Stepping Up:
A Social Inclusion Action Plan for Mental Health Reform 2007-2012

South Australian
Social Inclusion Board

Throughout this Report the term 'Aboriginal' is used to include all Indigenous people in South Australia.

Contents

Acronyms

ACIS	Assessment and Crisis Intervention Service
ADHD	Attention Deficit/Hyperactivity Disorder
AHA	Australian Healthcare Association
ALGA	Australian Local Government Association
BAS	Behavioural Advisory Service
CAMHS	Child and Adolescent Mental Health Services
CHS	Country Health Service
CMHT	Community Mental Health Team
COAG	Council of Australian Governments
COPMI	Children of Parents with a Mental Illness
CRC	Community Rehabilitation Centre
CRD	Centre for Reviews and Dissemination
CYFS	Children, Youth and Family Services
DFC	Department for Families and Communities
DH	Department of Health (UK)
DRG	Diagnostically Related Group
FTE	Full-time Equivalent
GAD	Generalised Anxiety Disorder
GP	General Practitioner
HHTF	Homelessness and Housing Taskforce
MBS	Medical Benefits Scheme
MIFSA	Mental Illness Fellowship of South Australia
NGO	Non-Government Organisation
NHS	National Health Service (UK)
PBS	Pharmaceutical Benefits Scheme

RAH	Royal Adelaide Hospital
RAISE	Regional Aboriginal and Islander Social and Emotional Wellbeing
SACE	South Australian Certificate of Education
SACHA	South Australian Community Housing Association
SAHT	South Australian Housing Trust
SRF	Supported Residential Facility
WHO	World Health Organization

A message from the Premier

Throughout Australia and, indeed, the world, attitudes to mental health are changing.

Stigma and denial are giving way to awareness, acceptance and understanding.

As a result, thousands of South Australians suffering from anxiety, depression and a range of other mental illnesses are today coming out from under the shadow that has long darkened their lives.

There is today a stronger emphasis on being frank about mental health, on intervening early in order to prevent illness, and on getting people back on track so that they can enjoy rich and rewarding lives.

The importance our State places on mental health is reflected in the fact that a firm target for the reduction of "psychological distress" has been included in *South Australia's Strategic Plan*.

It is in this social and policy context that I asked the Social Inclusion Board to have a close look at South Australia's mental health system, and to recommend ways in which it might be modernised, reformed and improved.

Under the leadership of its Chair, Monsignor David Cappo, the Board undertook research, obtained expert opinion and – by talking to hundreds of people across South Australia – carried out one of the most extensive programs of public consultation on mental health in the history of our State.

The result of that effort is this outstanding report, *Stepping Up*, which examines a wide range of issues, offers 41 recommendations for change, and maps out a five-year action plan.

On behalf of the State Government, I sincerely thank Monsignor Cappo and the Board for their insight, hard work and dedication to the cause of mental health.

The Government warmly welcomes *Stepping Up*, and it will carefully consider this thoughtful plan with the aim of bringing about even greater change for the better.

Mike Rann
Premier of South Australia
Minister for Social Inclusion

Foreword from the Commissioner and Chair of the Board

This report lays out a detailed five-year action plan to reform the mental health system in South Australia and to provide better, more responsive services and an integrated system of care. In doing so, the Board believes this will give much needed hope and deliver increased wellbeing for many South Australians.

Improving the wellbeing of the community of South Australia is the prime objective of the work of the Social Inclusion Board. We carry out this work by focusing our energy on addressing major social needs in our community. That is why when the Premier, Mike Rann, gave the Social Inclusion Board the mandate in August 2005 to prepare a major reform plan for the Mental Health System in South Australia, we knew that we had been given a very serious responsibility, one that we have not taken lightly.

Far from being overwhelmed by this responsibility, the Social Inclusion Board immediately set out with a clear resolve to provide the Government and the community with a plan of action for effective and rapid reform of our mental health system. The report *Stepping Up* is the result of our work. The report is so named because the Board has put together a newly developed stepped system of care. People who need mental health services will enter the new stepped system at the level their need demands and if necessary, they would move from step to step as their progress or regress requires. This new system of less intensive to more intensive services will be well integrated and clearly focused on the recovery needs of people.

In order to find out what was wrong with the old system of mental health—a system that had not received any major reform for decades— we needed to know what was working and what wasn't working well in our mental health services. We wanted to know what the community thought about the system, particularly those South Australians who have been consumers of mental health services, their families, their carers, and their professional helpers. We gathered an enormous amount of information locally, nationally and from expert advisers internationally. We are confident that the results of this work will mark a new and hope filled era in mental health in this state. I am sure that when this action plan is implemented South Australia will have a mental health system that is world class, fiscally responsible, consistent with the National Mental Health Plan, in harmony with the Commonwealth Government's initiatives in mental health and second to none in Australia.

The development of *Stepping Up* has truly come from the community. A great many people have been involved in working on this plan and I want to acknowledge with deep gratitude their generous commitment and expertise. I want to give special mention to those who are currently
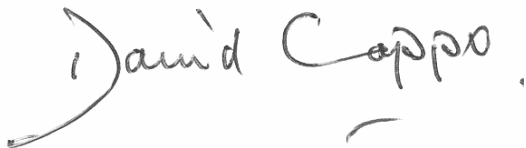
working in the mental health system. They are very dedicated people doing a great job. *Stepping Up* honours their work and provides them, and those new workers who will be drawn to the new system, with increased resources and hopefully less pressures.

The non-government sector has been outstanding in its support and generous giving of wisdom in our ongoing discussions. And many professionals in the field, as well as public servants in many government departments, have helped us to put together a 'joined-up' plan, a term that has been uniquely applied in the work of the Social Inclusion Board to mean new and innovative linkages across a wide range of government departments. The reader will note these unique linkages in these pages as *Stepping Up* responds to the varied, and at times, complex needs of people who will use the mental health system.

Above all, I wish to thank the members of the Social Inclusion Board and the Social Inclusion Unit. You have all shown not only a firm grasp of the social needs of the community, but also good strategies to properly answer our social needs.

And to our Premier, Mike Rann and to Gail Gago, the Minister responsible for the implementation of the Government's response to this report, I thank you both for your confidence in us in carrying out this important role for the community of South Australia.

I submit the report *Stepping Up*: *A Social Inclusion Action Plan for Mental Health Reform 2007-2012*, to the Government of South Australia for its consideration.

Monsignor David Cappo
Commissioner for Social Inclusion
Chair, Social Inclusion Board

Recommendations

DEVELOPING A PEOPLE-CENTRED SYSTEM

Recommendation 1

People with a mental illness who are consumers of the state's mental health services should participate at all levels of the system. This will require innovative ways of ensuring their meaningful involvement in planning, organising and evaluating services.

Recommendation 2

The carers and families of consumers must be seen as partners in the care process. They should be included in care planning processes, with the agreement of the consumer, and receive timely and appropriate information and support.

UNDERSTANDING THE PEOPLE WHO USE THE MENTAL HEALTH SYSTEM

Recommendation 3

The analysis of the people who use the current mental health system indicates that Aboriginal people, people who live in the country and people with complex needs should be considered as populations that require a specific focus in the implementation of the recommendations throughout this report.

Recommendation 4

The Department of Health should work from an "'understanding people as individuals" approach to planning mental health reform and delivery of mental health services. A people-centred approach means that consumers are recognised when they enter, re-enter or move through the different pathways across the system.

Recommendation 5

In support of a people-centred approach to planning, the Department of Health must ensure that it can report accurately and regularly on the numbers of individuals, their profiles and their interaction with the mental health system. Community mental health services must develop a system of individual (unique) identification that can become inter-operable with inpatient data collections.

IMPLEMENTING A STEPPED SYSTEM OF CARE WITH COMMUNITY SERVICES AT ITS CENTRE

Recommendation 6

The South Australian mental health system should fully adopt a recovery orientation that is focused on helping people dealing with mental illness to live a satisfying, hopeful and contributing life.

Recommendation 7
The principles of recovery should be translated into organisational cultural norms and behaviours that must apply across the system.

Recommendation 8
A stepped system of care must be implemented, ensuring there is sufficient volume at each level of care from the least to the most intensive–supported accommodation to community rehabilitation to intermediate care, acute care and secure care. The aim is to maintain the system in balance and guarantee recognition for people who present at each step. The Board supports using the modelling work of Andrews and Associates as the basis for planning and designing a stepped system for South Australia.

Recommendation 9
The Chief Executive of the Department of Health should take direct leadership responsibility for ensuring system redesign benefits Aboriginal people. A leadership group will be required who will undertake strategic audits of progress against key measures and report to the Chief Executive on progress and options for improvement.

Recommendation 10
Community mental health services must be situated at the centre of the system by:
- allocating lead responsibility to them for all facility-based and community care other than acute and long-term hospital care
- reorienting their functions and structure to implement the stepped system of care
- organising services across adult, older people, and child and adolescent sectors around geographic catchment areas to support a population health approach
- establishing formal networking to drive practice consistency and improvement within and across catchment areas.

Recommendation 11
The community mental health service should hold and manage funds that are linked to reform. Transition funding and the reinvestment of funds that can be freed up through implementation of the Plan must be enveloped and managed carefully. The arrangements will require extensive discussion and the development of a detailed model to ensure rigour and accountability.

Recommendation 12
In designing and implementing the reforms of community mental health services, it is essential that the Department of Health pay particular attention to the unique circumstances of country South Australia. This should be reflected in defining the country catchment area and in the functioning of the clinical networking, as well as in the community teams themselves and the Rural and Remote Mental Health Service.

Recommendation 13
South Australia should invest in facility and non-facility based intermediate care as an integral part of a stepped system of care.

Recommendation 14
Intermediate care should provide holistic nurse-led care. It should be planned, managed and evaluated on the basis of increasing responsiveness and choice for consumers, reducing the state's reliance on acute and emergency or unplanned admissions and, in collaboration with community mental health services, effective management of the pathways between hospital and home.

Recommendation 15
Mental health services must establish a focus on people with chronic conditions and complex needs. The requirement is to provide co-ordinated care that is supported by a joined-up approach across Government.

Recommendation 16
South Australia must advance a systematised response to people with dual diagnosis. This system must be particularly responsive to people with complex needs.

Recommendation 17
In implementing this response to complex needs, it is essential that privacy principles are not misused or misapplied so that information is not shared between agencies or with carers. This requires careful consideration by agencies of how they fulfil their duty of care, the process they use for gaining informed consent to share information and how they involve consumers in planning for potential future relapses.

Recommendation 18
People with chronic conditions and complex needs who are involved with the justice system should be a core client group for the focused and co-ordinated response to people with complex needs.

Recommendation 19
South Australia should continue to build the capacity in the non-government sector to deliver psychosocial rehabilitation and support services. The development should be framed within a partnership approach that builds on a system that will have community mental health at its centre.

Recommendation 20
South Australia should reassess its current investment in services provided by non-government organisations, based on the evidence from the evaluation that is due for completion in early 2007. A new and more rigorous contracting process that builds on the concepts of the stepped system is warranted. Rehabilitation and support services should be focused on helping people to step down from formal care to maintaining ordinary associations in society that support a meaningful life.

DEVELOPING A WORKFORCE FOR THE FUTURE

Recommendation 21
The Department of Health must immediately commence structured workforce planning that is geared to sustaining staffing levels in specialist services, to support a stepped system of mental health care.

Recommendation 22
Short, medium and long-term workforce development planning and initiatives need to be co-ordinated across government and non-government sectors. There must be a dedicated plan for improving training, recruitment and retention of Aboriginal people in clinical positions.

Recommendation 23
The Department of Health should negotiate private practice rights for psychologists to enhance their career development and support recruitment and retention. Other allied health professions should be encouraged to negotiate similar private practice rights.

Recommendation 24
The Department of Health should establish a job redesign strategy for the mental health system across the continuum of activity from incremental change in existing roles, to designing new jobs that support a mental health system that puts people first and is recovery oriented.

FOCUSING ON PREVENTION AND EARLY INTERVENTION

Recommendation 25
The impact of early childhood mental health promotion and prevention interventions should continue to be highlighted. Planning and staff development for programs supporting children during their early years should increase their focus on achieving such an impact.

Recommendation 26
The Department for Education and Children's Services and the Department of Health should negotiate the design of an integrated system for responding to children and young people with serious mental health or behavioural problems.

Recommendation 27
South Australia should be working towards professional school-based counsellors working in partnership with specialist child and adolescent mental health services.

Recommendation 28

Child and Adolescent Mental Health Services should remain as specialist services. However, they should operate functionally within their catchments to support a range of primary mental health care services to ensure that young people and their families experience seamless services. Aboriginal children and young people need to be regarded as a priority population.

Recommendation 29
The human and economic benefits of early intervention for younger people with early psychosis must be promoted. South Australia must fast track the development of a response to first episode and early psychosis, sited and managed as a specialist service. Careful planning and consideration must be given to appropriate settings and young people should be involved in the design and development of the program. Family interventions, education and support must be elements of the program.

Recommendation 30

In the context of the National Mental Health Action Plan, South Australia should:

- align the recommended developments in private practice rights for psychologists and other allied health staff with the National Action Plan.

- develop mental health nurse practitioner roles in country South Australia. The focus should be on access for people who are at risk because of shortages of GPs and a limited pool of visiting psychiatrists

- align the South Australian Government's commitment to the Healthy Young Minds Initiative with the MindMatters national initiative that aims to embed promotion, prevention and early intervention activities for mental health and suicide prevention in secondary schools in Australia

- align with developments in the field of guided self-management, including web-based technologies, that could be incorporated into specialist practice. particularly for rural and remote communities

- work with the Commonwealth to implement a universal system of routine depression screening by general practitioners and for hospital inpatients.

Recommendation 31

South Australia must have a clear plan of action for the future management of long-term aged residential care that is consistent with good practice and contemporary policy. A focus on earlier intervention is required, ensuring that people at risk and needing specialist services are identified and given priority access to services. Partnerships with the Commonwealth and aged care providers are essential to deliver a scalable and sustainable response.

REDEVELOPING GLENSIDE AS A CENTRE FOR STATE-WIDE SPECIALIST SERVICES

Recommendation 32

Recent international developments and the practices of the private hospital sector in Australia, should be taken into account in the design and management of mainstreamed mental health inpatient services. This is particularly with regard to the amenity of facilities and the recognition of the therapeutic value of space.

Recommendation 33

The South Australian Government should build on its commitment to retain Glenside and redevelop it as a stand-alone centre for state-wide specialist mental health services.

Recommendation 34

The principles that are contained in the Board's report should be used to guide the redevelopment to ensure that it delivers the desired structural and functional renewal of Glenside. The whole redevelopment should encourage every day interaction between the people who are using mental health services and the general community.

Recommendation 35

Establish a specialist service for Aboriginal people and locate it at Glenside. Co-location with the other specialist services proposed for Glenside–including

the drug and alcohol service and the early psychosis service–will benefit Aboriginal people. The specialist service will be supported by a dedicated research effort in Aboriginal mental health care.

ENCOURAGING AGENCIES TO WORK TOGETHER

Recommendation 36
The five mental health Partnerships for Joined-up Government that have commenced work should continue. Completing their agendas to deliver co-ordinated and where required, integrated responses to mental health issues are essential to the stepped system of care.

Recommendation 37
Reporting on the progress of the Partnerships should be formalised through the establishment of an Inter-Ministerial Committee, chaired by the Minister for Mental Health and Substance Misuse and supported by senior officials.

TACKLING STIGMA AND DISCRIMINATION

Recommendation 38
The South Australian Government should develop two campaigns:
- A targeted awareness campaign on the changes to the Equal Opportunity Legislation to protect people with a mental illness from discrimination.
- A 'slow stream' public health campaign under the banner of 'An Open Mind' to educate the community on the facts about mental illness and promotion of positive messages about people dealing with mental illness.

Recommendation 39
An Across-Government Action Plan should be developed and implemented to ensure that the South Australian Government is an exemplary organisation in managing the psychological wellbeing of employees and in the employment of people with mental health issues.

IMPLEMENTING THE PLAN – MAKING IT HAPPEN

Recommendation 40
The South Australian Government should implement the Social Inclusion Board's Plan of Action for the reform of the mental health system over five years.

Recommendation 41
In planning for the implementation of the Board's recommendations, the Department of Health must ensure that consumers, carers and families have meaningful input at all levels.

INTRODUCTION

The Premier of South Australia, Hon Mike Rann MP, referred mental health reform to the Social Inclusion Board in August 2005. He did this in the context of widespread community concern about the system's responses to people experiencing mental health conditions. The Premier requested advice on how to redesign the system to deliver improved outcomes for these people and for their families and carers.

Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012 presents this advice.

The Board's vision for mental health services in South Australia is that they are people-centred and recovery-oriented, so as to realise the hopes and aspirations that consumers and their families have communicated to the Board.

Stepping Up presents a course of action that must be taken if this vision is to become a reality. In summary:

- South Australia has to get back to knowing the people who use the services and recognising them in service development and delivery as individual people, each with their unique needs and life circumstances.

- This is a plan for all South Australians. It calls for a scalable and sustainable system for country South Australia. Development may look different on the ground in the country and not all services can be provided in country locations, but there should be equity of outcomes for all people.

- The plan also focuses on delivering improvements and better investment in services for older people, better integration of child and adolescent services and comparable outcomes for Aboriginal people.

- The Board has made specific recommendations on how the state can deliver the responsiveness and continuity of care that people and their families are looking for. This includes a stronger focus on early intervention, providing the full range of facility-based services required to reduce reliance on emergency and acute services and putting community services at the centre of the system.

- Glenside has a pivotal role in the Board's plan. Re-developed with new infrastructure to reflect a modern mental health system, it will

The Board's vision is to support people's recovery and help them to realise their aspirations for a meaningful life.

The plan must deliver outcomes for all South Australians including people in the country, older people and Aboriginal people.

be a place for the delivery of state-wide specialist mental health services.

- Finally, the Board recommends how South Australia must use the frameworks and the mechanisms of social inclusion. In its essence, this is a report on how to support people with mental illness to lead the satisfying and hopeful lives they so desire.

The frameworks and mechanisms of social inclusion are essential for people to achieve their goals in life.

LISTENING AND RESPONDING

Consultations

The first step for the Social Inclusion Board in formulating this advice was to consult widely with people involved with mental health in South Australia. It was clear from the outset that the success of any project to reform the mental health system would be dependant on engaging with the views of people with a mental illness, their carers and with those of service providers.

In total, over 1400 people were formally involved in the consultation process. In addition, various interest groups have presented their views to the Board. Members of the Board and the Social Inclusion Unit met with interested groups and individuals upon request. The Board, without bias or favour, has considered the full array of opinions.

> The Board consulted widely and, without bias or favour, has considered the full array of opinions.

The Board's consultation process

The consultation process with service users and providers included the following elements:

1. A phone-in was widely advertised and held 27-30 March 2006. A total of 288 phone calls were received with just over three in every five callers (61%) living in the metropolitan area. Consumers (29%) and carers (31%) accounted for 60% of callers.

2. An on-line survey was also advertised, to which 528 people submitted responses. The respondent category breakdown was as follows: consumers (10.8%); carers (9.1%); concerned citizens (10.5%); and health care providers (21.7%). The largest group was the 'other' category (34.1%), of which four in every five respondents (148 in total) were principals or teachers.

3. Four perspective panels – consumers and advocates, professions and workforce organisations, non-government organisations, public sector managers – were each convened for three meetings, chaired by Board members. Between December 2005 and April 2006 specific consultations with country South Australia and with Aboriginal people occurred in parallel with the panel meetings. A communiqué from each of the panels and the country and Aboriginal consultations was presented to the Social Inclusion Board for consideration in May 2006.

4. A reference group was established, comprised of 4-6 members from each panel and participants from the Aboriginal and country consultations. The communiqués provided the foundation of the discussion and debate. The Reference Group met on six occasions between May and August 2006 to discuss and build consensus regarding the following issues:
   - Policy drivers
   - Primary and intermediate care
   - Psychiatric disability, housing, rehabilitation and support services
   - Priority populations
   - Community-based clinical mental health care
   - Workforce.

The Board commissioned extensive research, examined the evidence and considered the advice of experts. Consideration was also given to developments in mental health policy in other states. Drawing on experience from its other references, as well as the evidence base, the Board has developed its advice on mental health reform within a social inclusion framework.

