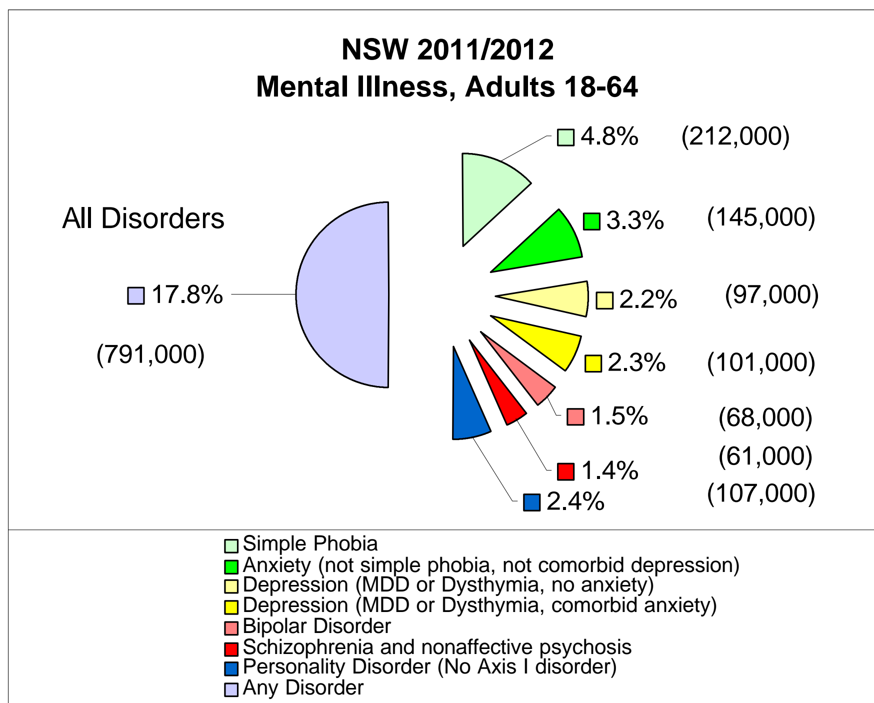
Review and refine

- Perform Gap Analysis versus current or planned future resource availability (NB: limiting resources may not be financial).
- Review, renegotiate as required, recalculate.

All Area Mental Health Services are now developing their service plans, including their service components, capital and workforce planning, and this is also the basis of the submissions for enhancement funding.

Adult Mental Health Services

The extent of morbidity and need has been identified through population projections. These are represented in the following diagram:



Source: National Survey of Mental Health and Wellbeing proportions adjusted to MH-CCP(2001) best estimates & NSW population projections

This indicates that more than 791,000 members of the NSW population as projected for 2011/12 are likely to be suffering from a diagnosable mental disorder with more than 68,000 suffering from schizophrenia and about half a million anxiety and depressive disorders.

Service components include the following:

Adult Services

- Community based
- Acute Inpatient
- Supported Accommodation
- Tertiary services
  - Non-acute inpatient services
  - Forensic

Adult Community Mental Health Services

The service model is one of integrated mental health services across community and inpatient sectors. The community mental health services are in themselves a spectrum of services and increasingly constitute the major and foundation component of mental health services, in line with National and NSW Mental Health Policy and International directions [3]

Adult community mental health services

- Emergency response
  - Urgent assessment and treatment
  - At community mental health centres
  - Outreach crisis services
  - After hours responses -extended hours services
  - In support of other emergency services including emergency departments, police and ambulance
- Acute care
  - Acute assessment and treatment
  - Prevention of admission to hospital
  - Community mental health centres
  - Outreach to the community
  - Liaison with primary care
  - Support to general hospital services
  - Follow up of discharged inpatients
- Longer term care
  - Rehabilitation
  - Case management (assertive, intensive)
  - Accommodation support
  - Disability support
- Supported Accommodation Framework
- Rehabilitation Framework
- NGO partnerships
- Promotion and prevention

As Thornicroft has emphasised, an appropriate integration of and balance with inpatient services as well as a range of supportive services including those delivered through non-Government organisations, provide the essential service mix.

Other key elements of adult, young peoples and older peoples mental health services are also included below, but may also be dealt with briefly again in relevant Terms of Reference.

Child and Adolescent Mental Health

Children and adolescents are in close interaction with their families and sensitive to family conflict, disruption and the impacts of abuse, adversity and deprivation. Children and young people are both vulnerable and resilient, from the earliest stages of development, to biological, psychological and social influences. These early years are the time of greatest gene-environment interaction and thus there is opportunity to influence outcomes through 'environmental' interventions.[4] Also very important is the growing body of evidence about the trajectory of problems into adult life so that morbidity patterns at the adolescent and adult stages of development are contributed to by these earlier problems and risk factors.[5]

Rates of illness are similar to those in adults, but patterns are different. Contrary to previous views that the problems of children are not significant, it is now known that these problems have major impact on the child and family.[6]

Children and young people with a mental health problem compared to those without, have been shown to be more likely to:

- Report feeling very stressed
- Have poor or fair physical health
- Perform below grade at school
- Use alcohol or other drugs
- Think about killing themselves[7] [8]

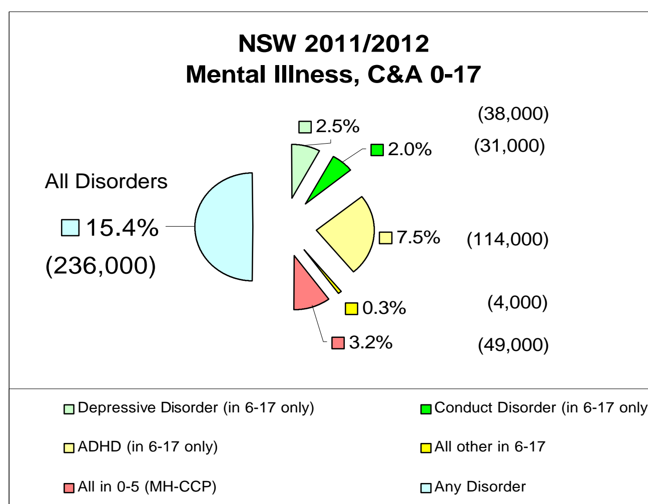
In summary, the problems of children and adolescents are frequently severe, may be disabling and may continue into or lead to great vulnerability in adult life. Most care for these age groups is in the community, but inpatient services are necessary for the very severely or acutely ill. These need to be coordinated and responsive to priorities and need. The US Surgeon General's Report emphasised the need for research and more effective treatments in this field. There is also considerable clinical opinion that disorders are coming on more severely and at a younger age, for instance repeat suicide attempts in 10-12 year olds

Child and adolescent services

- Similar rates of illness to that of adults (but different set of illnesses)
- Different pattern of services
- Majority of services in the community
- Increasing evidence for effectiveness of early intervention and prevention
- Trajectory of childhood problems into adulthood
- Need to coordinate use of inpatient resources

Epidemiology and Morbidity Patterns

Projections from the National Epidemiological data for children and young people to the year 2011/12 highlight the extent of mental health problems in these age groups. The following table indicates the levels and patterns of disorder in childhood and adolescence in terms of the currently available data from the Australian National Survey Data [9], the Western Australian Child Health Survey [10] and other relevant sources.



Source: National Survey of Mental Health and Wellbeing (C&A) proportions adjusted to MH-CCP(2001) best estimates & NSW population projections

Attention deficit disorder, anxiety disorders, conduct / disruptive disorders, and depressive disorders are the prevalent conditions. Internalising behaviours in earlier development reflect patterns similar to depressive and anxiety syndromes while externalising behaviours reflect those similar to conduct, disruptive and later antisocial syndromes. While this level of continuity of syndromes is not absolute, it represents some consistent trends, even to adult life. It highlights the importance of effective prevention and early intervention techniques, many of which have evidence of substantial potential benefits at this stage of the life cycle.

Child and Adolescent Mental Health Policy

The New South Wales policy, Making Mental Health Better for Children and Adolescents[11] has 5 key strategies which are being implemented across New South Wales.

Policy Framework: Making Mental Health Better for Child and Adolescents:
5 Key Strategies

- Strengthening the structure eg networks of child and adolescent services, Area coordinators
- Mental health promotion, prevention and early intervention eg preventing conduct disorder, suicide
- Better mental health care eg assessment protocols (MHOAT)
- Crisis and emergency response eg 24 hour access
- Quality and effectiveness eg information systems

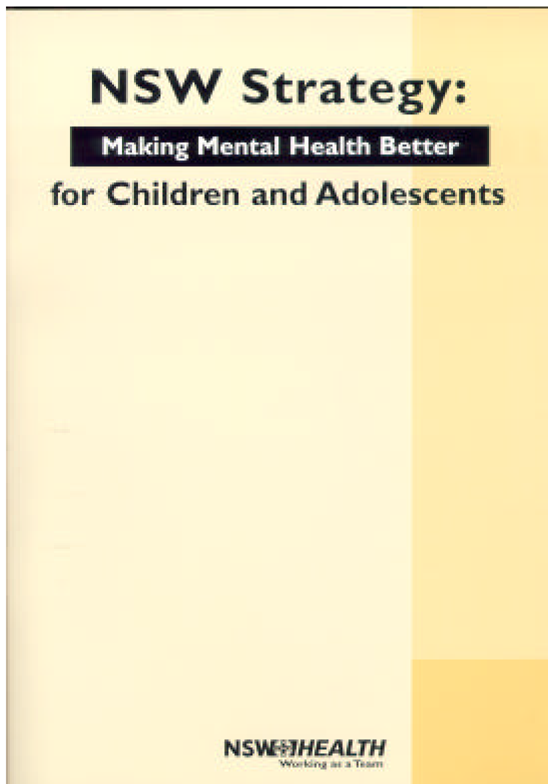
There is significant evidence, much from Australian studies, of the effectiveness of prevention or early intervention strategies in the early years of the life-cycle, so preventive interventions, universal, selected and indicated, should form a significant component of care.[12] These interventions, however, should not replace effective early intervention, treatment and ongoing management across the spectrum of interventions.

Child and adolescent community mental health services

- Emergency response
  - Linked to paediatric, specialist child and adolescent response systems and adult mental health services
- Acute service
  - Majority of clients
  - Assessment and treatment of discrete episodes
- Ongoing care
  - Small number of clients

Prevention and treatment

- Infancy
  - Perinatal care eg post natal depression
  - Home visiting programs
- Preschool
  - Parenting programs eg ADHD, conduct disorder
- School age
  - School-link, eg depression and anxiety
- Late adolescence and early adult
  - Early intervention and treatment eg psychosis



This approach is also taken up in the National Framework Promoting the Mental Health and Well Being of Children and Young People. [13] Prevention programs have been provided with a manual to assist evidence based program development.

