

# LET'S TALK ABOUT ACTION

Redressing Human Rights Abuses, Discrimination and Inequity in  
the Community's Response to The Plight of People With A Mental  
Illness or a Psychiatric Disability

Report of National Community Advisory Group Consultations Into  
**the** Implementation of the Recommendations of the Report of the  
the National Inquiry into the Human Rights of People with Mental

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# FOREWARD

**By**

Trisha Goddard  
Chairperson

National Community Advisory Group on Mental Health

Dear Workshop participants,

The National Community Advisory Group on Mental Health (NCAG) has pleasure in presenting "Let's Talk About Action", the report of the community consultation workshops undertaken on a national basis to examine the implementation of the recommendations of the Report of the Inquiry into the Human Rights of People with Mental Illness undertaken by the Human Rights and Equal Opportunity Commission (HREOC).

Seventeen workshops were held in fifteen metropolitan and rural locations around Australia. Over 1000 consumers and carers participated in these workshops. I find it exiting that so many consumers and carers stood up to be counted and NCAG values this input enormously, realising it took a lot of courage for many people to participate in the process. We didn't have much time, (only just over a month in fact) and a small budget, however, NCAG is confident that the views of a wide range of consumers and carers have been well represented in this report.

The title of this report, "Let's Talk About Action" summarises the views of consumers and carers in relation to the report of the Human Rights Commission. Federal, State and Territory Governments must now address the challenge of responding to the Human Rights Commission Report in a manner that takes account of these views. In doing this it is important that all governments are mindful of the comments made by consumers and carers regarding the current implementation of the national mental health Strategy.

NCAG wishes to thank:

- \* Workshop participants who readily shared their experience and valuable ideas with us.
- \* The State and Territory Consumer/Community Advisory Groups who gave us so much enthusiastic help and support in organising the workshops, and
- \* Judy Hardy, Consultant to NCAG and David Plant, Executive Officer, Australian Psychiatric Disability Coalition who conducted the workshops on behalf of and in close liaison with NCAG.

So where do we go from here?

NCAG is currently developing a plan of action to address the main issues arising from the workshops.

Just let me say thank you to everyone for remembering that NCAG is only as strong as the sum total of your voices ... thank you for making those voices so strong.

TRISH GODDARD  
Chairperson  
National Community Advisory Group on Mental Health.

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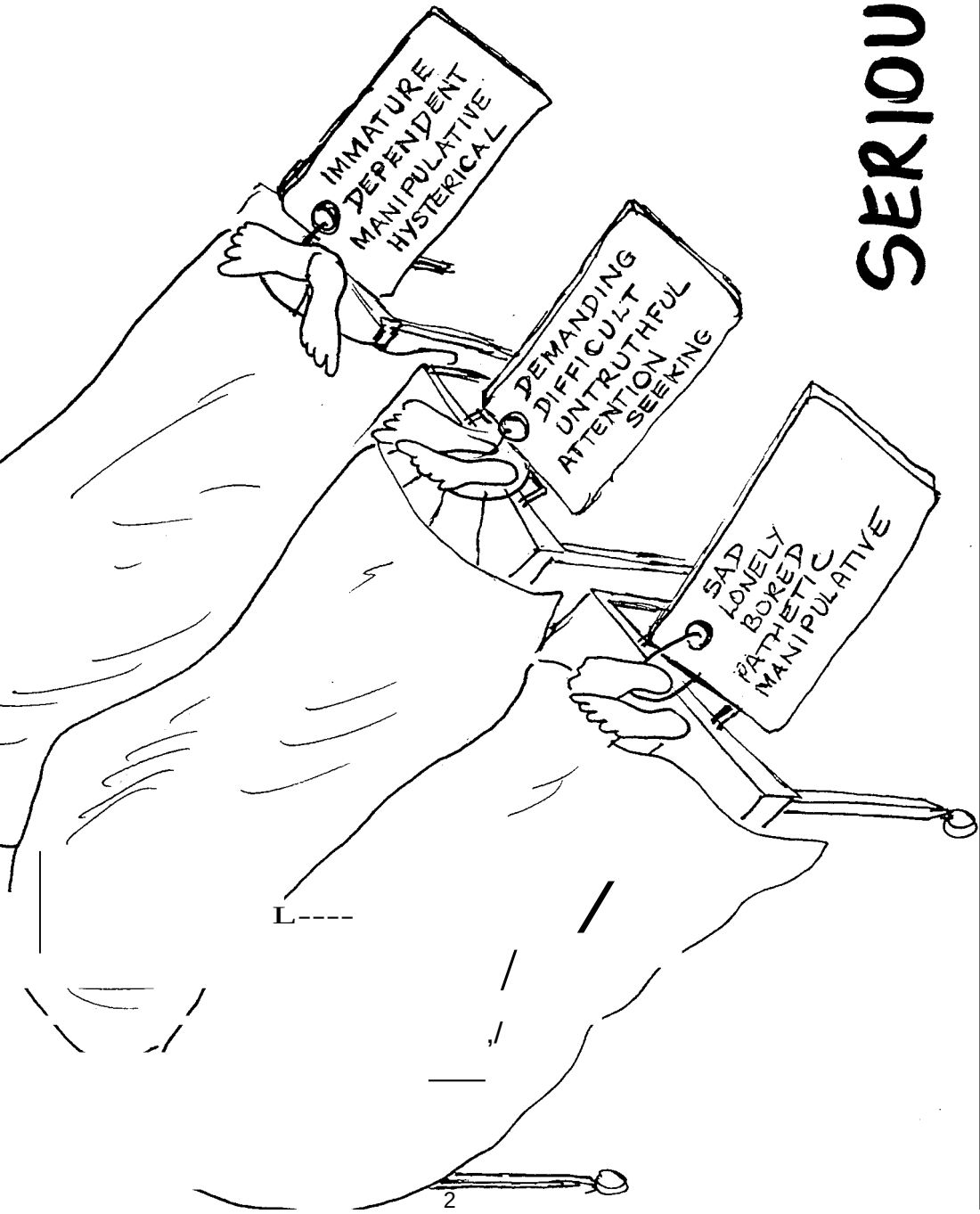
# **PART 1**

## **BACKGROUND AND CONCLUSIONS**

Being: Background to the consultations, conclusions drawn and recommendations made by the National Community Advisory Group on Mental Health following consultation workshops held with consumers, carers and the community.

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# Chapter 1

## INTRODUCTION

### 1.1 Background to the Consultation

In December 1993 the Hon. Brian Howe, Deputy Prime Minister'...:,, and then Minister for Housing, Local Government and Community Services announced that he had asked the National Community Advisory Group on Mental Health to consult with the community on priorities for implementation of the recommendations contained within the Human Rights and Equal Opportunity Commission's Report of the National Inquiry into the Rights of People with Mental Illness (the HREOC Report).

Australian Psychiatric Disability Coalition Inc. was commissioned to assist the National Community Advisory Group on Mental Health in organising the consultation process which was to be held during February and March 1994.

The assistance of State and Territory Community Advisory Groups was forthcoming and the workshop process conducted by Mr David Plant, Executive Officer, Australian Psychiatric Disability Coalition and Mrs Judy Hardy, Consultant to the National Community Advisory Group.

### 1.2 Process of Consultation

It was determined that consultation workshops would be held in fifteen cities and towns across Australia. The locations were to be each state/territory capital city and a limited number of provincial and rural centres which it was hoped would offer an overview of issues and responses contained within the HREOC Report. (See Appendix 1)

It was further determined that the consultation process would be targeted to ascertaining the opinions of consumers, carers and the community, in line with the charter of the National Community Advisory Group.

The Human Rights and Equal Opportunity Commission's Report spans two volumes, 5 parts and 31 chapters. Its findings and recommendations are extensive. The consultation workshops therefore, were structured to:

- \* identify priorities for action
- \* consider the adequacy of Government responses to date
- and \*
- \* in relation to the identified priorities, recommend on actions, solutions and

responsibilities for implementation.

With some local variation dependent upon time available, size of group, and the need to obtain advice on as broad a range of issues as possible, the workshop format identified in Appendix 2 was followed.

The Federal Government Discussion Paper (the Commonwealth Discussion Paper), "Report of the National Inquiry into the Human Rights of People with Mental Illness" (February 1994) was used in all workshops to assist in determining the adequacy of the Federal Government response to date.

### **1.3 Response to the Workshops**

The workshops were received both positively and enthusiastically by those in attendance. Indeed, they occurred within a general atmosphere of impatience for action and some controversy surrounding the "need for further consultation".

This controversy centred upon media reports which projected the view that the Human Rights and Equal Opportunity Commission Inquiry had consulted over a sufficient period of time, the recommendations of the Inquiry were clear and therefore, should be implemented.<sup>1</sup> Notwithstanding this view, workshop participants expressed significant appreciation that the views of consumers, carers and the community were being sought in developing government priorities and strategies for implementation.

An impatience for action was strongly reflected in the key issues identified by workshops. The need for further and on-going consultation particularly with consumers and carers, in order to monitor and guide government strategy, was strongly endorsed.

Attendance and participation in workshops is summarised in Appendix 3.

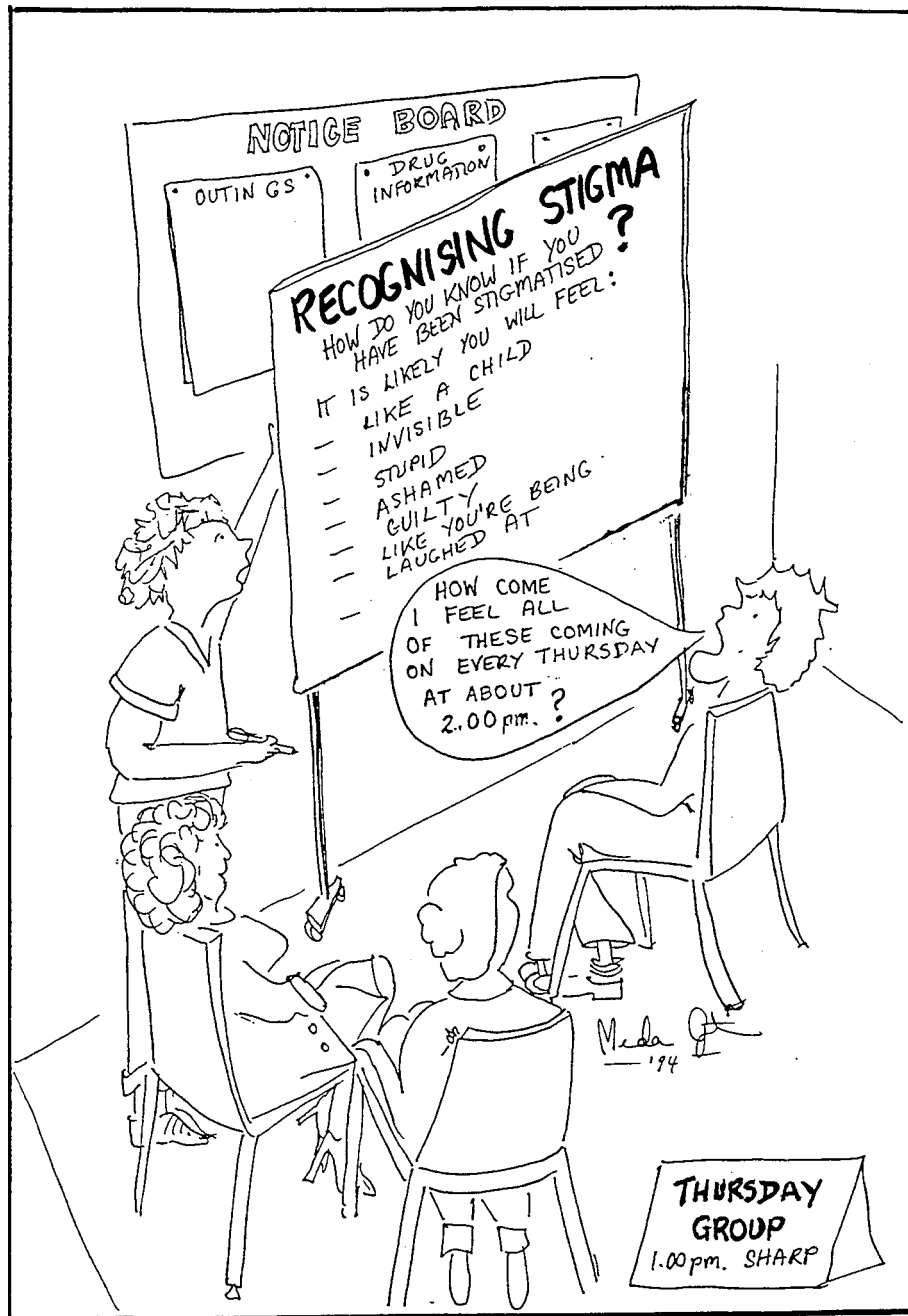
The National Community Advisory Group considers that this consultation process has been an early experiment in the process of effectively involving consumers and carers in the critique and development of mental health policy and its implementation. The scale of the undertaking was significant and was not without financial cost.

The process of enabling consumers and carers to be involved in the consultation process in a meaningful way is considered to be, of itself, a most important outcome. This report has been written with the clear objective of openly and honestly

As example, Caroline Milburn, "Outrage over Canberra's response on Mental Illness". Melbourne Age, 16 February 1994.

reporting the views of workshop participants as expressed throughout the consultation process. In doing so the "commonality" of issues and concerns has been highlighted. Where particular issues were identified which were not reflected in this "common view", these have been identified within the text.

The National community Advisory Group expect that the response of governments around Australia to this report will do justice to the signal value of both its content and its source.



## Chapter 2

### KEY ISSUES IDENTIFIED

Throughout the consultation process several key issues emerged which challenged current government strategies and which underpin the priorities and proposals for action which emerged throughout the process.

#### 2.1 HREOC Recommendations and Government Action to Date

Support for the recommendations of the Report of the Human Rights and Equal Opportunity Commission's Inquiry into the Human Rights of People with Mental Illness (HREOC Report), and the Federal Government's broad endorsement of those recommendations was overwhelming.

Workshop participants however, expressed some reluctance to the idea of prioritising recommendations for action. The general belief was that all recommendation of the HREOC Report should be implemented, and implemented "now". That is not to say that workshop participants were unaware of the need for Government to establish a process whereby implementation could occur. On the contrary, they were keen to see a detailed government response to all the recommendations of the HREOC Report, combined with proposals for implementation. Such a response should be guided by the findings of this consultation.

Although in general, Federal Government strategies and actions as outlined in the Commonwealth Discussion paper received qualified support by workshop participants there was a clear call for more action and greater resource allocation. **There was also a call for a significant redirection of effort at both state and commonwealth levels towards more effective community interventions which aimed at avoiding and preventing mental health crises.**

It was felt that:

*"...the present system encourages crises."*

#### 2.2 consultation and Government Responsibilities for Action

There was an underlying concern that

*"...the government has all these policies and strategies, but there is no change for me."*

Indeed, although there was acknowledgment that a process of change was under way, the nature and benefit of the change was unclear to many people. The lack of information at community level and the lack of control over events felt by those participating in the workshops was a significant concern.

For many, the process of change appears to have added to, not eased, the burden.

These concerns were underlined with what, at most meetings, could realistically be described as "collective relief" at the reassurance that "...the National Community Advisory Group has direct access to the Federal Minister". That is, this was seen as some redress to a belief that the relevant State and Federal Departments could not be relied upon to make decisions, take action or initiate appropriate responses.

### **2.3 Role of consumers and carers**

The consultation process revealed a strong call for consumer and carer involvement and control at all levels. That is:

a consistent demand for greater involvement in policy development and planning. Current approaches to consultation were seen as tokenistic, especially at state government level (with some variation between States).

a consistent demand for more and better information to be provided by professionals and for greater involvement in decision making regarding treatment, care and other service delivery issues. These concerns are somewhat different for carers and consumers but undoubtedly, there is a significant reaction against a system of care which is understood as unnecessarily patronising and paternalistic.

a consistent demand for consumer and carer involvement in the development and implementation of all education and training programs.

a consistent demand for realistic financial resources to be dedicated to supporting the role of consumer and carer self help groups and non-government organisations. This demand is clearly linked to a perception that this at least, is a level of service at which some degree of control can be exercised by consumers and carers.

### **2.4 The Theme of "Communication"**

"Poor communication" was a theme which featured strongly throughout the consultation process. That is:

At the treatment level there was a perceived unwillingness by professionals to provide even the most

basic of information to consumers and carers. Where information of this sort is given poor communication strategies are often adopted. That is, for example, it is inadequate to only give information on patient rights immediately upon admission to hospital, follow up is required. Similarly, information regarding medication is often never explained. When it is, to explain the effects of medication once, in the midst of an acute illness phase, and expect this to be understood on a long term basis, is a patently inadequate approach.