In undertaking its analysis and drawing its conclusions, it is the trust and hope for the future that people dealing with mental illness have placed in the Board that is the driving force behind the change agenda proposed in this report.

Context

The Board prepared this report to the Government at a time when there were several wide-ranging inquiries and important national developments in the area of mental health.

In August 2005, just as the Board was receiving its mental health reference, the Mental Health Council of Australia, the Human Rights and Equal Opportunity Commission and the Brain and Mind Research Institute released its review report, *Not for Service.* The report captured the current critical themes in mental health care from the perspective of those who use and deliver its services on a daily basis.

In December 2005, the National Mental Health Report (2005) was released and provided a ten year review of trends across the First and Second National Mental Health Plans.

At the same time the Senate Select Committee on Mental Health was finalising its investigations into the service system and delivered a comprehensive report in March 2006.

The Council of Australian Governments (COAG) released the *National Action Plan on Mental Health 2006–2011* in July 2006 that emphasises coordination and collaboration between government, private and non-government providers to deliver a more seamless and connected care system.

The South Australian Government commissioned a review of legislation relevant to mental health. In response to the resulting Bidmeade Report (2005), the Government has committed itself to reforming mental health legislation in South Australia.

The Board values the insights and understandings that have come from these investigations. They provide an important underpinning for the philosophy and direction of the Board's advice. The Board has built on

them to develop the reforms necessary to achieve a better system for mental health care in South Australia.

The Board recognises that a new system needs to fit into the national framework with clear understandings of responsibility between the Commonwealth and States and Territories. The Board has monitored the COAG process and its outcomes and took these into account in the deliberations that led to this report. This has been important for the Board in determining the scope of its advice to the South Australian Government.

Figure 1:   Focus of Board's advice in the context of Commonwealth and state responsibilities

State Responsibilities		Commonwealth Responsibilities
State Funded Primary Health Care	*COAG *Shared Care	Primary Health Care MBS & PBS
*Public Sector Specialist Mental Health Services and contracted NGOs		Private Specialist Mental Health Services
Employment, Training, Housing, Aged Care, Disability, Justice	*Social Inclusion Joined-Up	Employment, Training, Housing, Aged Care, Drug and Alcohol Services

*Focus of Advice

It is the Board's understanding that the State-funded mental health system is and should remain a specialist service. It should focus on providing services to those people who have serious conditions that require responses not readily available in the community or that require specialised expertise. Widening the range of people cared for by a specialist mental health system when it is not required has the potential to do more harm than good[1]. It also does not make good economic sense. Managing people in the normal settings of primary health care reinforces the fact that most mental health conditions are common problems and people should not, through shame or prejudice, fail to seek treatment through their general practitioner.

Focusing the specialist mental health system on people with serious conditions is sound practice and makes good economic sense

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[1] Baicker, K and Chandra, A, *Medicare Spending, the Physician Workforce and Beneficiaries' Quality of Care*, Health Affairs, 2004.

What we heard

The messages to the Board were clear and consistent from a range of perspectives and across the consultation:

- Consumers, carers and families want the system to understand and recognise them as individuals.
- Consumers want to access the services they need, when they need them.
- There should be more flexibility and choice tailored to people's individual circumstances.
- The hope for recovery must be consistently reflected in day-to-day practice.
- Carers and families want to be appropriately involved in planning and providing the care for their family member.
- Transitions between hospital and home are particularly difficult, especially with the system geared to deal with crises and emergencies, but less positioned to prevent a crisis occurring or to support the transition to a rehabilitation process in the community.
- Some people with complex needs and chronic conditions are not assertively followed up and get 'lost from the system' until they have another crisis.
- Stigma and discrimination are still issues.
- People with severe mental illness continue to be socially excluded.
- Issues relating to recruitment and retention of staff and workforce morale must be addressed.
- Leadership accountabilities and responsibilities between the Department of Health and the health regions need to be clearer.

Defining the problem

South Australia has an imbalanced mental health system with pathways that are congested and crisis-driven.

Having analysed these messages, the Board has concluded that the over-arching problem is a state specialist mental health system that is out of balance. People do not have appropriate accommodation or care to remain well in the community and avoid hospital admissions. When people need more intensive care, there are very few options for those who do not necessarily require an expensive hospital bed. Hospital beds are not then readily available for people with more urgent requirements and people are discharged with limited planning to make way for emergencies. The pathways of care that link the system are not currently managed to support responsiveness or continuity.

A system out of balance

South Australia:

- has overall 23 acute beds per 100 000 population compared with the national average of 19.9 and the Victorian level of 19.5
- spends at above national average levels on clinical community mental health services
- spends well below national average levels on community non-clinical care for people with mental illness (usually provided through non-government organisations)
- has an undersupply of supported accommodation places for people with mental illness.

The current configuration of the clinical system is based on a linear pathway — admission to treatment to discharge.

Figure 2:   Current system — configuration of care pathways
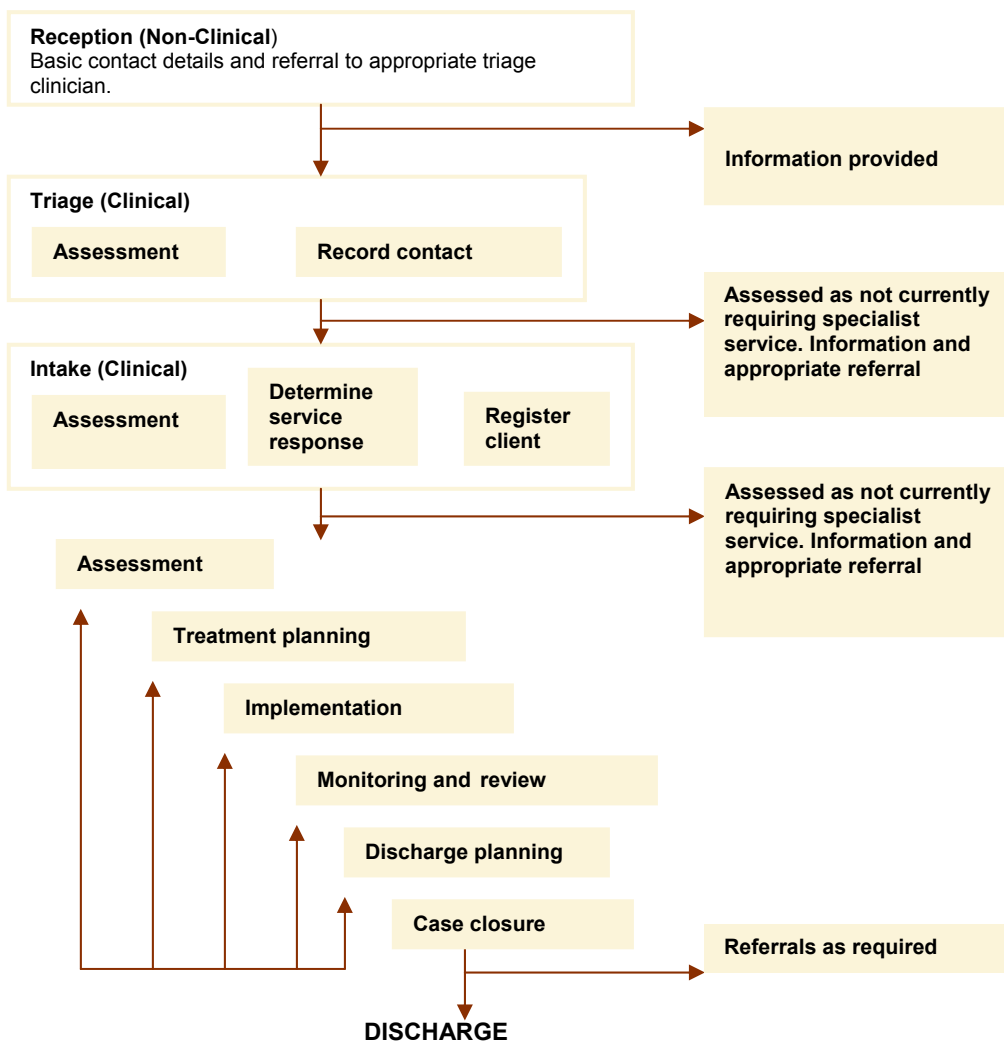
It is assumed that people will move through the system. Many people are on a 'slow stream' and remain in treatment for long periods, unable to move forward on their recovery goals. People get stuck in hospital because there are no other appropriate options, while others return a number of times because the transition to community is not managed.

Once discharged, consumers have no guaranteed re-entry or of being 'recognised' if they do. Re-entry is usually through a single entry crisis gateway (e.g. emergency departments in public hospitals) and generally treated as a new episode of illness, not a continuation of the previous episode.

Of greater concern is the fact that there is no consistency in the delivery of care across community specialist services. There are differences in responses between regions, within regions and between teams working from the same service models. The interfaces between child and adolescent services, adult services and services for older people are not generally managed for flexibility or to support continuity of care.

The result is that people have to navigate around the system, rather than the system being managed around the people.

This goes to the very heart of the frustration that consumers, carers and families, mental health professionals, referrers and other interest groups expressed throughout the Board's consultation.

A system under such stress cannot provide the care and support that its consumers need and expect. It cannot maintain inter-sectoral and across-government relationships effectively. It cannot support staff to avoid burnout and low morale and cannot sustain the resultant difficulties in recruitment and retention.

It is the Board's view that the problems are complex, they compound and confound one another and there are no simple solutions. The first priority for Government must be to restore strength and to improve the functioning of the clinical system. What is required is a measured, precise and committed plan of investment and improvement.

Responding

The Social Inclusion Board believes that South Australia should set its vision on a system that puts people first and is oriented to recovery. However, the Board wants to ensure that this vision translates into real improvements in the lives of consumers and their families. The consultation process has vividly demonstrated the full spectrum of people's lived experiences, from the very worst to the best.

Recommendation 1:

People with a mental illness who are consumers of the state's mental health services should participate at all levels of the system. This will require innovative ways of ensuring their meaningful involvement in planning, organising and evaluating services.

Recommendation 2:

The carers and families of consumers must be seen as partners in the care process. They should be included in care planning processes, with the agreement of the consumer, and receive timely and appropriate information and support.

At the strategic level, the national frameworks guide policy and planning in mental health and the Board fully supports this policy direction and intent. The challenge of the last decade has been how to translate principles and directions of national policy into a practical plan of action that is relevant to the social, economic and demographic circumstances of South Australia.

The Board's planning focuses on action. The time has come for South Australia to commit to a program of full-scale reform in mental health services. This must be complemented by a joined-up approach across government to support people to participate in a meaningful way in the life of the community. Therefore, the call goes out to all South Australians to tackle the stigma and discrimination that makes people feel as though they do not belong and diminishes us as a caring community.

The time has come for South Australia to commit to a program of full-scale reform in mental health services.

An agenda for decisive change is presented in this report. The aim is to progress the aspirations for a meaningful life repeatedly articulated to the Board by people with mental illness. It is clear to the Board that these aspirations are fundamental not only for the people who use our mental health system, but also for their carers, families and advocates, and are supported by the dedicated professionals who work in the mental health sector.

The most important message from the Board is South Australia can do this!

The Board is confident in the process it undertook to develop this report and is unanimous in its recommendations for change. In presenting *Stepping Up,* the most important message is that the Board is convinced that such a transformation in our state is eminently possible.

South Australia can do this!

The Board's advice is that the Government should commit to seven strategic directions and that those strategic directions should be implemented over five years:

One: *Understanding the people who use the mental health system.*

Two: *Implementing a stepped system of care with community services at its centre.*

Three: *Developing a workforce for the future.*

Four: *Focusing on prevention and early intervention.*

Five: *Redeveloping Glenside as a centre for state-wide specialist services.*

Six: *Encouraging agencies to work together – partnerships for participation.*

Seven: *Tackling stigma and discrimination.*

1. UNDERSTANDING THE PEOPLE WHO USE THE MENTAL HEALTH SYSTEM

This section of *Stepping Up* brings together the information from the Board's research on the people who use mental health services in South Australia. This section also includes a comparison with New Zealand, a country that collects and reports on individual people who use mental health services.

Systems that put people at the centre need to understand who the people are that use the services.

The purpose of this section is to provide a basis for the Board's recommendations, as well as a starting point for the implementation of the Board's recommended reforms.

A mental health system that puts people first needs to understand the people it serves as individuals. Developing an ongoing profile of the people who use services, together with an understanding of their social context and circumstances and the way they interact with the system, is the basis for realistic planning, service design and effective delivery.

Sources of information

The Social Inclusion Board has been successful in piecing together data to begin to build a picture of the people who use mental health services. Health systems accumulate good information around the diagnoses and events that bring people in contact with hospitals or mental health teams. The Board's challenge was to gather information about mental health and other related systems as a whole and about the people using the system.

The Department of Health and the Department for Families and Communities analysed information and generated specific reports that significantly assisted the Board in developing its analysis and understanding.

The Department for Families and Communities, in partnership with regional community mental health services-, undertook a ground-breaking audit of people using Adult Community Mental Health Services in August 2006.[2] The findings from the audit significantly contributed to our understanding in this area. Also, the Department of Health

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[2] The Audit was necessary because most of the ongoing data collection in the states and territories is generated for the National Mental Health Report. However, the report does not have reliable quality data on the number of individuals supported by community mental health services. See Department of Health and Ageing, *National Mental Health Report (2005),* Appendices Tables See Note a) page 66 – number of patients treated and service contacts by ambulatory care.

undertook for the Board a specific calculation of individual people using hospital services, and the Social Inclusion Unit carried out modelling based on a range of published prevalence and service usage data.

Information on older people and child and young people has been sourced mainly from the Clients in Common program,[3] work that was commenced in the previous Department of Human Services based on 2002 data.

People who need specialist services

As already noted, nationally and internationally, the focus for specialist services is on people with serious to severe mental health conditions. A significant proportion of the work will involve lower prevalence psychotic conditions and/or people who have a significant level of functional impairment because of their mental illness. The prevalence of psychotic conditions in the Australian community is estimated to be between 0.4% and 0.7% of the adult population at any one point in time.[4] This equates to 3900 to 6700 people in South Australia.

Somewhere between 4,900 and 6,000 people, at any one time, are clients of adult Community Mental Health.

Based on the Adult Community Mental Health Services Audit in August 2006 ('the Audit'), it would seem that the number of individual people aged between 18 and 65 receiving clinical support from these services at any one time is between 4900 and 6000.[5]

The calculation on usage of hospital services reliably concluded that 4,404 individual people were hospitalised during 2004-05, some of them more than once. Analysis of the Australian Bureau of Statistics Disability and Carers Survey estimated the number of people aged under 65 who had a psychiatric disability of a severity that classified them as high need was 4,500 individual people at any one time.

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[3] Based on data report generated from the Clients in Common project. This is a joint project of the Departments of Health and Families and Communities. The project sets out to describe the clients and patterns of their service use across the bulk of the service delivery arms of the above two departments. Data were obtained for the 2002-2003 financial year from Child and Adolescent Mental Health Service (CAMHS), Community Health Services (CHS), Child and Youth Health (CYH), Children, Youth and Family Services (CYFS), Disability Services (DS), South Australian Housing Trust (SAHT), South Australian Community Housing Authority (SACHA), Aboriginal Housing Authority (AHA), all metropolitan public hospitals, community mental health services and Glenside Hospital. (Further data were obtained from Mount Gambier and Whyalla hospitals and CHS.)

[4] Jablensky, Assen et al. *People Living with Psychotic Illness: An Australian Study 1997-98*, Department of Health and Aged Care, Canberra, 2000.

[5] The estimate for adult community mental health would only include people from the assessment and crisis intervention teams that were managed as clients at the time of the audit. The 4900 figure may be understated because a small number of teams did not fully participate.

The three estimates are not mutually exclusive. In fact, it is expected that there is a crossover between the core client groups in each category, as illustrated in Figure 3.

Figure 3:   Estimated numbers of individual people using community mental health and hospital services
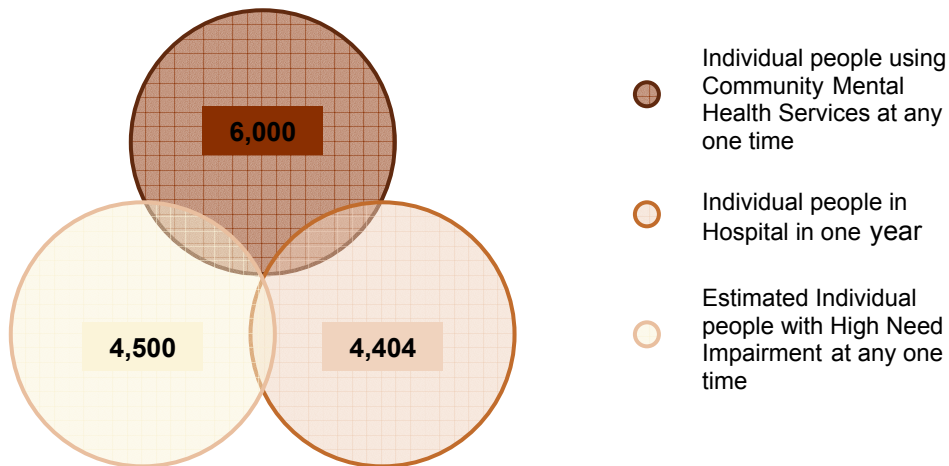
The extent of the crossover could only be confirmed by matching the identity of individual people across the three estimates. Systems must be developed to make such information readily available to support mental health system planning and development.

The profile of people using community mental health services

As already noted, the basis for realistic planning, service design and effective delivery must be in consideration of the people who use services, their social context and circumstances and the way in which they interact with the system. The Audit and other data give us a good insight into the profile of the people using community mental health services. We now have an understanding of the age profile (Figure 4), people's housing circumstances (Figure 6) their housing security (Figure7) and their sources of income (Figure 8)

In summary:
- 44% are females, 56% males
- 9% are Aboriginal people
- 66% of people are under 44 years of age
- 25% live in the country and 75% metropolitan
- 40% lived alone
- 85% report a long-standing mental health condition (of these, 18% are homeless or in vulnerable situations)
- 71% report the Disability Support Pension as their major source of income.

The Board has started the work of building a profile of the people who use Community Mental Health Services.