The mental health programs are provided through Area Mental Health Services. Each Area has an Area Coordinator of Child and Adolescent Mental Health. Child and Adolescent Mental Health Services are delivered in close partnership with general child, adolescent and family health services. They are also closely linked to general NSW initiatives such as Families First.

Families First

- NSW Government initiative - to enhance family life and health of infants - 0-8 years
- Cabinet Office, NSW Health, DOCs
- NSW Health - Health Home Visiting by early childhood nurses - before & after birth

Mental health initiatives supporting Families First include: integrated perinatal and infant care; parenting program for mental health – Triple P training; mental health support for professional health home visiting programs; specific playgroups and support for mothers with mental health problems; and linked with specialist mental health services and the Families First network of services.

Specific programs sit across the intervention spectrum and include perinatal, preschool and links to specialist mental health services. See also Chapter 4, Term of Reference D, Issue (iii).

Integrated Perinatal and Infant Care

- About 87,000 babies born in NSW each year
- About 15% of mothers with new babies suffer from PND
- Infants of depressed mothers can develop a depressed mood as early as three months
- Risk of abuse and long term adverse outcomes
- Counselling, home visiting and other interventions
- Prevention, early intervention and improved outcomes for mother and infant - short and longer term

Sources: O'Hara MW & Swain AM (1996); New South Wales Mothers and Babies Report, 2000; Olds et al (1997)

NSW Parenting Program for Mental Health

- Parenting problems can lead to emotional & behavioural problems
- 10 to 15% of 3-5 year olds have moderate to severe behavioural problems
- Children with conduct disorder cost the community 3-10x more and have increased risk of long term problems
- Positive parenting programs can prevent the onset of conduct disorder and decrease prevalence

Source: Marshall J & Watt P (1999)

Program development in these fields is being supported by the Centre for Mental Health. Other major programs for children and young people include those for children of parents with a mental illness.

Children with parents with mental illness

- 29%-35% of female clients of mental health services have children <18 years
- These children are at increased risk of developing problems as a result of:
  - parenting problems
  - family disruption during hospitalisation
  - associated genetic factors
- Specific programs for children and parents can lessen risk

Source: Cowling V (ed) (1999)

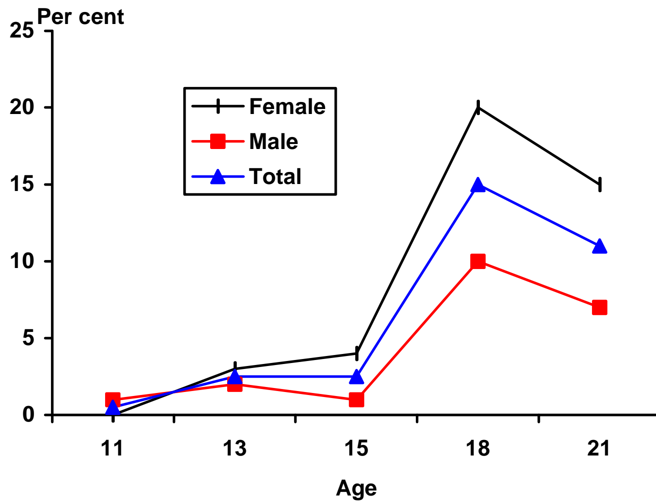
All families may need a safety net at times
The goal is to provide the help they need at the time when it can achieve the best outcome

These programs and the findings of the National Survey of Mental Health and Well Being for Children and Adolescents highlight the vital role of the family and the importance of integrating assessment and management of family issues and their dynamic interaction with the child's needs and problems.

Programs in Schools

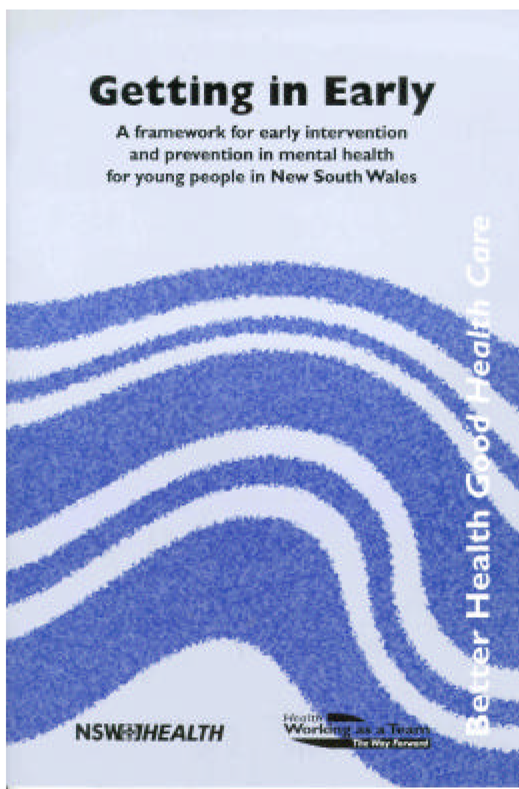
Programs in schools such as those focussing on anxiety prevention and early intervention[14] and depression prevention[15] are complimented by early intervention and treatment strategies as exemplified in the National Health and Medical Research Council Guidelines for the Prevention and Management of Adolescent Depression[16]. These programs are run through a partnership program between the Department of Education and NSW Mental Health, *School-Link*. The national program 'Mind Matters' for mental health promoting schools, also fits with this model.[17] This priority is also related to the dramatic rise in depressive symptomology in mid adolescence demonstrated in longitudinal studies in New Zealand, the Hunter and Melbourne. [18] These programs are described in more detail in Chapter 4, Term of Reference D, Issue (iii).

Develpoment of new cases of clinical depression by age and gender



Adolescents and Young People

Programs for those from 15-25 or 30 years of age are an important focus because this is the inception period for many disorders such as major depression and early psychosis; because of the benefits of early and effective intervention in altering trajectories towards more positive outcomes. A range of programs focusing on these age groups covers both the School Link and depression initiatives as well as early psychosis programs and those addressing comorbidity. The strategy "Getting in Early" sets the framework for these programs.[19]



School-Link
Helping Adolescents with Depression and Related Disorders

NSW HEALTH
Better Health Good Health Care

New South Wales has made a major investment in these programs, specifically for Early Psychosis, Adolescent Depression, and Suicide Prevention across the State, adapting models to local need.

Early psychosis programs

- 800 new young people affected each year in NSW*
- Onset generally occurs in late adolescence/ early adulthood
- Significant impact on young person & family
- Disrupts development, education, work
- Specialised early intervention programs decrease illness severity, disability and costs
- Early psychosis services
  - Available in all metropolitan areas
  - Increasingly available in rural NSW
- Early psychosis flag in MH-OAT to identify young people with early psychosis
- Early psychosis indicators, protocols being introduced to support good treatment and care

Source: Getting in Early : A framework for early intervention and prevention in mental health for young people in NSW. 2001

Child and Adolescent Mental Health Inpatient Services

The existing inpatient services have focused on specific programs with recent development of some capacity for emergency response. Most emergency response has been through the Children's Hospital at Westmead and other major paediatric hospitals at John Hunter and Prince of Wales. To ensure access to inpatient care, and a system responsive to acute and emergency needs, a series of linked networks for clinical services, protocol development and forward planning is being set in place. This will be partnered through Brief Emergency Assessment and Management Services (BEAMS) with paediatric speciality hospitals, general paediatric and community child health services.

Child and adolescent inpatient mental health services

- Three existing child and adolescent inpatient units
  - Rivendell (Central Sydney)
  - Redbank (Western Sydney)
  - Coral Tree House (Northern Sydney)
- New units
  - Gna Ka Lun (South Western Sydney)
  - John Hunter planned 2003 (Hunter)
- BEAMS (Brief emergency assessment and management services)
  - Child and adolescent mental health inpatient services delivered in general settings
- Networks
  - Similar to Paediatric Service Networks
  - Consistent with non-acute and acute mental health networks

Strategic Plan for Mental Health Inpatient Care for Children and Young People

- High prevalence of mental health problems
- Traditional focus on adult mental health
- Prevention
- Access - establishment of Networks
- BEAMS- Brief emergency assessment and management services
- Expansion of services

These networks and collaborative community child and adolescent mental health care will be targeting the patterns of morbidity delineated above and monitoring outcomes for children, adolescents and families through the child and adolescent component of the Mental Health Outcomes and Assessment Tools and Training program, adapted for child and adolescent mental health, known as MHOAT-CA. The program, as it applies to children and adolescents, is supported through the information systems currently in development. It will facilitate more systematic clinical skills for assessment and management planning, service protocols for documentation and systematic measures to evaluate outcomes. These latter measures include the Health of the Nation Outcomes Scale for Children and Adolescents, and the Strength and Difficulties Questionnaire which will allow clinical data to be linked to population survey data in which this is an element.

Child and Adolescent Psychiatry Telemedicine Outreach Services

The special needs of rural and remote areas for specialist child and adolescent mental health consultation, assessment and treatment programs is supported by a telemedicine outreach service from the Children's Hospital at Westmead, and through other centres. This program provides outreach visits and telepsychiatry consultation as well as education programs, and has been evaluated very positively for its contribution to both capacity building and service delivery in rural and remote areas.

Suicide Prevention

Suicide prevention is a major responsibility of NSW mental health services. NSW Health is the lead agency for a whole of Government approach. A number of education programs are mentioned in Chapter 4, Term of Reference D, Issue (iii).