At the level of interaction with "third parties" it was stressed that carers, community workers and other "non-mental health professionals" are not given appropriate information and that the information which they are able to provide is not valued by professional staff. A policy of "confidentiality" is often cited as the reason for not sharing information. It was felt that this policy is selectively and inappropriately applied.

At the level of policy and service development it was clear that there is only tokenistic commitment by governments or service providers to involving consumers and carers. It was also clear that the flow of information to consumers, carers and the community about what is happening on the policy and service development front is inadequate.

The comments made by consumers during the course of this consultation process were listened to very carefully and form the basis to this report.

## **2.s Focus for service Delivery: A Challenge to current Strategy Directions**

The present mental health service delivery system - and the reform of that system - is seen to be failing abjectly in addressing real need. In short, this system is seen to be an "illness" focused system in which access to services is determined by the amenability of the problem to be diagnosed as "serious mental illness"; and its amenability to alleviation by pharmaceutical or other medically controlled intervention.

This, in turn, means that many people with mental health care problems, whose need for assistance is serious, routinely miss out.

*"A person with depression would have to kill themselves before it would be called a 'serious mental illness'."*

*"A person with schizophrenia seeking admission to avoid a crisis would be told it is not serious enough. He/she would have to wait for a full blown crisis to develop."*

*"A person might have a serious mental illness, but it may be under control and managed. Therefore the 'need' is not serious. Another person may have a mental health problem which is not a 'serious mental illness' but their life is totally disrupted, the risk to self or others is great, the 'need' is serious."*

It is in this context that the majority of workshop participants challenged the concept of "serious mental illness" and promoted the concept of "serious mental health care problem".

**"Serious mental health care problems" are those problems associated with mental illness which, if not addressed, result in severe disadvantage, continued dependence on mental health treatment and crisis services, and which severely curtail the ability of the individual to live independently in the community to their fullest potential. The problem and the "need" associated with the problem are understood by reference not only to diagnosis, but to diagnosis in the context of impact on life circumstances.**

Within this definition of problem, consumer understandings and needs would be taken seriously, serious psychological stress would be included and the disturbance to a person's life circumstances would be taken into account in accessing services.

By addressing **"serious mental health care problems"** mental health services will:

- \* be acknowledging the fact that the majority of people with mental illness require only brief periods of hospital care.
- \* be required to address diagnoses which, at times, extend beyond currently accepted categories of serious mental illness and which include the serious mental health problems associated with, for example,

- Child abuse
- Sexual assault
- Domestic violence
- Loss and grief
- Attempted suicide
- Torture and trauma.

- \* be required to develop, often in collaboration with other health and community services, responses directed to meeting the needs of groups identified within the HREOC Report as "People with Particular Vulnerabilities".

In this scenario, legislative and service provisions for involuntary detention of mentally ill people are but one in a series of appropriate service delivery options directed at people with mental illness. In effect, the consultations

propose a community service system which is not designed around this one particular aspect of need.

This approach is consistent with United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. It is an approach which is also consistent with the Mental Health Statement of Rights and Responsibilities<sup>2</sup> adopted by the Australian Health Ministers conference in March 1991.

Both of these documents affirm the right to timely, effective and appropriate assessment, treatment, care and rehabilitation services. The Mental Health Statement of Rights and Responsibilities gives significant recognition to the importance of prevention and mental health promotion.

Because mental health services have traditionally been located in the health system and because of a minimalist funding approach, public mental health services have by default, and more recently by design, concentrated on serious mental illness and the alleviation or management of crises. The majority of services have been concentrated in hospital settings and within a small and dimly viewed pocket of the health system.

However, over recent decades it has been acknowledged that many people with mental illness can have serious needs without having a "serious mental illness".

In the way in which services are currently provided, the focus on "serious mental illness" has promoted a one dimensional view of mental illness and of the needs of people with mental illness ie. the clinical treatment problem. Today it is acknowledged that mental illness involves both illness and disability which requires not only treatment services but a wide range of human services.

**The solution proposed by workshops is for a range of services in the community which have a broad focus on the "serious need" associated with mental health care problems - be that medical need or need in whatever other form aimed at avoiding and alleviating crises.**

Mental health services which seek to address in a holistic manner the effects of the resultant disability and social disadvantage, the associated disruption and dislocation of personal life, as

well as the problems directly related to the mental illness itself would include:

Assessment  
Treatment  
Emergency and crisis intervention

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<sup>2</sup> Australian Health Ministers Conference Mental Health Statement of Rights and Responsibilities AGPS 1991

Clinical follow-up and support services  
Outreach support and prevention services  
Rehabilitation including vocational training and  
workplace support  
Information, education, training and health promotion  
Community and accommodation support options  
Advocacy  
Respite options  
Recreation  
Human development programs.

All of which must be tailored to the stage of the illness, the context of the mental health care problem, the severity of the disability, and must be culturally relevant and gender and age specific.

Without these services there are severe consequences for the individual and their families.

## **2.6 Commonwealth/State Responsibilities**

There was significant concern expressed by workshop participants that, even in the context of agreement related to the National Mental Health Plan, there were many instances in which " *the Commonwealth gives with one hand, and the States take it away with the other.*" There was concern that many States have been slow to implement important aspects of the National Plan, for example, the establishment of State Community Advisory Groups.

There was concern that some States have been reluctant to identify with the spirit of the National Plan, especially in relation to consumer involvement, community consultation, the development of strategies to tackle discrimination, and in the area of legislative reform in keeping with the United Nations Principles for the Protection of Persons with a Mental Illness and for the Improvement of Mental Health Care.

In addition, as previously indicated, there was significant concern expressed that government reform strategies to date are perceived as too narrowly identified with the medical treatment of severe mental illness and not effectively addressed to the broad range of mixed Commonwealth and state responsibilities in the areas of disability support, advocacy, income support, accommodation, community education, research, and equitable service provision across regions and areas of special need.

## **2.7 The Nature of the Mental Health system**

Workshop participants clearly reflected the view that the current mental health system is an exclusive club focused around the narrow views and interests of professional members.

In support of this view:

mental health professionals (in the context of an inadequate and inappropriate mental health system) were seen as the single most important source of discrimination and discriminatory practice.

consumers and carers are left uninformed about treatment options and choices, the effects of medications, what is written in medical records.

assistance is not made available according to mental health need. Rather it is "dished out" in response to crises (many of which could have been avoided), according to diagnosis and medically determined intervention options ( meaning that even some crises are ignored) and, too often, in a prescriptive, authoritarian, coercive and involuntary manner.

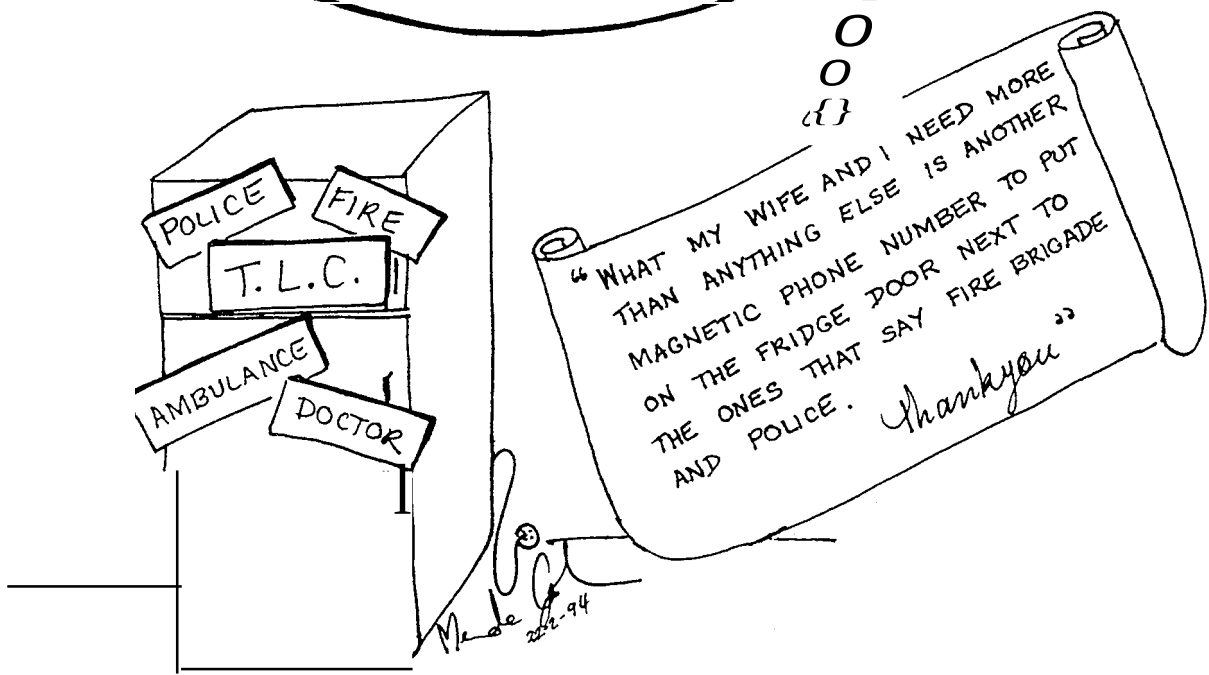
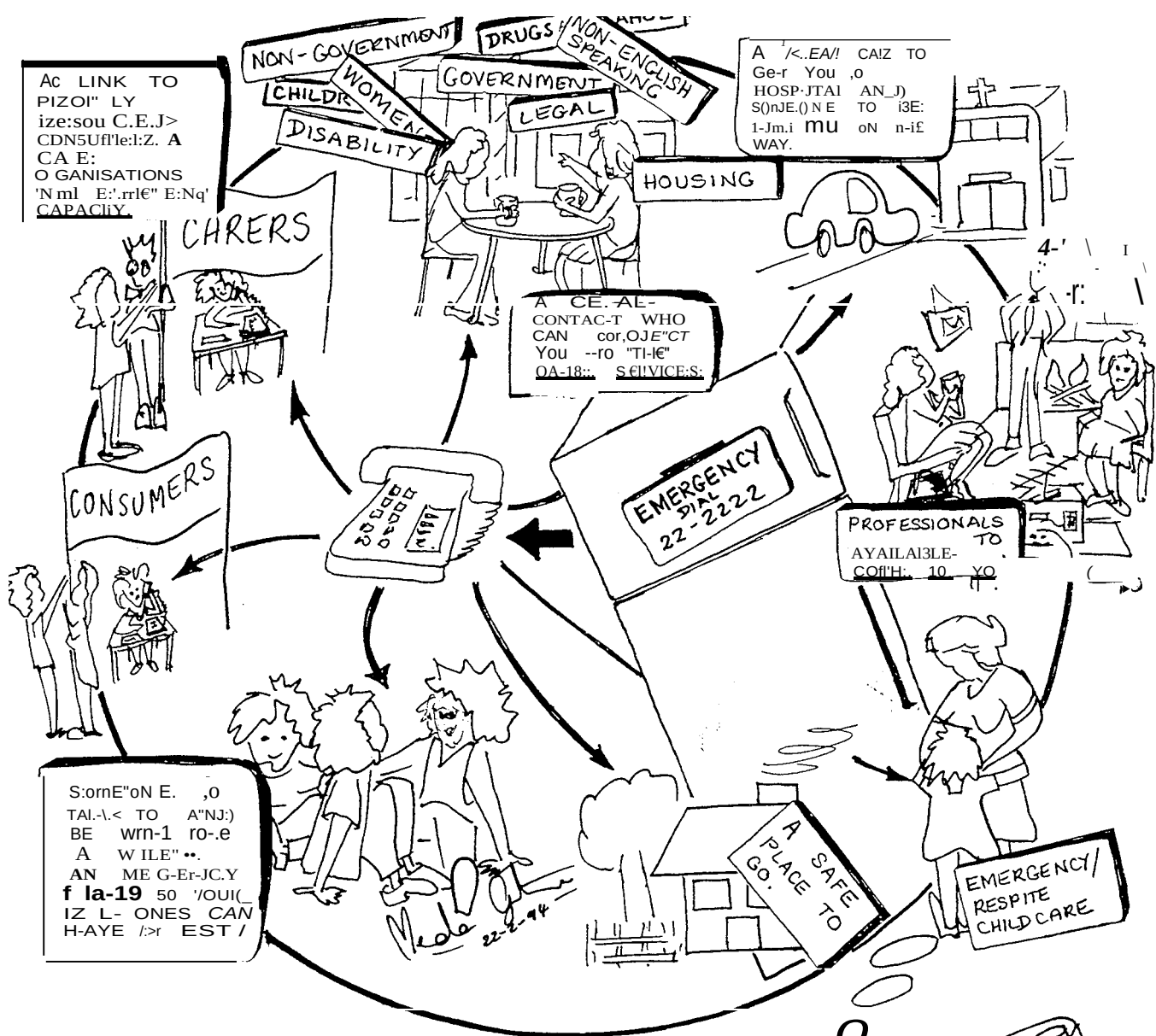
there is extremely poor interconnection and co-operation between the public and private sectors. And the role and importance of the non-government sector is not appropriately recognised or adequately supported.

The mental health system is not seen to be user friendly or interactive. That is:

it is difficult to access services when needed.

the initiative for seeking and using services is often taken away from the person needing help.

<sup>11</sup> ... *what is done is done "to you, not; wi "th you.*<sup>11</sup> It is imposed.



# 1

## Chapter 3

### NATIONAL COMMUNITY ADVISORY GROUP RECOMMENDATION FOR ACTION

1. As a result of its consultation with consumers, carers and the community, the National Community Advisory Group on Mental Health considers that the Report of the National Inquiry into the Human Rights of People with Mental Illness substantially validates the experiences of people with mental illnesses and provides strategies for action. The National Community Advisory Group on Mental Health therefore recommend that:

The Federal, State and Territory Governments, as a matter of urgency, provide responses to all recommendations contained in the HREOC Report which detail substantial endorsement of the recommendations, and identify

- \* those recommendations which require changes in policy, administration, practice or law; which have limited resource implications; and upon which, therefore, immediate action can be taken.
  - \* those recommendations which have substantial resource implications but upon which action can be or must be taken immediately.
  - \* those recommendations which have substantial cost implications and require strategic implementation over time. In these instances timelines and strategies must be identified.
2. The findings and recommendations of participants in the National Community Advisory Group consultations substantially challenge aspects of the way in which the current National Mental Health Strategy is being implemented and identify areas of concern not specifically highlighted within the context of the HREOC Report. The National Community Advisory Group therefore recommend that:
    - \* in light of their responses to the HREOC Report (see NCAG Recommendation 1 above), the Federal, State and Territory Governments provide detailed responses to the findings and recommendations of consultation workshops detailed in this report.
    - \* consistent with the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, the

Mental Health Statement of Rights and Responsibilities, modern knowledge and best practice in mental health care: the National Mental Health Strategy be further developed to focus upon "serious mental health care problems" and the prevention of crises, as well as its current focus on serious mental illness.

- \* the National Mental Health Strategy and State and Territory mental health services refocus and develop services to, in the first instance, prevent mental health care crises, manage them when they do occur, and implement strategies (for example, community support programs) to prevent their recurrence.
- \* the role of the National Community Advisory Group (NCAG) be further supported and strengthened by allocation of additional resources to the administration and research requirements of NCAG.
- \* the role of state and Territory Consumer/Community Advisory Groups be strengthened by allocation of additional resources to enable broad consultation and establishment, where appropriate, of area or regional Consumer/Community Advisory Groups.
- \* the Federal Government allocate significantly increased resources in the 1994/95 Budget, and in subsequent Budgets, to mental health reform and to services for people affected by mental illness and psychiatric disability having due regard to:

the recommendations of the HREOC Report  
the findings of this consultation process  
the broad program base of reform required  
an expanded role for non-government organisations and the private sector  
the need for regional equity in the allocation of resources  
the need to seriously target programs to areas identified under the heading of "People with a Particular Vulnerability."

3. Given the difficulties associated with Commonwealth/State responsibilities, cross portfolio complications, inequity in resource distribution, bureaucratic intransigence and the existing narrow focus of service delivery on the diagnostic categories and medical interventions associated with "severe mental illness"; the National Community Advisory Group recommend that:

- \* the Commonwealth and state/Territory Governments undertake a mapping exercise to document, in accessible and useable form, who is responsible for what, what gaps exist, what anomalies of funding and service provision exist.