Figure 4: Age profile of clients of Community Mental Health Teams

- 18-24 years of age
- 25-34 years of age
- 35-44 years of age
- 45-54 years of age
- 55-64 years of age
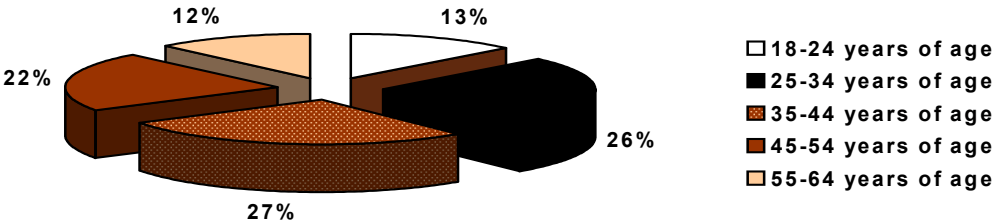
Figure 5: Location of clients of Community Mental Health Teams


Figure 6: Housing type

- Public/Social Housing
- Own Home
- Private Rental
- Supported Residential Facility
- Marginal
- Homeless
- Other or Unknown

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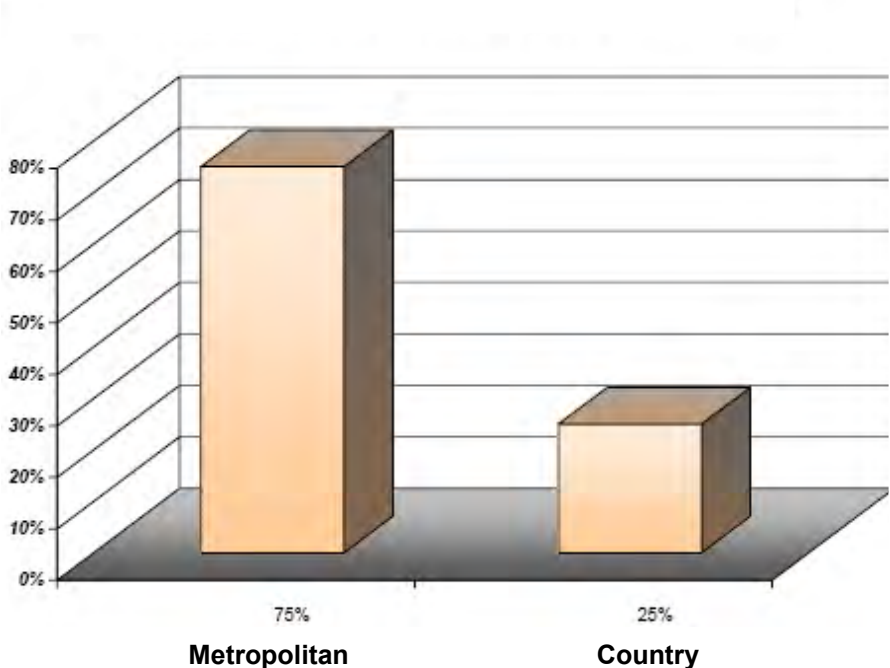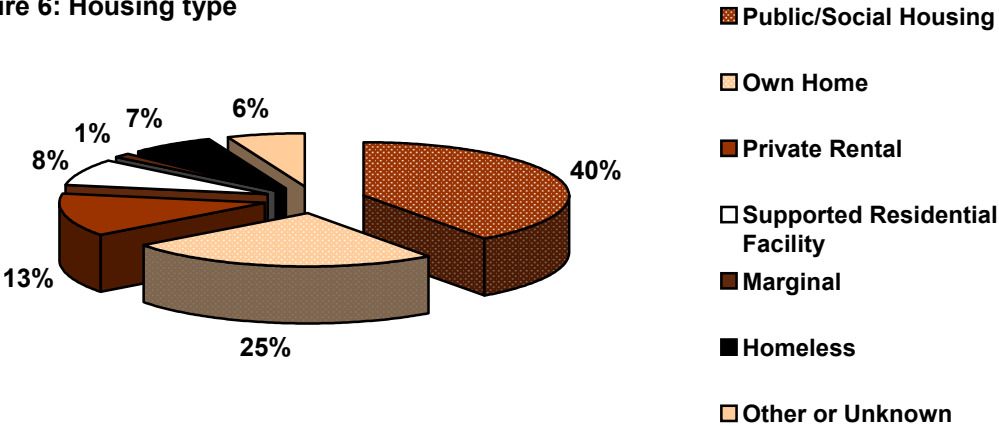
Figure 7: Stability of housing

Legend:
- Stable
- Vulnerable
- Homeless
- Unknown
- Hospital

Values shown: 10%, 8%, 4%, 0%, 78%
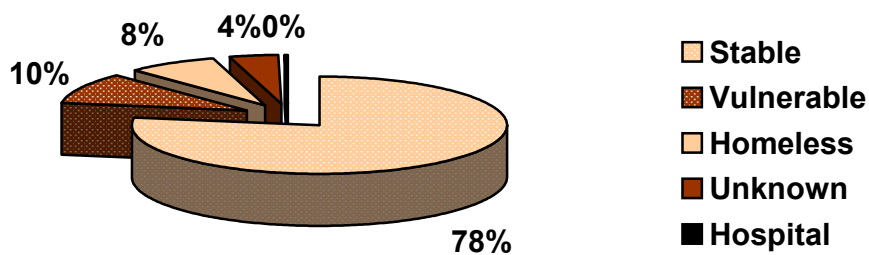
Figure 8: Source of income

Legend:
- Disability Support Pension
- NewStart Unemployment Allowance
- Wages
- Other
- Unknown or Nil

Values shown: 7%, 7%, 6%, 9%, 71%
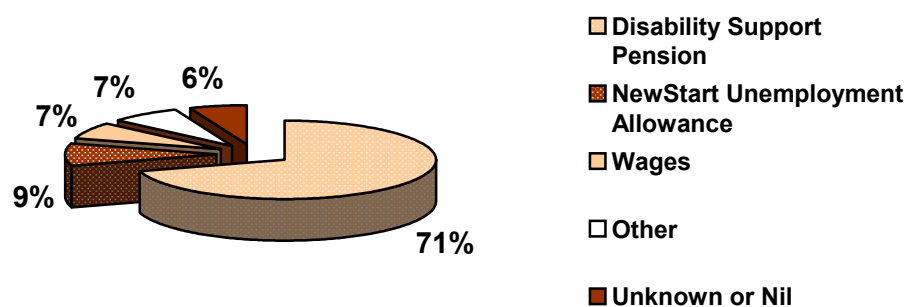
Also of particular importance is the finding that 24% of individuals in the audit have children under 18 years of age. Of these people, 58% have significant responsibility for at least one of their children. It seems that about 800 families[6] are being directly touched by the work of community mental health services at any point in time.

A country perspective

South Australia has 28% of its population living outside the Adelaide metropolitan area. This is comparable to national metro-country patterns of population distribution. However, there is an important difference in South Australia: in this state there are no regional centres with populations greater than 25 000. The predominant pattern is scattered settlement in small towns with populations of up to 3 000 with density becoming progressively lower in the far reaches of the state to the west and north. Road travel to Adelaide–or to the nearest centre that has commercial flights to Adelaide–is the main method of travel in country South Australia. Unlike some other states and territories, there are no commercial flights between regional centres without first flying to Adelaide and regional passenger rail services of the type seen in New South Wales, Victoria and Queensland are non-existent.

The unique characteristics of country South Australia must be taken into account in system design.

These unique characteristics of South Australia's country population must be taken into account in the redesign of the mental health service

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[6] Based on the higher estimate of 6000 clients.

system. For people living in country South Australia, integrated care has an important geographical imperative, which is easily forgotten in Adelaide, but whose consideration is essential for proper systems design.

Aboriginal people

The resident population of Aboriginal people in South Australia is 27,060 people representing 1.8% of South Australia's total population and 5.6% of the national Aboriginal population. Approximately half of South Australia's Aboriginal population lives in metropolitan Adelaide and half in regional, rural and remote areas. [7]

As in general health, Aboriginal people are relatively over-represented in the mental health system with nine percent of people using community mental health services identifying as Aboriginal. Overall, the number of people is relatively small (in the range of 300-500) and they are dispersed across the state.

The Aboriginal population is relatively much younger than the general population—a median age of 20.8 years compared with 37.8 years. The general lower life expectancy in the Aboriginal community, combined with the lower life expectancy for people with severe mental illness, means that there are very few Aboriginal people in the profile of services for older people.

Imprisonment rates for Aboriginal people are more than twelve times higher than the non-Aboriginal population.[8] The rate of juvenile detention for Aboriginal males is forty times greater—over 1000 per 100 000 compared to 25 per 100 000.

If South Australia's mental health system is to provide effective interventions to assist Aboriginal people with a mental illness, and their families, these factors need to be taken into account. The particular challenge for those designing service systems is that the Aboriginal population of South Australia is relatively small and dispersed, and their relative disadvantage is significant.

The advantage is that in absolute terms the numbers of Aboriginal people needing mental health services is small. A well-resourced system can rise to the challenge, provided it has the necessary cultural competency and works at developing an Indigenous mental health

South Australia must rise to the challenge of delivering culturally competent mental health services for Aboriginal people.

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[7] Australian Bureau of Statistics, *Population Distribution, Indigenous Australians, 2001,* Australian Government, Canberra.

[8] Steering Committee for the Review of Government Service Provision, *Overcoming Indigenous Disadvantage Key Indicators 2005* Report, Aged standardised imprisonment rates, June 2004.

workforce. These issues are discussed in greater detail in subsequent sections of the report.

Older people

Based on prevalence studies, South Australia could expect about 9000 people aged between 65 and 74 years and about 8500 people aged 75 years and over to have some kind of mental or behavioural problems in the course of a year. Of the total of approximately 17 000 people, the most common condition experienced will be some form of mood disorder (such as depression) or anxiety related problem, which in the main can and should be managed and treated in a primary care context.

An area of growing concern in mental health for older persons is dementia. The capacity of the aged care sector to manage dementias without recourse to state specialist mental health service has increased enormously. However, dementia is frequently associated with other mental health problems such as depression or psychotic features.[9]

An estimated 3000 people over 65 require specialist mental health services each year.

There are very few older people with conditions such as schizophrenia and bipolar disorder. People with a severe mental illness are less likely to survive into old age. People with mental illness have a 2.5 times higher mortality rate than the rest of the population, which is equivalent to a life expectancy in the 50-59 year age group.[10]

While no detailed information on the profile of patients of mental services for older people was available, there is some information from other sources. Based on data collected for the Clients in Common program,[11] a reasonable minimum estimate of the number of persons 65 years and over who would be consumers of state government funded mental health services is 3100 per year. The expected gender breakdown is 31% male and 69% female, with 77% of the total living in the metropolitan area. We also know that in 2004-05 there were 523 people over the age of 65 who where hospitalised one or more times in a designated mental health bed.

The profile is very different for older people and the system must respond to a different set of needs.

It is clear that the profile of mental illness is very different in older people than in the 18-64 year old age group, resulting in a different set of needs. These differences need to be accounted for in service design. A partnership with relevant Commonwealth Government agencies will be essential.

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[9] Australian Bureau of Statistics, *Mental Health in Australia: A Snapshot, 2004-05.*
[10] Lawrence D and Coghlan R, *Health Inequalities and the Health Needs of People with a Mental Illness*, 2002.

Children and young people

It is estimated that 14.2% of Australian children aged four to 17 years have a diagnosable mental disorder. The most common condition is Attention Deficit/Hyperactivity Disorder (ADHD), which affects 11.1% of children and young people. A quarter of those with ADHD have one or more other mental health conditions at the same time.

The other two most common mental health conditions in children and young people are conduct disorders (aggressive, delinquent behaviour) and depressive disorders (depression and anxiety).[12]

Males have a higher prevalence of conduct disorders and ADHD than females, but there is little difference in the prevalence of depressive disorders. 27% of male children and young people with ADHD will have two or more mental health conditions, compared with 15% of females.

An estimated 5,000 children and young people will need specialist services with most treated and managed in community care.

The majority of these conditions are treated and managed in community settings. In fact, of the estimated 14.2% of children and young people with a mental illness or behavioural problem, half will rate 'low' on a 'problem level scale'. Only one in ten will rate 'very high'. In this context, we know that only 305 people under the age of 18 were hospitalised one or more times in a designated mental health bed in 2004-05.

The Clients in Common data indicates that 8810 children and young people were consumers of state government funded mental health services in 2002-03. Of these 61% were female and 39% male. The data show that only 60% are from the metropolitan area suggesting either an undercount in the city or, more likely, a greater focus in the country by state funded services because there are fewer options for access to private psychiatrists and psychologists.

Based on work by Michael Sawyer and associates[13] it might be expected that about 5000 children and young people with a diagnosed mental illness or behavioural problem will come into contact with state specialist community mental health programs as part of their treatment. Using data from the Clients in Common program, it seems that in 2002-03 CAMHS had 3052 children and young people as registered clients, probably an undercount, but still close to the expected number.

Again, the profile of mental health conditions in younger populations is very different from that seen in the dominant adult (18-64 years of age) service system. This difference needs to be accounted for in service planning and implementation.

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[12] Australian Bureau of Statistics, *Mental Health in Australia: A Snapshot, 2004-05.*
[13] Sawyer et al. Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, *The Mental Health of Young People in Australia*, Publication Production Unit, Commonwealth Department of Health and Aged Care, Canberra, 2000.

Of particular relevance for this population is the basic principle–articulated in the introduction to the Report–that State funded specialist mental health system should focus on providing services to those people who have serious conditions that require responses not readily available in the community or that require highly specialised expertise. The fact that prevention and early intervention are more relevant for mental health service to children and young people must also be kept to the fore when thinking about service planning. These issues will be explored further in Chapter 4 (prevention and early intervention) and Chapter 5 (encourage agencies to work together).

People in the justice system

The current approved capacity for the South Australian prison system is a total of 1,692 prisoners, comprising 1,579 male and 113 female prisoners. During the 2005-06 year, there was an average daily population of 1,548 prisoners. Of these, 540 were remanded in custody and 1007 were sentenced prisoners. Over the course of a full year, in excess of 3300 individuals move through the South Australian prison system.

Community Corrections manages approximately 5500 offenders in the community daily. The range of community-based orders include home detention, home detention bail, parole and community service orders. During the 2005-06 year, 8542 individuals commenced new community corrections orders. The majority of these orders were community service orders (almost 2735) and post prison supervision for individuals released from prison, including parole (almost 990).

At any one time, between 140 and 150 people are being cared for by the forensic mental health service. This includes about 40 people managed in a secure forensic care environment, both prisoners and people detained under section 269 of the Criminal Consolidation Act (1935). The remaining 100 or so people are being cared for in the community under strict conditions set by the courts.

The elevated prevalence of mental illness amongst people involved with the criminal justice system is well documented and a worldwide phenomena.[14]

The prevalence of schizophrenia is estimated to be between four and seven percent for the prison population, while only making up between 0.5 to 0.7% of the general population.[15]

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[14] Corrective Services Administrators Conference, unpublished paper *Prisoners with Mental Health Problems*, 2006.

[15] Select Committee on Mental Health, *A National Approach to Mental Health–from Crisis to Community,* Senate Printing Unit, Parliament House, Canberra, 2006.

Recent research conducted at the Queen Elizabeth Hospital by McFarlane et al (2006)[16] has found that, at some point in their life, 84% of people with a severe mental illness admitted to the psychiatric ward had been physically assaulted and 56.9% had experienced sexual assault. Of all participants 66% had committed at least one act of violence towards someone else in the past. This research demonstrates a strong link between the prevalence of violent behaviour in people with a severe mental illness and past experience of criminal victimisation. This provides insight into the high prevalence and adverse effects of victimisation on people with severe mental illness and the impact this has on their resilience and behaviour.

The Board is of the view that the issue of mental illness among people in the justice system requires particular attention in the context of agencies working together (Chapter 5 of this report). The complex nature of the needs of many of these people, and the relatively short sentences served by most people committing less serious crimes, make this joined-up approach the most appropriate response.

People in hospital[17]

Over the course of a year there will be 7900 admissions to designated mental health beds in South Australian hospitals. As we have already noted, these 7900 admissions are for the treatment of 4400 individual people. Obviously, some people will be admitted to hospital for psychiatric care more than once in a year.

In 2004-05, the majority of people hospitalised in a designed mental health bed went into hospital only once in the year — 879 people had two admissions, 333 three admissions, 154 four admissions and 193 had more than four admissions. The last three groups are strong markers for people with more complex needs who tend to revolve through the hospital system.

The ratios of males and females among patients hospitalised for mental health conditions tend to be similar to that for community mental health service consumers. In the specific collection of mental health hospital data referred to at the beginning of this chapter, female numbers only exceeded males in two age brackets: under 18 and 66-75 years. Somewhere between 3.8% and 7% of the people in designated mental health hospital beds each year will be Aboriginal people.[18]

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[16] McFarlane et al. *The Prevalence of Victimisation and Violent Behaviour in the Seriously Mentally Ill*, University of Adelaide, Adelaide, 2006.
[17] Information from 2004-05 financial year.
[18] The higher figure is based on including all those coded 'unknown'.

Figure 9: Numbers of individual people hospitalised as in-patients 2004 - 2005 by gender
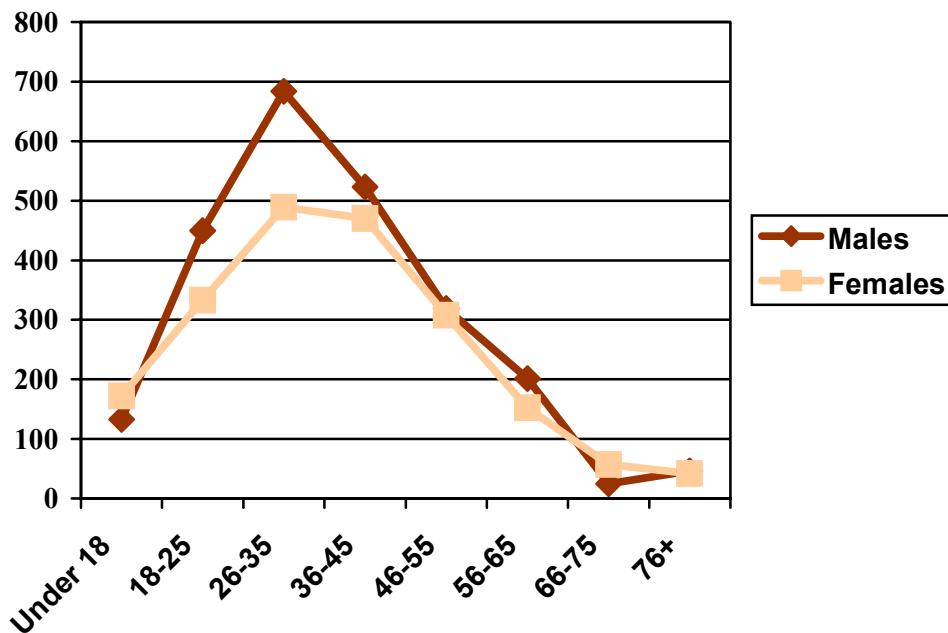
Risk factors

The Community Mental Health Audit identified the following range of risk factors that give some insight into the levels of functional impairment for people using adult mental health services:

Social isolation	65%
Substance abuse	44%
Lack of family support	42%
Behavioural problems	37%
Poor health	28%
Chronic disease	21%
Victim of violence	20%
Contact with criminal justice system or offending behaviour	16%

However, there is a broad spectrum of functional capacity across these risk factors. In this context it is important to remember that diagnosis of a severe mental illness does not in itself determine an individual's functional capacity.

The nature of the risk factors identified in the Audit and the spectrum of functional capacity presented in Figure 10[19] reinforces the point that there is scope to help people with a mental illness to build their social capital and improve their life chances. In this context, social capital means the networks, social ties and mutual obligations that are

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[19] Jablensky, Assen et al. *People Living with Psychotic Illness: An Australian Study 1997-98*, Department of Health and Aged Care, Canberra, 2000.

accumulated over time and can be drawn upon and used in a way that produces personal, economic and social gain.

Figure 10: Spectrum of functional capacity for psychotic conditions

%

Persistent inability to maintain minimal personal hygiene	0.5
Occasionally fails to maintain minimal personal hygiene	2.6
Inability to function in almost all areas	7.4
Major impairment in several areas	18.4
Serious impairment in social or occupational functioning	17.9
Moderate difficulty in social or occupational functioning	17.3
Some difficulty in social or occupational functioning	27.0
No more than a slight impairment	7.1
Good functioning in all areas	1.6
Superior functioning in a wide range of activities	0.1
Total	**100.0%**

poor functioning   good functioning

Bringing the picture together

Based on the data the Social Inclusion Board has been able to gather, a good picture of the users of the adult services (18-65 years) as individuals can be presented:

- Two thirds of the adults using community mental health services are relatively young, under 45. They are likely to be living alone, some without family support.

- The majority have no meaningful employment and are reliant on a disability support pension. The majority are socially isolated and almost half have a substance abuse problem.

- Over a third are in touch with the justice system either as a victim of violence or because of offending behaviour.[20]

- Almost a quarter of the people have children and a majority of those have a parenting role.

- Aboriginal people are over-represented and are relatively younger and relatively more likely to be living in rural and remote communities.

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[20] This is consistent with the findings of McFarlane et al., 2006.

- Almost a quarter of the people are living in vulnerable situations or marginal accommodation such as boarding houses, caravans or rough sleeping.

- Between 80-150 people with psychotic conditions will be in prison, either sentenced or on remand.

In contrast, the picture for children and young people and older people is much more limited. More work is required, but the method used here provides a starting point.

In considering the picture of adult community mental health service consumers–and in building up the picture of older people and children and young people–it is important to remember that these statistics represent men and women living in our community who, despite their functional capacity, can be profoundly socially excluded because of stigma and discrimination.

The profiles include men and women who are often profoundly socially excluded.

A comparison – New Zealand

Very few of the jurisdictions around the world that the Board had been monitoring publish regular information on individual people using their mental health services. New Zealand does this and is regarded as having one of the best mental health systems in the world and certainly one that has fully reorientated its system to care in the community.

The following information is a data series from New Zealand reporting across the whole mental health system, which includes inpatient, community, child and adolescent, and drug and alcohol services for a population of just over four million people.

Over four years the monthly patterns have been relatively consistent for individual people. There were 47,399 individual people for adult community mental health teams reported for 2004 across New Zealand. New Zealand does not have a separate sector for people over 65, meaning that this should be compared with the total of the adult and older persons sectors in South Australia.