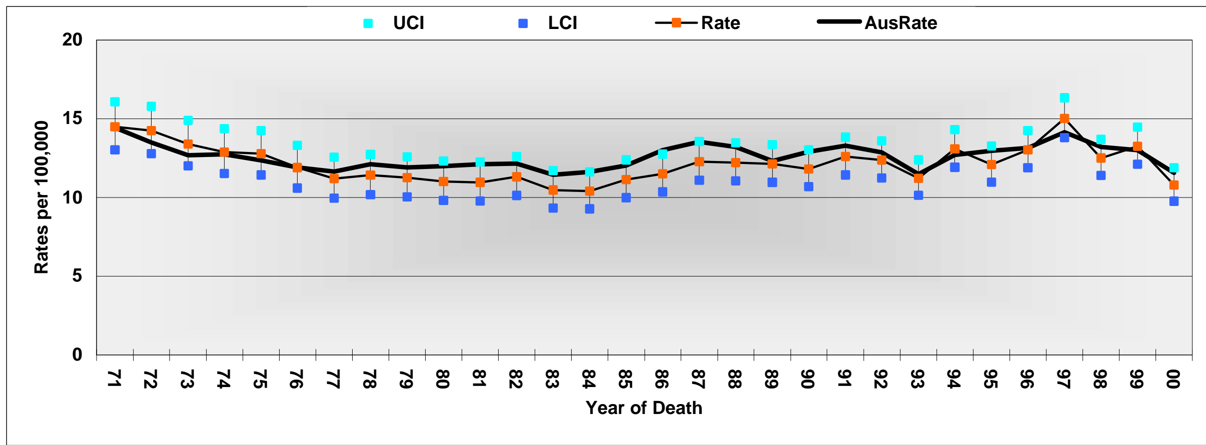
Suicide is strongly linked to mental health problems and disorders with heightened risk for those so affected.

Suicide Prevention in NSW

- More than 700 people die by suicide in NSW each year*
- Suicide has an enormous impact on the whole community, particularly families and friends
- The human and economic costs of suicide and suicidal behaviour are great
- Depression and other mental illness increases suicide risk

Source: NSW Suicide Prevention Strategy 1999

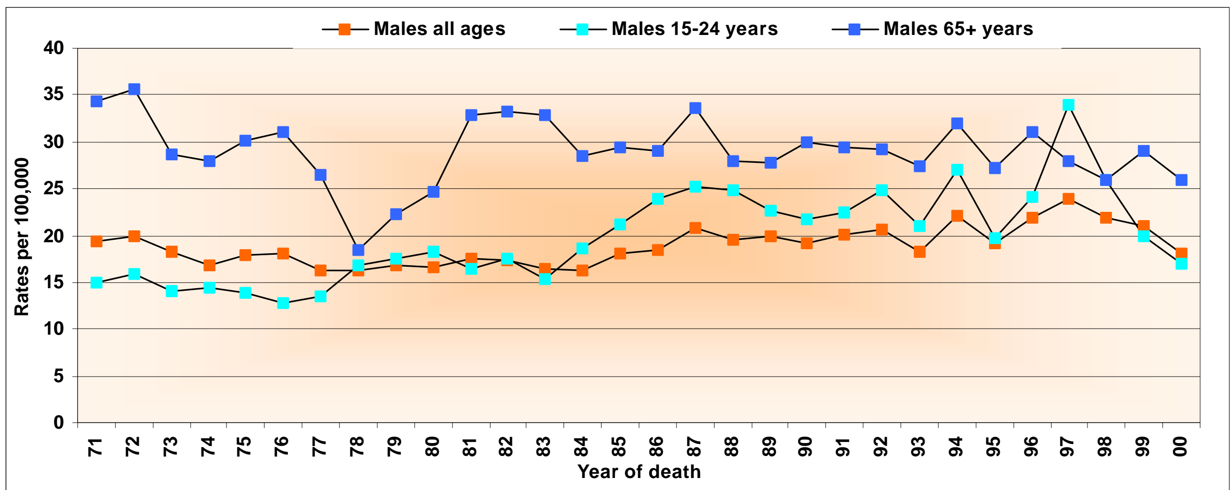
Suicide Rate, NSW v Australia, 1971-2000



Source: CMH analysis of ABS mortality data. Note: Data for 2000 is incomplete

There has been a very strong effort for suicide prevention in NSW supported by the strategy 'We Can All Make a Difference'[20] the NSW Suicide Data Report [21], Care and Support Packs for those Bereaved by Suicide [22], Circular 98/31 for Health Service response (currently under revision), and other important reports. [23] [24]

Suicide Rates, males by age groups, NSW 1971 to 2000



Suicide rate is highest for older males. Suicide rates in young males versus all males have increased since 1983. Suicide trends show a decline in suicide rates since 1997 for all age groups

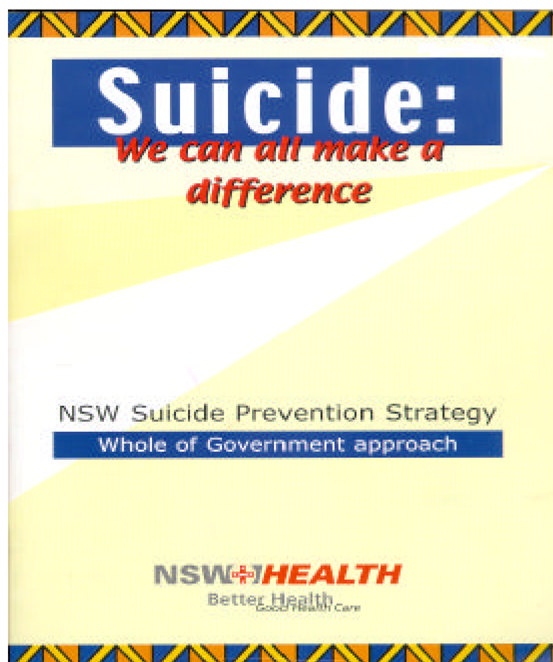
Source: CMH analysis of ABS mortality data. Note: Data for 2000 is incomplete

NSW Suicide Prevention Strategy

- Whole of government approach - developed with16 other NSW Government Department
- NSW Health is lead agency
- *We can all make a difference: NSW Suicide Prevention Strategy*- comprehensive, involving families, schools, groups and local communities
- Provides a framework for suicide prevention across NSW
- Circular 98/31: Policy guidelines for the management of possible suicidal behaviour

NSW Suicide Prevention Strategy: 5 key strategic directions

- We can all make a difference: increasing communities ability to prevent suicide. Eg MindMatters Program
- Connect and care: providing outreach and support for groups at higher risk. Eg *NSW School Link Program*
- Suicide, an emergency: enhancing the effectiveness of services in suicide prevention. Eg *Policy Circular 98/31*
- Care and Support: providing support for people affected by suicide. Eg *Care and Support Packs for Families and Friends Bereaved by Suicide*
- We need to know more: improving information on suicide prevention. *Eg NSW Suicide Data Report*



Emergency Mental Health

There is an increasing focus on the capacity to provide emergency assessment and response, emphasised by the high level of acuity of many patients, their presentations to emergency departments and to the extended hours crises services provided in the community.

Emergency Departments are a focus of initiatives in mental health in NSW as worldwide. This response was developed through the Report on Mental Health Care in Emergency Departments, the implementation of memoranda of understanding and mental health liaison processes with mental health nurses in Emergency Departments, as well as performance indicators for this program. The development of handbooks has supported these processes.[25]

Emergency departments

- Entry point for acutely disturbed patients
- Highly charged atmosphere
- 2-4 % of ED presentations are *recognised* acute mental health problems
- Difficult to manage in ED, yet need for thorough physical and psychiatric assessment

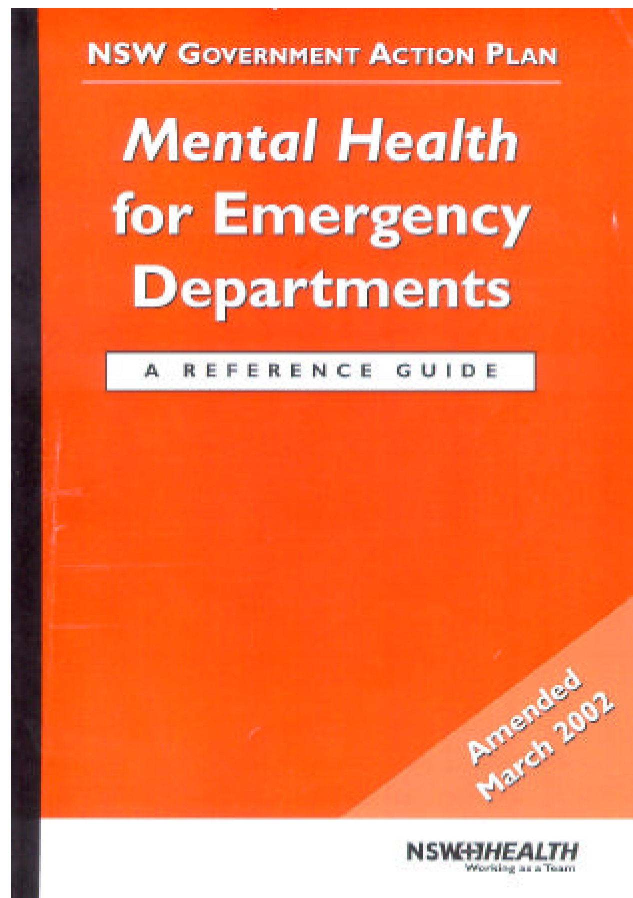
Source: South Eastern Sydney AHS Mental Health Triage Guidelines Project 2000

Emergency mental health response

- Mental health consultation- liaison nurses to emergency departments
- Working group for mental health care in emergency departments
- Emergency department mental health manual
- Memorandum of understanding with ED
- Central contact point for mental health services
- Improved triage process
- Memorandum of Understanding with Police

Crises, extended hours and emergency response services are present in all Areas and responsive as possible and appropriate to need, providing acute assessment, triage and treatment proportionate to identified need.

Disaster Emergency Response is also a part of public sector mental health emergency and follow-up response and is described in greater detail below. Area Mental Health Staff have been trained in evidence based practice through the NSW Mental Health Disaster Manual.[26]



Depression and Anxiety Disorders

NSW mental health policy and program implementation has provided a range of strategies which address the key components of the National Depression Action Plan[27] These include: Postnatal Depression Program; Depression Prevention and Early Intervention in schools through the School Link program and NHMRC Guidelines for adolescent depression; circulation of clinical practice guidelines for the treatment of depression in adults; partnership programs for the detection and management of depression in primary care; screening guidelines for depression in the elderly and management protocols. A community depression program in rural areas has been developed to increase understanding of depression and promote access to early and effective treatment. Programs are complimented by specialised clinics and centres to focus expertise, education and research.

A similar framework is being developed for *anxiety disorders*. It also relies on prevention programs and early intervention for preschool and school age children; guidelines for treatment of anxiety disorders in adults; and specific programs for Post Traumatic Stress Disorder. There are also partnership programs with general practitioners.