\* the Federal Government develop direct programatic and funding responsibilities for:

establishment nationally of a viable and comprehensive non-government sector covering self help initiatives, and disability support including community support and rehabilitation, accommodation support and respite, employment support, day activity programs, community education and health promotion.

establishment of national service standards which are consistent with those associated with Disability Services.

establishment of a National Advocacy Program.

establishment of a National Mental Health Act for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

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## PART2

### FINDINGS

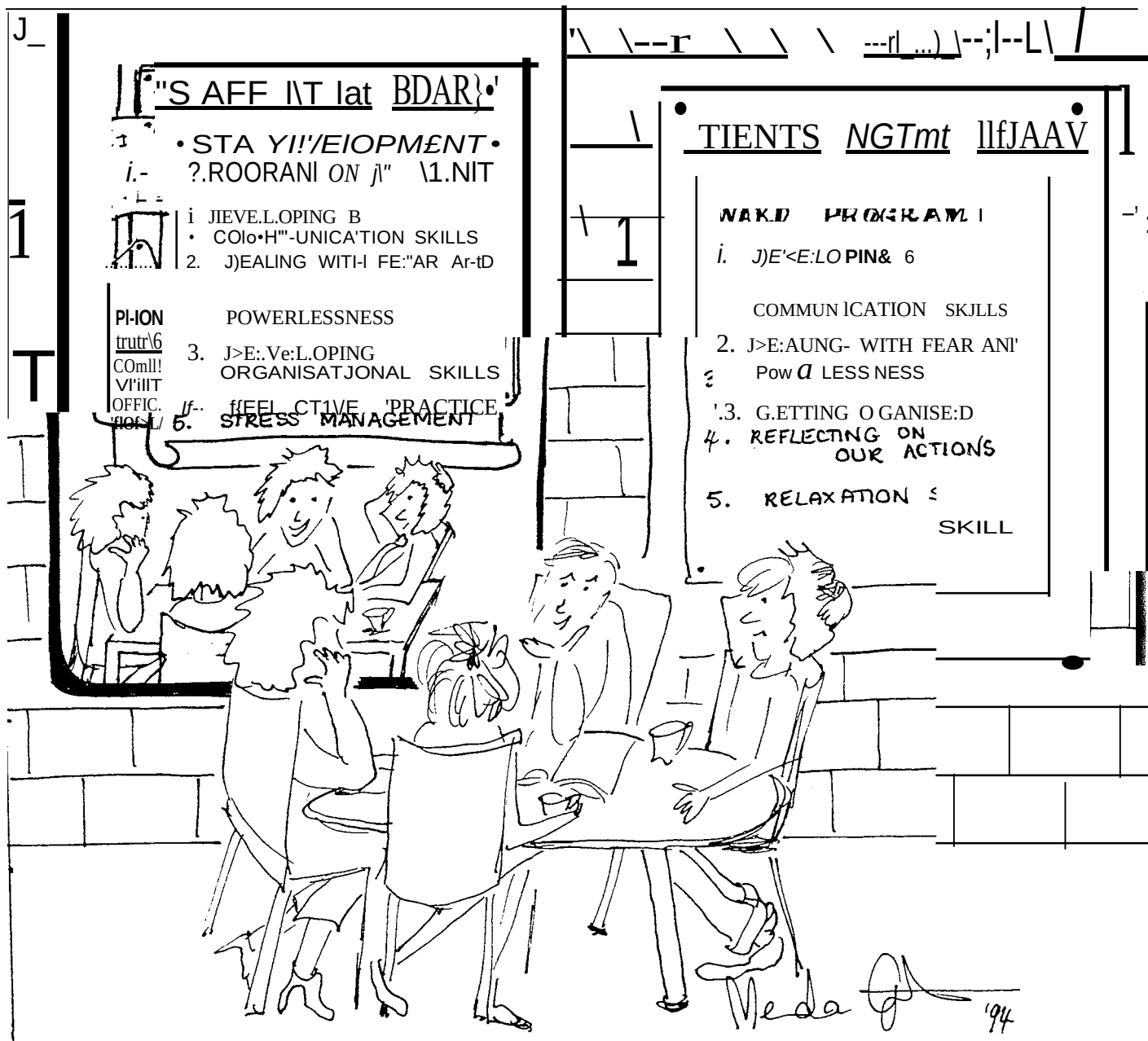
Being: A summary of the findings and recommendations of consultation workshops.

*"While the Inquiry welcomes the initiative recently taken by governments in endorsing a National Mental Health policy and Plan, a major injection of resources will be needed before we are in a position to comply with our international obligations under the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.*

*In short, regardless of welcome government initiatives to date, the Report leaves no doubt of the continuing susceptibility to discrimination and abuse of persons affected by mental illness; and the dearth of adequate community service responses to assist consumers, carers and communities affected by mental illness and its consequences.<sup>113</sup>*

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<sup>3</sup> Human Rights and Equal Opportunity Commission Human Rights and Mental Illness, Report of the National Inquiry into the Human Rights of People with Mental Illness, p 908. AGPS Canberra 1993.



## Chapter 4

# TREATMENT AND CARE SERVICES

Intersectoral linkage formed a central thrust of the HREOC Report. That is, the need for linkage, co-operation and co-ordination between private and public, government and non-government, health, housing, community, income support and other services.

*"Poor inter-sectoral links, the ambivalent stance of the private sector and a reluctance on the part of government agencies to co-operate on the delivery of services to people with mental illness have contributed to the alarming situation described in this report."*<sup>4</sup>

Recommendations made include:

- increased funding for integrated mental health services.
- increased funding for and involvement of non-government organisations.
- increased involvement of private mental health services in treatment and care.

The development of a full range of treatment services including effective crisis and emergency responses, appropriate referral mechanisms, options for 'asylum', and effective discharge planning, are recommended. Several recommendations of the HREOC Report relate to appropriate procedures and the safeguarding of rights.

Consultation workshops were concerned with similar issues but reinforced criticisms of the narrow approaches of current mental health services in relation to range, availability, spread and underlying assumptions.

### 4.1 Mental Health Services

Time and again workshop participants supported the view that the mental health system itself is the most significant source of discrimination with which they have to deal. Consumers and carers claim that they are not listened to, they are not given information, they are not advised of choices or reasons for decisions. Consumers and carers do not see the mental health system or the mental health reform process as working effectively for them.

<sup>4</sup> Human Rights and Equal Opportunity commission Op Cit  
p 908.

These perceptions and experiences seemingly underlie the strong support which was evident for:

- \* the development of effective advocacy programs
- \* an expansion of mental health service provision and the National Mental Health Strategy away from the narrow definitions and restrictions implied by the term "serious mental illness" to include those encompassed by the term "serious mental health care problem". (See 2.5 above).
- \* a refocussing of mental health services to provide 24 hour intervention and support which is aimed at preventing crises and effectively managing them when they occur.
- \* focussing on development of a broad range of community services including strong support for those provided by self help consumer and carer groups and non-government organisations as well as community based treatment and care services.
- \* the view that most services in the community are provided by family, friends and non-mental health professionals with or without mental health professional support. It was stressed that mental health professionals are not necessary for many service delivery needs in the community, although training and support is.
- \* the need to empower consumers and carers in the process of service delivery, in the process of service planning and development, and in the development and delivery of education and training.

It was observed that:

*"The Government Discussion Paper has not one strategy which depends on consumers and carers, or even asks them."*

#### **Recommendations from Workshops:**

- \* That the National Mental Health Strategy be further developed to give critical attention to "serious mental health care problems". (See 2.5 above). Within this definition of problem consumer understandings and needs would be taken seriously, serious psychological distress would be included and the disturbance to a person's life circumstance would be taken into account in accessing services.

- \* That the National Mental Health Strategy and State and Territory mental health services refocus and develop services to, in the first instance, prevent mental health crises, manage them when they do occur, and implement strategies eg. community support and rehabilitation, to prevent their recurrence.
- \* That the role of the National Community Advisory Group in implementing the National Mental Health Plan be further supported and strengthened by allocation of additional resources to their administration and research requirements.
- \* That the role of State and Territory Community Advisory Groups be strengthened by allocation of additional resources to enable broad consultation and establishment, where appropriate, of area or regional Community Advisory Groups.
- \* That the Federal government allocate significantly increased resources to mental health service provision and mental health reform having due regard to:

the recommendations of the HREOC Report  
 the findings of this consultation process  
 the broad program base of reform required  
 an expanded role for non-government  
 organisations and the private sector  
 the need for regional equity in the allocation  
 of resources  
 the need to seriously target programs to areas  
 identified under the heading of "People with a  
 Particular Vulnerability."

## 4.2 Health Professionals

**The overwhelming belief of workshop participants was that they experience more stigma and discrimination from mental health professionals than from any other sector of society. It should be noted that this stigma and discrimination occurs within the context of an inadequate and inappropriate system of mental health care.**

Many Mental Health Professionals are considered to:

have poor communication skills;

be paternalistic in their attitude to consumers and carers;

refuse to recognise that consumers and carers have a legitimate right to be involved in all aspects of care;

be ill equipped to function outside institutions (many would go so far as to say " have no understanding of community care");

have not kept up to date with recent changes in mental health service delivery; and

have no idea how to establish the effective links with other organisations which are necessary to support people in their every-day lives.

Workshop participants stated that education and training is crucial to address all of these issues.

#### **Recommendations from Workshops:**

- \* That the Royal Australian and New Zealand College of Psychiatrists review its training program to ensure that graduates treat consumers and carers with dignity and respect.
- \* That mechanisms be developed for ongoing monitoring of the practice of all mental health professionals and their re-registration.

#### **Comments on commonwealth Government Strategies:**

- \* Consumers and carers need to be involved in ,the development and delivery of all education programs (see 5.4 below), including to the Commonwealth Rehabilitation Service and the Disability Services Program.
- \* Provision of \$100,000 over three years to the Public Health Education and Research Program is inadequate and a 1995 starting date is too late. This program also needs to target mental health professionals who, generally speaking, currently have little information and no commitment to the area of mental health promotion and mental illness prevention. Non-government organisations, many of whom have a much stronger interest in this area should form a significant part of the target group.
- \* Training for General Practitioners must be mandatory and linked to registration to practice. The government strategy outlined is far too soft. Who will take responsibility?

## **Inpatient care and Treatment**

workshop participants saw ready access to both community based and inpatient care and treatment as required, as essential. They stated strongly that the manner in which the National Mental Health Policy is being implemented currently restricts access to services. In essence, it was claimed that the emphasis on "serious mental illness" and the interpretation given to that term' meant- that access to services was based simply on narrow diagnostic criteria which did not reflect real need.

Access to services should be needs based as well as diagnostic based. The term "serious mental health care problem" was seen as a more appropriate term of reference. (See 2.5 above).

Additionally, it was a concern of workshop participants that the term "least restrictive environment", though meant to offer some protection, was being applied in practice in a way which justified treatment in restrictive environments because no alternative service existed - and often excused the coercive treatment of otherwise voluntary patients.

It was stated that the rights of inpatients as provided for by the United Nations Principles for the Protection of Persons with a Mental Illness and for the Improvement of Mental Health Care are currently not well protected and that there are few mechanisms to ensure this protection. Or, it seems, little commitment by government to development of effective mechanisms. Rights are violated particularly in relation to:

- access to treatment
- transportation to hospital
- lack of dignity accorded to consumers by health professionals
- lack of consumer and carer input to treatment plans
- lack of access to complaints mechanisms and adequate redress of harm.

There was a concern about the "over-reliance " on medication in treatment. Personal counselling and psychotherapy approaches should be further developed.

A significant concern was expressed that standards for inpatient care should not vary between the public and private sectors. There was a call for more use to be made of private sector services but with application of appropriate legislative requirements.

The current lack of education for General Practitioners was said to be a barrier to accessing services appropriately.

The sexuality of consumers is an area which has not been effectively considered in service development , delivery or design. This "oversight" needs to be addressed and mechanisms developed which allow appropriate sexual expression. Education

programs are required which focus on safe sex.

Complaints and advocacy systems were an area of considerable concern. All inpatients need to be better informed on the role of official visitors. Current official visitor schemes were criticised for their reliance upon "prominent members of the local community" which limits effectiveness in rural areas; their overuse of "retired staff members"; their lack of use of consumers and carers; their reliance upon "being accompanied by a medical practitioner"; and their capacity to "travel as a pack, not do much good, and be concerned about how clean the toilets are...". All inpatients need to be better informed of the role of official visitors and advocacy services, and how to access them.

Protection of inpatients from sexual abuse and exploitation was identified as a serious and unaddressed need.

The poor physical health care of inpatients was seen as a significant and avoidable concern.

#### **Recommendations from workshops:**

It was recommended that:

- \* Information about services should be available via a 008 number.
- \* Voluntary access to services must be seen as the first and preferable option. Need as expressed by consumers and/or their carers should be a critical determinant of access to services. The development of national admissions criteria is supported.
- \* Psychiatric Assessment for the purpose of involuntary detention must be undertaken by a Psychiatrist or Psychiatric Registrar.
- \* Physical assessment of inpatients should be undertaken by Physicians or General Practitioners. Regular physical examination of long term patients is required given the current lack of attention given to general health care needs and the poor health of many longer term residents.
- \* Information on rights, responsibilities and complaints procedures must be given to patients and their carers in terms which they can understand and in culturally appropriate ways. For some people it will be necessary to have an independent advocate present at the time this information is provided. Interpreters must be available and appropriately used for people of non-English speaking background. At all times consumers and carers must be treated with dignity and respect and not as "incompetent" or as "naughty children".

- \* Treatment plans must be developed and agreed jointly by health professionals and the consumer. Carers must also be involved in this process with permission of the consumer. The views of consumers and carers must be taken seriously by health professionals.
- \* Transport to Hospital must, as the general rule, be by ambulance or private transport. People transported to hospital by ambulance involuntarily should not have to pay for ambulance charges.
- \* Statewide policies must be developed to ensure that medication must only be used for treatment purposes and not as a management or control tool. This requires:
  - that clear protocols and monitoring mechanisms be established for the use of PRN medication.
  - compliance with national maximum dosage and drug prescription standards.
  - compliance with Commonwealth requirements for the reporting of adverse drug reactions and effects.
- \* Doctors must provide full information to both consumers and carers on the purpose of medication and possible side effects throughout the period of treatment. Education on medication should be provided in group situations for both consumers and carers.
- \* Psychiatric facilities should afford privacy to consumers and their carers. Visiting areas and covered smoking areas are essential.
- \* All psychiatric inpatient facilities must utilise the services of dietitians. Currently, many fail to provide "...edible, nutritious meals".
- \* Effective complaints mechanisms must be implemented in all States and Territories which include:
  - A system of official visitors which utilises consumers and carers as visitors and has a mandate in both hospital and community services.
  - Facility based, independent, trained and salaried advocates with full access to consumer records (with consumer permission). Advocates also require guaranteed access to staff to discuss issues on behalf of consumers.
  - Standards which ensure that complaints are, as a general rule, dealt with before a person leaves hospital. Data must be kept on recurring complaints.
  - Require all criminal incidents to be reported to Police.

- \* Effective and appropriate **Protocols and Safeguards** must be developed for the use and review of seclusion. These must cover "unofficial seclusion" in areas not officially designated as seclusion rooms.
- \* Hospital records must be available to consumers and with permission, carers and advocates. There should be provision for consumers to add their own comment to the notes on a regular basis.
- \* Discharge planning is crucial. It must encompass:
  - on-going management of medication
  - provision for continuity of care
  - accommodation and support
  - employment/activity/recreation
  - rehabilitation

All people discharged should be linked to an appropriate community service. A copy of the discharge plan should be given in writing to the consumer and, with consent, a separate copy to the carer. Plans should be developed via care conferences with the consumer and primary carer.
- \* Meaningful activity must to be available for inpatients and should include music, dance, arts and crafts and physical exercise regimes. The focus should be on personal and community rehabilitation and social skills (rather than living skills).
- \* The right to a second opinion should be promoted, assisted and appropriately enforced. It is acknowledged that this is difficult to achieve in rural areas. A request for a second opinion might be initiated by a carer.

#### **comments on Commonwealth Government strategies:**

- \* Mainstreaming of acute psychiatric facilities must be accompanied by education for both mental health and general hospital staff to ensure effective working relationships, compatible knowledge bases and access to shared and appropriate information. To date these issues have not been adequately addressed.
 

Moves such as "mainstreaming" do not decrease the need for official visitors and direct access to health complaints mechanisms. Abuse can occur just as readily in a General Hospital.
- \* Workshop participants had not heard of the General Practice Strategy or the Medicare Incentive Program. Significant concerns were raised regarding the ability of General Practitioners to participate in new models of discharge planning as no confidence exists regarding

their level of understanding of mental illness.