Figure 11:   Number of contacts, bed nights and individual people seen at all District Health Boards 2001–2004 [21]
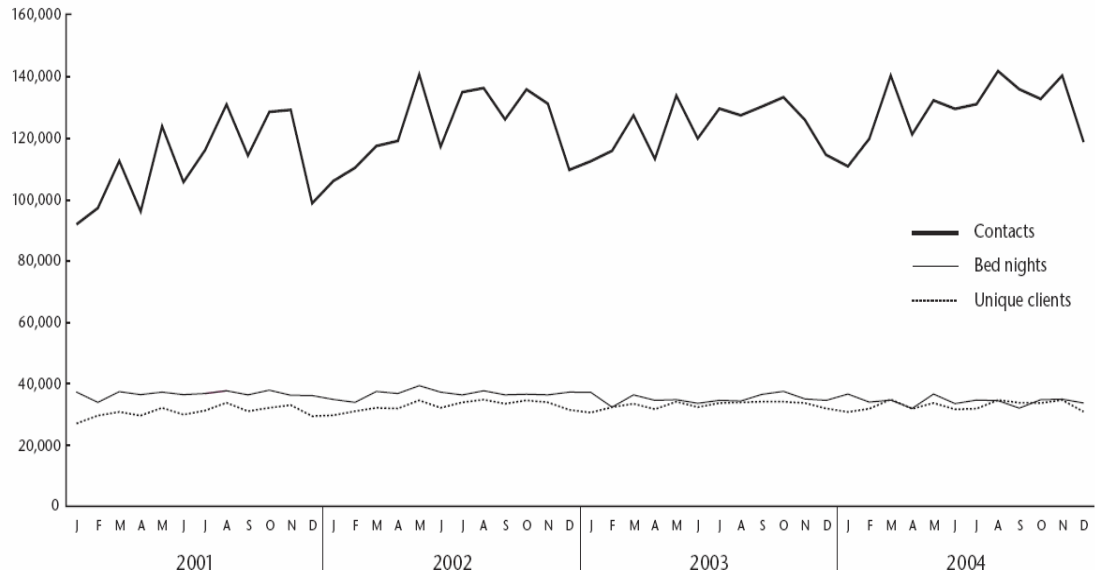
The annual count is 2.6 times the monthly count, which means 18,230 individual people in an average month, and represents 0.6% of the adult population. Translated to South Australia, the estimated average monthly count for South Australia is 5700 individual people. Assuming that the patterns are the same for South Australia, the annual count would be around 14 800 individual people.

The Department of Human Services Clients in Common Project for the 2002-03 financial year identified 12 000 people who were users of the mental health system which suggests that the annual count is likely to be somewhere between 12 000 to 14 800 individuals.

Unmet demand

It is often quoted that between 40-60% of people with a mental health problem do not get a service and half of those that do are not getting effective evidence-based interventions. This gives the perception of a significant unmet demand.

In order to examine this issue in detail, the Board used the modelling of Andrews and Associates to identify the service requirements and costs

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[21] New Zealand Health Information Service, Ministry of Health, *Mental Health Service Use in New Zealand*, 2004.

between current and ideal coverage.[22] The conclusion that the Board has come to is that the biggest gaps between current and ideal coverage are in the area of primary care and for high prevalence conditions, such as depression and anxiety. A relatively small proportion of the service gaps were in the specialist mental health system. For example, for the seven conditions with the greatest service gaps,[23] the cost implications for providing best practice interventions as described by Andrews and Associates, would be in the order of 81% from the Medical Benefits Scheme (MBS), 14% from the Pharmaceutical Benefits Scheme (PBS) and 5% from state government funded inpatient and community based services.

Less than 5% of the service gaps in mental health to cover unmet need are likely to be in the specialist mental health system.

This again reinforces that for specialist mental health services the issue is not high levels of unmet demand, but how services are organised and implementing strategies to ensure consumers receive effective evidence-based interventions.

Conclusions

Drawing on the information and analysis in this section, the Board believes there is no evidence community mental health services are dealing with high numbers of people at any one time or with escalating demand. This suggests that community mental health services have a sufficient number of staff to deal with the number of people currently seen and that the number of clients is close to expected levels, based on prevalence studies.

The mental health system is not stressed by the scale of demand but by the complexity of the client group and system responses.

The profiles show clearly that most of the people with enduring mental illness who are long-term consumers have a range of significant risks and problems in their lives. While there may not be a demand problem in volume, the system is stressed by an inability to respond to the full range of complex needs of a necessarily demanding client group.

There were consistent messages from the consultation that there are gaps in the system and disjointed pathways that disrupt continuity of care, resulting in people's circumstances running to a crisis. The system is out of balance. In this context clinical staff are focused on dealing with the illness and are not always able to help with the other aspects of life that would help the person's recovery and prevent their condition deteriorating. As such, even though there is a genuine desire to support recovery, the system is not oriented in that direction.

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[22] Andrews, Gavin et al. *Tolkien II, A needs based, costed stepped-care model for Mental Health Services*, WHO Collaborating Centre for Classification in Mental Health, 2006.

[23] Panic Disorder/Agoraphobia, Obsessive-Compulsive Disorder, Alcohol Harmful Use, Anorexia Nervosa, Bulimia Nervosa, Social Phobia (Social Anxiety Disorder), Generalised Anxiety Disorder (GAD).

Therefore, building a better understanding of the people who use the mental health system is an essential starting point for the reforms that will achieve the vision the Board has articulated.

Recommendation 3:

The analysis of the people who use the current mental health system indicates that Aboriginal people, people who live in the country and people with complex needs should be considered as populations that require a specific focus in the implementation of the recommendations throughout this report.

Recommendation 4:

The Department of Health should work from an 'understanding people as individuals' approach to planning mental health reform and delivery of mental health services. A people centred approach means that consumers are recognised when they enter, re-enter or move through the different pathways across the system.

Recommendation 5:

In support of a people centred approach to planning, the Department of Health must ensure that it can report accurately and regularly on the numbers of individuals, their profiles and their interaction with the mental health system. Community mental health services must develop a system of individual (unique) identification that can become inter-operable with inpatient data collections.

2. IMPLEMENTING A STEPPED SYSTEM OF CARE WITH COMMUNITY SERVICES AT ITS CENTRE

This section of *Stepping Up* outlines the Board's advice on how to re-balance the mental health system in South Australia by:

1. implementing a stepped system of care
2. situating community mental health services at its centre
3. integrating services across the government and non-government sectors
4. establishing intermediate care options
5. coordinating a response to people with complex needs.

The consistent message from the consultations and the Social Inclusion Board's research is that our mental health services can only be fully effective when all of the component parts are in place and in balance. The way of the future is to rebalance and enhance the existing system to unlock its full potential.

The consensus view that emerged from the consultation process is that a balanced system is characterised by:

- Responsiveness
- Continuity of care
- Flexibility
- Choice
- Inclusiveness
- Effectiveness.

Recovery as an approach, not a program

Rebalancing the South Australian mental health system will involve a significant change process. Change is always challenging and engaging the hearts and minds of all stakeholders is crucial. Implementing the *Stepping Up* vision will be as much about changing culture as changing structures.

An organisational culture that supports the vision will engage hearts and minds and strengthen the reform process.

Therefore, the functional and structural reform of South Australia's mental health system needs the strength that can only be provided by working from one prevailing organisational culture that is consistent with the overall vision.

The majority view from the consultation is that the prevailing organisational culture of the mental health system should be an orientation to recovery.

> Recovery is '*a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and, or roles. It is a way of living a satisfying, hopeful and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effect of psychiatric disability* .'
>
> ***National Mental Health Plan 2003 –2008*** [1]

The Board has examined the recovery literature and practice internationally. It is clear that there are a number of different interpretations and academic debates.

The Social Inclusion Board supports a recovery-oriented system, not because of those debates, but because of the hopes and aspirations that came through in the consultations with consumers and their families. If recovery means developing new meaning and purpose in one's life, and knowing that one belongs, then that is what the Board intends for mental health reform in South Australia.

Recommendation 6:

The South Australian mental health system should fully adopt a recovery orientation that is focused on helping people dealing with mental illness to live a satisfying, hopeful and contributing life.

Recommendation 7:

The principles of recovery should be translated into organisational cultural norms and behaviours that must apply across the system.

A stepped system of care

The Board supports the implementation of a stepped system of care for mental health. Such a service system is organised as a range of steps from the least intensive to the most intensive. The system is balanced by ensuring there is sufficient capacity at each of the less intensive service steps so as to limit the need for more intensive options. Costs

The Board supports a recovery orientation but it must deliver meaningful outcomes for consumers and their families.

are likewise graduated across the steps from the least expensive to the more expensive.

In recommending the adoption of a stepped system the challenge for the Board was to identify the basis on which to make an assessment of the amount of services to provide at each step and the relative costs per unit of care at each step.

While there are very few existing models in which structured assessment and clinical guidelines are linked to a comprehensive continuum of care,[24] the work of Andrews and Associates[25] stands out. The Board chose to use their model to guide the analysis of what might be appropriate for South Australia. Andrews' work is built on costing the delivery of evidence-based interventions for 15 psychiatric conditions modelled on the prevalence and severity of these conditions in the Australian population.

The Board supports a stepped model of care where capacity and cost is graduated from least to more intensive and more expensive.

Figure 12:   Facility-based components of a stepped system of care

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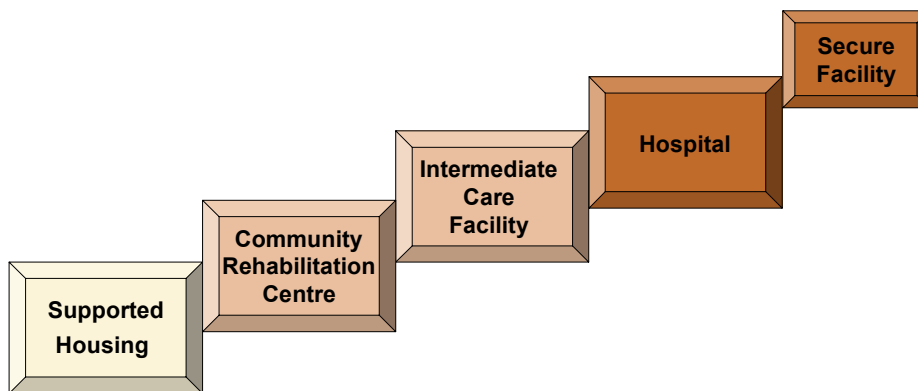
[24] New Freedom Commission on Mental Health, Subcommittee on Acute Care, Background Paper, June 2004, page 6. The Trieste region in Italy and the national health system in New Zealand have both significantly implemented aspects of a stepped system. At this point in time, Victoria is the Australian state most advanced in this regard.

[25] Andrews, Gavin et al. *Tolkien II, A needs based, costed stepped-care model for Mental Health Services*, WHO Collaborating Centre for Classification in Mental Health, 2006.

Figure 12 outlines the graduated steps in facility-based services to support a stepped system.

The foundation for the stepped system is people being supported to live in the community and in their own homes, wherever possible, by providing the necessary supports.

Supported housing

For people who struggle, for a variety of reasons, to maintain their tenancies, **'supported public housing places'** is the first formal step in the system. These are accommodation places available in public housing that are targeted at people affected by a psychiatric condition or disability. Allocation is on the basis of a formal partnership agreement between the state health department, the relevant public housing authority and support services.

The concept of 'supported places' indicates that, as a component of the formal partnership arrangement, the agencies assist the person within their home by providing ongoing clinical and disability support. The modelling by Andrews and Associates concludes that 34 such places are required for a population of 100 000 people.

This means that for South Australia's adult population we would require about 350 such places. South Australia currently has only 101 places that could be designated as supported public housing places.

Some people require more intensive support to maintain their housing. For this group, **clustered housing**–usually single bedroom units–with staff on site 24 hours a day is required. The focus of the staff's work is to provide supervision and practical support. Up to seventeen places are required for a population of 100 000 people. This means between 120 and 150 places for South Australia's adult population, whereas at present South Australia has only 49 such places.

Rehabilitation and recovery

Some people with complex needs are not able to fully benefit from the rehabilitation services currently provided in their own homes or in supported housing. For this group, facility-based rehabilitation is the next step in the care system. The recommended volume is eight places per 100 000 people. There are 60 beds already in planning in Community Rehabilitation Centres (CRCs), the first 20 of which will come on stream in July 2007. These are, in effect, a form of supported accommodation and their recurrent tenancy costs need to be managed in this way. In the longer term South Australia may need as many as 80 such places, however, any decision to build more than 60 places should be deferred until the state has a fully functioning intermediate care system.

Intermediate care

Intermediate care is a graduated step down from acute hospital services. It provides higher levels of nursing care than can be provided in a person's home. Intermediate care is for people who 'step up' from the community because they are likely to require acute care soon if this early intervention is not provided. It is also for people who 'step down' from acute care who require continuing care in order to manage back in the community. Currently, South Australia has no beds of this type and their development in other Australian states and territories is in its early stages. Based on modelling undertaken by the Social Inclusion Unit, it is estimated that South Australia should have at least 90 intermediate care beds.

90 intermediate care beds will provide a new step up or step down option between home and hospital.

Hospital acute beds

For people experiencing an episode of serious mental illness an admission to an acute hospital bed is often necessary. As already noted, South Australia's overall acute bed numbers are above national averages. There are 25.4 beds per 100 000 population adult acute beds compared with the national average of 23.4 and the Victorian average of 19.9. Andrews and Associates estimate that a fully functioning stepped system of care only requires 10 acute beds for a population of 100 000 people (plus some additional beds for crisis presentations). The modeling of between 190-220 adult beds in the stepped model of care aims for somewhere between the Victorian benchmark of 19.9 and 23 adult acute beds per 100 000 population which is a very feasible target for South Australia and within a range that will accommodate population projections to beyond 2012.

Secure care

At the other end of the system, there is another gap that needs to be filled for the stepped system to work efficiently. Thirty to forty secure rehabilitation beds are required for people who cannot remain safely in the community. The current use of long stay beds in hospital settings is no longer appropriate. In a stepped system these long stay resources should be shifted to secure rehabilitation and care facilities, as well as to 24-hour supported accommodation.

30 to 40 secure rehabilitation beds are needed for people who cannot remain safely in the community.

These proposed changes are presented in summary form in Figure 13.

The facilities (or beds) in the stepped system are also supported by non facility-based approaches to intermediate care, rehabilitation and supported accommodation. Hospital in the home is a step up/step down arrangement suitable for people who have a secure home and a carer to help them through the acute phase. Intensive packages of psychosocial rehabilitation are used to return people from institutional living to a life in their own home in the community.

These non-facility based supports are an important component of the stepped system and must be managed to ensure that they support the effective implementation of a stepped system in South Australia.

Figure 13: **Facility-based services in a functioning adult stepped system of care[26]**

Secure Rehabilitation
Current 0
Proposed 30-40

Acute In-Patient Beds
Current 252
Proposed 190 - 220

Intermediate Care
Current 0
Proposed 80 - 92

Community Rehabilitation Centres
Current 0 (60 in development)
Proposed 60 – 80

24hour Supported Accommodation
Current: 49
Proposed: 120-150
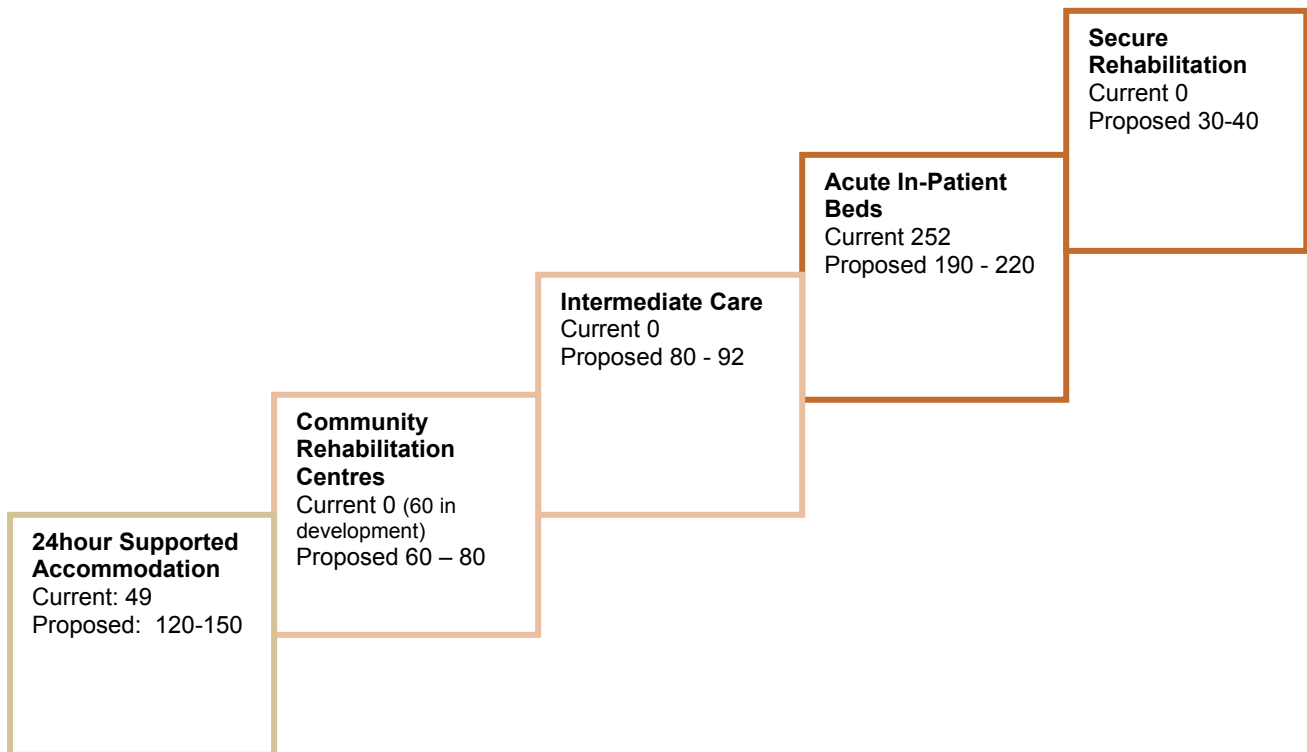
Overall adult bed numbers increase from 375[27] currently to between 480 and 582 in the stepped model, although there are variations in the bed types and mix. The major differences are in acute beds and in the shift of existing extended care beds into community residential care, community rehabilitation centres or transferred into aged residential beds. The benchmark that is proposed for acute bed numbers is consistent with both internal Department of Health modelling and external commissioned work given the range of alternative facility-based options proposed.

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[26] Adult forensic beds are not included in the modelling and assumed at current 40 beds.

[27] Includes 74 extended care adult beds that are not fully comparable to secure beds. Extended care patients would be accommodated across a range of bed types in the stepped model including a minority in secure care.

Recommendation 8:

A stepped system of care must be implemented, ensuring there is sufficient volume at each level of care from the least to the most intensive–supported accommodation to community rehabilitation to intermediate care, acute care and secure care. The aim is to maintain the system in balance and guarantee recognition for people who present at each step. The Board supports using the modelling work of Andrews and Associates as the basis for planning and designing a stepped system for South Australia.

The Board heard from Aboriginal advocates that their major concern was Aboriginal communities not benefiting from the broader changes to the design of the mental health system. It is the Board's experience from other references that, unless there is a specific and concerted effort to ensure benefit flows to Aboriginal people, their concerns are well-founded. The Board therefore believes that implementation will require strong leadership from the top with a focus on the needs of Aboriginal people in the overall reform process.

The Board believes that leadership from the top will be required to ensure that Aboriginal people benefit from the system reforms.

Recommendation 9:

The Chief Executive of the Department of Health should take direct leadership responsibility for ensuring system redesign benefits Aboriginal people. A leadership group will be required who will undertake strategic audits of progress against key measures and report to the Chief Executive on progress and options for improvement.

Community mental health at the centre of the system

The shift from institutional to community based care is the centrepiece in national and international mental health policy and planning. The Board's assessment is that, while there has been significant investment by government to build the capacity of community mental health services, community clinical care has not yet been positioned to ensure its full potential is realised.

A key focus of the Board's advice to government is to situate community mental health services at the centre of the system, as illustrated in Figure 14.