Mental Health Strategies for Special Populations

Within the framework of *Caring for Mental Health*, the needs of special populations are highlighted as a focus for service planning and delivery, the following being the major ones:

SPECIAL POPULATIONS

- Rural and remote
- Indigenous
- Culturally and linguistically diverse (CALD)

Rural and Remote Mental Health

There are special needs and issues for rural populations, including distance and isolation, changing social infrastructure, source of income, and social determinants of health and difficulties in attracting specialist and often general health workforce.

Rural Mental Health

- About 1.8 million people in rural NSW
- Prevalence of mental disorders similar to that in urban areas

Source: National Survey of Mental Health and Wellbeing Report 2 1999

Priority rural mental health issues

- Access to services
- Youth suicide rates
- Aboriginal mental health
- Changes in rural infrastructure
- Loss of specialised workforce

There are many Commonwealth programs for rural health generally, but the programs described below are significant NSW mental health developments in response to identified issue. The programs complement the broader implementation of the programs described earlier for acute and non-acute care, child and adolescent and older peoples care.

Rural mental health initiatives

- Rural mental health funding growth by $30 million 2000-2003
- New inpatient services
- Increased community mental health staff
- Centre for Rural and Remote Mental Health
- Telepsychiatry
- CAPTOS (Child and adolescent psychiatry telemedicine outreach service)
- Fly in psychiatrists and area of need support

Aboriginal People and Torres Strait Islanders and Mental Health

Aboriginal peoples and Torres Strait Islanders have the most disadvantaged health status of all Australian peoples. Social disadvantage and the effects of this; past policies such as the separation of children from parents as described in the Stolen Generation's report 'Bringing them Home'; poor physical health and premature mortality; high rates of incarceration; and low levels of home ownership all contribute negatively in terms of mental health and well-being [28]

The Aboriginal and Torres Strait Islander definition of health generally is holistic; that is, includes physical, mental, social, emotional, spiritual and other aspects. *Social and Emotional Well-Being* is the preferred term for mental health. It is also clear that on all indices, social and emotional well-being levels are worse than for non-indigenous Australia.

Aboriginal & Torres Strait Islander Peoples

- Comprise 1.8% of the total population of NSW unevenly distributed across the state.
- Number 109,925 -the largest population of any State or Territory (1996)

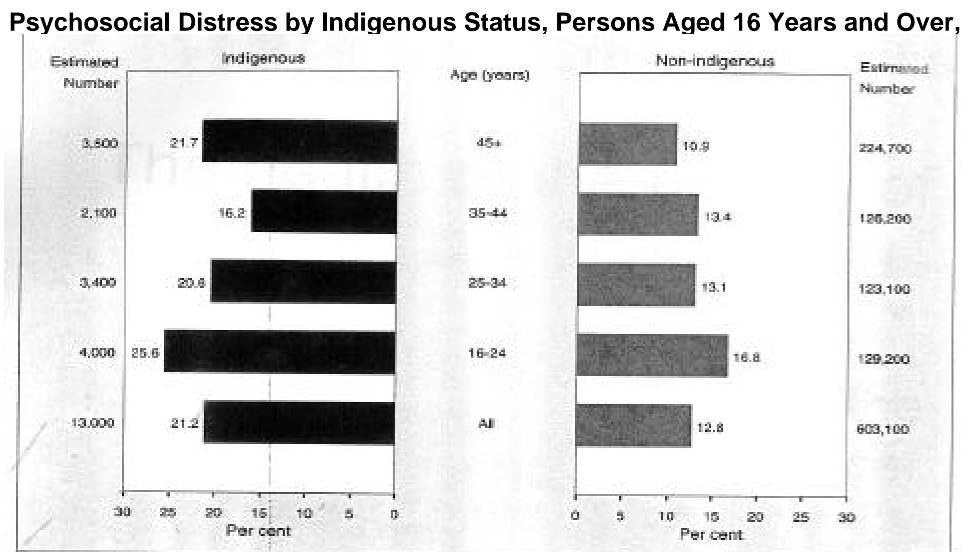
(Source: *Chief Health Officer*, NSW Health May 2000:106).

Aboriginal & Torres Strait Islander Peoples : Data

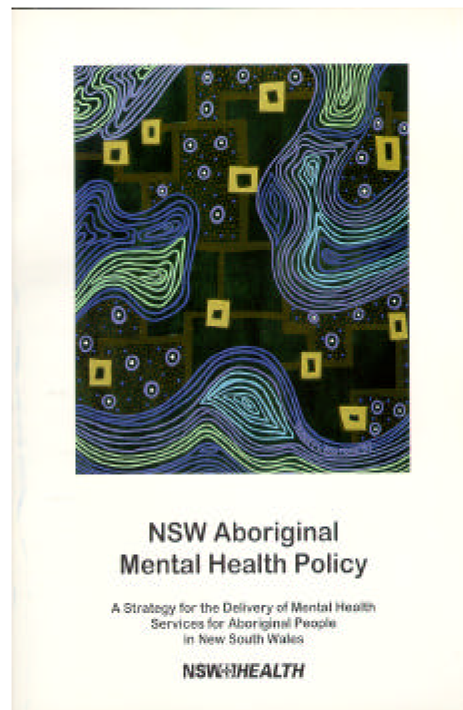
- Suicide rates: higher
- Deaths by homicide/deliberate injury: higher rates
- Mental disorder separations: higher
- Mental distress: higher

The use of the 'K10' measure (Kessler 10 items) as a measure of psychological distress in a population based survey, has highlighted the fact that indigenous mental health distress is at a higher level than that of the general NSW population.

Psychosocial Distress by Indigenous Status, Persons Aged 16 Years and Over,



Source: The Health of The People Of New South Wales & Report of the NSW Chief Health Officer, May 2000



The NSW Aboriginal Mental Health Policy was released in 1997 after extensive consultation and development.[29] Its major components have been in place since that time. A review process is underway and will produce the basis for the new Aboriginal Mental Health Policy for NSW.

NSW Aboriginal Mental Health Policy (1997)

1. All policies, strategies and programs to reflect a respect for the Aboriginal person as an individual, within a family, community, nation and society.
2. Aboriginal community and ACCHS are consulted in identification of needs, development, implementation evaluation of programs and services.
3. Recruitment of Aboriginal people into AHS is conducted in partnership with ACCHS.
4. Education in an integral aspect of the workplace for Aboriginal and non-Aboriginal people.

NSW Aboriginal Mental Health Policy review themes

- Partnerships together
- Workforce
- Child, adolescent and family
- Service pathways and care
- Resource base

***Mental Health Programs for People of Culturally and Linguistically Diverse Backgrounds**.*

The NSW population is so diverse that the identification of the many different ethnic, social and religious groups that comprise it presents many challenges in terms of both the understanding of mental health needs and appropriate and culturally sensitive response to these. Issues of concern range from language and access, the use of health care interpreters skilled in mental health, the stresses that may be found through migration, the loss of familiar country, traumatic experiences such as those of refugees, and social difficulties associated with transition such as finding work, education, a home and a meaningful way of life. Many, many immigrants and refugees have made such transitions successfully, so it should not be assumed that mental health outcomes will be negative.

Nevertheless, there are diverse ways in which many mental health problems and disorders are perceived and experienced and there may be many different experiences in relation to these including stigma, shame, blame, use of traditional healers and so forth. Providing culturally competent and appropriate mental health services which ensure access and appropriate treatment is critical to equity and outcomes.

NSW Health has a mental health policy framework *Caring for Mental Health in a Multicultural Society* [30]. This policy will be reviewed and further policy development processes set in place through 2002/2003. Many programs are further supported by implementation through the activities of the NSW Transcultural Mental Health Centre and other specialist programs in transcultural mental health, for instance in South Western Sydney and linked to Torture and Trauma services such as NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors .

People From Culturally & Linguistically Diverse Backgrounds (CALD)

Over 2.3 million (24%) were born overseas
Key issues

- Less frequent use of mental health services compared with the general community
- Present at a later stage in their illness
- Culturally appropriate services
- Migrant issues
- Refugee and torture and trauma

Policy Framework

Caring for Mental Health in a Multicultural Society, developed in 1998.

- Information to people from CALD about mental health & services
- Better co-ordination between MHS and multicultural services
- Enhancing and supporting primary care mental health services
- Promotion, early intervention and prevention to CALD communities
- Enhancing and supporting of MH professionals to provide timely, appropriate & effective mental health services people from CALD, including bilingual workers
- Culturally appropriate assessments, diagnosis and treatment

Key role of Transcultural Mental Health Centre

Other Populations with Special Needs

It is possible to define many different populations in terms of the specific needs and mental health. These will not be dealt with in detail here but for example include:

- *Women and Mental Health*: Post natal depression, roles as carers, differential impact of psychotropic drugs, different patterns of morbidity, are amongst the issues for women.

- *Men and Mental Health*: High levels of comorbidity with substance abuse, more severe and earlier onset of disorder such as schizophrenia are amongst the issues for men. [31]

- *Lesbian, Gay and Transgender Populations*: Particular difficulties may arise in terms of stigma, discrimination, risk of HIV/AIDS, 'coming out' and so forth which may impact on mental health and well-being.

(i) The number of subsidised, supported and unsupported accommodation services in the community for people with mental illness, by Area Health Service

Accommodation for people with mental illness includes:
- Public housing – secure, long term and affordable rental housing assistance.
- Supported housing – leased to Non Government Organisations and then allocated to clients in need of specialist support services.
- Boarding houses – generally by the private sector, licensed by the Aging and Disability Department. The licence stipulates that a boarding house cannot have more than two people with high support needs unless there is 24 hour supervision.

In May 2000, the Centre for Mental Health completed a survey of current housing and accommodation support services for people with mental health problems in NSW. Aside from boarding houses and SAAP-funded services, there were 1250 places (beds) that represented housing and accommodation support for people with mental health problems. The availability of places varied from 7.6 per 100 000 to 55 per 100 000 population per area halth service.

Few services offer home-based outreach support people needed to live in program accommodation to receive support services. In March 2002, there was an increase to 1499 supported accommodation places (beds) available in NSW. Anecdotal reports from area health services indicate there has also been an increase since May 2000 in the availablility of outreach accommodation support, provided flexibly to people in their own home, wherever that may be.

Some findings of the 2000 survey were:
- Half of the properties were share accommodation with three or more residents, one third had two residents and the remainder were single residency properties.
- Two thirds of the programs were for people aged between 19 and 65, one fifth targeted 17 and 18 year olds with the remainder catered for persons over 65 years.
- 87% of the programs had an identified Entry and Exit policy.
- 80% provided a service based on the person's prior residency in the Area Health Service and in some cases specific sector catchment area
- 92% of programs had exclusion criteria – history of violence, criminal record, co-morbid mental illness and substance abuse.[32]

The table below shows the distribution of supported accommodation across area health services, ranging from 9.6 in Greater Murray to 86.7 in Mid Western per 100,000 of population.