- \* Workshop participants see access to Medicare funded psychologists as a priority issue to be addressed when examining options for discharge planning.
- \* Concerns have been expressed as to whether a Public Patients Hospital Charter will address the special needs which people with mental illness have. A special focus on these issues is required.
- \* There is also some concern that the rights of people should not differ between public and private systems. That is, the protection of mental health law should apply in both the public and private sectors.
- \* Independent complaints bodies are required before the 1998 deadline. Will such bodies be resourced to address the specific issues that are likely to be raised by people with mental illness eg. abuse of power, informed consent, treatment in the "least restrictive environment"? Will the staff have the skills to work with people with mental illness?
- \* Workshop participants in general had not heard of the Best Practice in the Health Sector Program and were unable to comment on this strategy.

#### **4.4 The Public Sector Interface**

Workshop participants expressed concern (and felt disadvantaged) by the current poor relationships between the public and private mental health sectors. Many felt forced to seek assistance from the private sector as a result of the manner in which they National Mental Health Strategy is being implemented.

Many people whose only income is Social Security Benefits, are now dependent on the private sector for outpatient medical care. Few such people have been able to access public day and rehabilitation programs. Continuity of care is also an issue for these people if inpatient stays are required.

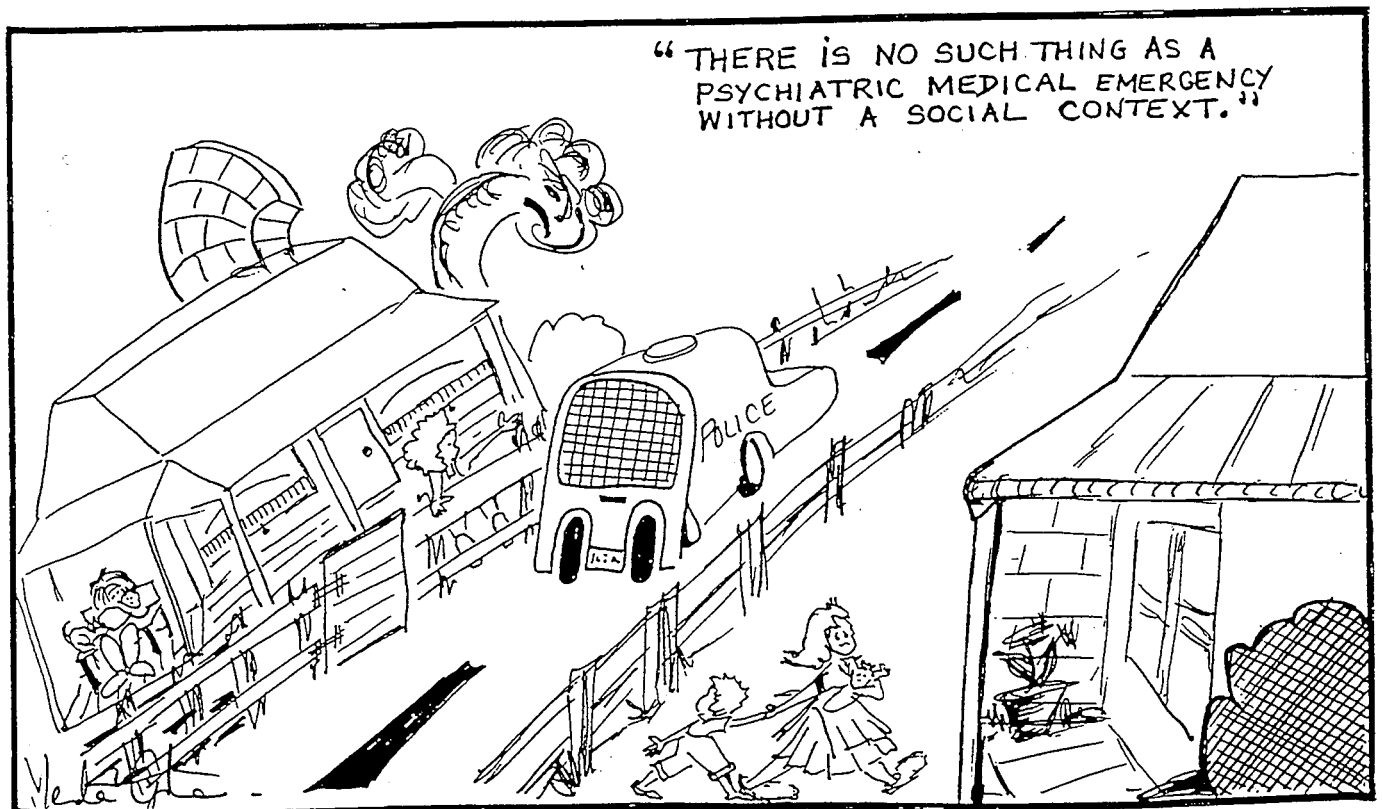
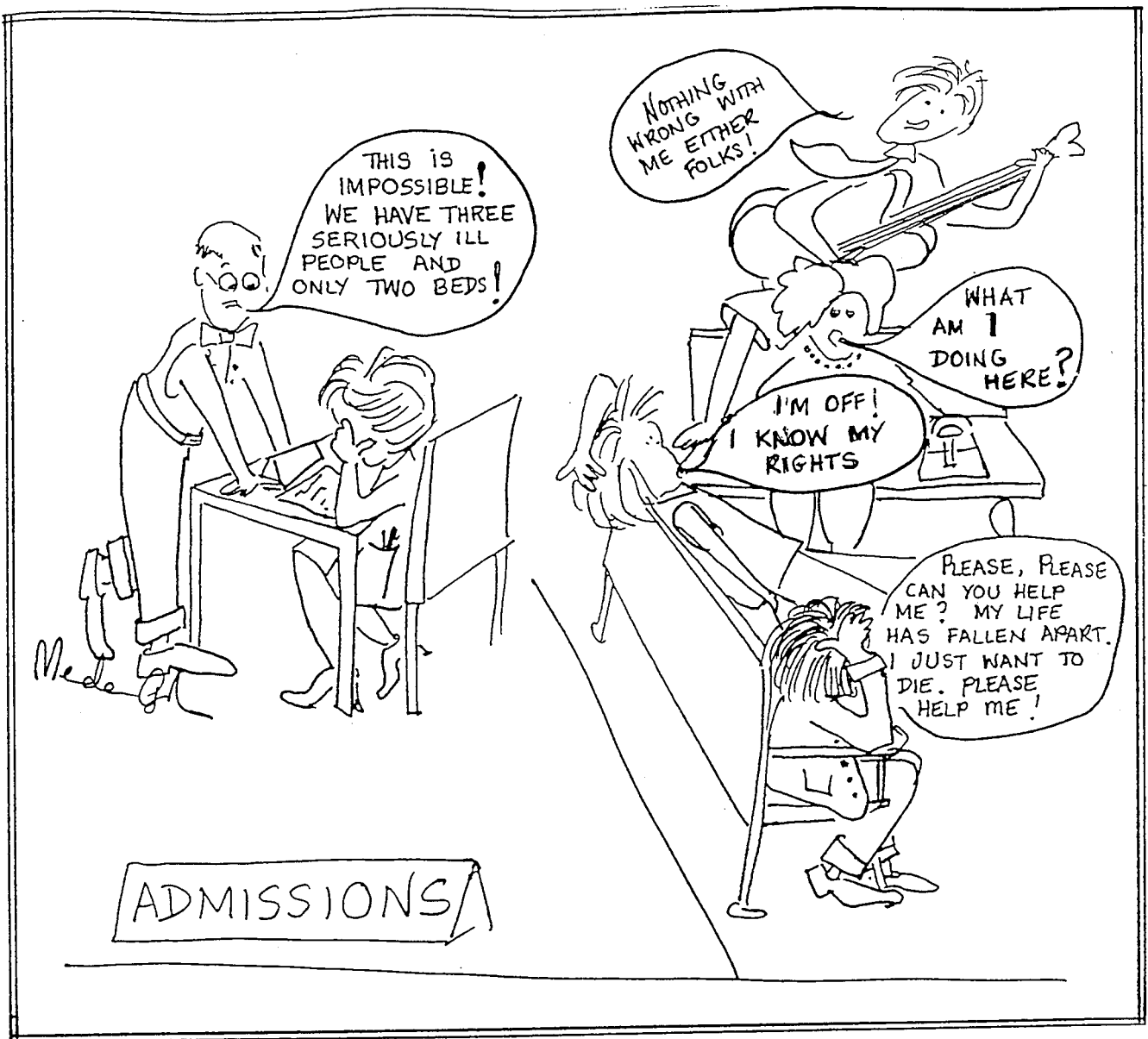
Workshop participants felt that standards should not vary between the public and private sectors and that the role which the private sector plays needs to be more clearly recognised by public sector services.

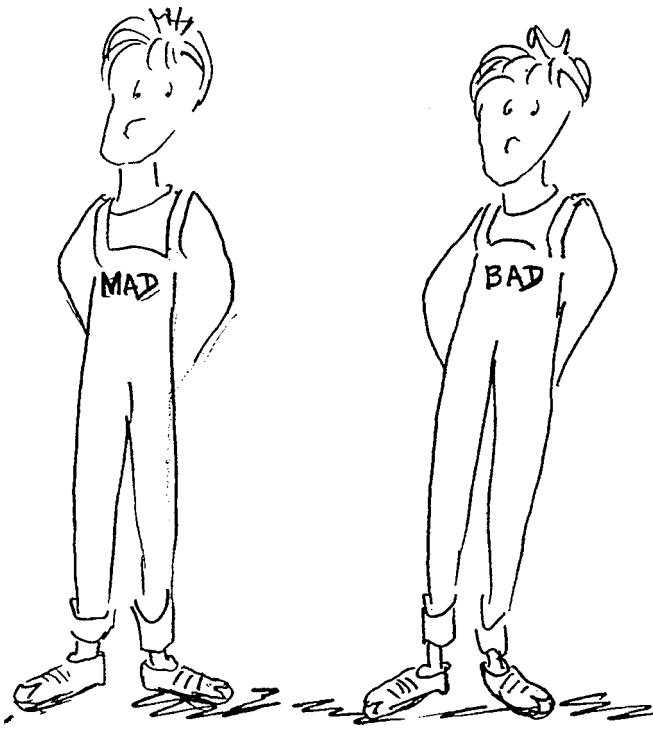
The paucity of resources devoted to service delivery in the non-government sector and, in many places around Australia, the lack of credibility given to non-government sector services by public sector services, and the consequent lack of interface between them, were significant concerns. More is said on the issue of non-government services in Chapter 5.

### **Recommendations from Workshops:**

Workshop participants recommend that:

- \* Public and private sector mental health service and non-government sector services work in closer co-operation with each other.
- \* Private sector consumers and health providers, and the non-government sector be represented on all relevant government committees.





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## Chapter 5

# COMMUNITY SERVICES

The general conclusions of the HREOC Report found that:

( *"In general, the savings resulting from deinstitutionalisation have not been redirected to mental health services in the community. These remain seriously under funded, as do the non-government organisations which struggle to support consumers and their carers. While the movement towards mainstreaming mental health services may alleviate the stigma associated with psychiatric care, there is a serious risk it will not receive the resources it so desperately needs."*<sup>5</sup>

The HREOC Report recommends priority funding for psychiatric disability programs to provide equity with other areas of disability. The primacy of **community** treatment and care is reinforced. The need for a full range of services is restated. case planning, involvement of General Practitioners, access to generic services, and the need for more effective income support mechanisms are all stressed.

Specific and significant recommendations are made concerning housing and accommodation, employment and education and training.

In keeping with subject headings found in the HREOC Report, workshop findings, recommendations and responses to government strategies are reported below under the headings of:

Community care and Treatment  
Accommodation, Boarding Houses and Homelessness  
Employment  
Education and Training  
Prevention and Early Intervention

### 5.1 **community care and Treatment**

Workshops participants considered that essential components of an integrated system of community care would include:

- \* Access to responsive, extended hours multidisciplinary teams that are flexible in response and available to provide a range of

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<sup>5</sup> Human Rights and Equal Opportunity Commission Op Cit p 908.

supportive care services aimed at minimising the necessity for crisis intervention, and effectively managing crises when they occur.

- \* A wide range of accommodation options with varying levels and types of support (see 5.2 below).
- \* A range of day activity, pre-vocational training, vocational training and employment options combined with support services, as required, to facilitate participation.
- \* Access to Advocacy and "buddy services".
- \* Information, education and training for:
  - the general public
  - consumers
  - carers
  - General Practitioners
  - Police
  - other generic service providers
  - Mental Health professionals
- \* A range of Respite services for both consumers and carers, in and out of normal places of residence.
- \* Services which are cultural sensitive, age and gender specific.

Workshop participants identified a number of specific issues which need to be addressed to ensure that the HREOC Report's recommendations related to community care and treatment are implemented. These include:

- \* Broadening the focus on "serious mental illness" to ensure that the criteria for accessing mental health services moves beyond a narrow diagnostic basis to a more holistic approach based on "serious mental health care need". (See 2.5 above).
- \* Access via a single point of contact to extended hours assessment and treatment teams based in both metropolitan and rural areas.
- \* The non-government sector must be recognised and supported as an integral component of any system of community care. The capacity of an effectively developed non-government sector to provide a broad range of community support services must be clearly understood.
- \* Development of area based service directories which are written in simple language, easy to access and kept up to date. It is considered essential that all key

points of contact eg. General Practitioners,

District Nurses, school counsellors, Infant Welfare centres etc. have and use such directories.

- \* Generic programs eg. HACC, SAAP, and Disability Services must develop affirmative action and access policies for people with a psychiatric disability.
- \* Advocacy services are required to assist access to public, private and non-government organisation services.
- \* The role and needs of carers must to be addressed.
- \* Mechanisms must be developed to enable consumers who attend private psychiatrists to access public community mental health services as required.
- \* Consumers require access to models of care which provide alternatives to and additions to "the medical model".
- \* Current models of care management do not ensure continuity of care.

#### **Recommendations from Workshops:**

- \* Community education to reduce stigma and discrimination
- \* Community services to establish 008 numbers for information and advice.
- \* Service directories be compiled for each local area and distributed to Police, General Practitioners etc.
- \* HACC and SAAP to develop affirmative action policies for people with a psychiatric disability
- \* Existing disability advocacy services be allowed and encouraged to advocate on behalf of people with a psychiatric disability.
- \* "Buddy" systems be established on a local basis to assist consumers to access services and to maintain (or pursue) accommodation and employment options.
- \* In Tasmania it was recommended that specialist Mental Health Resource Centres for J?On-government organisations be established at a regional level to provide:
  - a clearing house function for information
  - a meeting house
  - a centre for networking
  - support for new non-government organisations.

This would require premises, infrastructure (telephones,

administration costs etc.), trained facilitators, marketing.

Such centres would have a major education and training function and would act as a focus for the recruitment and training of volunteers to assist with tasks of daily living.

- \* Establishment of a variety of respite services including:
  - supported community based housing
  - in home care to allow carers to go away
  - holiday programs for consumers and carers
- \* Reimbursement of volunteers "out of pocket" expenses
- \* Access to an independent locally based grievance procedure
- \* Establishment of consumers as "official visitors" to monitor service provision.
- \* Establishment of significant funding programs for non-government organisations which guarantee adequate and on-going funding, and promote innovation and development.

#### **comments on Commonwealth Government Strategies:**

- \* With the exception of the ACT, the development of State/Territory strategic plans required to access Mental Health Strategy funding has been carried out without consultation with consumers and carers.
- \* Community services are primarily being established in metropolitan areas only.
- \* The non-government sector is not "getting a fair go" in relation to allocation of National Mental health Plan transition funding and funding for innovative services.
- \* Government strategies are broadly supported but inadequate.

## **5.2 Accommodation, Boarding Houses and Homelessness**

Accommodation and accommodation support are issues of vital concern to consumers, carers and the community. Concern was expressed regarding:

- the availability of a range of accommodation options
- the choice to be exercised by consumers
- the availability of varying levels of support
- the separation of the landlord function, support

function and clinical care function.

the need to ensure that access to secure and affordable accommodation is included as a vital component of discharge planning.

Workshop participants considered that the public, private and non-government sectors all have a role to play in the provision of accommodation and support. However, it was held that the function of landlord, the function of clinical care provision, and the function of community living support should be separately managed (though closely co-ordinated).

It was held that a greater variety of accommodation options (as in bricks and mortar) could be effectively utilised if there was a greater availability of community living support services and a greater availability and flexibility in the way in which clinical services are delivered. In short, many current accommodation issues are really issues of inadequate community living support and clinical support. Currently, in many cases, community living support (in the home) is only provided if a person lives in designated accommodation, usually managed by the support service provider. This is often also the case in relation to appropriate, at home, clinical care. Currently, in many locations and situations neither support is available.