Figure 14: Community mental health care at the centre of the system
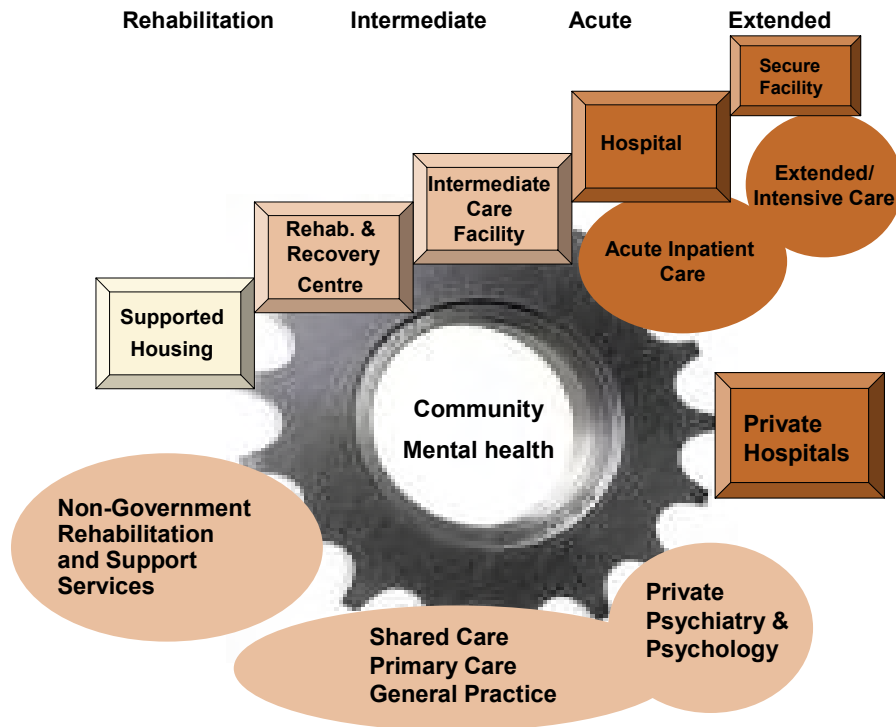
Rehabilitation   Intermediate   Acute   Extended

Secure Facility

Hospital

Extended/ Intensive Care

Intermediate Care Facility

Rehab. & Recovery Centre

Acute Inpatient Care

Supported Housing

Community Mental health

Private Hospitals

Non-Government Rehabilitation and Support Services

Private Psychiatry & Psychology

Shared Care Primary Care General Practice

Community mental health services are those services and teams that are delivering care outside of hospital settings across the child and adolescent, adult and older people sectors.

The Board's view is that community mental health services should become the 'cog' driving the system. They must have responsibility for managing the partnerships with primary health care, private specialists, other government sectors and the non-government sector.

Community mental health services should also have responsibility for all mental health services outside of acute inpatient services and long-term care. This responsibility would include all intermediate care facilities. The role for community mental health services would focus on:

- leading an integrated model of rehabilitation and recovery
- preventing escalation through people being managed in the least restrictive, most appropriate and cost effective options
- facilitating integration across community and bed based services
- ensuring continuity of care between the community, hospital and between the stepped levels of care
- managing appropriate shared care arrangements between primary mental health care and the specialist system
- holding and managing funds freed up through the implementation of the reform process.

Situating community mental health services at the centre of the system has implications for the way functions are currently allocated to different teams–assessment, rehabilitation and continuing care. It would also require a more energetic approach to multi-disciplinary work, the holding and managing of funds and a new approach to defining the catchment areas in which teams would work.

Changes to team functions

The care functions of the community mental health service are: assessment and crisis intervention, continuing care and assertive care. Currently, these functions are located in separate teams. Together, they make up over three quarters of the staff capacity in the adult community mental health services sector.

The view of the Board is that a detailed functional assessment of community mental health services is necessary. Changes in the way functions are allocated to teams will be required, in order to realise the vision the Board has of community teams at the centre of the system.

Assessment and Crisis Intervention Service

When first established, the Assessment and Crisis Intervention Service (ACIS) model was for mobile specialist emergency teams to be at the frontline, responsible for triaging cases, conducting initial assessments, doing crisis intervention work and taking responsibility for acute and sub-acute treatment in the community. The model also included continuous involvement for ACIS teams in pre-admission, admission, early discharge planning and post-admissions phases for people who receive inpatient treatment on a 24/7 basis. A 2002 review concluded that the ACIS teams were operating from very individualised models and unable to fulfil the range of functions envisaged in the original model.[29]

This fits with the trend around Australia, where crisis intervention services function largely as frontline assessment and triaging, as they have become overwhelmed by out of hours demand.[30] They are increasingly drawn into inpatient settings, as mainstream hospitals struggle to manage mental health presentations at emergency departments.

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[29] Tobin, Margaret, *A New Millennium, A New Beginning Discussion Paper series: Emergency Demand Management and the Role and Function of ACIS: A Review,* Adelaide, Department of Human Services, 2002.

[30] Select Committee on Mental Health, *A National Approach to Mental Health–from Crisis to Community,* Senate Printing Unit, Parliament House, Canberra, 2006.

Figure 15: Current functions – Community Mental Health Teams

Legend:
- Continuing Care
- Assess/Crisis
- Mobile Assertive
- Rehab & Recovery
- Hospital In Home
- Early Intervention
- Day Programs
- Specialist

Pie chart values: 30%, 36%, 13%, 2%, 5%, 2%, 3%, 9%
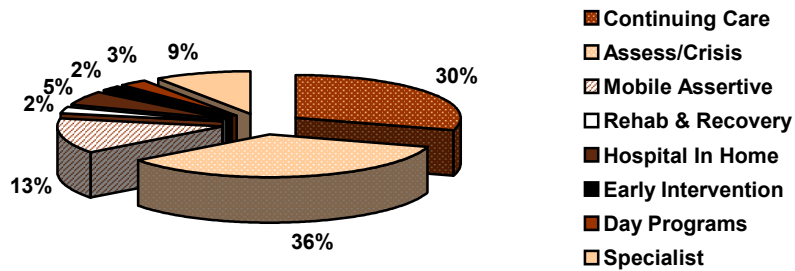
Continuing care

The mainstay of care is with the continuing care teams who engage with almost half of the community mental health service consumers at any one time (see Figure 15). They function on a Monday to Friday basis within usual business hours and largely from a clinic base.

Currently, there is no consistent description of their role from region to region or within regions. The range of descriptions includes:

- Provide assessment, treatment, rehabilitation, support, information and advocacy for people whose mental health problems have a significant impact on daily living.

- Provide a case-management based service. Also provide a short-term intervention service, to assist consumers to resume their usual lifestyle post an episode of illness. Also provide a mental health homeless outreach service.

- Provide psychosocial rehabilitation and disability support for consumers with enduring mental illness/psychiatric disability.

- Provide a range of recovery-focussed community based linkage, follow-up, treatment, educational, psychosocial rehabilitation, medical and case management services.

Assertive community treatment

Assertive community treatment is designed for consumers with complex needs aged 18-64 years who have severe and enduring mental illness and are prone to relapse. The models for assertive community

treatment are the best evidenced for reducing hospital admissions.[31] Fidelity to the evidence-based models is a key requirement for delivering good outcomes for the consumer and the system. The models recommend about 10 staff per 100 clients.

In South Australia, teams providing this kind of assertive clinical care are called Mobile Assertive Care Teams. They currently report 46 staff working in this area. This should allow about 460 people with complex needs to be supported at any one time.

Multi-disciplinary teamwork

One of the strongest messages from the consultation was the need to restore multi-disciplinary teamwork in mental health teams. Each of the professions expressed to the Board a level of frustration with what they saw as a generic case-management model. The functional assessment must squarely address these concerns and develop appropriate responses.

The Board strongly advises against any restructuring of the team system in community mental health services until the functional arrangements are clear and agreed upon and geographic catchment areas are defined (see below).

Catchment areas

The Board recommends that community mental health services across the adult, child and adolescent and older people sectors should be organised around geographic catchment areas to support population based service delivery. Community mental health services will be responsible for the range of specialist services to the population across each catchment.

One of the trends identified in the international literature is the shift towards larger catchment areas. Small catchments lead to structural and functional fragmentation and that is clearly evident in the South Australian system. On this basis, the current sub-regional arrangements for adult community mental health services are too small to become the catchment areas.

The current geographical alignments for child and adolescent, adult and older persons services in the metropolitan area (north and south of the River Torrens) appear to be a product of history, rather than any recent and considered assessment of population structure, distribution and need.

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[31] Centre for Reviews and Dissemination, University of York, *Scoping Review of the Effectiveness of Mental Health Services*, CRD Report 21, 2001.

The management of the transitions between the three sectors–child and adolescent, adult and older people–was the subject of intense criticism in the consultation process. The Board believes that transitions can be more effectively managed when there is alignment of services across one catchment area.

Determining the appropriate catchment areas will require detailed modelling work taking into account population structure, distribution and geographical and socio-economic factors. International experience indicates that catchment areas should not be smaller than 250 000 people and not larger than 400 000. As a starting point, the Board suggests five catchment areas, four in the metropolitan area and one in country South Australia.

Each catchment area should be responsible for the delivery of services to Aboriginal people in their population. Catchment areas that have high numbers of Aboriginal people may be able to establish an Aboriginal team to assist their community mental health services to engage with Indigenous people. The Regional Aboriginal & Islander Social and Emotional Wellbeing (RAISE) model developed in Port Augusta is a strong prototype for this style of service model that has shown promising results in avoiding hospital admissions. Catchments with low numbers of Aboriginal people may need to access consultancy services through a specialist Aboriginal team. This is discussed further in Chapter 5.

Networking to support consistent practice

As a second force for reform, the Board proposes clinical networking with a focus on:

- Enhancing multi-disciplinary teamwork across the mental health system that supports a recovery orientation. Networking would establish clear operational policies around the function and make-up of teamwork, communication, co-ordination, protocols, and conflict resolution.
- Establishing and implementing operational protocols and practice that support integration across inpatient and community clinical care to improve transitions.
- Continuous practice development to establish appropriate levels of consistency and evidence-based optimal care strategies across the catchments. The Mental Health Care Improvement Initiative that has been trialled by the Department of Health during 2005 and 2006 provides a framework for this work.

The Board envisages that the networking would be led by senior clinicians across the professional groups; medical, psychology, nursing, occupational therapy and social work. The requirements for culturally competent practice for Aboriginal people must be addressed.

Recommendation 10:

Community mental health services must be situated at the centre of the system by:

- Allocating lead responsibility to them for all facility-based and community care other than acute and long-term hospital care.
- Reorienting their functions and structure to implement the stepped system of care.
- Organising services across adult, older people, and child and adolescent sectors around geographic catchment areas to support a population health approach.
- Establishing formal networking to drive practice consistency and improvement within and across catchment areas.

Recommendation 11:

The community mental health service should hold and manage funds that are linked to reform. Transition funding and the reinvestment of funds that can be freed up through implementation of the Plan must be enveloped and managed carefully. The arrangements will require extensive discussion and the development of a detailed model to ensure rigour and accountability.

Issues for country South Australia

The Board is impressed by the service integration that has been forged in the country, to some degree, through sheer necessity. The Rural and Remote Health Service based at Glenside working collaboratively with community mental health services, has developed a community psychiatry approach that co-ordinates care at different levels. Specialists working in a tertiary setting provide acute inpatient care and also ensure overall continuity of care through working relationships with key workers and general practitioners.

Sheer necessity in the country has contributed to more collaboration and service integration.

The use of teleconferencing facilities (Telemed) for consultations, assessment and review deals, to some degree, with the tyranny of distance. Also, the 24 hour emergency triage and liaison service provided by the Rural and Remote Health Service is a well-used and highly valued service across country South Australia.

At any one time, one-third to one-half of country residents who are hospitalised for a mental illness are in mainstreamed mental health beds in general hospitals, rather than in the Rural and Remote Health Service beds at Glenside. This is because of emergency admissions, limited bed availability at Rural and Remote, and the fact that for some country consumers these mainstreamed beds are closer to their home

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(for example a person from the Barossa Valley going to Lyell McEwen Health Service or a person from Victor Harbor going to Flinders Medical Centre).

One of the most consistent concerns identified by country people in the consultation process was the way transitions between hospital and community are managed when mainstream hospitals in metropolitan Adelaide are involved.

To address this and other issues for country consumers and their families, it will be essential that the Department of Health pays particular attention to the unique circumstances of country South Australia identified in Chapter 1. While the same services cannot be provided in the country as are found in the metropolitan area, equality of outcomes is a reasonable and achievable goal.

Particular attention should be paid to improved discharge planning from metropolitan mental health beds in general hospitals, the functioning of the single country catchment area with community mental health services at its centre and the continuing role of the Rural and Remote Mental Health Service.

With regard to the clinical networking to support consistency of practice, it will be especially important that proper adjustments are made to support best practice in country South Australia. The aim should not be for consistency between metropolitan and country, with regards to inputs and outputs. Instead, the goal should be consistency of outcomes between the two and then consistency of services across the country region.

Recommendation 12:

In designing and implementing the reforms of community mental health services, it is essential that the Department of Health pay particular attention to the unique circumstances of country South Australia. This should be reflected in defining the country catchment area and in the functioning of the clinical networking, as well as in the community teams themselves and the Rural and Remote Mental Health Service.

Invest in intermediate care

Intermediate care forms a range of service types, with the common aim of providing short-term interventions that act as substitutes for acute admissions or hospital stays. The aim is to assist people to return to their everyday lives in a timely, supported and appropriate way. Intermediate care can be facility-based or community-based.

During the Board's consultation process, consumers and carers consistently raised the lack of services to support the transitions between hospital and home for people with a mental illness as one of their key issues. The burden on carers and families trying to support people who are acutely unwell is becoming unsustainable for many.

In acute psychiatric care, the major driver of costs is the longer length of stay compared to other specialties. The number of hospital stays is trending down, but the length of stay is increasing. The number of occupied bed days for people with schizophrenia disorders with mental health legal status (i.e. detained under the Mental Health Act) in South Australia has risen 45% over the last five years.

If the system is to improve, gains need to be made in both reducing lengths of stay and avoiding emergency admissions, because patients held longer than 24 hours contribute significantly to bed day costs.[32]

Evidence from a 2006 national snapshot survey showed that 36% of people in mental health beds in South Australia could have been immediately discharged if intermediate care, rehabilitation support or more accommodation services were available.[33]

This highlights the importance of precise targeting for the proposed facility-based intermediate beds. The specifications that are developed for implementation of intermediate care must address this issue. Those people who have a continuing care plan and stable accommodation in the community will be prime candidates for intermediate care.

It is highly probable that people who have complex needs and lack stable accommodation in the community could get stuck at this level of care. Partnerships between intermediate care and co-ordinated care for people with complex needs will be essential if they are to be candidates for intermediate options.

Senior clinicians have suggested to the Board that there are people being discharged from hospital who are still quite unwell and would greatly benefit from a short period of convalescence. The Board is influenced by this view and proposes that South Australia's model of facility-based intermediate care needs to adopt a holistic, practice nurse-led approach. The first focus would be on nursing care to consolidate treatment and restore basic health and wellbeing patterns that may have been disrupted by or untreated during hospitalisation. The Board is also influenced by consumers who advocated strongly for step-up arrangements because of the empowerment that comes from

Intermediate care must be carefully targeted to people who can benefit most from this option and who will not get stuck at this level of care.

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[32] Unpublished information on Designated Mental Health Beds, Department of Health, South Australia, *Occupied Beds Days by Diagnostically Related Group (DRG)*– 2001-2005.

[33] Australian Health Ministers' Advisory Council, National Mental Health Working Group, Homelessness and Housing Taskforce, *Australian Mental Health Inpatient Snapshot Survey*, Draft Report, May 2006.

avoiding an admission to hospital. Community Mental health services would manage all admissions to and discharges from intermediate care facilities.

In the main, it would be expected that people discharged from intermediate care facilities would return to home or accommodation in the community. However, there should be a clear pathway between the intermediate care facilities and the Community Rehabilitation Centres (CRC). The CRC is the next step for those people whose lives are more complex and for whom returning home may not be an appropriate option.

The Board believes that, as intermediate care facilities become well established in the South Australian mental health system, there will be opportunities to reduce demand in the acute sector. Intermediate care facilities are ideal treatment sites to provide an increased level of specialist mental health care in some country or urban fringe locations.

Recommendation 13:

South Australia should invest in facility and non-facility based intermediate care as an integral part of a stepped system of care.

Recommendation 14:

Intermediate care should provide holistic nurse-led care. It should be planned, managed and evaluated on the basis of increasing responsiveness and choice for consumers, reducing the state's reliance on acute and emergency or unplanned admissions and, in collaboration with Community Mental Health Services, effective management of the pathways between hospital and home.

Focus on people with chronic and complex needs

The Board believes that the first phase in the implementation of a stepped system of care must tackle the crisis in acute psychosis care. This situation is contributing to the congestion in our hospitals, and adding to the poor mental health and life outcomes of some people with serious mental illness. Tackling the issue means focusing on people with chronic conditions and complex needs.

There are five markers that generally, but not exclusively, indicate complex needs. These markers can occur in various combinations and intensities:

- People with a chronic course of psychotic illness particularly with patterns of deterioration.
- People with co-occurring drug and alcohol problems.
- People with a history of homelessness or living in marginal accommodation.
- People living chaotic lifestyles associated with repeat admissions to hospital and high use of emergency care.
- People cycling through the criminal justice system, often for low tariff offences that may be associated with their mental or functional impairment.

Analysis of information relating to each of the markers suggests somewhere between 400-800 people in South Australia fit this profile. Aboriginal people are likely to be over-represented in this group. The Board believes that using these markers of complexity is useful as a starting point in establishing the scale of the service focusing on this population.[34]

Between 400-800 people fit the profile of complex needs and may also be known to drug and alcohol, justice or homelessness agencies.

The Board recognises the characteristics of this group from its other references, particularly in the Drugs Summit initiatives and Homelessness Action Plan.[35] Some of these people will not be current consumers of community mental health services. For a variety of reasons, they are regarded as 'lost' from the system. The consumers themselves may not adhere to medication, resist treatment or avoid staff from community mental health services. They may move address or get evicted and not notify their mental health provider of their new address.

Data-matching across a number of government programs with potential common clients is recommended as a starting point. Information on what services are currently provided can then guide the delivery of a more intensive, co-ordinated rehabilitation and social care package designed to keep the person out of hospital and improve their quality of life. The package can be case-managed through whatever client relationship is more comfortable and preferable for the individual.

There are important privacy issues at stake, which are sometimes seen as a barrier to data-matching and integrated services. However, the challenges are not insurmountable. Careful consideration is required in terms of:

Careful consideration must be given to dealing with privacy issues that may prevent sharing information to support co-ordinated care.

- how to fulfil one's duty of care to highly vulnerable consumers
- the process for gaining informed consent to share information
- how to involve consumers in planning for potential future relapses.

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[34] Refer to the Social Inclusion Unit, *Specification Paper on Co-ordinated Care for People with Chronic and Complex Needs*.
[35] Department of the Premier and Cabinet, *Social Inclusion Agenda*, South Australia, viewed 15 February 2007, <www.socialinclusion.sa.gov.au>

Re-admission rates vary five-fold between those people who adhere to medication and avoid using drugs and alcohol and those people who do not. Speedy access to assessment and detoxification for drug and alcohol disorders for people with chronic and complex needs is essential. The identification of this group must translate into priority treatment protocols for people with co-existing drug problems and mental health conditions.

Assertive care models need a better balance between medical-therapeutic and rehabilitation recovery outcomes to help people who are most excluded.

The effectiveness of assertive care, in terms of reducing inpatient utilisation and promoting continuity of care, is consistently well evidenced in the national and international literature.[36] However, most studies show no real enhancements in social functioning, vocational outcomes or offending. The focus on people with complex needs will require an assertive co-ordinated care model that has a better balance between medical-therapeutic and rehabilitation recovery outcomes. The Board is very clear that helping people who are most in need, but least likely to be well served by any of the systems, is a fundamental goal of social inclusion.

Recommendation 15:

Mental health services must establish a focus on people with chronic conditions and complex needs. The requirement is to provide co-ordinated care that is supported by a joined-up approach across Government.