Supported Accommodation (as at March 2002)

AREA HEALTH SERVICE	No of beds	Per 1000,000 population
Western Sydney	103	15.1
South Western Sydney	128	16.4
Northern Sydney	221	28.7
Central Sydney	213	43.3
South Eastern Sydney	150	19.4
Central Coast	36	12.2
Wentworth	44	13.9
Hunter	62	11.4
Illawarra	82	23.1
New England	25	14.3
Macquarie	12	11.4
Mid Western	148	87.6
Southern	43	22.7
Greater Murray	25	9.6
Far West	0	0.0
Northern Rivers	139	50.7
Mid North Coast	68	25.0
TOTAL	**1499**	**23.1**

Source: NSW Accommodation Survey 2002 Update

Disability support services are provided by:

- 53% NGO
- 11% Area Health Service
- 12% volunteers
- 18% others

Properties used in these programs are owned by:

- 51% Department of Housing
- 24% Area Health Service
- 6% shared ownership between Department of Housing and Area Health Services
- 9% NGO[33]

The Centre for Mental Health has also developed a draft paper titled '*Framework for the Provision of Housing and Accommodation Support for People with Mental Health Problems and Disorder in NSW'*. When released the document will provide strategic direction for the area health services and other key stakeholders for developing partnerships at the local level. The document will make it clear that area health services are responsible for ensuring access to Housing and Accommodation Support Services throughout the State.

The Centre is also currently involved with five housing and mental health projects in partnership with other stakeholders including the Department of Housing, area health services, the University of Western Sydney, the Office of Community Housing, the Department of Ageing, Disability and Homecare and the Department of Community Services.

The projects are:

- The Assisted Tenancies Project Pilot

- The Woolloomooloo Homeless Project
- Predictors of housing vulnerability and incipient homelessness for people with mental health disorders
- The Stage One expansion of the Joint Guarantee if Service for people with mental health problems and disorders
- Mental Health and SAAP Linkages Project.

Accommodation issues, including these projects, are also referred to in Term of Reference G, Issue (ix.)

(ii) The relationship between mental health services, the non-Government mental health sector and the business community

Specific partnership programs which have been the focus of initiatives with mental health services include:

- Consumers and Carers
- Non-Government Organisations
- Other Government Departments as exemplified below
  - Education – School Link
  - Housing – Joint Guarantee of Service
  - Police – Memorandum of Understanding
- Other health sectors as exemplified below
  - Maternal and Child Health
  - Youth Health
  - General Health Care
  - Public Health (NSW Health,[34]

The Mental Health Integrated Program (MHIP) is a joint Commonwealth and State funded program to develop and implement innovative models for the delivery of mental health services locally. A number of projects and strategies have been introduced in Areas. These have provided the flexibility to trial locally generated solutions for improving mental health services. Most trials are in a two year phase with final evaluation reports due in November 2002. Examples include improved liaison and support services for general practitioner consultation in the Illawarra Area following the establishment of a telephone support network to general practitioners seeking support on guidance and advice with managing patients with mental illness; increased training and secondary consultation activity and the provision of support to general practitioners and remote health service staff in the Far West and a project to improve networks for consumers and carers in the Hunter Area Health Service.

Of great significance in addition to the above are the partnerships with general practitioners to compliment the care of people with mental health problems and disorders. This is an active partnership program aimed at bringing service systems closer together. It builds on shared care developments, but extends beyond them to better recognise the special contributions of general practice.

Partnerships with general practice project objectives and indicators

- Collaboration: general practice representative in Area Mental Health Planning
- Access: percentage of new clients to mental health service who have a GP
- Communication: percentage of discharge summaries sent to GP

Partnerships with general practice

There are 7,000 GPs in NSW

- 80% of the Australian community see a GP each year
- Most people who seek help for a mental health problem, do so from a GP
- GPs provide mental health interventions to 27% of people attending their practices
- Partnership between mental health services and general practitioners
- Three broad components
    - Local Area Mental Health and Divisions of GP
    - State Centre for Mental Health and Alliance of NSW Divisions of General Practice
    - Commonwealth aware and responsive to national agenda

A priority under the Second National Mental Health Plan is to strengthen the complementary and integrated roles of public and private sector mental health services.[35] Private mental health services are provided by general practitioners, private psychiatrists, psychologists, social workers, counsellors, non-government organisations and private hospitals.

Not all costs associated with these services can be identified because services with private psychologists and other non-medical practitioners are not reflected through government systems of costing, that is Medicare. Additional costs would also occur through workers compensation and other schemes.

MBS services and costs in NSW are described below:

MBS and PBS services for mental health in NSW

- 4.5 Million MBS Attendances for Mental Health problems
    - 3.50 Million MBS GP attendances +/- 0.4M (est 1999-2000)
    - 1.02 Million MBS Psychiatric Attendances (2000-01)
- 5.3 Million PBS Prescriptions of Psychoactive Rx
    - 0.46 Million PBS Antipsychotic Rx (2000-01)
    - 3.01 Million PBS Antidepressant Rx (2000-01)
    - 0.62 Million PBS Anxiolytic Rx (2000-01)
    - 1.16 Million PBS Hypnotic/ Sedative Rx (2000-01)
    - 0.06 Million PBS Stimulant Rx (2000-01)
- $200 Million in MBS Attendances for Mental Health problems
    - Estimated $100M for estimated 3.1M - 3.9M GP attendances
    - $96.6 Million for MBS Psychiatric Attendances 2000-01
- $133 Million PBS Payments for Psychoactive Rx
    - $48.4 Million PBS Antipsychotic Rx (2000-01)
    - $75.8 Million PBS Antidepressant Rx (2000-01)
    - $ 3.8 Million PBS Anxiolytic Rx (2000-01)
    - $4.6 Million PBS Hypnotic/ Sedative Rx (2000-01)
    - $0.8 Million PBS Stimulant Rx (2000-01)

Source: HIC (2000-01)

Other mental health costs in NSW would be met by the Commonwealth through pension entitlements and the Department of Veterans Affairs' health services/provision for mental health.

Non-Government Organisations

Non-Government Organisations (NGOs) are private not-for-profit community managed organisations that receive government funding to provide community support services for people affected by a mental illness. The Burdekin Report noted that NGOs are responsive to the mental health needs of consumers and that they are flexible in their approach to service delivery. Their role in disability support is clearly identified as distinct from the clinical role of Area Health Services.

The role of NGOs in the provision of mental health services in NSW broadly include:

- Peak/statewide representation of members; for example, Mental Health Co-ordinating Council, NSW Consumer Advisory Group, St Vincent de Paul Society, Aboriginal Health and Medical Research Council of New South Wales, Carers NSW and the Mental Health Association NSW.
- Disability support – services of organisations such as Aftercare, Richmond Fellowship and the Psychiatric Rehabilitation Association, include accommodation support, residential services, outreach, respite, rehabilitation, non-clinical case management/co-ordination, supported employment, social/recreational.
- Self help/mutual support, usually consumer and/or carer driven peer support groups, such as the Schizophrenia Fellowship, ARAFMI and Anxiety Disorders Alliance. Membership includes people experiencing problems related to a specific illness, condition or circumstance and/or their families and carers. In recent years there has been an increased focus on NGO based psycho-social rehabilitation services with the emergence of the Clubhouse model and supported employment services.
- Advocacy/information/education services. This may be the organisation's primary role, such as the Mental Health Association of NSW, or a secondary role.

The National Mental Health Strategy recognises the need for formalised NGO partnerships through policies, procedures, protocols and funding. The NSW Government has identified increased involvement in health care provision by NGOs as a key policy commitment. The Mental Health Implementation Group is currently developing a Framework for NGOs and Mental Health to formalise and progress partnerships.

Through the NSW Health NGO Grant Program, 350 grants totalling $14.7million were allocated across 271 NGOs in 2000. Examples of partnership initiatives with the Centre for Mental Health are:

- Guidelines for Management of Schizophrenia, a joint undertaking by the Schizophrenia Fellowship of NSW and the Centre for Mental Health
- Funding of the Mental Health Co-ordinating Council to undertake the Mapping Analysis and Performance Project and the Mental Health NGO conference in October 2001. The Project identified a total of 372 mental health services provided by NGOs. The number of services is to a large degree determined by population. In 1999 75% of the NSW population lived in metropolitan areas. 72% of mental health services provided by NGOs are located in metropolitan Area Health Services.
- Funding of Carers NSW to provide support programs for carers of people with a mental illness.

Business community

The Centre for Mental Health provides funding through NISAD for Mr Don McDonald who has been giving information talks to business, industry, and unions to enhance understanding of schizophrenia.

Public/Private sector partnerships are also being progressed between public sector and private sector mental health services.

Through liaison with Rotary, Areas are providing input to community education. Members of the business community are involved in Rotary and in the fund-raising for mental health research.

A number of NGOs run rehabilitation programs linked to industry to promote effective work based rehabilitation.

Further information on the links with the business community are found in Chaptr 4, Term of Reference D, Issue (iii).

(iii) The availability of health facilities that cater to the needs of people with dual diagnosis such as mental illness and alcohol and other drug use

Comorbidity is the co-occurrence of two or more illness conditions. The comorbidity of mental health problems and illnesses and alcohol and other drugs is a very significant problem. There is increasing concern about cannabis and psychostimulants contributing to both the precipitation of illness and more adverse course and outcome as well as evidence of high levels of co-occurrence of physical health problems and mental health problems. This leads both to greater complexity of assessment and treatment and may also contribute to higher levels of morbidity and mortality from a number of physical illnesses in those who have a mental illness. There may be higher mortality for people with illnesses such as cardiovascular disease if there is comorbid depression. These factors highlight the need for mainstreaming mental health in the general health system, and similarly the involvement of general practitioners.

Another major area of comorbidity is mental health and developmental disability problems. The Mental Health Implementation Group will be providing guidelines to assist clinical management in this and other aspects of comorbidity under its clinical partnership initiative.