A role was seen for "buddies" or advocates to assist with the obtaining of accommodation and in monitoring the maintenance of reasonable standards.

And issues of definition were highlighted in relation to boarding houses, private hotels and special accommodation places.

The following particular problems were highlighted:

- \* The role of SAAP in provision of accommodation requires clarification. Some SAAP workers reported a willingness to be more involved with this target group providing mental health support was forthcoming. However, many people seeking SAAP services are considered to have dual and multiple disabilities and in the experience of SAAP workers not seen as a priority for service provision by mental health services. SAAP workers need increased skills in the identification of mental illness and the management of disruptive behaviour. There was also a call for funding levels to reflect the level and intensity of service provision required.
- \* Mothers experiencing mental illness and their children have particular needs in relation to accommodation and support.
- \* A number of boarding houses and private hotels are not considered to be safe places of accommodation for women.
- \* Proprietors of special accommodation houses, boarding

houses, private hotels and hostels operate in isolation from systems of care. They frequently have little information regarding availability of community services or how to access them. And "outreach work" by community mental health and community support services is limited.

- \* Standards for accommodation and incentives for proprietors to meet those standards are urgently required.
- \* Many consumers consider all types of communal accommodation as institutional and unacceptable
- \* In Victoria it was claimed that 80% of Special Accommodation house residents are aged over 65. currently, these people have no access to the Commonwealth subsidised hostel program and are kept poor because of current financial arrangements which leave them with no money.

#### **Recommendations from Workshops:**

- \* The role of Local Government in the enforcement of legislation and standards related to accommodation should be upgraded.
- \* Development of an accommodation support program linking public and other housing stock, community living support services, and clinical care services flexibly and according to need. The Victorian Housing and Support Program was pointed to. Appropriate involvement of Commonwealth and State funding is required to devise such schemes nationally.
- \* Funds allocated to facilitating access to accommodation (eg. bond and relocation) must be substantially increased. It is claimed that current funds are expended in the first 3 4 months of the year. A specific allocation of funding to assist people with a psychiatric disability - who may also require assistance more than once - is recommended.
- \* Hospital discharge protocols must require appropriate and affordable housing to be available.
- \* Community living support services and clinical services must be made available to people where they choose to live and not be linked only to specified accommodation facilities.
- \* National standards and enabling legislation must be developed for the provision of supported accommodation for people with psychiatric disability.

- \* More flexible use should be made of existing institutional and community houses to provide respite accommodation for consumers and carers.
- \* Specific respite accommodation and support should be available on a regional basis.
- \* Public Housing Authorities must develop policies which are flexible enough to meet the needs of people with mental illness. As example, policies which enforce eviction where a dwelling is unoccupied for more than six months, even where rent has been paid, and the tenant is in hospital, are considered detrimental and inappropriate.

**comments on commonwealth Government Strategies:**

- \* There is strong support for review of Commonwealth, State and Territory legislation related to the monitoring and protection of tenants' rights in boarding houses. However, it was pointed out that the existence of appropriate legislation is useless unless it is enforced. It would appear that legislation already exists in a number of states that could be enforced to improve living conditions for many people with mental illness or psychiatric disability.
- \* The Commonwealth Government discussion paper identified no strategies to address the issue of homelessness.
- \* 10% of the Community Housing Program is an inadequate allocation of resources. Reference was made to the fact that 100% of funding from this program was allocated to Youth Housing following the Human Rights and Equal Opportunity Commission Inquiry into Homeless Youth.<sup>6</sup> Mental Health needs a more significant affirmative action allocation than this.
- \* The allocation of bricks and mortar is not enough. Support services are essential.
- \* Strategies which utilise "passive" terms such as "work with", "co-operate" require milestones by which to measure progress. What will the measure of success be? How will consumers know if the strategy has been implemented or successful?

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<sup>6</sup> See Human Rights and Equal Opportunity Commission, our Homeless Children AGPS 1989

### 5.3 Employment

Workshop participants acknowledged the difficulties of obtaining employment in the current economic climate. However, they stated clearly that employment or valued alternatives were a significant requirement of community care and rehabilitation for people affected by mental illness and psychiatric disability.

Workshop participants identified several specific issues which need to be addressed:

- \* a wider and more flexible range of pre-vocational programs are needed. Some of these programs should be available in people's homes.
- \* Support is an essential component of employment programs and must be available in an on-going manner. Support may take many forms and be both on and off the job.
- \* More flexible working arrangements need to be utilised if employment programs are to be successful, for example, job sharing, part-time employment, transitional employment, self employment.
- \* Commonwealth Rehabilitation Service (general) case managers need a better understanding of people with mental illness. There was a concern that people with a mental illness or psychiatric disability are not treated with respect.
- \* Commonwealth Rehabilitation Service (psychiatric pilots) and mental health staff need to develop better working relationships.
- \* Commonwealth Rehabilitation Services (psychiatric pilots) are said to "cream off" the people with greatest employment prospects. They do not address the "hard end", leaving this group to non-government organisations.
- \* Linkages and co-operation between government (Commonwealth and State) disability service areas and government (Commonwealth and State) mental health service areas are poor.

#### Recommendations from workshops:

- \* Development and implementation of a Commonwealth and State employment strategy for people with a psychiatric disability which contains the following eight key aspects:

A targeted educational program aimed at employers, unions, community organisations, government

departments, General Practitioners, consumers, carers and mental health professionals to give employment and occupation of people with a psychiatric disability high profile, priority and a positive image.

Provision of clear and adequate information to consumers regarding available assistance and programs aimed at assisting return to work or valued occupation. Such information should be routinely available and reinforced as an aim of treatment plans.

There needs to be a significant redefinition of what is "employment" to focus on "activity" and "valued occupation". Employment should be understood to encompass employment activity of less than 20 hours duration per week.

Assessment and evaluation of options needs to be based on quality of life as well as economic indicators.

Linkage of all relevant government departments is required to ensure co-ordination of services, sharing of information and knowledge.

Recognition must be given and use made of personal, family and friendship networks in delivery of services.

Flexible delivery and access to training and educational courses including assistance for self directed study is needed.

Employment incentives must be spread over a longer period of time, linked to local employment contracts, and more controlled and targeted than universal tax incentives. These should include no limit on hours worked and be available to all people with a psychiatric disability.

- \* Development and implementation of education strategies to assist:

Consumers to understand the range of vocational training and employment support options available.

General Practitioners, Commonwealth Employment Service staff, and Department of Social Security staff to be aware of vocational training and employment support options and how to access them.

Employers to change their attitudes towards  
employment of people with a psychiatric disability

and to provide a range of employment options.

Mental Health professionals and employment specialists to work together.

- \* The maintenance of places at Universities and TAFE for people who fall ill whilst studying.
- \* University and TAFE colleges to provide on-site support for people with a mental illness undertaking programs of study. An existing program at Baulkham Hills TAFE was referred to as an example.
- \* Employment incentives must be available over longer periods of time for employers who take on people with a psychiatric disability.

**comments on Commonwealth Government Strategies:**

- \* Continued funding of Commonwealth Rehabilitation Service pilot psychiatric projects is supported. However, much scepticism exists regarding the claimed success of these projects in responding to the needs of people with serious disabilities.
- \* Disability Reform Program measures introduced to date are not considered successful. The Disability Reform program is considered to have demonstrated a poor understanding of psychiatric disability. This is reflected in the low priority accorded by it to this target group.
- \* There is support for the review of the Disability Support Program but little hope exists that things will change for the better.
- \* The allocation of \$0.6m in 1993-94 to fund places for people with a psychiatric disability in open employment programs is considered to be a pittance. Open employment should be seen as the primary preferred option for all people with a psychiatric disability.
- \* The process for assessment of skills proposed as part of the supported wages system needs to be flexible enough to cope with the fluctuating levels of wellness and skill level frequently associated with psychiatric disability. There is a significant fear that many people will be abused and used as "cheap" labour if assessment occurs during a period of illness or poor coping. Appeal and review mechanisms need to be part of the process.
- \* Public Service agencies currently discriminate severely against people with a psychiatric disability. This needs to change dramatically and quota levels introduced to ensure a certain minimum number of places are available

for people with a psychiatric disability. The public

service should lead the way in the employment area by the adoption of affirmative action strategies.

- \* There is no faith that the Commonwealth Employment Service has the ability to adequately case manage people with a psychiatric disability. Massive attitudinal change and re-educational programs are required.

#### 5.4 Education and Training

Education and Training was identified by workshop participants at all locations as a priority issue for action. For many participants, education and training were seen as the cornerstones to change in relation to discrimination and service reform. A comprehensive strategy was recommended and the following matters were considered.

- \* Education of General Practitioners to improve their knowledge and management of mental illness is critical.
- \* Education of Mental Health professionals is critical in order to ensure that they develop a less patronising and discriminatory attitude to consumers and carers.
- \* Community Education is essential. Media support needs to be generated to "popularise" Mental Health issues (using appropriate language and outcomes). Existing "SOAPS" and programs with high viewer ratings should be accessed to promote (and de-stigmatise) Mental Health topics.
- \* Consumer Education is required to assist people to understand and manage their illnesses. This would include information regarding rights, service options, medication and alternative therapies, accommodation, activity and employment options.

Education packages need to be culturally relevant and not confined to written communication. The reading ability of many people is affected by medication. Printed matter that is used must be written in simple, culturally appropriate language. Consumers also want education and training to assist them to advocate and lobby on their own behalf and to participate in a meaningful way in policy, planning, service development and evaluation and staff training activities.

Both consumers and carers should participate in school education programs.

- \* Carer Education and Training is required in similar areas.
- Non-government organisations are perceived as being particularly good at developing appropriate information

packages and for running education and awareness programs. However, they need to be funded for this activity. And their own staff must be supported by access to appropriate staff development and training programs.

- \* Primary Health Care Providers are seen as the gate-keepers to the Mental Health system. They are poorly prepared for this, currently fail to recognise mental illness and are seen to often perpetuate mental health problems by the prescription of unnecessary or inappropriate medication.

Regular and compulsory undergraduate and post graduate training of General Practitioners is essential to ensure up to date mental health knowledge and information. Such training should be linked to ongoing registration.

All education of General Practitioners needs to encompass information regarding non-government organisations and how to access their services.

All primary health care providers should have access to printed sheets for required distribution to patients regarding each specific drug, how it works, and its side affects.

Education and training for primary health care providers will assist with Mental Health promotion and prevention.

- \* Education Authorities (schools, TAFE, Universities) need to adopt a more flexible approach to the education of people with mental illness and their carers. Education programs need to take account of the episodic nature of mental health problems, maintain places for people experiencing acute episodes of illness and provide specific support as required via the appointment of trained officers who could assist students to link with treatment and support services. A program at Baulkham Hills TAFE was given as an example of a useful initiative at TAFE level.

#### **Recommendations from Workshops:**

- \* That the Commonwealth and State Governments develop, fund and implement a comprehensive educational and training strategy aimed at school children and young people; mental health professional; General Practitioners; community service providers including Police, Commonwealth Rehabilitation Service, Department of Social Security; consumers and carers; and workers in non-government organisations including Home and Community Care workers, Supported Accommodation Assistance Program Workers, and workers in programs specifically targeted to people with a psychiatric disability.

Such a strategy must:

be targeted at attitude change; at the development of appropriate skills; and at the provision of information and knowledge regarding mental illness, psychiatric disability, medication and services available.

significantly involve consumers and carers in its development and delivery.

be managed where feasible by non-government, community organisations, many of whom have demonstrated expertise in the development of educational packages.

be adequately funded.

#### **comments on commonwealth Government Strategies:**

- \* A portion of funding under the Higher Education Equity Program needs to be specifically allocated to people with psychiatric disability as an affirmative action strategy.
- \* The number of school liaison officers needs to increase and they require specific training to assist them to work with students with mental health problems.
- \* Development of a strategic framework for people with disabilities in TAFE is supported. However, there is a need to specifically target mental health issues. There is little faith that generic disability programs will ever address, or give equal access to people with a psychiatric disability without an affirmative action program.
- \* There is little direct satisfaction in those strategies which "...refer the issue of access to education...to the Ministerial Council... to report" or " request the Human Rights and Equal Opportunity Commission to investigate and develop guidelines for the provision of support to students..." or "... refer recommendations on vocational education to the National Training Authority...". These actions are supportable but:

What is the time frame for response and action?

What guarantees of action will there be?

#### **5.5 Prevention and Early Intervention**

Workshop participants frequently expressed frustration that current mental health services are crisis and illness focussed services. They expressed a desire to see a redirection of service delivery to focus on:

prevention of crises.

early intervention.

promotion of "wellness" through rehabilitation, community integration and support, and health promotion activities.

As an example, workshop participants would prefer to see extended hours mental health teams which had a responsibility to maintain health, to assist at an early stage, and to prevent and manage crises; than to have teams whose focus was predominantly crisis intervention.

It was acknowledged that prevention and early intervention are linked to education and awareness programs and that these need to be provided in an ongoing manner through schools and the popular media.

General Practitioner's are acknowledged as having a key role to play in prevention and early intervention. They are not currently equipped to act effectively in this manner. School counsellors are also seen as crucial given the early onset of many mental illnesses.

Workshop participants felt strongly that the manner in which the National Mental Health Policy is being implemented is counter-productive to prevention and early intervention. Consumers stated and restated their experience that if they present early for assistance particularly but not exclusively inpatient assistance - then they are told that they do not meet the criteria for service delivery, In effect, they should go away and come back when they are more ill ie. when they are in crisis.

Workshop participants focused on the necessity to recognise and develop mechanisms for intervention in situations which potentially lead to or complicate the experience of mental illness at a later stage. For example:

- Child abuse
- Sexual assault
- Domestic Violence
- Torture and trauma
- Loss and grief
- Attempted suicide
- Conduct disorders
- Drug and alcohol abuse
- Homelessness

The issue of prevention and early intervention was a primary issue for carers who are concerned for their own mental health. Solutions suggested include:

access to advocates;

regular access to respite;

access to extended hours mobile services; and most importantly,

to be listened to and taken seriously by mental health professional staff.

#### **Recommendations from Workshops:**

- \* Recommendations related to prevention and early intervention are characteristic of recommendations throughout all sections of this report. The development of an effective mental health service system, of adequate and appropriate community services, of services designed to meet the need of special needs groups, of consumer and carer empowerment and choice, of comprehensive educational and training strategies, of responsive government policies and programs, and of a legislative framework which recognises and supports accepted and basic human rights throughout Australia are essential elements of a system of care which holds prevention and early intervention as essential precepts.

#### **comments on commonwealth Government Strategies:**

- \* Development of National Mental Health Goals and Targets is supported. There is a fear that there will be inadequate resources to implement them.
- \* "Considering the recommendations of the report *Scope for Prevention in Mental Health...*" is not strong enough - **implementing** them is desired.
- \* The commitment to mental health of the National Health and Medical Research Council was questioned.
- \* A national communication strategy is seen as essential. To have any impact this will need to be an ongoing program. The communication strategy must also be targeted to mental health professionals ,,,,and State, Territory and Federal Governments to get them to change their policies and practices to focus on prevention and early intervention.

*"It happened in the drug and alcohol area - why can't it happen in mental health?"*



## Chapter 6

# LIVING WITH MENTAL ILLNESS

The HREOC Report concluded that:

*"People affected by mental illness are amongst the most vulnerable and disadvantaged in our community. They suffer from widespread, systematic discrimination and are consistently denied the rights and services to which they are entitled."*

*"The level of ignorance and discrimination associated with mental illness in the 1990s is completely unacceptable and must be addressed."*<sup>7</sup>

The effects of stigma and discrimination are the subject of HREOC Report recommendations related to the need for public education programs, effective implementation of disability discrimination legislation and the practices of insurance companies.

The excessive burden borne by carers; yet again, the lack of community support services to assist; and the lack of credence given to carers by professionals: are all the subject of recommendations.

The failure of current services to adequately respond to the needs of children who have parents with mental illness is said by the HREOC Report to require changes in professional and agency practice, service co-ordination, specific programs of support for children, and the allocation of resources to non- government organisations.

Workshop participants endorsed these conclusions and were strongly supportive of the recommendations of the HREOC Report. Consumers and carers participating in workshops overwhelmingly expressed the desire to be treated as a unique person with dignity and respect, to be listened to, to have a say in all aspects of their treatment and care. This is by no means the current response of the mental health system.