Recommendation 16:

South Australia must advance a systematised response to people with dual diagnosis. This system must be particularly responsive to people with complex needs.

Recommendation 17:

In implementing this response to complex needs, it is essential that privacy principles are not misused or misapplied so that information is not shared between agencies or with carers. This requires careful consideration by agencies of how they fulfil their duty of care, the process they use for gaining informed consent to share information and how they involve consumers in planning for potential future relapses.

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[36] Health Evidence Bulletin (Wales), *Mental Health National Services Framework,* 2004, Millbank Memorial Fund, *Evidence-Based Mental Health Treatments and Services: Examples to Inform Public Policy*, 2004.

Complex needs and forensic services

Specialised services for people in contact with the courts or the corrections system are generally called forensic mental health services. There are five broad categories of people in contact with the criminal justice system who may also require mental health services. People:

- who are interacting with the police
- under community orders or being supervised by community corrections
- being held on remand
- who have committed an offence, but who are mentally unfit to enter a plea of guilty or not-guilty
- serving sentences in a prison.

The Board believes that there are three principles that should be applied to the delivery of mental health services to these five populations.

- Every person with serious mental health problems coming into contact with the criminal justice system should have their mental health care provided in a non-forensic mental health service, unless there are legal and service quality and safety reasons why this should not be the case.
- Forensic mental health facilities should be focused on treatment and rehabilitation in a secure environment rather than facilities offering mainly containment.
- Non-forensic patients should not receive care in a secure forensic environment.

The Board has found that forensic mental health practitioners are consistently committed to the principles that support best practice.

In South Australia, James Nash House is the state's forensic (or secure psychiatric) hospital. There is also a community-based forensic mental health team. The dedicated staff who work in South Australia's forensic mental health services consistently demonstrate a strong commitment to these principles.

It is important to note that–unless very severe–the recommended treatment for most people with depressive and anxiety conditions does not involve state mental health services (hospital or community), but is managed through general practitioners. In a prison context, the prison health service fills this primary health care role.

When sentenced prisoners have serious mental health problems the forensic mental health service has a central role. It is, likewise, the necessary service for managing people who have committed a serious crime, but are mentally unfit to enter a plea. In a state the size of South Australia this means that a single facility, preferably close to the state's

major prisons, will be required to ensure there is adequate provision for both of these populations.

Wherever possible, forensic patients who are supported in the community should have their mental health services provided by community mental health services, rather than specialist forensic services. The Board is aware that the complex interplay between justice considerations and health considerations makes this a challenging area. It will be important that specialist forensic services continue to have a consultancy and support role in this context. It is also the Board's view that its recommendation for a focus on people with chronic conditions and complex needs (see Recommendation 13) will provide the essential context for the justice and mental health systems to work on a joined-up approach.

> **Recommendation 18:**
>
> People with chronic conditions and complex needs who are involved with the Justice system should be a core client group for the focused and co-ordinated response to people with complex needs.

Government and non-government partnerships

Psychosocial rehabilitation

The Board strongly supports the continued development of capacity in the non-government sector. The Mental Health Coalition[37] has been an active participant across the consultations and has provided valuable advice, as have many other non-government organisations. (See Appendix 2.)

Specific mental health funding to the non-government sector in South Australia was limited prior to the 2005/06 budget when the Government made a significant one-off injection of funds. The Board is convinced that the investment to date has increased responsiveness and supports choice for consumers.

The Board understands the capacity of current funding to the non-government sector, which relates to people with a psychiatric condition and/or functional disability, as a combination of programs across the Department of Health and the Department for Families and Communities as outlined in Table 1.

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[37] Mental Health Coalition of South Australia, *Mental Health: Let's Make It Work*, 2005, Mental Health Coalition of South Australia, *Current Profile of the Specialised Community Mental Health Rehabilitation and Recovery Sector*, 2006.

Table 1: **Current non-government organisation activity and funding focused on people with mental illness/psychiatric disability**

NGO activity	Funding Per Annum
RECURRENT	
Department for Families & Communities	
DFC Psychiatric Support – Rough Sleeper Packages	$2 837 000
Community Support Inc.	$1 017 256
Department of Health	
Block funded NGO – membership-based organisations/specialist interest groups	$1 798 900
Recurrent psychosocial rehabilitation services by NGOs	$1 795 200
Joint DFC & Health	
Facility-based (49) and non-facility based (101) supported accommodation projects	$2 888 281
Country Health	
NGO funded activity	$762 500
TOTAL RECURRENT	**$11 099 137**
ONE-OFF	
Department for Families and Communities	
Supported Residential Facilities (SRF) Support Project	$1 316 640
Department of Health	
Strategy 6 – Care packages from the $25 million one off[38]	$4 700 000
Respite, group rehabilitation, peer support and carer support from the $25 million one-off.	$2 000 000
TOTAL ONE-OFF	**$8 016 640**

It is clear that the one-off funding has added considerably to the volume of services being funded by the Department of Health and provided through non-government organisations. At this point the actual output and the impact of these services is not known. The Central Northern Adelaide Health Service is undertaking an evaluation of programs under the one-off funding allocation of $25 million in the 2005/06 budget. The evaluation is due for completion in early 2007 and was not at a stage where it was able to provide reliable information to the Board for this Report.

There must be an assessment of achievement across existing investment as the basis for determining future capacity in the sector.

The Board believes that South Australia has a highly professional non-government sector providing mental health services. This sector must be supported and developed. The Board concludes that there is a clear opportunity to assess and, if necessary, refocus the Government's investment in non-government organisations. A thorough assessment of achievement delivered by both recurrent and one-off funded activity

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[38] The $25 million one off included non-government organisation funding and other funding that was to be expended over two or three years.

is possible and should be the basis of decisions about how to best build on the capacity that has been developed in the non-government sector over the past few years.

Integrated approach to psychosocial rehabilitation

The Board's view is that psychosocial rehabilitation is not the unique preserve of any one sector. A partnership approach is required across the government and non-government sectors to support a recovery-oriented system.

The Board's clear advice is for South Australia to continue to invest in community mental health services and to restore a sense of purpose by placing them at the centre of the state system. Consumers need the working relationships between the teams of the state government community mental health services and non-government providers to be based on partnerships around consumers' recovery goals. They need a range of psychiatric, psychological, social, family interventions, vocational and occupational therapies that are delivered in a co-ordinated way by the sector best placed to respond.

In the area of psychosocial rehabilitation, the Board recommends that an integrated approach across the government and non-government sectors is what will work best for South Australia. South Australia has had a distinct history of government and non-government sector relationships that has concentrated on co-operation, collaboration and a degree of pragmatism upon which we can build.

There is an international trend emerging around the integration of social and clinical care in mental health. Birmingham, a site of excellence in mental health services in the United Kingdom, has been particularly innovative in this regard. They have integrated social care and community clinical care in a way that is delivering impressive results. This includes the co-location of staff from social care agencies with those of the community mental health service.[39]

The Social Inclusion Board envisages a system for South Australia in which functions can move seamlessly across and between government and non-government sectors based on the needs of consumers, carers and communities — a system that is not driven by a menu-based view of services and preconceptions about roles.

The Board also envisages a system in which there is portability of qualifications and experience, and in which there is opportunity for professionals to extend their skills.

> A recovery-oriented system requires a partnership approach that is not driven by a menu-based view of services and preconceptions about roles.

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[39] Birmingham and Solihull Mental Health Trust, *Annual Report, 2005-06.*

It is imperative that the catchment areas of the community psychosocial rehabilitation and support, psychiatric disability support and community mental health services are in alignment.

<div style="background: #faf6d8;">

Recommendation 19:

South Australia should continue to build the capacity in the non-government sector to deliver psychosocial rehabilitation and support services. The development should be framed within a partnership approach that builds on a system that will have community mental health at its centre.

</div>

Catchment areas for services in the non-government sector must align with those for community Mental health services.

A new contracting process

It is the Board's view that there should be a new and more rigorous contracting process for services in the non-government sector. In developing the service specifications for the contracting process the following guiding principles are suggested:

- Services should wrap around the consumer.
- Services should move with the consumer.
- Services should support housing tenancy.
- Services must respond to the person's social inclusion goals.

Figure 16: **Starting point for a stepped framework for re-contracting non-government organisation services**

Coordination

Rehabilitation

Personal Support

Flexible Options

Participation in Membership based
Organisations/Centres
including Consumer-led.

Civil Associations – Communities of Work,
Education, Faith,
Sport, Leisure, Industry, Civic Affairs and Interests

Increasing
intensity
of support
services

Increasing
connection
with
community

The Board supports a framework for psychosocial rehabilitation and support that builds on the concept of stepped systems. Just as is the case in clinical services, it is important that there are graduated options (see Figure 16).

Each of the steps represents a group of interventions with growing intensity of support. Costs per consumer outcome should be graduated accordingly. The Board believes that connections with community and social networks are increased through participation in membership-based organisations and civil associations in the mainstream of society; such participation is essential for building social capital.

Flexible options

Flexible options are designed to support choice. For example, brokerage funding could be a flexible option used to improve responsiveness in situations in which there are difficulties in access to or availability of services, facilities or resources. Contracted agencies or community mental health services would hold brokerage funding. Decisions are made based on assessment and agreed care plan priorities.

The Board believes there should be a new contracting process with a framework that builds on the stepped model.

Examples of use of brokerage funds could be for private dental health care, given the oral health problems associated with long-term use of medication, or responses to other lifestyle risk factors such as smoking. Brokerage could be used to purchase a respite service locally for a carer in a rural town in which no formal service arrangements exist. Flexible options should also explore the possibilities for consumer directed payments.[40]

Membership-based organisations/centres

Membership and volunteer-based organisations have been the mainstay of the community sector in South Australia for many years. A Service Integration and Capacity Building project has been led by the Mental Health Coalition of South Australia focusing on consolidation to improve viability and capacity. A number of organisations are pursuing amalgamations to increase their capacity and improve the quality of services. Among the developments has been the amalgamation of the Mood Disorders Association with the Mental Illness Fellowship of South Australia (MIFSA), which now has almost 1000 current members.

The value of these organisations to consumers, carers and families was emphasised to the Board during the consultations. They are constitutionally accountable to their members and have boards that must include carer and consumer representation. There is considerable value realised from volunteering. MIFSA, for example, has 140 volunteers who contribute over 20 000 hours per year, which represents 60% of the total hours of service.

Clubhouse SA is based on an internationally evidence-based model of 400 clubhouses around the world. The main aim of Clubhouse is to support people to connect with the community by providing the opportunity to explore options related to employment, health, education, skills-based training and social activities.

In the country consultation, there were a number of volunteer-based centres that had developed to provide a meeting place for consumers and carers. Most had limited access to funding. Some had secured one-off funding through Community Benefit SA.

Membership-based and volunteer organisation interventions offer opportunities for people with mental illness to build social capital. In that context, they form an important band of NGO activity in mental health and are key players in improving social inclusion. It is important that there is sufficient capacity within the organisations to service people who are self-managing their recovery plans.

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[40] Department of Health, *Direct payments for people with mental health problems: A guide to action,* DH London, February 2006.

Stepped packages of care

The term 'packages' is used here to mean any pulling together of a range of interventions. In keeping with the stepped approach, the Board recommends that packages of care should include a combination of interventions built up from the bottom step. Packages should be put together with the consumer, focused on recovery and building connection with the community.

The more intensive packages will involve some measure of support and rehabilitation, but should also include, or have a plan to include, interventions from the other steps. The most intensive may also include some level of co-ordination.

Consumers must have the capacity to direct the components of their package and to express preferences to facilitate choice. Clearly, this means a partnership approach between individual consumers and service providers at all steps.

'Packages of care' should include a combination of interventions that are agreed with consumers to support recovery and build community connection.

Recommendation 20:

South Australia should reassess its current investment in services provided by non-government organisations, based on the evidence from the evaluation that is due for completion in early 2007. A new and more rigorous contracting process is warranted that builds on the concepts of the stepped system. Rehabilitation and support services should be focused on helping people to step-down from formal care, to maintaining ordinary associations in society that support a meaningful life.

3. DEVELOPING A WORKFORCE FOR THE FUTURE

This section presents an analysis of the number and profile of staff in the current mental health workforce, followed by a discussion of future workforce issues. The focus is on developing the mental health workforce to ensure that it is positioned to implement the stepped system of care and deliver improved outcomes for people with complex needs. This highlights the need for workers with multi-disciplinary skill sets and a partnership work culture.

Insights and advice from the full range of professional organisations and unions who participated in the Workforce and Professions Panel (see Appendix 2) influenced the Board in the development of this section of the report. Their individual and collective input was greatly appreciated.

South Australia has traditionally run a high-cost mental health system with staffing levels across most professional groups well above the national average. In the National Mental Health Report 2005, South Australia recorded the highest number of staff per 100 000 for nursing and medical staff and has done so consistently for the last ten years.

South Australia's mental health system has staffing levels well above national averages and has done for the last ten years.

Figure 17: **FTE equivalent staff employed in specialist mental health services**
(South Australia compared to National Average) *
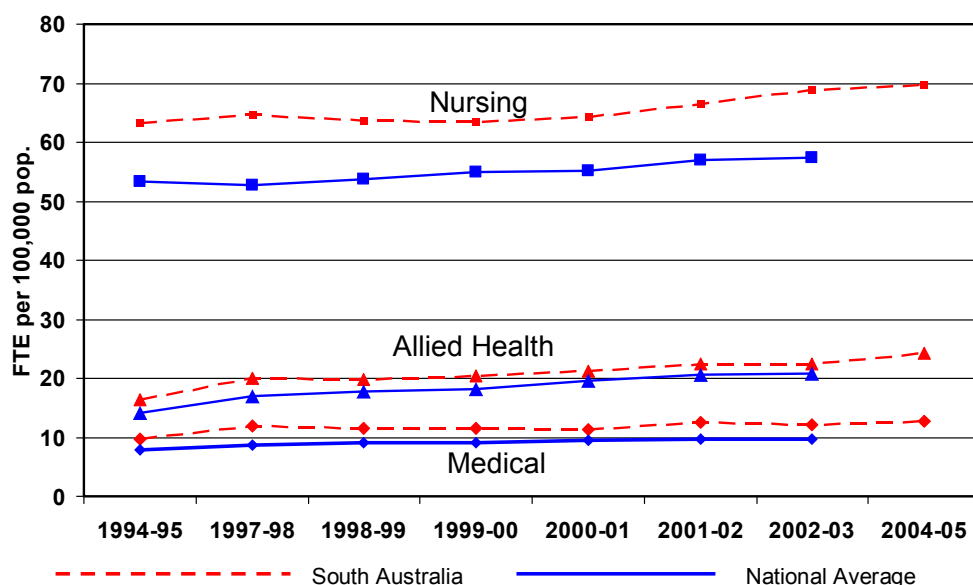
Source: National Mental Health Report, 2005 & unpublished Department of Health data for 2004-05

*Data not available for 1995-96 and 2003-04

53

The hospital sector also employs a high number of domestic and administrative staff largely associated with the Glenside site.

Clinical staff numbers in hospitals have decreased from 64.6 per 100 000 population in 2003 to 61.9 in 2005. At the same time, community mental health service staff numbers have increased.

Table 2 below shows that, in comparison with other jurisdictions, South Australia has maintained relatively high direct care (staff that work directly with consumers) staff numbers in community mental health teams. Unpublished data for 2004/05 puts the figure at 43.6 per 100 000. This would not include the additional $10 million allocated in the 2005/06 budget for 116 positions. The majority of this funding has gone to community services.

Table 2:   **Number of full time equivalent direct care staff employed in community mental health services per 100 000 population[41]**

Year	ACT	WA	SA	VIC	NSW	NT	TAS	QLD	Nat. Avg.
1992-93	22.9	17.4	21.8	22.2	18.8	25.8	20.4	13.8	19.1
1997-98	25.6	35.2	35.2	33.8	29.8	36.4	23.4	23.1	30.4
1998-99	30.4	37.0	34.3	36.9	31.3	32.3	22.4	25.6	32.2
1999-00	36.3	37.6	36.3	35.9	32.8	34.0	22.9	27.6	33.2
2000-01	39.0	41.1	36.0	36.1	33.5	30.0	26.1	28.5	34.0
2001-02	42.7	43.0	39.0	37.4	35.3	40.2	31.9	29.8	35.9
2002-03	47.7	43.8	39.7	38.5	36.0	32.0	31.7	30.8	36.7

South Australia has a relative undersupply of psychologists and declining numbers of occupational therapists.

In terms of occupational groups, the proportional breakdown of medical staff between consultant psychiatrists, psychiatry registrars and other medical officers is close to the national average, as is the proportional breakdown for nurses between registered and non-registered.

The most significant skew for South Australia is in allied health numbers with the relative over-supply of social workers (SA 53%, National Average 30%) and an under-supply of psychologists (SA 21%, National Average 34%). The most recent analysis suggests that the number of occupational therapists in South Australia may also be declining.

Staffing numbers and profile

Understanding the size and composition of the mental health workforce has been an important focus of the Board's research. The interactions between staff and people who use the system are fundamental to the delivery of high quality, effective services.

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[41] Department of Health and Ageing, *National Mental Health Report (2005),* Appendices. Table A-36, Commonwealth of Australia, Canberra.

Community mental health services

The Social Inclusion Board requested a snapshot of staffing numbers across community mental health from the Department of Health in May 2006. This identified 721 full-time equivalent staff broken down as follows:

Figure 18:   **Community mental health staff breakdown by professional group**

Legend:
- Nursing
- Social Work
- Psychologist
- Medical
- Occupational Therapist
- Multi Class
- Operational
- Administrative
- Managerial

Pie chart labels: 11%, 1%, 4%, 7%, 5%, 37%, 8%, 8%, 19%
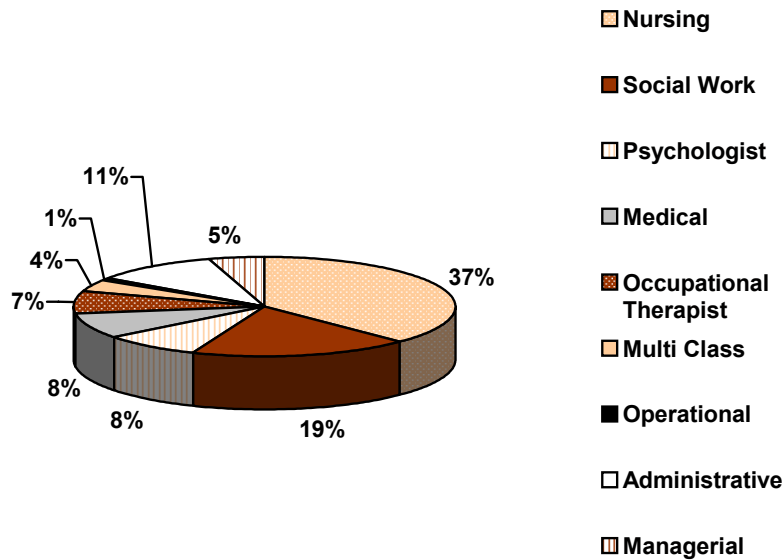
In community mental Health teams, nursing and social work are the dominant professions.

Nursing and social work are the dominant professions representing over half of the community mental health services workforce. Of the workforce 16% is occupied in managerial and administrative positions.

In-patient services

The 2004-05 figures show that there were 1276.2 staff in inpatient settings, of which 25% were in non-direct roles. These figures were updated in January 2006 and there had been no significant change.

Figure 19: Hospital staffing breakdown – acute and extended care – by occupational group

The professional staffing breakdown is consistent with a hospital setting. Domestic staff make up 16% of the in-patient staff profile.