Co-morbid mental health and substance use disorders

- Substance use disorders co-occur with a wide range of mental disorders
- High prevalence (eg 25% comorbid lifetime cannabis use disorder in Australian patients with psychosis)
- Substance use worsens prognosis
- Substance use makes treatment more difficult
- Association or causation?
- Common risk factors, self medication, or substance induced?
- Mental Health and Substance Use Disorders Service Delivery Guidelines

Results of the 1997 National Survey of Mental Health and Well-being show a considerable degree of co-morbidity in substance use disorders and other mental health disorders. About one in four persons with an anxiety, affective or substance disorder had at least one other mental disorder.

A small number (0.8%) had all three types of disorders.

> '*The high rates of comorbidity have a number of implications for treatment and management. Mental disorders complicated by alcohol and other drug use disorders, and vice versa, have been recognised as having a poorer diagnosis than those without such comorbid disorders.*'[36]

The Second National Mental Health Plan identified comorbidity of mental health and substance use as a high priority and emphasised the importance of partnerships in service delivery and reform.

> '*Activity under the Second Plan will focus on a national response to this priority area concentrating on prevention, targeted at the antecedents of these co-occurring disorders, as well as the development of improved treatment and management through better collaboration and coordination between mental health and drug and alcohol treatment services.*'[37]

The National Comorbidity project is a Commonwealth initiative dealing with this problem.

The Centre for Mental Health, in partnership with the Drug Programs Bureau, consulted widely and developed and released service delivery guidelines in June 2000. The document '*The Management of People With Co-existing Mental Health and Substance Use Disorder: Service Delivery Guidelines and Discussion Paper*'[38]. contains information about existing and proposed service delivery across New South Wales. All services have implemented these guidelines and should provide integrated services or collaborate as clinically appropriate.

A review of the Guidelines was undertaken by the Centre for Mental Health in November 2000. At that time, most area health services had made significant implementation progress including the establishment of working groups to monitor the progress.

Initiatives developed for people at risk or with dual disorders by area health services include:

- Central Coast – a health promotion pamphlet '*Young People Drugs and Psychosis'* and the '*Bong Off Marijuana Intervention Course*' for young people
- Hunter – a designated Dual Diagnosis Service, comprising an inpatient unit, a centre based community service, a limited outreach service and a consultation/liaison service, provides an integrated service to people with co-existing mental health and substance use problems
- Greater Murray – Reacting Early for Dual Diagnosis Intervention Project
- Western Sydney – Interactive Drug and Alcohol Intervention for Young People Project.
- Northern Rivers has a Dual Disorders Steering Committee that examines the needs of persons with a drug and alcohol mental health issues. The Committee meets regularly and has begun to train mental health workers in the needs of persons with dual disorders.

Two pilot projects involving the Illawarra and Central Coast Divisions of General Practice, local mental health and other services have been funded to develop a model of partnership for service integration for people with dual diagnosis. Partnerships with GPS, public and private mental health services and alcohol and other drug services, NGOs and consumer and carer organisations are being developed.

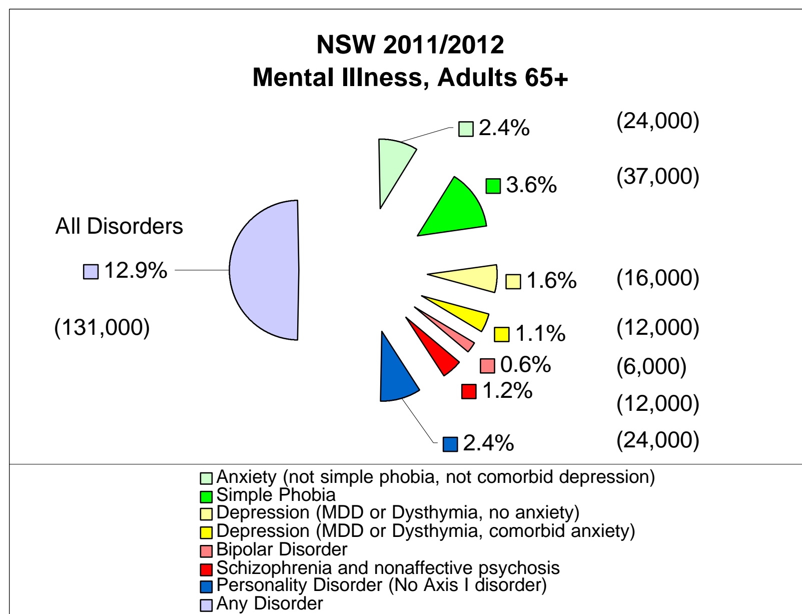
The Centre for Mental Health has also allocated $150,000 to The University of Sydney to develop a postgraduate mental health nursing course in Dual Diagnosis. The allocation is made up of $100,000 for course development and $50,000 for 10 scholarships.
In May 2001, the Centre for Mental Health also funded the Richmond Fellowship to conduct a research project and provide a recommendation to the Department of a service model establishing residential support services for people with co-morbid mental health and substance use disorders.

(iv) *The relationship between mental health services and other specialised facilities such as nursing homes, behaviour modification units (dementia care) and aged care generally*

The population of older (and particularly very old) people is increasing rapidly. In 2000, people aged 65 years or more constituted 12.8% of the NSW population, compared to 12.5% in 1995. In 1999, the median age of 34.9 years is projected to increase to between 43.6 and 46.5 years in 2051. The proportion of the population aged 65 and over is expected to increase substantially, from 12% in 1999 to between 24% and 27% in 2051. The proportion aged 85 and over is expected to almost quadruple, from 1.3% in 1999 to around 5% in 2051.[39]

This increase is likely to result in significant demand for specialised mental health service provision for older people. Increasing longevity is accompanied by increasing levels of disability and chronic illness. More people with life long mental illness and associated disabilities will grow older. Depression associated with physical illness, dementia or disability for older people will increase. Suicide rates for men over 75 years of age are the second highest of any age group in NSW. Behavioural or psychiatric disturbance associated with age related dementia is a significant issue for families and carers and the aged care sector. Older people's mental health problems show a very high comorbidity with physical health problems such as stoke, cardiovascular disease, cancer and depression.

Epidemiology and morbidity estimates are based on the National Epidemiology Survey data, projections for older people in institutional settings, and projections from international data – see diagram below:



Source: National Survey of Mental Health and Wellbeing proportions adjusted to MH-CCP(2001) best estimates & NSW population projections

National, state and area mental health policies focus on the need to ensure better integration and coordination between service planners and providers to improve mental health care for the aged care population. The NSW Health Caring for Older People's Mental Health Policy released in January 1999 reflected the goals of the Second National Mental Health Plan in identifying partnerships with a range of government service providers, consumers, community groups and local health workers as critical for future service delivery.[40]

The majority of older people with mental health problems are cared for in their own communities and homes by general practitioners, aged care health services and general community mental health services. Inpatient services are provided in a variety of settings including general hospitals, general hospital acute psychiatric units, psychiatric hospitals, specialist psychogeriatric units or hospitals, and private psychiatric hospitals.

Assessment, treatment and management for older people with mental health problems requires collaboration between aged care services and mental health services in the government and non government sectors and with general practitioners as well as social and voluntary organisations and families and carers. This includes the need for specialist mental health services for the aged to work together with other aged care services such as geriatric medicine, community aged care services and facilities, welfare, housing and transport services.

Mental health services in NSW offer assessment and management to older people for the full range of mental illnesses and their consequences. This includes the major psychiatric conditions such as schizophrenia and depression. Services also assess and treat secondary psychiatric or severe behavioural or aggressive disturbances associated with organic disorders such as dementia. Older people with mental health problems or disorders may also experience complicated complex physical co-morbidities that require specialised intervention.

There are a number of specialist mental health services for older people in some areas. These provide consultation-liaison to aged care and general hospital services, as well as patient-family education. Almost all services undertake community based assessment, inpatient assessment, treatment and management, assessment in institutional and residential care, training for health professionals, and are involved with prescribing and monitoring medication. Many undertake community based treatment and management, treatment and management in institutional or residential care, provide outpatient clinics, counselling, assist with placement, and arrange community supports.

Several initiatives, currently in place to review and improve service collaboration, include:

1. Best Practice Models

A Best Practice Model for the Use of Psychotropic Medication in Residential Aged Care Facilities and Guidelines for the Management of Challenging Behaviour in Residential Aged Care Facilities in NSW has been developed by the Centre for Mental Health. Over 3,000 copies have been distributed throughout the sector.

Last year the NSW Institute of Psychiatry was engaged to develop and implement an education and training program about the Best Practice Model and Guidelines. The program focussed on issues relating to the use of psychotropic medication in residential aged care facilities and targeted service providers and staff who may have responsibility for medication management in a residential aged care facility, such as general practitioners, management and staff working in residential aged care facilities.

Another key component of the program involved consultation with key stakeholders in residential aged care to ensure relevance and applicability. As part of the program, a Manual has been developed to provide a resource for service providers in residential aged care facilities

2.. Treatment Guidelines

Guidelines prepared by the Royal Australian and New Zealand College of Psychiatry, Faculty of Psychiatry of Old Age, for assessment of depression, suicidal behaviour and management of behavioural disturbances in older people have been circulated to Aged Care Services and Adult Mental Health Services. These are to be implemented in conjunction with primary health care providers and aged care facilities.

3. NSW Health Interdepartmental Planning

A NSW Health initiative is focussing on reform of the interface between acute care and aged facilities with the development of a discussion paper '*Improving the Aged/Acute Care Interface in NSW*'. The paper proposes reform of the Commonwealth and State responsibilities for dementia care and the Centre for Mental Health is contributing to the development of an implementation strategy from the mental health perspective.

4. Dementia with Challenging Behaviours

The Department of Ageing Disability and Home Care convenes the Dementia Group and is the lead agency. The role of the Group is to implement the Action Plan in NSW with a budget of $10 million. NSW Health has major responsibilities under the Plan. Mental Health is a significant issue for the target group, particularly people with dementia and behavioural and/or psychiatric disturbance. The Centre for Mental Health is participating in this initiative through advice on access and policy issues.

Highly aggressive behaviour by older people has been one of the most problematic areas to manage for mental health and aged care services. The further development of collaborative arrangements between mental health and geriatric services for people with severe behavioural disturbances, often associated with dementia, is a priority issue for all sectors.