### 6.1 Discrimination

Many consumers participating in workshops indicated that this was the first time that anyone had ever asked them what they thought about the mental health system. Some consumers were

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<sup>7</sup> Human Rights and Equal Opportunity Commission Op Cit  
p 908



clearly fearful of being involved:

*" if I say what I need to say today will they  
lock me up tomorrow?"*

For the consumers and carers who attended the workshops,  
living with mental illness means:

being "ignored"  
being "treated as a small child or an idiot"  
"having no rights"  
being "discharged with no notice and no  
accommodation"  
being "assaulted and sexually abused by staff"

The blame was laid squarely on mental health staff and in particular on psychiatrists. Both consumers and carers stated repeatedly they experienced more discrimination from mental health professionals than from any other section of the community.

Any strategy to address discrimination which does not have, as its core component, changing the attitude of mental health professionals towards consumers and carers and enabling /consumers to exercise choice and access alternative services, 'is considered to be a waste of time.

Discrimination is encountered at both a personal and group level from government departments via discriminatory policies and programs that either prohibit access, or give low priority to people with mental illness and psychiatric disability. And significantly, although the National Mental Health Policy is acknowledged and supported, consumers and carers repeatedly expressed the view that:

*"I am no better and in some cases worse off now than I  
have ever been. A lot may be happening on paper, but nothing  
is changing on the ground."*

State Strategic Plans have, in all cases, except in the ACT, been developed with little or in most cases no consumer, carer or community consultation. State and Territory Governments are seen as unwilling to listen to consumers and carers or to respond to needs as identified by them. This only adds to the experience of stigma and discrimination.

The commitment of State and Territory Governments was further questioned by workshop participants who perceived them as:

*"... wanting the Federal Government to come up with the  
dollars to fix everything, but not wanting to let go of  
control of service delivery - and in many cases not even  
maintaining the pre National Mental Health Strategy  
funding commitment to mental health."*

Consumers and carers who live with mental illness have the

same needs for general health services, income support, housing, insurance, recreation and accommodation services as the rest of the population. They do not however, receive equal access.

Workshop participants saw the key to achieving equality of access as attitudinal and policy changes at an individual and government level.

### **Recommendations from Workshops:**

To have any impact on discrimination, consumers and carers want and recommend that:

- \* Mental health professionals, and in particular psychiatrists, treat them as real people, discuss treatment options, recognise and respect their skills and act as advocates for them in negotiating on an intersectoral basis for the myriad of services they require from time to time.
- \* Access to independent advocacy services and "buddy system".
- \* The implementation of the National Mental Health Plan to be re-directed to focus on prevention of crises and early intervention with a view to minimising the impact of mental health care problems.
- \* Information regarding the purpose and potential side affects of medication and the practice of using medication as a control tool to cease.
- \* Equitable access to Commonwealth and State run and funded generic services.
- \* Consistent standards of care around Australia.
- \* National Mental Health legislation based upon the United Nations Principles for the Protection of Persons with a Mental Illness and for the Improvement of Mental Health care.
- \* Equitable access on a national level to new drug therapies.
- \* More information (newsletters, consultations, etc.) regarding policy and service development which is occurring at both a State and Federal level to ensure meaningful input.
- \* Resources to be made available for training and support for consumers and carers to ensure that participation is

not tokenistic.

### **comments on commonwealth Government strategies:**

- \* The National Mental Health Strategy is seen to be useless without a significant change in attitude by mental health professionals, retraining of mental health professionals to function in the community, a significant increase in availability and access to the wide range of community services required, a broader interpretation of "serious mental illness" based on impact on a person's life rather than on a narrow range of diagnostic labels and the potential of that diagnosed illness to respond to medication. (See 2.5 above).
- \* Consumers and carers primarily see projects of national significance as ones that are community controlled and delivered by the non-government sector. They are concerned however, that funding for such projects will be time limited, create expectations, and then be dropped.
- \* Reforms to the drug evaluation system are supported.
- \* No faith exists that State or Territory Governments will report accurately on activities, particularly relating to the lack of consumer and carer involvement in the National Mental Health Report.
- \* Much concern exists about the extremely narrow focus of the Strategic Review of the Disability Services Program and the lack of opportunities for consumers and carers to participate meaningfully in this process. In essence no hope is held for the Disability Services Program changing its focus at all.

### **6.2 carers**

The discriminatory experiences that consumers describe regarding their relationship with mental health professionals is repeated by carers.

The long term burden of care for many consumers rests predominantly with carers. This is particularly true in rural and remote areas. However:

Information which carers have and are able to contribute to inform treatment and care options is largely ignored.

Carers are not involved in the development of treatment plans.

Information readily shared between health professionals is kept from carers on the basis of "confidentiality".

Carers are often expected to accept their relative/friend back into their home at short notice with no information regarding the needs of the consumer, little or no information regarding medication or day to day management of behaviour, no guarantee of assistance next time there is a crisis and no options for respite care if required.

carers have little hope of a personal life and are frequently substantially financially disadvantaged.

The majority of carers are women and "caring" is still understood to be a female role with "intrinsic" rewards and sacrifices!

Carers attending workshops were adamant that this situation must change.

It is important to note that throughout this consultation process "carers" were more likely to select workshops which addressed issues other than their own needs. This appears to be reflective of their capacity to bear the burden which the mental health system fails to carry. And their lack of confidence that this burden will ever be effectively shared.

#### **Recommendations from Workshops:**

Carers recommended the following as top priorities for action:

- \* Education for mental health professionals, particularly psychiatrists to change their attitude to carers. They wish to see national guidelines developed to address carers' rights, the issue of confidentiality and mechanisms to enforce the use of such guidelines.
- \* Development of a range of respite care options for consumers, for carers, in home and out of home. Such options could include versions of foster care, alternative accommodation and support options, and subsidised holiday programs. Emergency respite services are essential.
- \* Provision of practical information sheets and courses regarding medication and management techniques to cope with disruptive behaviour.
- \* Readily available extended hours support services to prevent crises and to deal with them when they occur.
- \* Mental health professionals to negotiate "contingency solutions" with consumers at times when they are well.
- \* Involvement of carers in discharge planning processes.
- \* Carer participation in all education programs to present

a carer perspective.

- \* Access to information services via a single point of contact, preferably a 008 number.
- \* Carers to participate in the monitoring and evaluation of services.
- \* Carers to be trained and appointed as official visitors to both hospital and community services.

**comments on commonwealth Government Strategies:**

- \* Few carers who attended the workshops had ever heard of the Carers Package and had received no benefit from it.
- \* A review of the Domiciliary Nursing Benefit is supported. However, it was felt that this may be of most benefit to those caring for people with dementia.
- \* Significant disappointment was expressed regarding the lack of government strategies in this area.

**6.3 Children of People with Mental Illness**

Workshop participants were particularly concerned about the forced separation of parents and children, the lack of in-home support, the lack of services available to deal with post-natal depression, and the lack of attention to the special support needs which children of people with a mental illness may experience including the fear of developing illnesses themselves.

The answer to all of these concerns was thought to be in development of appropriate services. In situations where child protection is an issue it was felt that children are sometimes unnecessarily removed and/or parents denied access/custody in family law cases because of the inadequacy of services and because of false preconceptions on the part of relevant authorities.

**Recommendations from Workshops:**

- \* That mental health professionals involved with people with mental illness who have children must ensure that they pay particular attention to the needs of the children.
- \* That children whose parents have a mental illness must have access to information and education programs to assist them to understand mental illness.
- \* Children of parents with a mental illness must have

access to age appropriate, ongoing support and counselling.

- \* That schools acknowledge the importance of their role in attending to the needs of children whose parents have a mental illness and adopt a flexible attitude to the provision of both education and support.
- \* That health, education and welfare professionals who are working with children who live with parents with mental illness be aware of and where appropriate, link the child to flexible respite programs eg. after school programs, adventure camps, sporting, drama, music activities, etc.
- \* That children whose parents have a mental illness should be involved and considered in the discharge planning process.

#### **comments on Commonwealth Government strategies:**

- \* The Government Discussion Paper does not address this issue at all. This lack of response is appalling.

#### **6.4 Community Participation**

Workshop participants were pleased that the National Community Advisory Group's consultations had been specifically targeted to "consumers, carers and the community". For many it was easier to talk in a forum which had not been designed around the needs of service providers and where only relatively small numbers of service providers were present.

The level of participation by consumers and carers varied from one location to another. This appeared to reflect the degree to which mental health professionals and the practice of mental health services were considered to be paternalistic and controlling. The more consumers felt this, the less prepared they were to participate. This appeared to be a more significant problem in the Northern Territory and perhaps, the Australian Capital Territory, than elsewhere. The degree of consumer and carer participation was also linked to how well established and resourced the non-government sector was.

The majority of workshop participants expressed the opinion that they were offered more opportunities for consultation by the Federal Government than by State or Territory Governments. Evidence of this was the lack of consultation undertaken by States and Territories (other than the ACT) in the development of the State Strategic Plans required for States and Territories to access National Mental Health Strategy funding for service reform. Workshop participants now understand this is an annual process and will be lobbying for input to determine priorities in future years.

Some State/Territory Community Advisory Groups feel that the Mental Health Departments use them as a token gesture towards community consultation. Documents are presented at the last minute for comment in an impossibly short time-frame.

**The experience of consulting on draft Mental Health legislation in the Northern Territory was of particular concern.** In this case there has been no public release of draft legislation. The Northern Territory Community Advisory Group was provided with an "early draft" for very quick comment on the basis that the draft was "confidential". Later drafts/amendments have not been seen.

Workshop participants were strongly of the view that the development of Mental Health legislation and Mental Health policy must be a public process involving significant input from consumers and carers. This is not occurring currently.

In Western Australia there was significant concern that development of a State Community Advisory Group has not yet occurred.

In short, workshop participants welcomed the Commonwealth Government's attempts at consultation. However, they were not optimistic that their views would be taken seriously unless they were able to be provided directly to the Federal Minister. An assurance was given that this would occur. **No confidence exists that any State Department or the commonwealth Mental Health Section will listen or respond to consumers and carers.**

#### **Recommendations from Workshops:**

- \* That State Community Advisory Groups be adequately resourced and mandated as the mechanism to undertake consumer, carer and community consultation. Adequate time frames must be allowed for such processes.

Governments must refer appropriate issues and developments for timely advice.

- \* That the level of consumer and carer input to policy development and service management be increased by implementation of the following measures:

All Boards of Management of mental health services must comprise at least 40% consumers and carers. Such people must be provided with adequate training, sitting fees and transportation costs.

Bulletins to be issued every 3 months at both a State/Territory and Federal level outlining new activities (and results of previous initiatives). The NCAG newsletter was seen as one mechanism to achieve this.

The NCAG mailing list to be expanded to cover all people who participated in workshops.

The NCAG newsletter to be used to provide a summary of major documents such as the National Mental Health Report and the Report of this consultation process.

Funding of consumers and carers to participate in consultation processes and transport costs to be covered.

Allowance of extended time for consultation meetings and workshops. In many cases people's stories are part of their responses and time is required to allow this to occur.

NCAG to be funded to develop and distribute guidelines for consultation at both a State/Territory and National level. Issues that need to be covered include - locations for meetings that are acceptable and accessible to consumers, meeting process and language used in discussions papers, advertising and promotion of the consultation.

Development and distribution of "Lobby Charts" (organisational and political) for consumers, carers and non-government organisations. It was felt that Governments develop structures to suit workers however the community does not understand these structures and cannot keep up to date with changes. This decreases their ability to participate in consultative processes.

Non-government organisations to be funded to employ lobbyists.

Increased funding for non-government organisations to:

- prepare community educational literature;

- hold regular meetings to train consumers and carers in lobbying, meeting procedures and involvement in "community participation" processes;

- develop submission writing skills.

All Government reports to be made available (multiple copies) to municipal libraries as soon as possible following publication, as many people are unable to afford to purchase.

NCAG to undertake regular consultation on a national basis to seek input to, and disseminate the results of, work undertaken by the Australian Health Ministers Advisory Committee on Mental Health and its sub-committees.

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## Chapter 7

# PEOPLE WITH PARTICULAR VULNERABILITIES

The HREOC Report concluded that:

*"Individuals with special needs children and adolescents, women, Aboriginal and Torres Strait islander people, people from non-English speaking backgrounds, those with dual or multiple disabilities, people in rural or isolated areas and prisoners - bear the burden of double disadvantage and seriously inadequate specialist services."<sup>118</sup>*

The HREOC Report devotes separate chapters to the special needs of

Elderly People  
Women  
Children and Adolescents  
People with Dual or Multiple Disability  
People in Rural or Isolated Areas  
Aboriginal and Torres Strait Islander People  
People from Non-English Speaking Backgrounds  
Forensic patients and prisoners

The need for specialist services; service co-ordination; mechanisms to assist access; control of services by the community of interest; education and training strategies; pilot research projects; strategies directed at "pernicious abuse" within current systems of care: all feature in HREOC recommendations related to people with particular vulnerabilities.

### **comments on Commonwealth Government strategies:**

The Government Discussion paper reflected an incomplete and grossly inadequate response by government to "people with particular vulnerabilities". There was severe criticism of government, both Federal and State for their lack of commitment, including resource commitment, in all areas.

Indeed, it was generally held that in all areas headed "people with particular vulnerabilities", government action was required to address:

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<sup>8</sup> Human Rights and Equal Opportunity Commission Op Cit p 908.

the absolute lack of resources

the absolute lack of understanding of appropriate service development

the absolute lack of an agreed philosophical and strategic approach to underpin service development

the "inability" of existing mental health and other relevant services to address need without significant specialist service development and community input.

### **Recommendations from Workshops:**

The Workshops concluded that:

- \* The needs of particularly disadvantaged groups must be an inherent consideration in development and implementation of all services for people with mental illness and/or psychiatric disability. This involves the development of meaningful strategies not "empty words" of good intent.
- \* The areas of particular vulnerability identified within the HREOC Report represent areas of significant social disruption and dislocation far in excess of demonstrated government and community commitment to dealing with them. Comprehensive government strategies, including significant resource allocations are required to deal with them. The current lack of realistic government commitment is reflected by the use of "passive verb" strategies such as "will encourage, will co-operate" in the Government discussion paper. Workshop participants were concerned to know if the government would actually "do" something!

One typical workshop report claimed that:

*"The discussion paper is very disappointing in that it says nothing new in terms of strategies but simply reiterates existing inadequate strategies. Many of these strategies involve general programs which do not target or reach special needs groups. Most of the action recommendations of the HREOC Report have been ignored."*

### **7.1 People in Rural and Isolated Areas**

It was stressed that very little is known about the extent of mental illness and mental health care problems in rural and isolated areas. That is, where there are no mental health services there are no mental health statistics! In some states this fact appears to have underlined a reluctance by Government to commit resources to a problem which, of its very nature, is difficult for urban based health administrators to understand and address.

Politically, it is evident that dealing with health issues in rural and isolated areas requires commitment to allocation of resources in areas which may hold very little political return.

Nonetheless, there is no apparent reason for believing that mental health problems in rural and isolated areas are any less apparent or any less serious or any less complex than those found in urban areas. Indeed, workshop participants drew a very clear picture of mental health problems in rural and isolated communities which are multi-dimensional and poorly addressed.

That is, mental health care problems are likely to have significant association with drug and alcohol abuse, domestic violence, child abuse, family break down, community disarray.

Workshops also indicated very clearly that in isolated communities it is "natural systems of care"; families, neighbours and whatever level of community organisation is possible, which "manages" mental health problems. Professional assistance in most places is extremely limited or non-existent. Where it is available, it is to deal with crises and then, too often, by the strategy of removing the individual from their community and family. The cost of such removal is significant and might be better addressed to establishing treatment and support services within the community.

That is, professional assistance tends to be too little, too late. And faulty in outcome.

In the Northern Territory, it was claimed that Aboriginal people are often transported from remote communities by aeroplane "held down under a net" or in the back of a Police van "for three days, never let out and fed through the bars".

#### **Recommendations from Workshops:**

- \* That all States and Territories develop Rural and Isolated Regional Mental Health Plans and allocate funding for:

Establishment of independent community committees with responsibility for administration of a discrete budgetary allocation to provide support services, counselling services, training for carers and other non-traditional mental health workers and services: in order to assist the community in the provision of "natural systems of care".

Establishment of mental health teams in all regional areas to provide specialist mental health treatment and care within the context of "natural systems of care".

Establishment of innovative staffing models for rural and isolated area mental health care teams utilising, for example, inducements for staff to locate in such areas, intensive in-service training, expanded use of telemedicine, contracting to urban based centres of excellence for service provision to isolated areas.