- Nursing
- Other Health Professional
- Medical
- Admin.
- Domestic
- Other Personal Care

16%   1%

9%

9%   59%

6%
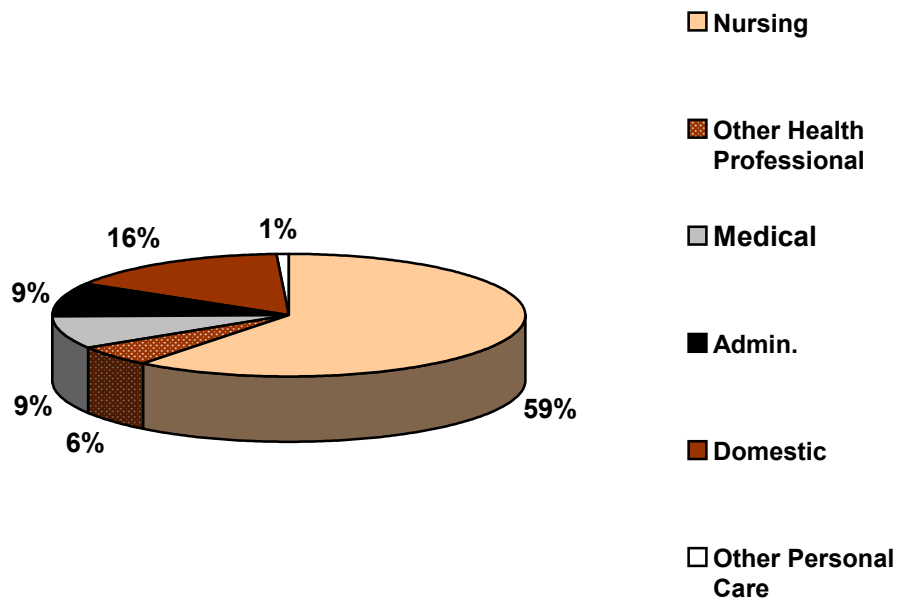
Domestic staff outnumber medical and other health professionals (social workers, psychologists) in the hospital system. There are as many administration staff as there are medical officers. 78% of domestic staff work on the Glenside site and a further 14% work on the Oakden extended care site.

Community staff in non-government organisations

Non-government organisations are increasingly responsible for providing community psychosocial rehabilitation and support services, information, education and advocacy. Staff working in organisations providing these services fill a wide variety of roles. They include:

- Social workers
- Counsellors
- Peer workers and peer specialists
- Consumer and carer consultants
- Support workers
- Group facilitators
- Fieldworkers
- Educators and trainers
- Volunteers (in various generic and specific roles)
- Planners and project officers
- Managers, administrators and coordinators.

Information on the number of people working in non-government organisations providing these services, as well as any workforce trends,

is not yet known. The SA Health and Community Services Skills Board is currently undertaking a one-off collection, which will provide a useful snapshot to start the process of considering how to further develop their contribution to system reform.

Staffing across sectors

Staff for the adult sector make up the largest proportion of government employees working in the mental health system.

Figure 20: **Percentage of community mental health staff by mental health sector**

Legend:
- Staff in Child and Adolescent
- Staff in Adult
- Staff in Older Persons
- Staff in Other

8% 2% 25% 65%
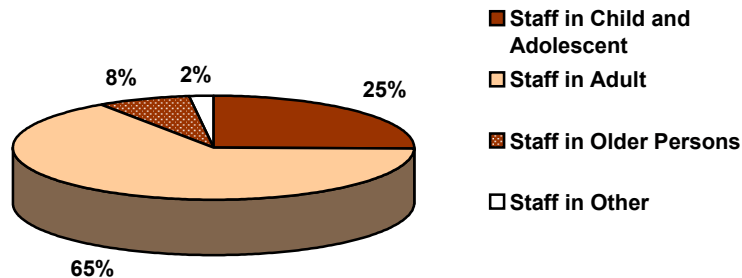
However, on a comparable population basis overall staff capacities are relatively similar for the adult and child and youth health sectors:

- 52.9 staff per 100 000 children and young people 0-17
- 49.2 staff per 100 000 adult population.

The ratio for the older people's sector reinforces the concerns that have been expressed to the Board about shortfalls in service responses:

- 23.8 staff per 100 000 population over 65.

On a population basis, this ratio is less than half that of the adult and child and youth sectors.

In terms of country and metropolitan areas – the ratios are relatively similar at 42.5 staff per 100 000 for the city and 42.7 per 100 000 for country South Australia.

Capacity for the older people's sector is less than half that for the adult and child and adolescent sectors. Country and metropolitan area ratios are virtually the same.

Staffing capacity

Assuming the higher estimate of 6000 people at any point in time using adult community mental health services, the average ratio of direct staff to individual people would be 1:15. Frequency of contact reported in the Audit ranges from several times per week to less than once per month. 63% of individuals were in contact with a team from their community mental health services once a fortnight or less. Any direct staff positions currently held vacant would have an impact on the staff to consumer ratios.

Age profile

The following age profile of the specialist mental health workforce is based on the composition of the Victorian workforce.[42] Given the relative ageing of the South Australia population, it is likely that this analysis underestimates the ageing effect. The Department of Health has identified an average annual replacement rate for nurses, occupational therapists and psychologists that are significantly higher than national averages, which would reflect the ageing of the South Australian workforce.

Figure 21: Specialist mental health workforce – age profile
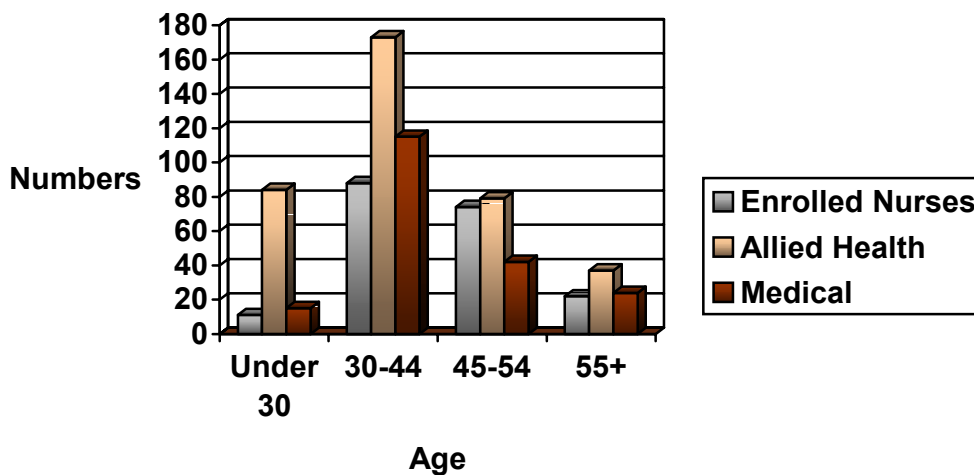
Recruitment and retention

Retention and recruitment are inextricably linked. The factors that cause staff to leave a workplace are likely to be things that will deter others from joining it.

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[42] The Board could not source an age profile for specialist mental health staff from the SA Department of Health.

In its study and plan for workforce development to 2012, Victoria found that turnover accounted for between 72% to 92% of annual recruitment targets. This led them to conclude: 'turnover, rather than service growth, is anticipated to be the primary driver of forecast workforce recruitment requirements to 2012.'[43]

South Australia is facing significant challenges in recruitment and retention for mental health services in the not too distant future. A key pointer is the increasing length of time taken to fill new positions, as well as vacancies in existing positions, particularly in country areas.

A key strategy in workforce planning will be to ensure that mental health services focus on increasing their labour market competitiveness into the future. The general consensus is that there are three important factors:

- People moving very strongly towards work-life balance models.
- People are motivated by a complex structure of rewards that are heavily supported by non-financial benefits.
- People will move quickly if their expectations are not met.

It is generally agreed that a policy measure of increasing participation could provide a buffer against workforce shortages. There are three aspects of this measure:

- Re-entry schemes attracting qualified people not currently working in their profession back into the workforce.
- Workplace re-design and flexibility of arrangements to retain older workers.
- Skills escalator approaches, in which staff are recruited across a spectrum of ages, backgrounds and qualifications. They are encouraged, through lifelong learning, to renew and extend their skills and knowledge to enable them to move up the escalator. Combined with enhanced work roles and increased responsibilities, this will lead to greater job satisfaction.

Aboriginal people in clinical roles

There are currently very few, if any, Aboriginal people employed in clinical roles in the mental health system. There is national and international evidence that clinicians who come from the same culture as the consumers increase the trust and faith that culture has in the mental health system.[44] A strong drive will be required to support Aboriginal people into clinical streams and recruit graduates from

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[43] Department of Human Services, *Victoria's Direct Care Mental Health Workers, The Public Mental Health Workforce Study, 2003-04 to 2011-12*, May 2005.
[44] Dr. Lloyd Sederer, Consultancy Advice on New York's experience in improving mental health services for the Hispanic population.

medicine, psychology, nursing and other professions. Greater support for allied health and community mental health cadetships, including enrolled nurse cadetships, to include mental health specific work placements is warranted.

Consideration should be given to establishing incremental levels for Aboriginal mental health workers, dependent upon achieved competencies consistent with the skills escalator approach. The Board supports the current initiatives to develop a route for Aboriginal people to enter the workforce via a specific 'peer worker' program.

Recommendation 21:

The Department of Health must immediately commence structured workforce planning that is geared to sustaining staffing levels in specialist services to support a stepped system of mental health care.

Recommendation 22:

Short, medium and long-term workforce development planning and initiatives need to be co-ordinated across government and non-government sectors. There must be a dedicated plan for improving training, recruitment and retention of Aboriginal people in clinical positions.

Recommendation 23:

The Department of Health should negotiate private practice rights for psychologists to enhance their career development and support recruitment and retention. Other allied health professions should be encouraged to negotiate similar private practice rights.

Job redesign

Incremental change is important but more radical shifts are needed in job redesign.

Job design needs to be considered as a continuum of activity that results in redefined roles. Incremental change is an important strategy and very consistent with the redesign process managed by the Department of Health through the Care Improvement Initiative.

However, there is increasing interest in mental health internationally in a more radical rethink. The United Kingdom, for example, has advanced signficant work in redesigning roles and developing new jobs. [45]

Workforce considerations are one driver of job redesign. The changing nature of demand in the future and the requirements of an inclusive people-centred mental health system require new skill sets, particularly around partnership, teamwork and communication.

The increased number of people with complex needs who cut across sectors and systems is highlighting the need for workers with multi-disciplinary skill sets and a partnership work culture who can traverse and manage at the interfaces.

> ***Recommendation 24:***
>
> The Department of Health should establish a job redesign strategy for the mental health system across the continuum of activity from incremental change in existing roles, to designing new jobs that support a mental health system that puts people first and is recovery oriented.

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[45] Department of Health, United Kingdom, *Fast forwarding primary care mental health –'Gateway workers',*. 2002.

4. FOCUSING ON EARLY INTERVENTION AND PREVENTION

South Australia has adopted a population health approach. In that context, it is essential for the state to work alongside the Commonwealth on a range of early intervention and prevention strategies, as a good investment for both governments. While the major responsibilities and investment for the state must be in specialist secondary and tertiary services, opportunities to work across the continuum using a shared care approach with primary health care are important at a number of levels, including providing a broader range of opportunities for public sector staff.

The generally poor physical health of people with a severe mental illness also needs to be addressed through primary health care focused on early intervention. Physical health problems often confound rehabilitation and recovery goals and contribute to limited participation in employment and community life.

Investing in prevention— mental health services for children and young people

As already noted, a discussion about the mental health and wellbeing of children and young people is in essence a conversation about prevention and early intervention. As a community, we recognise that for children and young people to grow and develop as healthy individuals, they need safety and security within their primary relationships, opportunities to play and learn, and the positive self-esteem that comes from knowing they are valued and cherished by family and friends.

The vast majority of children (86%) do not develop mental health or behavioural problems during childhood or adolescence. At any point in time only about 2% of children and young people will require specialist mental health expertise.[46] Regardless of this, a continuing commitment to promoting psychological wellbeing among children and young people is essential.

Early childhood

South Australia is investing significantly in children during their early years. The *Every Chance for Every Child* home visiting program has

Early intervention and prevention is a good investment for both Commonwealth and state governments.

Promoting the psychological well-being of children and young people is the essence of prevention.

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[46] World Health Organization, 2003 *Caring for children and adolescents with mental disorders: Setting WHO directions*. World Health Organization, Geneva, 2003.

been established and is being expanded. South Australia's network of Early Childhood Development Centres is also expanding to 20 with the establishment of a further 10 centres. These centres provide education services for children and their parents and help children in the transition from the early years to junior primary school, as well as providing health and community care services. These programs build the resilience and coping skills of children, young people and their families, and ultimately contribute to psychological wellbeing.

It is the Board's view that these existing early childhood programs (including ante-natal programs) will in and of themselves deliver positive outcomes in the area of psychological wellbeing.

Recommendation 25:

The impact of early childhood mental health promotion and prevention interventions should continue to be highlighted. Planning and staff development for programs supporting children during their early years should increase their focus on achieving such an impact.

Education and school based services

Schools are already progressing initiatives that educate young people about mental health and mental illness. Partnerships with organisations such as *beyond blue*–the national depression initiative–are integral to this work. The Board believes that a holistic curriculum that delivers mental health education and prevention messages integrated within existing programs and subjects–rather than as a separate add-on–is the ideal for the state to be working towards.

Professional school based counsellors supported by specialist CAMHS is the best approach for young people.

One of the more difficult relationships, which has been continually brought to the Board's attention by families, is the relative roles of schools and specialist services for children and young people who have serious mental health or behavioural problems. The Board is aware that the Department for Education and Children's Services and the Department of Health are continuing to work towards delivering integrated services for these young people. This will necessarily mean changes for both systems.

The Board's view is that a systemic response, which integrates professional school based counsellors with specialist mental health services, provided through Child and Adolescent Mental Health Services (CAMHS), is the way for the future. In this context, CAMHS programs should be targeted at the smaller number of young people who require specialist mental health expertise, as well as providing a consultancy service to support professional school based counsellors in their work.

The younger profile of the Aboriginal population indicates more demand for child and adolescent services. Western Australia found that 24% of Aboriginal children aged between four to 17 years were at high risk of clinically significant emotional or behavioral difficulties.[47]

Primary care and specialist services in the community

In the last two years, both the Commonwealth and state governments have increased their investment in mental health services for young people. The Commonwealth Government's decision to fund *headspace:*,the National Youth Mental Health Foundation, is of particular relevance. This, together with increased access to psychologists and psychological services through the Medical Benefits Scheme, significantly changes the landscape in which CAHMS services now operate.

Creating a specialist youth service is not the right response to the boundary issues that must be resolved within the catchments.

At this point, the Board does not believe that creating a specialist youth sector is right for South Australia. South Australia cannot afford to create more boundaries that need to be managed and navigated, or to duplicate services. More importantly, young people could be unnecessarily drawn into a specialist service, which must be avoided. The Board recommends integrated catchments as a framework for the sectors to resolve their boundary issues to support their catchment's population. Transitions between child and adolescent and the adult sector must be a first priority. The Board is convinced of the good sense and need for a specialist early psychosis response, which is discussed in the next section.

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[47] Western Australian Government, 2006 *Delivering a Healthy WA: Western Australia's Mental Health Strategy 2004 – 2007*Department of Health, Office of Mental Health, Perth, 2006.

> ***Recommendation 28:***
>
> Child and Adolescent Mental Health Services should remain as specialist services. However, they should operate functionally within their catchments to support a range of primary mental health care services to ensure that young people and their families experience seamless services. Aboriginal children and young people need to be regarded as a priority population.

Groups needing special attention

Recognising children living in families with parents who have a mental illness and often fulfilling a caring role is very important. The Board has identified that there could be as many as 800 families in this situation in South Australia. The Board is aware of the work of Children of Parents with a Mental Illness (COPMI) and believes that work of this kind must receive continued support.

Other groups of young people who have been brought to the attention of the Board, who need an improved focus, are young people who have both an intellectual disability and a serious mental health or behavioural problem, particularly those with Autism spectrum disorders. Again, it is essential that their needs are explicitly considered in the implementation of the recommendations relating to children and young people.

Reform must include attention to children whose special needs have less prominence and require an improved focus.

Developing a response to first episode psychosis

The median age of onset of most serious mental illness is late adolescence or young adulthood. There is clear evidence overseas and in Australia that the first episode is the best point at which to provide health, family and vocational interventions to achieve full recovery.[48] People that have good recovery from a single episode are three times more likely to be in paid employment than those who have a chronic illness. They are much less likely to have problems with household activity or severe social withdrawal.[49]

Given the human and economic costs, this focus has to be one of the best investments for South Australia. If young people go undiagnosed and untreated to a point where psychosis is full blown then recovery and rehabilitation will be significantly more complex and expensive. Consequently, the transition to adulthood and social and economic participation is seriously disrupted, often irreparably.

A response to first episode psychosis is one of the best investments for young people and for South Australia.

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[48] Turner, Mark et al. *Evaluation of Early Intervention for Psychosis Services in New Zealand: what works?,* Health Research Council of New Zealand, July 2002.

[49] Harvey et al, *Disability, homelessness and social relationships among people living with psychosis in Australia,* Low Prevalence Disorders Study Group, National Mental Health Strategy, October 2002.

Modelling based on the work of Andrews and Associates indicates that a South Australian early psychosis program would need to focus on a population of around 400 young people per year. This represents around six to seven young people entering the program per week, with clear pathways out of the program through two management stages after 52 weeks. At this volume and throughput, the program will need to be sited and managed as a specialist service.

The design of the program must involve young people and must ensure that the first episode is a positive experience.

Careful consideration must be given to the appropriate setting for acute treatment. At the first level, the Board strongly supports 'hospital in the home' for those young people who are suitable candidates. The overarching requirement is that the placement and management of inpatient acute beds for this group must support a positive first episode treatment experience for the young person. Dual diagnosis inpatient services could provide a less stigmatising gateway for those young people for whom substance misuse is implicated.

A mechanism to involve young people in the design and development of the program response is essential.

Recommendation 29:

The human and economic benefits of early intervention for younger people with early psychosis must be promoted. South Australia must fast track the development of a response to first episode and early psychosis, sited and managed as a specialist service. Careful planning and consideration must be given to appropriate settings and young people should be involved in the design and development of the program. Family interventions, education and support must be elements of the program.

Opportunities from the National Action Plan

At the meeting of the Council of Australian Government (COAG) on 14 July 2006, ministers jointly announced the National Action Plan on Mental Health 2006-2011. The Plan has provided the essential scope for state and territory governments to work with the Commonwealth on areas in which collaboration and co-ordination will generate the best possible outcomes. Shoring up the continuum of care across primary, secondary and tertiary services was supported across all the professional and interest groups as an important outcome of the COAG process.

The centrepiece of the Commonwealth commitments under the Action Plan is changes to the Medical Benefits Scheme (MBS) to improve access to psychiatrists, clinical psychologists and other allied health professionals.

This initiative provides new capacity in the private sector that will support early intervention. General practitioners will now have scope to refer people who can be managed in a primary care setting provided they have some specialist backup. These enhanced services will set the stage for improved teamwork across private practice. The Commonwealth expects that, at the end of five years, over 35 000 people will have benefited from the changes, which, on a population share basis, would mean 2500 South Australians.

From a state perspective, the full implementation of the stepped system relies on good working relationships between state mental health services and primary health care providers, particularly general practitioners. South Australia has invested $3.25 million in supporting shared-care case management with general practice and funding for practice nurses, psychologists and allied health. The Board is keen to see these partnerships continue.

The Commonwealth is also funding services in the non-government sector around respite, personal mentors and social connection for people with severe mental illness. There is a clear opportunity for South Australia to have a joined-up approach and to reduce the risk of duplication and overlap as the state develops its investment in the NGO sector.

The COAG plan is a further opportunity for South Australia to continue developing the partnerships across the continuum of care.

Recommendation 30:

In the context of the National Mental Health Action Plan, South Australia should:

- Align the recommended developments in private practice rights for psychologists and other allied health staff with the National Action Plan.

- Develop mental health nurse practitioner roles in country South Australia. The focus should be on access for people who are at risk because of shortages of GPs and a limited pool of visiting psychiatrists.

- Align the South Australian Government's commitment to the Healthy Young Minds Initiative with the MindMatters national initiative that aims to embed promotion, prevention and early intervention activities for mental health and suicide prevention in secondary schools in Australia.

- Align with developments in the field of guided self-management, including web-based technologies, that could be incorporated into specialist practice particularly for rural and remote communities.

- Work with the Commonwealth to implement a universal system of routine depression screening by general practitioners and for hospital inpatients.

Depression is the most common, and consequently costly, mental health condition in Australia. If detected and treated, depression can be cured in most patients. Early detection and treatment will have significant economic and social benefits.

In the context of early intervention and prevention, there is significant opportunity for the state and Commonwealth to work together on a universal system of routine depression screening by general practitioners. Screening tools are available and used to good effect overseas. Screening by GPs will reduce the impact of depression and also support the management of other conditions such as diabetes and heart disease.