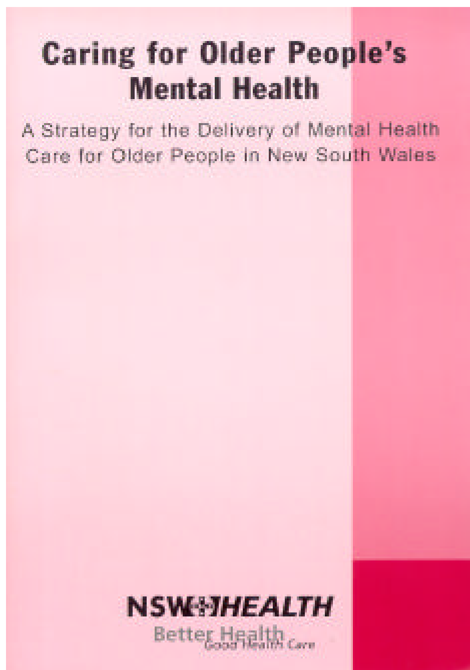
Specific strategies have been developed for older Aboriginal and Torres Strait Islanders, older people from culturally and linguistically diverse backgrounds and older people in rural and remote areas. The needs of older Aboriginal people are being addressed through trauma and loss counselling programs, family support and the appointment of Aboriginal Mental Health workers. The mental health needs of older people from non-English speaking backgrounds may be exacerbated by cultural and linguistic barriers. They have significantly higher rates of suicide compared with the overall community. The use of telepsychiatry and visiting specialist services support local rural workers in the provision of mental health care for older people.

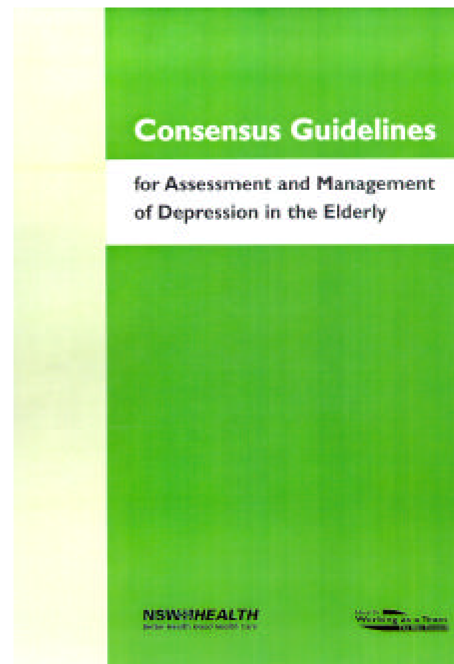
Policy Framework for Older People's Mental Health

This covers 5 key strategies including community and inpatient services. Most services are provided in the community, but specialised inpatient services also exist in the major metropolitan areas or larger centres. A planning group is addressing the growth and development needs for this age group, including the overlap of care with dementia services and the implementation of necessary infrastructure including a Coordinator role in each Area Mental Health Service.

Policy Framework 'Caring for Older People's Mental Health': 5 Key strategies

- Partnerships eg GPs, Aged Care Services
- Better Mental Health Care eg depression screening
- Promotion,Prevention and Early Intervention eg suicide prevention
- Specific groups of older people eg CALD
- Quality and Effectiveness eg outcome measurement; MH-OAT





Special initiatives are in place to support older people's mental health programs:

- Guidelines and Protocols
  - Psychotropic Medication in Residential Aged Care
  - Depression in the Elderly
  - Dementia Brochure (15 community languages)
  - Challenging Behaviour in Residential Aged Care
- Resources
  - Mental Health Planning Group
  - Telepsychiatry
  - Outreach to rural areas and nursing homes

Guidelines, special suicide prevention protocols and training, testing models such as those of telepsychiatry outreach in a model similar to that which is effective for child and adolescent mental health care are some models. Special care suites in nursing homes to deal with mental problems of residents and current initiatives are also being trialled.

Services in the Community.

Components of services are listed below:

- Emergency response
  - Urgent assessment and treatment
  - Collaboration with emergency departments
  - Collaboration with aged care teams
  - Collaboration with primary care
- Acute care
  - Acute assessment and treatment
  - Prevention of admission to hospital
  - Community mental health centres
  - Liaison with primary care and aged care
  - Support to nursing home services
  - Follow up of discharged inpatients
- Longer term care
  - Rehabilitation
  - Case management
  - Accommodation support
  - Disability support
  - Nursing home support
- Promotion and prevention
  - Depression and suicide prevention
  - Early intervention services
  - Disaster mental health response
  - Carer support

(iv) The availability of non-clinical case management support for specific populations such as people who have been released from gaol, people from non English speaking backgrounds, indigenous people and people who do not have a mental illness but are experiencing a mental health disturbance

NSW Health has a responsibility for clinical service provision and provides clinically focussed case management as appropriate to the person in the community, and may also provide some care coordination. Non clinical case management support is frequently provided by non government agencies and other relevant public sector agencies.

Non clinical case management for prisoners would be arranged by the correctional service, if appropriate, or through the Parole Service. Follow-up of forensic patients is provided in specific ways with allocated case managers in area health services, but in each case the core role involves clinical monitoring, and if appropriate coordination of support, but not 'non-clinical' case management.

(v) The numbers and types of self-help, mental health organisations and groups that are financially supported by the Centre for Mental Health

The following information refers to non-government organisations funded by the Centre for Mental Health for the financial year 2000/2001.

- *NSW Peak Mental Health non-government organisations:*

- *Mental Health Coordinating Council NSW*

Peak organisation funded ($266,290) to support NGO sector efforts to provide efficient and effective delivery of mental health services plus one off grants for a NGO Mental Health Conference and to develop mental health standards.

- *NSW Consumer Advisory Group*

Centre for Mental Health contribution ($185,000) to consumer and carer input into mental health policy making process and one off to identify new models to access the needs of young mental health consumers.

- *NSW Association for Mental Health Inc*

The Association provides mental health information service across NSW, including 1800 access to country residents in NSW. This is an important service assisting access to mental health services across the state. Recurrent funding is provided by NSW Health.

- *Mental health carers:*

The Centre for Mental Health provides $1 million each year to fund programs that support carers of people with a mental illness.

- *Association for Relatives and Friends of the Mentally Ill (ARAFMI) and Southern Area Health Service - $231,000*

The project will focus on carers and existing service providers (for example general practitioners) in the Queanbeyan and Cooma districts to provide personal and emotional support, and will produce an accredited training package. It will compliment and reinforce the existing mental health service projects targeting the children of parents with a mental illness.

The Association also administers a Centre for Mental Health grant of $80,000 for the Obsessive Compulsive Disorder Project

- *Carers NSW Inc* - $300,000

Grant for training, support and counselling for carers and implementation of Carer Mental Health Consortium and development of a training package for mental health providers.

- *Narrabri and District Community Aid Service* - $103,000

Grant for a pilot project to identify and meet the needs of mental health carers in the Narrabri Shire with a key focus on young carers.

- *Self-help Groups and Organisations:*

- *GROW (NSW)* - $428,000

Funded to provide support and self-help groups for mental health consumers.

- *NSW Association for Mental Health Inc* - $52,060

Grant for mental health information services, in service training and to develop a Support Group Consortium.

This supplements the NGO Grant Program of $300,000 allocated in 1998/99 for the provision of a training program for self-help support groups across NSW. The grant allocation was to be distributed over three years to support the development of self-help support groups for people with depression, mood disorders and anxiety and phobias.

- *Accommodation and Housing Support for People with Mental Health Problems and Disorders:*

- *Aftercare*- $45,000

One off grant to identify models of care including support and accommodation for people with high support needs.

- *Richmond Fellowship of NSW* - $30,000

One off grant for research project to develop a service model for residential support services.

- *St Vincent De Paul Society – Matthew Talbot Hostel* - $15,000

One off grant to develop and deliver a mental health training package for hostel staff.

- *St Vincent de Paul Society – Vincentian Village* - $135,000

Project funding for mental health workers at Vincentian Village, a service for homeless people in the inner city area.

- *St Vincent De Paul Society* - $15,000

One off grant for the Compeer Program.

- *Schizophrenia Fellowship of NSW Inc* - $22,500

One off grants for the employment of a support worker in Greater Murray area and a multicultural mental health worker.

Accommodation issues are also addressed in g (i) & (ix).

- *Aboriginal Services Grants:*

In NSW, the delivery of health services to Aboriginal people is governed by the 1997 *NSW* Aboriginal Health Partnership Agreement between the NSW Minister for Health and the Aboriginal Health and Medical Research Council of NSW. The Partnership Agreement was reviewed, renegotiated and signed-off in May 2001. At a regional level, partnership agreements are being progressively signed between local area health services and aboriginal community controlled health services in their local area. Between 1997 and 2000, 10 of the 17 area health services signed partnership agreements.

The agreements aim to facilitate a significant improvement in the delivery of services to Aboriginal people and to ensure that their unique expertise is brought to the health care processes. Ten Aboriginal Mental Health Worker positions were funded in nine Aboriginal Community Controlled Health Services from National Mental Health Reform Incentive Funds over two years non-recurrent.

Aboriginal Medical Service Co-op Ltd	$100,000
Awabakal Newcastle Aboriginal Co-op Ltd	$50,000
Bulgarr Ngaru Medical Aboriginal Corporation	$50,000
Coomealla Health Aboriginal Corporation	$50,000
Cummeragunja Housing and Development	$50,000
Katungul Aboriginal Corporation and Community	$50,000
South Coast Medical Service Aboriginal Corporation	$50,000
Tharawal Aboriginal Corporation	$50,000
Thubbo Aboriginal Medical Cooperative Ltd	$50,000

An additional grant was allocated by the Centre of Mental Health to determine the severity of the intergenerational issues significant to Aboriginal children who were taken from their families, and the consequences of this separation on the first, second and third generation of their descendants.

- *Aboriginal Health and Medical Research Council* - $90,000

Grant for Grief and Loss project to develop strategies to address these issues, which are culturally acceptable to individual communities within specific regions.

- *Educational Grants:*

- *Australian Academy of Science* - $5,000

One off grant for Schizophrenia Forum October 2000

- *Alliance of General Practitioners NSW* - $333,000

One off grant for education package for General Practitioners.

- *Mental Illness Education – Aust (NSW) Inc* - $169,600

Grant for school based mental health awareness program and '*insight*' program to secondary schools.

- *The Peer Support Foundation Ltd* - $176,900

Social skills development program, providing education and training for youth, parents, teachers, undertaken in schools across the NSW.

- *NSW Institute of Psychiatry* - $846,384

One off grants for mental health education initiatives.

- *Royal Australian and New Zealand College of Psychiatry*- $363,940

One off grant to develop and deliver support, supervision and training of psychiatrists working in area of need positions in rural and outer metropolitan areas.