Development of educational programs to "multi-skill" existing health workers eg. counselling skills.

Development of peer support and effective supervision for remote area nurses. It was claimed that many such workers are relatively young, inexperienced and are left unsupported when dealing with critical incidents.

- \* That integrated and holistic models of health and welfare service delivery be developed in regional centres. This may require multi-function service centres and co-operative funding initiatives from State and Federal Governments and between Departments.

## **7.2 Elderly People**

Inconsistency between Commonwealth and State Government policies and programs, inappropriate funding formulas, inadequate levels of service provision, programs which do not match identified need, "tight fisted" approaches to income support, and overwhelming support for the range of recommendations contained in the HREOC Report were all featured in workshop conclusions.

Overall there was a significant concern that government strategies are failing to address or understand that the population is ageing and that expanded and appropriate service delivery strategies, innovation and flexibility to meet identified need, and co-operation between Commonwealth, States and Territories, professionals and community are essential if an effective service delivery system is to be developed.

Specific concerns identified included:

- \* State governments are reducing resource commitment to long term care eg, closure of geriatric centres in Victoria, closure of the incontinent laundry service in Tasmania.
- \* The mental health reform process is resulting in the closure of specialist psychogeriatric facilities with no increase in psychogeriatric care in the community.
- \* There is poor co-ordination between programs eg. the National Action Plan for Dementia is developing an

information system regarding services, the HACC program is doing likewise, but separately.

- \* State funded agencies are having difficulty accessing funding under the National Action Plan for dementia care.
- \* There is uncertainty about "who is responsible", ie. geriatric psychiatry is a State responsibility, the Aged Care Program is a Commonwealth responsibility.
- \* There is competition for resources between general adult psychiatric services and geriatric psychiatric services. Mainstreaming is worsening the position for geriatric psychiatry. Workshop participants supported maintenance of a specialised focus.
- \* Dementia is an area of significant concern particularly in relation to the need for appropriate facilities, need for respite services, need for appropriate funding formulas to stop closure of facilities, need for facilities for younger dementia patients, need for appropriate community services, need for respite care, need for out of hours community services, need for more effective carer supports. There is in particular, a concern for a "small but growing" number of people who "do not fit into Nursing Homes or community care" because of behaviour.
- \* There was support for Standards Monitoring Teams in Nursing Homes but a concern expressed that "some aggressive dementia patients" are being removed in order to maintain the standards. When such a person is seen to be inappropriately placed in a Nursing Home there is no requirement to find the appropriate placement.
- \* The Social Security system is seen to severely limit access to the Carer Support Pension. Additionally, there is an "administrative problem" which results in severe financial disadvantage for people on married pension rates when admission and discharge to respite care happens outside of the pension cycle. Where this occurs payments are made at the lower single rate for the full pension period, the stay in respite care may not take up the entire period, the result is financial disadvantage.

#### **Recommendations from Workshops:**

- \* That the Residential Classification Index and the Personal Care Assistance Instrument be reviewed to enable appropriate levels of funding for ambulant dementia patients and those with behavioural problems.
- \* That the Commonwealth fund development of a range of dementia specific nursing homes and hostel facilities.

- \* That funding of community options programs and day care facilities be increased. This must include funding for incontinent laundry services.
- \* That emergency respite care facilities be funded and developed.
- \* That education programs be implemented for General Practitioners regarding dementia care management, assessment and treatment of mental illness in the elderly, and appropriate medication management.
- \* That medicare funding be reviewed to facilitate General Practitioners in providing appropriate care, including the allocation of adequate time, to aged persons.
- \* That programs be established specifically aimed at assisting aging carers to develop and implement appropriate alternative care plans when required or desired.
- \* That effective pre-release and post release programs for elderly prisoners with mental health or potential mental health problems be established.
- \* That programs appropriate to the needs of elderly people from non-English speaking backgrounds, and Aboriginal and Torres Strait Islander people be established.
- \* That Domiciliary Care Nursing Benefits be increased and that eligibility criteria which is seen as excluding carers of dementia sufferers be amended.

### **7.3 Children and Adolescents**

The lack of resource allocation for disturbed children and adolescents was a significant concern of all workshops. This was claimed to be a "top priority" for resource allocation by many workshop participants. It was also, it appears, an altruistic priority for many ie. it is not a priority which could be said to have been aimed at meeting the particular needs of a large proportion of people participating in workshops.

The Government Discussion Paper response was noted as being "one small paragraph on page 23". This paragraph gave no recognition to the need for resource allocation and service development.

#### **Recommendations from Workshops:**

- \* That age appropriate mental health services be established at regional level.

- \* Establishment of multi-disciplinary assessment and service delivery protocols across government departments.
- \* Development of adequate child and adolescent inpatient facilities and day assessment and treatment services to enable appropriate assessment, treatment and where necessary, schooling on-site. In-patient units should be small, homelike and local.
- \* Development of inpatient facilities to stop the practice of holding mentally ill young people within the juvenile justice system.
- \* A significant increase in child and adolescent mental health professionals.
- \* All persons working with children and adolescents to be trained in the identification of "early warning signs" and be subject to and aware of appropriate referral policies.
- \* Establishment of a program targeted at "attention deficit disorder" to ensure appropriate intervention and to broaden treatment options from what is claimed to be a current over-dependence on medication.
- \* Training of health, community services and education workers about child and adolescent mental health.
- \* Development of "community level strategies" and "peer support strategies" to address issues of eg, youth suicide, alcohol and drug usage.
- \* Funding of non-government organisations to establish self help and support groups for troubled children and parents of troubled children.
- \* Establishment of child and adolescent services separately and under a different bureaucratic umbrella from adult services.

#### **7.4 People with Dual and Multiple Disabilities**

As reported in Chapter 4 of this report, workshop participants were particularly concerned at the narrow definition of "serious mental illness" which underlies the current National Mental Health Strategy and actual public mental health service provision. This concern is extended to a broader service system which appears intent upon "classification" rather than "response to psychiatric need".

The Government discussion Paper was again severely criticised for its lack of attention to the issues associated with multiple disability. Improved research is welcomed but it is required in far more areas than will be covered by the Drug

Abuse Research and Education Advisory Committee within the Department of Human Services and Health. Similarly, case management approaches are supported but must be addressed far more broadly than in the context of "vocational outcomes".

**Indeed, such narrow, minimalist and unco-ordinated responses by government form a large part of the difficulties experienced by people with dual and multiple disabilities.**

#### **Recommendations from Workshops:**

- \* Co-ordinated service provision by disability, mental health, drug and alcohol services with a - commitment to encouraging rather than blocking poly-service usage. This requires development of networking and case management mechanisms based upon consumer choice and preference.
- \* Establishment of case management mechanisms which enable dollars to follow the client and address client need. The South Australian Management Assessment Panel approach was considered relevant.
- \* Cross training of professionals in mental health, disability, drug and alcohol abuse etc. etc.

#### **7.5 Aboriginal and Torres Strait Islander People**

Workshops were held in several locations where Aboriginal and Torres Strait Island people were able to represent their own issues. However, those present issued a strong warning that this consultation process was clearly inadequate to the range and complexity of groups, to accessing the wide range of opinion and need. In other words, **many of those who took part in the workshop process were intensely conscious of their inability to represent all aboriginal groups. The consultation process was also limited in not having access to aboriginal presenters and interpreters. Workshop recommendations should be interpreted with this in mind.**

Nonetheless, there was a consistency about the views and recommendations which were presented. These were based on a clearly stated perception that aboriginal culture is just as complex as it was in the past and that the major mental health problems being experienced by aboriginals and aboriginal communities are the symptoms of past dispossession from land, family and culture; of fears regarding treatment by Welfare Authorities, Police and Health Services; and of actual and current inappropriate treatment from these services.

**For aboriginal communities in isolated areas there were particular concerns. The following picture concerning Central Australia was presented in a submission from Dr. Ofra Fried, District Medical Officer, Alice Springs Rural District:**

"There is one (1) only person - a psychiatric nurse - employed to provide community mental health services to the 12,000 or so people scattered in a multitude of communities throughout Central Australia.

"There are no Aboriginal mental health workers employed to provide any culturally appropriate services or support to this predominantly Aboriginal population.

"The only inpatient facility is Ward 1 in Alice Springs Hospital which is not in any way culturally appropriate.

"Availability and utilisation of **interpreters** is extremely limited. Many Aboriginals do not speak much English and many others speak Aboriginal English. As with other people of non-English speaking backgrounds or for whom English is their second language, communication becomes more difficult during situations of distress, and this is exactly when it is most vital that they are able to tell their story (or that of their relation or friend) accurately.

"Many Western **concepts** of mental illness and mental health are dissimilar to Aboriginal concepts. This underlays difficulties in the areas of research, planning, diagnosis and treatment. It also limits the acceptance of the (Western) treatment offered, by the patient and their family and community. Traditional ways of thinking about mentally disturbed people are not sought out, understood, or utilised by non-Aboriginal health providers. They nevertheless exist in a vital form in the lives of many Aboriginal people and inform their choices and actions.

"The **right; place to be**, for treatment or for safety, may not be the psychiatric ward. The disturbed person who is taken from his/her known world into that ward, which is alien in all respects, is not in a good situation for recovery. There may be ways of providing places more suitable, and more accessible to the patient's family.

"**Transport** of disturbed or potentially violent persons is often very difficult and is over huge distances. Air transport is sometimes possible but only with stringent restraint - both chemical and physical. It is costly, requires extra personnel, and because of the safety requirement for restraint may be invasive of the person's liberty. Neither is road transport an easy matter, and often the police are required to assist.

"**Distance** is also an issue when follow-up supervision and treatment is required. Our single nurse must cover 834,000 sq. kms. and cares for approximately 100 patients out bush. He has no assistant, no driver and no dedicated vehicle.

*"The **safety** of bush staff, whomust handle sometimes extremely **difficult** situations, is a vital issue. Many of them are single women (either Aboriginal Health Workers or nurses), and most are not psychiatrically trained, nor trained in the management of explosive or violent situations. They often have very **little** support, for example there may be no policeman, and no doctor for hundreds of kilometres.*

*"There is a great lack of understanding in so many areas relating to the provision of mental health care to Aborigines out bush . . . .*

*"... research needs to take into consideration the views, needs and wishes of Aborigines. What do they consider to be their main issues? Many Aboriginal communities are not keen on being the subjects of research, having been investigated in the past, with much benefit to academic scholars, but **little** to themselves. Many are understandably keen to have input into and control over the direction, the content and the outcomes of any investigations thift are done. Looked at from another point of view, a.03/ such research would be meaningless without Aboriginal.input, assistance and control."*

#### **Recommendations from Workshops:**

- \* Consultation with local groups regarding development of locally appropriate solutions.
- \* Holding of an Aboriginal and Torres Strait Islander mental health conference on a yearly basis.
- \* Establishment of traditional healing places in urban, rural and isolated areas.
- \* Development of a register of support services for aboriginal people.
- \* All relevant services must have aboriginal workers to assist, advise and educate. Such workers should be properly paid and recognised for the professional knowledge and expertise required of their role ie. cultural expertise must be seen as a valuable qualification in its own right.
- \* Create and develop a viable career structure for indigenous people in mainstream health settings.
- \* Development of educational programs for non-aboriginal workers regarding aboriginal culture and issues. There is a need for special programs to target discriminatory practices amongst Police and health professionals.
- \* Targeting of discriminatory practices within some

aboriginal services ie. it is claimed that aboriginal children who have a non-aboriginal parent are sometimes denied access to services.

- \* Establish training courses for aboriginal mental health workers through TAFE. In Darwin a pilot course has run as an extension of the aboriginal health workers course for the past year. There is currently great uncertainty about continued funding. Communities must be involved in identification, selection, employment of trainees and workers.
- \* Establish educational and culturalisation programs for dispossessed aboriginal people.
- \* In Townsville it was recommended that an Aboriginal and Torres Strait Islander Health Team be integrated into Mental health Services to provide a full package of education and training, community outreach and acute care services. This should occur within the next 12 months to two years.
- \* It was recommended in Queensland that state government funding for aboriginal issues needed to be increased and more appropriately administered. That is, funding should be directed to sustainable service provision and not be provided as a "...one off pacifying medium".

comments on Commonwealth Government Strategies:

A concern expressed almost universally amongst participants in workshops concerning Aboriginal and Torres Strait Islander People was a lack of faith in ATSIC administration and representation.

## 7.6 People from Non-English Speaking Backgrounds

Workshops were able to provide only limited input regarding the concerns of people from non-English speaking backgrounds (NESB). Indeed, it was thought that, in common with issues concerning Aboriginal and Torres Strait Islander peoples, there was a need for a consultation process which consulted directly and intensively with the relevant groups.

However, dissatisfaction with the lack of proposals for action in the Government Discussion paper was again a focus for workshop concern. The discussion paper proposes only to "consider" the recommendation of three recent reports and to "...ensure (that) access to interpreting services is part of the Public Patients Hospital Charter".

In contrast, workshops which expressed a reluctance to "*... have input without adequate representation*" were able to recommend as follows.

### **Recommendations from Workshops:**

- \* Establishment of interpreter services with adequate training in interpreting for mental health clients. ie. this is considered to be an area needing special skill.
- \* Establishment of service delivery protocols which require available interpreter services to be used.
- \* That the Australian Institute of Health and Welfare and the Australian Bureau of Statistics develop adequate data bases on the incidence and nature of mental health problems in NESB communities.
- \* That all NESB groups be surveyed in relation to mental health needs and appropriate service provision.
- \* That government demonstrate its commitment to NESB mental health by the provision of adequate and appropriate program funding. This should not be in the form of one off or annual project grants.
- \* That all mental health staff be given cross cultural training.
- \* That mental health services adopt a policy of recruitment and training of NESB staff.

### **7.7 Forensic Patients and Prisoners**

Concerns related to forensic patients and prisoners were most clearly represented in workshop groups concerned with Aboriginal and Torres Strait Islander issues and those concerned with rural and isolated areas.

#### **Recommendations from Workshop:**

- \* There was universal agreement that all prisoners affected by mental illness should be held in hospital facilities.
- \* Adequately funded, statewide forensic mental health services with direct working links to all regional mental health services should be established in all States/Territories.
- \* Regional mental health services, with assistance of statewide forensic mental health services, should provide mental health services to all Courts, local gaols and lock-ups.
- \* In Townsville, it was recommended that:

The recommendations from the Royal Commission into Aboriginal Deaths in Custody be implemented by way

of special legislation.

The application of these recommendations should be broader than Aboriginal specific.

A 25 bed "safe care unit" should be established within 3 years to cover the area from Mackay north.

The "safe care unit" should:

- have a university affiliation and a research and teaching function

- have a culturally appropriate staffing structure

- have a central location in Townsville

- provide services to both males and females

- offer advice and assistance to Courts on mental health issues

Relevant legislation should be reviewed to enable such a "safe care unit" to provide:

- good clinical practice

- good interaction with community and mental health services

- forensic services in the community.

## **7.8 Women/Gender**

There was some controversy in workshop discussion but general agreement that the issues related to gender and mental health required consideration in relation to both men and women. That is, incidence and type of mental health problem are known to vary by gender (eg. higher male suicide) and there is a need to understand this phenomena and respond to it appropriately.

The recommendations of the HREOC Report in regard to women were supported. However, there was a concern that the HREOC Report failed to recognise the importance of many of the issues identified by women eg. the issue of 'safety'.

The Government Discussion Paper was again criticised for an inadequate response. In particular, it was felt that a government strategy to "examine and raise awareness" about issues concerning violence and the links between violence and mental illness in women who access supported accommodation services skirted around the need to do something about an obvious and difficult problem.

Many participants were unaware of the content and thrust of the "National Women's Health Policy" so were unable to discuss fully the implications of the government's reliance on this strategy in addressing issues such as the needs of mothers who have a mental illness and their children.

Workshop participants focussed on the necessity to recognise and develop mechanisms for intervention in situations which potentially lead to or complicate the experience of mental health problems at a later stage. For example:

- Child abuse
- Sexual assault
- Domestic violence
- Loss and grief
- Attempted suicide
- Torture and trauma
- Conduct disorders
- Drug and alcohol abuse
- Homelessness

The first five "situations" in particular were seen as having specific relevance to a large proportion of women presenting with mental health problems. Service delivery responses were seen to be inadequate.

Workshop participants also identified the following particular concerns:

Mothers experiencing mental illness and their children, have particular needs in relation to accommodation and support.

A number of boarding houses and private hotels are not considered to be safe places for women.

For some consumers and carers who attended the workshops, living with mental illness means being "*... assaulted and sexually abused by staff*".

#### **Recommendations from Workshops:**

- \* Establishment of education programs for women in asserting their right to information and appropriate treatment.
- \* Legislative regulations to ensure that General Practitioners comply with the recommendation of the HREOC Report that they provide clear and comprehensive information about drugs which are being prescribed and about alternative, non-pharmaceutical treatments.
- \* Provision of specialised rehabilitation services to both perpetrators and victims of domestic and gender related violence.

- \* Recognition must be given to the fact that many women with mental health care problems also have difficulties related to sexual/emotional/physical abuse/assault. Assistance must be provided which goes beyond that of offering assistance to leave abusive situations. Assistance which stops and ends at that point is inadequate for those who are able to use it and is totally useless for those who are not able to utilise it.
- \* That Medicare provisions be extended to encompass provisions for payment of Psychologists.
- \* That there be grounded research into the relationship between gender and serious mental health care problems.
- \* That examples of best practice in women's mental health care be documented and the information disseminated.
- \* That all mental health services be required to examine and address issues of personal safety including gender related safety within their service.

## **7.9 cross Border Issues**

Consumers and carers who live in border areas (eg. Albury/Wodonga, Coolangatta/Tweed Heads, Australian Capital Territory) feel that Mental Health Departments have failed to recognise the special difficulties associated with cross border service provision. These include:

The development of different policies and treatment strategies by each State.

The necessity to involve two treatment teams when the inpatient facility very clearly functions according to a single State's legislation and admission procedures.

The problems associated with two pieces of legislation.

Staff development and education programs are only available to half a team in some cases.

Advocacy services funded from one State have no authority to act/support a client if they require hospital admission in another State.

Funding provided for public education cannot sensibly be provided to only half the town!

## **Recommendations from Workshops:**

- \* That there be National Mental Health legislation for the Protection of Persons with Mental Illness and for the

Improvement of Mental Health Care.

- \* That Mental Health Services should be funded on a regional basis and that regions be constructed across State boundaries where geographically and socially appropriate. (This may involve two States jointly funding a single team).

#### **7.10 Other**

Acquired brain injury and the difficulties faced by victims of torture and trauma were both raised as particular issues requiring attention.

There is an on-going concern that people with acquired brain injury are still being mis-diagnosed as mentally ill and/or held inappropriately in mental health facilities. A different but related concern is that of over medication as a means of "control".

The inadequacy of service provision to assist victims of trauma and torture was noted by workshops. Access to psychological services through medicare funding, establishment and funding of peer support groups and establishment and funding of specialist clinics to support both such strategies was seen as essential. Current specialist clinics are few in number and reliant upon voluntary and part time staff.

#### **Recommendations from Workshops:**

- \* Education of General Practitioners regarding acquired head injury awareness, treatment and care.
- \* Stricter guidelines on use of tricyclic drugs.
- \* Stricter control over prescription of drugs over and above recommended limits.
- \* Establishment of Clinics for victims of trauma and torture in regional centres.

## **Chapter 8**

### **LEGISLATION AND OTHER POLICY ISSUES**

The HREOC Report makes specific recommendations in relation to prioritising research, prevention, early intervention and the development of standards and accountability mechanisms. The requirement for nationally consistent Mental Health, Guardianship and Anti-Discrimination legislation; and some of the parameters of such legislation, are subject to specific recommendation in the HREOC Report. Other legislative recommendations concern the Federal Aged or Disabled Persons care Act, the National Health Act and the Social Security (Disability and Sickness Support) Amendment Act.

Workshop participants were supportive of these findings and recommendations and found as follows.

#### **s.1 state and Territory Legislation**

Workshop participants support the recommendations of the HREOC Report related to State and Territory legislation. They also supported action being taken by the Federal Government in relation to developing nationally consistent legislation based upon the United Nations Principles for the Protection of Persons with a Mental Illness and for the Improvement of Mental Health Care.

However, workshop participants would like to push the process of legislative reform one step further in light of the significant human rights and social justice issues associated with reform of mental health care. This is consistent with current approaches related to family law, industrial relations, Medicare and Aboriginal land rights.

Workshop participants recommended that all mental health legislation should be Commonwealth legislation, adopted by the states and Territories and applicable across Australia.

#### **.Recommendations from Workshops:**

- \* Development of National Mental Health Legislation based upon and guaranteeing implementation of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. such legislation should be developed with reference to:

equitable participation by consumers and carers in the legislative development process.

regular review of all compulsory treatment orders and long-term voluntary hospital placements.

Efficient and accessible appeal mechanisms.

Relevant information from carers should be taken into account at all legal proceedings.

All consumers should have access to legal representation before review, appeal and complaints tribunals.

The use of interpreters for people from non-English speaking backgrounds and for Aboriginal and Torres Strait Islander populations should be mandatory (subject to safeguards regarding availability and need).

Legislative and regulatory protections should also apply to the private sector.

There may be specific, culturally appropriate, legislative requirements for Aboriginal and Torres Strait Islander people.

- \* Amendment of State and Territory Incorporation Acts to remove provisions which make it impossible for people of "unsound mind" to serve on Boards of Management. Interpretation of these clauses is seen to be discriminatory and act as an impediment to principles of consumer empowerment and involvement in service provision.
- \* Development of clauses linking Mental Health legislation and Disability Services legislation. There is currently no mechanism for ensuring that the standards developed as part of Disability legislation are applied in the Mental Health arena.
- \* Mechanisms to ensure compliance with United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care.

## **8.2 Federal Legislation**

Workshop discussions related to Federal legislation considered the following issues:

- \* The Federal Government must take a more significant role in mental health as a way of overcoming inconsistencies between States, and current abuses found in mental health practice and legislation.
- \* The need for affirmative action on behalf of people with

a psychiatric disability in all areas covered by the Disability Services Program specifically, and in all other relevant areas of Commonwealth administration.

- \* The need to review private health insurance packages to ensure that their content or marketing strategy does not infringe the right of people with mental illness to obtain equal access to services.

#### **Recommendations from Workshop:**

- \* That all relevant Federal legislation must be amended to preclude existing legislative discrimination on the basis of mental illness.
- \* That Medicare be extended to encompass provision for payment of psychologists.

#### **comments on commonwealth Government strategies:**

- \* Changing Federal Government legislation to eliminate discriminatory provisions is welcomed. However, it is not enough. Unless specific priority is given to addressing the needs of people with a psychiatric disability, there is a belief that Departmental practices and current target groups will not change.
- \* overall the identified strategies were supported however, workshop participants felt there was too much emphasis on:

"reviewing"  
"examining the issues"  
"promoting access, etc"

rather than on actual action being taken.

### **8.3 Mental Health Research**

Workshop participants support the recommendations of the HREOC Report.

It was also stated that the allocation of research funds is heavily weighted in favour of medical interventions and the search for a "cure". There is a need to focus more research effort on the action research required to evaluate, test and develop service delivery, educational and self help approaches to alleviate the problems associated with mental illness and psychiatric disability.

In general however, it was felt that the overall amount of money allocated to research in mental health compares very poorly with that allocated to other areas.

Very little research funding is currently seen as being available to the non-government sector. There is inadequate assistance for this sector to apply for research grants and little support for the legitimate research methodologies which are likely to be applied. Research grants are perceived as going to " ... the same people to do the same sort of thing".

Workshop participants stressed that people using services must be given the opportunity to participate in the design and monitoring of research projects.

**Recommendations from Workshops:**

- \* That the Federal and State/Territory governments significantly increase funding available for mental health research.
- \* That an increased and significant proportion of research funding be devoted to the action research required to evaluate, test and develop service delivery, educational and self-help approaches to alleviating the problems associated with mental illness and mental health care.
- \* That the non-government sector be supported in the development and implementation of research programs.
- \* That consumers and carers be involved in the design and monitoring of research projects.

**comments on commonwealth Government strategies:**

- \* In light of concerns expressed regarding the direction of research funding workshop participants feared that the \$5m allocated to the National Health and Medical Research Council as part of the National Mental Health strategy would have too narrow a focus.
- \* Little is known in the field about how to apply for Research and Development Grants Advisory Committee funding.
- \* The National Health and Medical Research Council requires a strong mental health presence and representation.
- \* Strategies to improve the national data collection systems are supported. However, it was considered that ready access to and promotion of the information available was important.

## **8.4 Accountability**

Workshop participants support the recommendations of the Human Rights Inquiry related to accountability.

Workshop participants felt that service delivery standards need to be nationally consistent and not vary between the public and private sectors. Standards need to be monitored in a manner similar to that occurring in the nursing home area. Monitoring should be undertaken by independent teams of people. Such teams must include consumers and carers.

Consumers and carer are concerned to have input into the development of service standards. It was recommended that draft standards should form the basis for a national consultation process to be undertaken by the national community Advisory Group.

The need for a national system of advocates and advocacy services was a significant concern raised by workshop participants. Participants expressed the view that advocacy services should be Federally funded to facilitate the monitoring of State services free from the threat of funding withdrawals in a situation where criticism is not well received. Advocacy services must relate closely with individual consumers and carers and not become too legalistic.

NCAG and State/Territory Community Advisory Groups are perceived to be in a position to keep governments accountable. Their role in this area needs to be expanded and supported.

Non-government organisations are also considered to have a role in ensuring accountability of government services and Departments. However, some non-government organisations have been threatened with funding cuts when they have taken their advocacy role seriously. Some non-government organisations reported that they had been told specifically they would be de-funded if they took concerns direct to the relevant Minister.

The overwhelming issue raised when discussing accountability was how to make mental health professionals, psychiatrists and nurses in particular, accountable to consumers and carers.

Psychiatrists are seen as not being accountable to anyone. There appears to be no adequate system to address complaints regarding their behaviour. The Royal Australian and New Zealand College of Psychiatrists is not perceived as taking consumer or carer complaints seriously, or of acting upon them effectively. This situation is particularly difficult for rural people who have few choices in terms of being able to "vote with their feet".

### **Recommendations from Workshops:**

- \* That the Federal Government develop a National Advocacy Program and fund non-government organisations to provide Advocacy Services for people with a mental illness or psychiatric disability.
- \* That generic disability advocacy services receive increased funding to facilitate a focus on psychiatric disability. The implementation of this would require careful monitoring to ensure an appropriate shift in focus.
- \* That consumers and carers be actively involved in the development and monitoring of standards of service delivery.
- \* That consumers and carers be appointed as "Official Visitors" to ensure services are accountable.
- \* That the Royal Australian and New Zealand College of Psychiatrists involve consumers and carers in the development, establishment and monitoring of mechanisms to ensure that Psychiatrists are held accountable for service provision to consumers and carers.
- \* That the National Community Advisory Group and State Community Advisory Groups be resourced to undertake an active monitoring role of policy development and service delivery in the public, private and non-government sectors.
- \* That the Federal and State Governments and the National Community Advisory Group be required to report accurately on activities and consumer involvement in the National Mental Health Report.

### **comments on commonwealth Government strategies:**

- \* Standards must also cover the private and non-government sectors. Consumer and carer involvement from the public, private and non-government sectors is essential in the development of standards. The National Community Advisory Group must undertake consultation on a national basis in relation to draft standards.
- \* Standards should be consistent with those applicable in Disability Services.
- \* The Australian Council on Health Care and Royal Australian and New Zealand College of Psychiatrists clinical indicators project is considered likely to:

be too focussed in its outlook

have produced very little to date

be costing too much.

- \* The Royal Australian and New Zealand College of Psychiatrists must improve its quality monitoring practices and address the significant issues related to:

attitudes held by psychiatrists to consumers, and the processes for re-accreditation of psychiatrists.

- \* The quality monitoring processes of other groups eg. Nurses also require examination. Such examination might also benefit from assistance by the Commonwealth.

- \* The development of a National Minimum Mental Health Data Set is supported, providing consumers and carers are involved in this process and that confidentiality can be assured.

- \* It was considered that the National Report on Mental Health will only be of use as a mechanism for accountability if:

It is written in plain English.

It is truthful.

It is readily available.

Mechanisms are developed for consumers to provide feedback as to its accuracy and the impact that any changes made have had on them.

**APPENDIX 1**

**WORKSHOP TIMETABLE**

| <b>City</b>   | <b>Date</b> | <b>Time</b>  |
|---------------|-------------|--------------|
| Melbourne     | Feb 14      | 9.30 - 4.00  |
|               | Feb 15      | 9.30 - 4.00  |
| Launceston    | Feb 16      | 9.30 - 4.00  |
| Hobart        | Feb 17      | 9.00 - 3.30  |
| Albury        | Feb 18      | 9.00 - 3.30  |
| Canberra      | Feb 21      | 9.30 - 4.00  |
| Sydney        | Feb 22      | 9.30 - 4.00  |
|               | Feb 23      | 9.30 - 4.00  |
| Lismore       | Feb 24      | 11.30 - 5.00 |
| Brisbane      | Feb 28      | 9.30 - 4.00  |
| Townsville    | Mar 2       | 9.30 - 4.00  |
| Alice Springs | Mar 7       | 12.00 - 6.00 |
| Darwin        | Mar 9       | 9.30 - 4.00  |
| Broome        | Mar 10      | 9.30 - 4.00  |
| Port Augusta  | Mar 14      | 11.00 - 3.30 |
| Adelaide      | Mar 15      | 9.30 - 4.00  |
| Perth         | Mar 17      | 9.30 - 4.00  |

**APPENDIX 2**  
**MEETING PROGRAM**

**9.30 - 10.30                      INTRODUCTION**

**10.30 - 11.45                      WORKSHOPS BLOCK 1**

All participants to consider in small groups:

What does your group see as the priority issues  
for this state? Can you prioritise them in order  
of importance?

**11.45 - 12.30                      PLENARY 1: REPORT BACK**

**12.30 - 1.30                        LUNCH**

**1.30 - 2.45                        WORKSHOPS BLOCK 2**

Workshop topics will be determined by reference to priorities  
identified in Workshop Block 1. Questions to be asked are:

What needs to be done? Who needs to do it? e.g.  
Government (which and which Department), non-  
government organisations, Consumers, Carers,  
Private Sector...? How can we best be part of the  
process?

**2.45 - 3.00                        AFTERNOON TEA**

**3.00 - 4.00                        PLENARY 2: REPORT BACK AND SUMMARISE**

There will be a recall of the question:

**How can we be part of the process?**

### **APPENDIX 3**

#### **ATTENDANCE AT WORKSHOPS**

##### **Melbourne**

###### **Day 1**

Attended by approximately 80 people of whom the majority, (approximately 75%) were consumers. Only small numbers of health professionals attended.

A specific group was established to look at priorities for examining issues from a carers perspective. Only three people elected to participate in this group.

###### **Day 2**

Attended by approximately 60 people of whom approximately 60% were consumers. Specific issues of complaint in relation to the Federal Government Discussion Paper were raised very vocally by non-government organisation service providers.

##### **Launceston**

Attended by approximately 30 people, the majority of whom were carers, however at least 40% were consumers.

##### **Hobart**

Attendance of 70, the majority carers and some health professionals.

##### **Albury**

Attendance of 27, primarily service providers (including some afrom the intellectual disability area) and carers. The small Wnumber of consumers present made significant contributions.

##### **Canberra**

Attendance of approximately 35 at various times during the Pday, including a group of 7 student nurses with a tutor. c Consumers very much in the minority.

##### **Penrith**

Attendance of approximately 35, including approximately 10 rAboriginal and Torres Strait Islander people who made specific frecommendations in a number of areas but cautioned against the use of these without much wider consultation.

### **Sydney**

Attendance of 47. Mix of Service Providers, non-government organisations, carers and some consumers. Service Providers have not brought consumers with them.

### **Lismore**

Attendance of 55. Good mix of consumers, carers, service provides. All participated very vocally in the workshops.

### **Brisbane**

Attendance of 130+. Unique situation - how to manage such large numbers. Twelve workshops conducted simultaneously. People stayed in the same groups both morning and afternoon and were able to develop very specific recommendations.

### **Townsville**

Attendance of 42. Eight groups run, four in the morning and four in the afternoon.

### **Alice Springs**

31 people attended. About 80% were professionals although most were from areas other than direct mental health service delivery. There was a small .group of consumers and a smaller group of carers.

### **Darwin**

Consumers and Carers were solidly represented in the 31 who attended.

### **Broome**

The group in Broome was small with only six people in attendance. Discussion of the issues affecting isolated areas was vibrant.

### **Pt. Augusta**

Attendance of 26 was drawn from the Pt Augusta, Whyalla, Pt. Pirie areas. There was a mix of community service workers, consumers and carers.

### **Adelaide**

92 people attended in Adelaide. There was strong representation from consumers and carers and community workers from a range of areas of interest.

### **Perth**

A total of 112 registered on the day.