- *Royal Australian and New Zealand College of Psychiatry* - $100,000

One off grant for the management of challenging behaviour in nursing homes and Psychiatrists (Faculty of Psychiatry of Old Age) to develop and deliver a model of telepsychiatry for psychogeriatric patients in rural communities.

One off grants were made to a number of organisations to improve mental health nursing education, recruitment, retention and provide support for the mental health and well-being of all nurses in NSW.

Avondale College	$ 18,847
NSW Nurses Association	$100,000
NSW College of Nursing	$141,250
TAFE NSW	$125,000
Australian Catholic University	$ 39,506
Charles Sturt University	$249,639
Southern Cross University	$100,393
University of Technology, Sydney	$166,986
University of Western Sydney	$451,218

- *Neuroscience Institute of Schizophrenia and Allied Disorders (NISAD)* - $1M recurrent for 5 years –

The institute provides research into the causes, prevention and treatment of schizophrenia. Particular focus over this five year period will include developing methods to detect and prevent schizophrenia in young people before onset, investigating new treatments and their side effects, ensuring that new genetic knowledge is applied to understanding the genetic risk factors of schizophrenia, enhancing understanding of the interaction between illicit drug use and the onset and relapse of schizophrenia. NISAD also assumes a role in raising awareness about schizophrenia and addressing stigma about this illness.

- *Black Dog Institute* (BDI) - $1M recurrent plus $3.2M capital investment non-recurrent.

This new facility is a scientific institute committed to addressing the problem of depression, building on the work of the University of NSW Mood Disorders Research Centre clinical activities. The capital funding will ensure a stand alone facility on the Prince of Wales hospital site at Randwick. Priorities of the BDI include: education and training of general practitioners and other health professionals, developing treatment guidelines for health professionals, postnatal depression programs, holding satellite clinics and rural outreach programs to advance diagnosis and management of depressive and bipolar disorders and providing diagnostic and educational telepsychiatry services to rural NSW.

(vi) The determinants of the numbers of acute hospital psychiatric inpatient beds and community residential beds

Future planning for specific bed based, community residential and general community mental health facilities is based on the Mental Health-Clinical Care and Prevention (MH-CCP) model.

(vii) The availability of respite services for people with mental illness and their carers

There are variable levels of respite services provided at area health service levels through non government agencies, area health services and other agencies.

(viii) The interdependency and interchangeability of different types of support services in the community

> *'Non clinical support services for persons with mental illness is essential to reduce the burden of mental illness, particularly for persons with chronic long term disability. Our experience is that mental health clients are experiencing improved access services run by other government departments for example, housing and other health services.'*[41]

National, state and area mental health policies identify that, ideally, clinical care, rehabilitation, disability and accommodation support and other services are to be delivered to the individual in their home. Individuals identified as having high support needs are assessed to determine the most appropriate program. Choice regarding housing and accommodation support options is based on a comprehensive clinical/rehabilitation/ability assessment with input from all relevent members of the multidiciplinary team and family members or carers. This is particularly so when considering residential rehabilitation, inpatient or community extended care for people with high support needs. Where possible, options are delivered in the least restrictive manner in a way that meets the needs of the individual as they change over time.

- *Clinical Rehabilitation and Disability Support*

Rehabilitation in the mental health field is an evolving concept which is considered to have two service provision components:

- Clinical rehabilitation - interventions to assist people to recover from mental illness or an episode of mental illness by improving their role functioning and increasing ability/decreasing disability, and developing skills and resources.
- Accommodation support and/or disability support - interventions aimed at the maintainance of role functioning, skills and independence.[42]

Clinical rehabilitation and disability support are delivered differently with clinical rehabilitation provided on a time-specific basis with a focus on increasing role functioning or skills in a specific area of the consumer's life and disability support provided generally on a more long term basis or while required. Area mental health services are predominantly the providers of clinical rehabilitation although a few specialised NGOs have some capacity in this regard. Disability Support Services are predominantly provided through the NGO sector.

Non-acute inpatient care is coordinated by NSW Health. These services provide clinical services and support for people with high levels of disability where there is a safety risk identified for either the person or the community. Where possible, services are provided in the least restrictive setting. When low risk is identified, services for people with high disability support needs are provided in the community.

Building based services are only considered for people requiring staff support overnight. In some situations building based services are used for the provision of respite care. For those not requiring support overnight, clinical care, rehabilitation and support services including respite care are coordinated by the range of agencies necessary and delivered in the home of the individual's choice.

Accommodation support services are provided by the NGO sector. Strong links are developed locally between accommodation support services and mental health services. Accommodation service staff and mental health staff work collaboratively with each individual to plan care, rehabilitation and support and identify the role of the individual, the accommodation support staff and the mental health staff.

Accommodation support services focus on maximising the independence of the consumers receiving services. Interventions based on individualised assessment may target activities of daily living including domestic chores such as shopping, cooking and cleaning; personal care tasks, such as showering and taking medication as prescribed; health care, including identification of general health and mental health treatment, and rehabilitation needs; and seeking assistance when required. Interventions may also focus on income support issues such as identification of a source of income, maintainance of budget, and rent payment.

Clinical care, rehabilitation and disability support services are coordinated by a 'care coordinator' in consultation with the consumer. The 'care coordinator' is based with the agency providing the majority of the services. This will differ for each individual and will be based on the available services in each geographical area. Clinical Services ensure linkages are in place between accommodation support and other disability support services to ensure maximum participation in the community for people with mental health problems.

The general practitioner's role is vital in terms of continuity of care. Clinical mental health services work with general practitioners to ensure that all persons with mental health problems using housing and/or accommodation support services have a general practitioner who oversees their physical and mental health care.

Individual service planning considers the maintenance of linkages with families/carers, community and social networks as fundamental. Services are delivered in a culturally sensitive manner and include the use of interpreters or other cultural brokers as necessary. They focus on assisting consumers to establish and/or maintain a meaningful role in the community through education and employment. Service provision also considers literacy and communication issues and access to relevent service providers such as the Commonwealth Employment Service, Commonwealth Rehabilitation Service, TAFE, Adult Migrant English Service and Supported Employment. Social and leisure support including behavioural interventions to assist individuals to live in close proximity to others and maintain existing relationships, social networks and important community links is essential.

- *Statewide Projects*

1 Joint Guarantee of Service for People with a Mental Illness – expansion project
The Joint Guarantee of Service (JGOS) was developed in response to concerns about a lack of coordination between health and housing services. It and was signed in September 1997 by the Directors-General of the NSW Department of Housing and NSW Health.

The JGOS defines the roles and responsibilities of both Departments and outlines the processes and procedures for the Departments to follow to enable them to work together cooperatively. In particular, confidentiality protocols were developed to permit the exchange of necessary information and to support cooperative planning around joint programs and practice models. In particular, confidentiality protocols were developed to permit the exchange of necessary information and to support cooperative planning around joint programs and practice models.

The JGOS has three parts: principles, guidelines that have been signed off at both Area and regional levels to facilitate local implementation, and attachments that include templates to assist local implementation and action.

The key benefits of the Joint Guarantee of Service are:
- improved outcomes for consumers through coordinated service provision and sustained tenancies;
- improved consumer and staff satisfaction;
- establishment of protocols and procedures to guide action;
- development of informal networks between health and housing staff;
- sharing expertise and knowledge, including that of consumers;
- increased opportunity for early detection and intervention;
- shared responsibility for problem solving and risk management; and
  less interdepartmental conflict.

A Steering Committee including representatives from the Departments of Housing and Health and members from consumer and community groups ensured the full implementation of the agreement in NSW.

A project is under way to expand the JGOS partnership to include the Department of Community Services, SAAP program and services, the Office of Community Housing, the Aboriginal Housing Office and service providers. The partnerships may be further expanded at a later stage to include other key stakeholders.

2 Assisted Tenancies Project
The Assisted Tenancies initiative seeks to build onto the JGOS partnership between NSW Health and the Department of Housing. The pilot proposal is aimed at people with moderate to high support needs who would not ordinarily meet priority-housing criteria to manage a

tenancy. The assisted tenancy will be a new type of tenancy arrangement designed to enable the target group to live in their own home provided with individualised support. There will be opportunities to develop new partnerships with disability support providers funded through the Department of Ageing, Disability and Homecare. The project will be piloted in South Western Sydney and the Central Coast.

3 The Woolloomooloo Homelessness Project

The Woolloomooloo Homelessness Project, coordinated by the Department of Housing, is a Partnership Against Homelessness Project. The Steering Committee has been developing and monitoring strategies to reduce the number of people rough sleeping in the Woolloomooloo area and related issues.

4 The Inner City Homelessness Action Plan

A Partnership Against Homelessness Working Party is developing a Draft Action Plan for Inner City Homeless. The development of the Action Plan has been identified as a desirable outcome of the Woolloomooloo Homelessness Project Steering Committee. It is anticipated that there can be significant benefits gained by examining the successful strategies used for the Woolloomooloo Project and using them to broaden the strategy to target homelessness for the inner city of Sydney.

The Action Plan aims to improve the quality of services rough sleepers receive from agencies, while at the same time increase the options available to meet their individual needs. The Plan also aims to enhance collaboration in service delivery and service management to address homelessness in the inner city and initially to target hotspots of rough sleepers in the inner city and move people into permanent housing options with support as necessary. Discussions have been taking place with inner city mental health service providers to map out the strategies in place for ensuring access to and the provision of mental health services to rough sleepers.

5. The SAAP Linkages Project

The Links project is an initiative jointly funded by the Centre for Mental Health, NSW Health and the Department of Community Services to develop, establish and trial linkages between the Supported Accommodation Assistance Program (SAAP) service providers and mental health service providers. The team will work in three areas of NSW to improve linkages between mental health service providers and SAAP services.

6. Richmond Fellowship – Dual Diagnosis/Supported accommodation project

In May 2001, the Centre for Mental Health funded the Richmond Fellowship to conduct a research project and provide a recommendation to the Department of a service model establishing residential support services for people with co-morbid mental health and substance use disorders.

7. Aftercare – Development of Supported Accommodation Model(s) for people with high support needs

In May 2001, the Aftercare Association was funded by the Centre for Mental Health to develop supported accommodation model(s) for people with high support needs. The Centre for Mental Health is represented on the Steering Committee and one sub-committee exploring models of care.

A draft strategy developed by the Mental Health Implementation Group and shortly to be released deals with future developments in rehabilitation in mental health with the focus on the fullest possible recovery.

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