The state would complement this by routine screening of hospital inpatients and referral to general practice for treatment on discharge.

Earlier intervention for older people

During the Board's consultation process, many participants argued that the whole area of mental health services for older persons is neglected on the basis that it is seen as a normal process of ageing.

Depression and other high prevalence conditions in older people are often ignored despite the evidence of the efficacy of early detection and treatment. Advocates were also concerned about dementias, deliriums and behavioural disorders that are associated with people being hospitalised or prematurely moving into residential aged care, at significant cost to state and Commonwealth governments.

An emerging issue that was highlighted throughout the state, but particularly in country South Australia, was the fact that many carers of people with serious mental illness are themselves ageing and this will have significant implications for future service provision.

The Board believes there is scope for the state to develop an earlier intervention focus in services for older people. As a first step, the state needs a clear action plan around the future management of long-term aged residential care that is consistent with contemporary policy.

Over the ten-year life of the National Mental Health Framework, South Australia has been noteworthy for the percentage of inpatient beds in stand-alone hospitals. Since the mid-90s, South Australia has reported rates of non-acute hospital beds per 100 000 more than twice that of other jurisdictions. The over-supply, on a per capita basis, is for long stay aged beds.

It is the Board's considered view that the time has come for South Australia to commit to a strategic agenda for older people's services, in partnership with the Commonwealth and the non-government sector.

This should include:

- An understanding that moving to a shared care/aged care model of residential care supports people's respect and dignity by normalising their care in the least restrictive environment. This is complemented by the commitment to choice that is upheld in the Commonwealth's framework for residential care.

- There are currently 120 aged long-term care beds in the system. 55 of these beds are licensed and certified as residential aged care beds by the Commonwealth and have been since before 1997, although they have never featured in national reporting. They provide the base upon which the state and the Commonwealth can examine the scope for further licensing. In the spirit of partnership, the state would meet appropriate financial responsibilities for shared care arrangements.

- The state should forge partnerships with non-government sector agencies that have the appropriate experience and track record in working with people who have psycho-geriatric conditions. There is a wealth of experience in other states, which South Australia can draw upon.

- One of the more interesting new developments is the co-location of high dependency units in residential aged care facilities. This means that once the person is able to move into mainstream residential aged care they are not required to move from the facility, but just to another section. This supports the principle of ageing in place and could be usefully incorporated in the multi-purpose facilities options for country South Australia.

The second step would be to situate the state appropriately in early intervention. The Board's position on adult mental health care generally, is that people should not be drawn into a specialist system inappropriately. The Board is clear that it would not want to see expectations on state specialist services that cut across the responsibilities of primary care and aged care for older people with mental health problems.

From an earlier intervention perspective, an important focus is providing support to residential aged care agencies so that people can remain in this setting and do not escalate to require specialist services.

The Board is aware of the Behavioural Advisory Service (BAS) funded by the Commonwealth. The BAS is a telephone response service for aged care facilities that have management difficulties with people with

The first step is to move long-term hospital care to a normalised shared/aged care model.

The second step is an appropriate investment in early intervention for older people living at home or in aged care facilities.

dementia and challenging behaviours. Since its inception, the service has had contact with 80% of aged care facilities across the state. Services vary between once only telephone calls to intensive intervention lasting up to 12 weeks. The service addresses the 'tyranny of distance' for people living in remote areas.

Some examination is required of what and where the opportunities might be in South Australia, so as not to duplicate the role of existing services.

At a second level, services for people managed in community care could be a focus. However, there would need to be careful targeting to ensure that earlier intervention is focused on those older people who are at risk of requiring hospitalisation or moving into residential care.

There are two key challenges for South Australia. Firstly, according to the Board's modelling, the number of older people with a functional impairment because of a psychiatric condition and likely to need specialist services at any one point in time is likely to be relatively small – around 1500 people. These people would be dispersed across the state.

The early intervention effort for older people must be sustainable and scalable across South Australia.

Secondly, it would be difficult to design a program response that could be scaled and provided across the state at a reasonable cost. The response would need to be scaled from existing services, such as domiciliary care or home and community care services and perhaps, multi-purpose services in country South Australia. There is real scope for a strong partnership between mental health services and aged care to work up the possibilities for South Australia to boost its earlier intervention effort for people living in the community. In this context, the Board has referred the issue to the partnership group that is focused on housing, social and aged care. (See Section Six)

Recommendation 31:

South Australia must have a clear plan of action for the future management of long-term aged residential care that is consistent with good practice and contemporary policy. A focus on earlier intervention is required, ensuring that people at risk and needing specialist services are identified and given priority access to services. Partnerships with the Commonwealth and aged care providers are essential to deliver a scalable and sustainable response.

5. REDEVELOPING GLENSIDE AS A CENTRE FOR SPECIALIST SERVICES

Throughout the consultations, the Glenside site was viewed as a valuable asset for mental health. At the same time, the buildings that make up the campus were seen as an increasing liability: their age, state of disrepair and especially their design make them inappropriate infrastructure to support modern mental health services.

Glenside has a long history of providing two streams of care. Firstly, longer-term institutional care for people with enduring disability because of mental illness. Secondly, hospital-type care for people who are acutely unwell because of a serious episode of mental illness.

The Social Inclusion Board recommends the redevelopment of Glenside as a centre for specialist mental health services. This proposal is made in light of international developments and the usual practice of private psychiatric services in Australia. Most importantly, it is recommended as a specific response to the unique population and service system issues for South Australia's mental health system.

Glenside is viewed as a valuable asset and should be redeveloped as a centre for specialist mental health services

De-institutionalisation and mainstreaming

In the developed world, de-institutionalisation has seen the number of people accommodated long-term in hospitals like Glenside dramatically reduce over the past 15 to 20 years. The Social Inclusion Board supports the continued closure of long-term or 'extended care' beds at Glenside, provided they are replaced with supported accommodation places in the community.

Across Australia, most acute care beds for mental health conditions are now provided in psychiatric wards of general hospitals. The transfer of beds from stand-alone psychiatric hospitals like Glenside to general hospitals is referred to as mainstreaming. Mainstreaming has been one of the core objectives of the National Mental Health Plans for over a decade. South Australia has been slower than other states and territories to mainstream acute mental health beds, but in the last few years has made significant progress. The Social Inclusion Board has and will continue to support viable and appropriate mainstreaming efforts.

The Board has considered the future of Glenside in the context of continued support for mainstreaming and developments internationally in in-patient services.

Nonetheless, the Board understands why there is some unease reflected in the conclusion of the Senate Select Committee on Mental Health that there are limitations, because the environments of general

hospital wards can be less than therapeutic for seriously ill people in disturbed states.[50]

With changing design standards, general hospital sites–with a focus on short lengths of admission (average of three to five days)–will struggle to provide the space and tranquillity that facilitate effective treatment for people with serious mental illness.

The Board has noted the emerging practice in the United States and United Kingdom to build new stand-alone specialist psychiatric hospitals. For example, the Birmingham (UK) Mental Health Trust is in the process of building a new 137-bed psychiatric hospital providing core specialist services, older adult services, acute adult mental health beds and an intensive therapy unit for patients whose behaviour is so disturbed that they cannot be managed in open acute treatment places.

This state of the art public hospital is due to be completed in 2007 and will provide:
- single room sleeping space with en-suite for each inpatient
- significant day space, including provision of women-only day space, therapeutic activities space and space in which patients can withdraw and seek solitude
- facilities for visitors, including child friendly spaces
- dining areas for main meals and ward/unit kitchens for the preparation of snacks and hot drinks by patients and staff
- external space.[51]

The Board also notes that in Australia 75% of the 1727 private psychiatric hospital beds are in stand-alone mental health facilities, not in general private hospitals.[52] In South Australia, all three private hospitals providing mental health services are stand-alone facilities.

The Adelaide Clinic–91 beds: provides a full range of general, acute and specialised psychiatric services, including an elderly assessment and treatment unit.

Fullarton Private Hospital–44 beds: includes a specialised adolescent unit in addition to providing general acute psychiatric care, and a stand-alone day patient facility.

Kahlyn Day Centre–licensed as the Kahlyn Private Hospital for 40 beds but now run as a day program with inpatient services provided through the Adelaide Clinic. Specialises in the treatment of drug and alcohol disorders and general acute psychiatric care.

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[50] Select Committee on Mental Health, *A National Approach to Mental Health – from Crisis to Community,* Senate Printing Unit, Parliament House, Canberra, 2006.
[51] Birmingham and Solihull Mental Health NHS Trust, *Birmingham New Hospitals Project: Outline Business Case,* 2002.
[52] Department of Health and Ageing, *National Mental Health Report 2005,* Commonwealth of Australia, Canberra, 2005.

All three Adelaide facilities are owned and operated by Ramsay Health Care. They promote client services such as a bistro-style dining room, light and airy lounges, paved courtyards and tranquil garden areas to enhance the non-institutional feel of the buildings.

Recommendation 32:

Recent international developments and the practices of the private hospital sector in Australia should be taken into account in the design and management of mainstreamed mental health inpatient services. This is particularly with regard to the amenity of facilities and the recognition of the therapeutic value of space.

Building on the government's commitment

The South Australian Government is already committed to retaining the Rural and Remote Mental Health Service at Glenside and to consolidating drug and alcohol services on the site.

Recommendation 33:

The government should build on its commitment to retain Glenside and redevelop it as a stand-alone centre for state-wide specialist mental health services.

In making this recommendation, the Board is proposing a complete structural and functional renewal of Glenside so it may make a final break from the past. The Board's vision is a new future for Glenside, not a revival of its institutional past.

The World Health Organization (WHO) describes specialist stand-alone mental health services as specialist public or private hospital-based facilities offering various services in inpatient wards and in specialist outpatient clinic settings.[53] They are not seen as merely modernised mental hospitals. They include acute units, high-security units, specialist units for particular population groups, such as children and elderly people and other specialist services.

Specialist mental health services are recognised by WHO as an essential component of any properly functioning mental health system and that providing these services through stand-alone institutions is a valid response. An important caveat placed on this proposition by WHO is that people should not be encouraged to use such facilities as first-

The Board's vision is for complete structural and functional renewal of Glenside not a return to its institutional past.

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[53] World Health Organization (2003) *Organisation of Services for Mental Health: Mental health policy and service guidance package*, Singapore.

line mental health care providers. Determining the right mix and proper balance of mainstream, co-located and specialist institutional mental health services depends on a complex range of population and service system issues.

In jurisdictions with larger populations, it is possible to minimise the types of acute services provided through stand-alone specialist mental health facilities, as well as the number of consumers serviced through such facilities. This is especially the case when there is a large number of significant tertiary hospitals each serving a defined region. Accordingly, Victoria has been able to reduce its stand-alone service to 143 beds (12% of the state's total mental health beds), with the majority (115 beds) being for forensic clients.

In jurisdictions with small populations and a single tertiary hospital, co-location of all specialist mental health services on the one site is also possible. The Northern Territory and the Australian Capital Territory have not had stand-alone public psychiatric hospitals for the ten years of national mental health reporting and Tasmania had mainstreamed all of its mental health beds by 2001.

Local population and planning issues

For some specialist services, South Australia does not have the population size to justify more than one such program. An early psychosis program is one example. If a single service is created, it needs to be centrally located to be easily accessible for the young adult populations, from not only the northern and southern suburbs, but also those from country South Australia.

Centralisation is the only viable option for low threshold services given the size and distribution of South Australia's population.

In considering the location of single specialist state-wide services, the Board has been strongly influenced by the observation of the late Dr Margaret Tobin. In the context of her discussing Glenside, she stated that it is always difficult for a regionally focused hospital to fulfill a state-wide role.[54] Regional budget and service delivery responsibilities cannot be allowed to have priority over the needs of the whole population of the state.

The services recommended for Glenside are those for which centralisation on one site is the only viable option for a state of South Australia's size and population distribution.

In addition, Glenside is currently the site for twenty acute beds (Cleland Ward) and 10 intensive care beds (Brentwood North), for which there is

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[54] Margaret Tobin, *Glenside in the New Millennium: Charting the Future. Mental Health in South Australia Discussion Paper Series,* Discussion Five (D5-02), Department of Human Services, Adelaide, January 2002, page 8.

little scope to mainstream to the Royal Adelaide Hospital in the next ten years. Due to space limitations on the Royal Adelaide Hospital site, the mental health development is contingent on other developments and the decanting and demolition of existing facilities.

In the meantime, the amenity of the buildings that house the Cleland and Brentwood wards is such that they require urgent replacement. The Board and the Department of Health are in agreement that these should be redeveloped on Glenside in the shorter term and in a built form that can be reprovisioned in the future to suit different functions.

Principles to guide the re-development

The beginning point in considering the uses for the Glenside site is that it should continue to be seen as an asset to be used to benefit the most vulnerable people in our community living with mental health issues.

This is in keeping with its origins in the 1870s.

Its value is heightened by its close proximity to the Adelaide central business district, the size and amenity of the site and the relatively harmonious relationship with the surrounding neighbourhood. At no time during the Board's extensive consultation process did any neighbourhood group come forward to express concerns about the government's decision to retain Glenside.

The redevelopment will be guided by a set of principles that draw together the range of views.

In considering the redevelopment of the Glenside site, the Board has worked closely with the Department of Health and other interested parties. The Department of Health has drawn together the views of the parties as a set of principles that cover the focus of service to be delivered on the site, the planning and design of the site, community relationships and how the value of the site should be optimised.

Recommendation 34:

The principles that are contained in the Board's report should be used to guide the redevelopment to ensure that it delivers the desired structural and functional renewal of Glenside. The whole redevelopment should encourage everyday interaction between the people who are using mental health services and the general community.

Guiding principles for the Glenside redevelopment

1. The primary purpose of the site will be to provide modern, state of the art facilities that meet the service needs of people with a mental illness or people with a drug and/or alcohol dependency.

2. The mental health services remaining on the campus will be of sufficient size to achieve clinical sustainability and viable staffing arrangements.

3. Other services should only be added to the site if they can enhance the primary purpose of the site.

4. Design of facilities will optimise the benefits of the healing space of the gardens and grounds of the Glenside Campus for mental health clients and their families, all who work on site and the local community.

5. The design, location, scale and form of buildings will provide an environment that is as home-like as possible, which facilitates multi-purpose opportunities and the ability for flexible adaptation over time.

6. The redevelopment will design and locate facilities in a manner that supports service partnerships to enhance improved mental health and drug and alcohol treatment outcomes.

7. Site planning and building design will meet best practice standards in ecologically sustainable design resulting in more efficient use of energy, water and other natural resources.

8. Landscape and environmental design features will be used to promote recovery, protect privacy and provide safety.

9. The redevelopment should strengthen community support and acceptance of the importance of the range of health services provided on the Glenside Campus and maintain and enhance the relationships with neighbours to the site.

10. Optimise the social, economic and environmental value of the site by establishing a model for integrated governance.

11. Develop facilities in a manner that supports cost-effective and efficient service provision and that matches the level of care and management required by clients, as these change over time.

12. Build partnerships with other government agencies and local government to deliver environmental outcomes that contribute to broader state and regional natural resource management objectives.

13. Encourage the positive engagement of the private sector to optimise the economic benefits of their investment in the realisation of the master plan in accordance with these principles.

Services to be located at Glenside

In recommending that the Glenside site be redeveloped, the Board is of the view that all mental health services located on the renewed site should be in new, purpose built, adaptable, state of the art facilities. It is in this context that the Board recommends the physical linking of the core clinical services, to maximise the benefits of their co-location on the site. Other services should be located separately to maximise their integration into the wider community.

The clinical services in scope are: the proposed Early Psychosis Service, the Rural and Remote Mental Health Service, Drug and Alcohol Services, the proposed Aboriginal Mental Health Service, the replacements for Cleland, Brentwood North and Helen Mayo House and a secure rehabilitation service. The other services include supported accommodation and an intermediate care facility.

Early psychosis

A team specialising in community treatment and support for young people aged 18-25 years of age should be based at Glenside. Preferably entered through something that is 'shop front' in design, the program base could also provide clinic-based services. Designated early psychosis acute beds could be provided on the Glenside site. These could be in a unit physically linked to both the base of the early psychosis team and the other beds on the site. This would facilitate a youth friendly focus, while at the same time addressing safety and quality of care issues with 24 hour back up from the larger units on the site.

Early psychosis services must have a youth-friendly front end with specialist back up.

Dual diagnosis

As already announced, drug and alcohol inpatient services will move to Glenside to replace existing facilities at Norwood and Joslin. It is essential that these services are sited and managed to support the delivery of dual diagnosis inpatient capacity for the general population and especially for the proposed mental health services on the campus. The intention is to co-locate the drug and alcohol inpatient treatment service with mental health services so that specialist drug and alcohol staff can more easily provide consultancy type support to mental health staff on a 24 hour basis and vice versa.

The capacity to deliver dual diagnosis services from one site is a significant development for South Australia.

Rural and remote

The retention of the Rural and Remote Mental Health Service on Glenside has already been announced. The 23-bed inpatient service and the associated consultancy service are highly regarded by consumers, carers, general practitioners and health care workers

across country South Australia. A new building for this service will improve the amenity of inpatient accommodation and reinforce Glenside as the 'nerve centre' of an integrated response for country South Australia.

Aboriginal mental health

A state-wide specialist clinical team needs to be developed for Aboriginal people with an enduring mental illness. The Rural and Remote Mental Health Service would support the team because of their strong relationships with rural and remote Aboriginal communities through the work of visiting psychiatrists and consultancy support to primary health care. The Rural and Remote Mental Health Service is also in a position to provide more educational and training opportunities through clinical placement for Aboriginal mental health and general health workers. The objective is to develop, trial and document clinical service models that can be scaled and sustained across South Australia.

The development of a specialist capacity in mental health and a dedicated research effort supports the Board commitment to ensuring benefit for Aboriginal people.

The specialist team, on a consultancy basis, will support catchments that do not have threshold levels of Aboriginal consumers. These arrangements will be refined as the team develops and forms a critical mass of Aboriginal and mental health professionals.

Clinical development will be supported by a research effort in Aboriginal mental health. New Zealand has invested strongly in its research capacity and they are now in a position to apply evidence-based Maori models into practical service delivery. The Board supports this emphasis for research in South Australia–continuous quality improvement of service models and therapies that will have direct impact on the treatment and outcomes for Aboriginal people. There is scope to use the research base for clinicians across Australia interested in developing their skills and experience in remote mental health practice.

Recommendation 35:

Establish a specialist service for Aboriginal people and locate it at Glenside. Co-location with the other specialist services proposed for Glenside–including the drug and alcohol service and the early psychosis service–will benefit Aboriginal people. The specialist service will be supported by a dedicated research effort in Aboriginal mental health care.

Secure care and rehabilitation

Glenside provides the amenity and space that is required for modern standards of intensive and extended care and rehabilitation for patients

needing a secure environment for their own protection and that of the community. These are not forensic patients and are a group of people who have traditionally been cared for on the Glenside site. The Board's view is that their care should continue to be managed there.

Intermediate care

The redevelopment of Glenside offers an opportunity to very quickly construct and open an intermediate care facility. Other sites across the state need to be found and construction progressed. However, an early example in which the model can be developed, tested and modified is ideally suited for the Glenside site.

Supported housing

The development of at least two clusters of about 20 single bedroom units, each with a small administration centre to locate 24 hour staff is recommended. These can be situated in an area in which a small amount of private housing can be built around them. In this way community-based supported housing can be developed without neighbours having concerns. The clusters of units will be in place first and people who move in around them will do so in full knowledge of the existence of the supported housing.

Links with the community

As expressed in the guiding principles, the Board believes that the redevelopment should strengthen community support and acceptance of the importance of the range of health services provided on the Glenside Campus. Maintaining and enhancing the relationships with neighbours of the site will be an important mechanism for achieving this outcome.

The redevelopment will bring new activities on site to support Glenside as a place of healing and a part of South Australia's community life.

The same principle should be applied to engage the private sector with the site. Retail and commercial office space on the site will bring a broader range of people into contact with it and support the de-stigmatising process. All of this must be done in a way that preserves the overall tranquillity of the site and is to the benefit of people with a serious mental illness.

Finally, there are heritage-listed buildings on the Glenside site. Restoring these buildings and creating new functions for them that bring people from the community on to the Glenside site on a regular basis will be an important part of the renewal process.

6. ENCOURAGING AGENCIES TO WORK TOGETHER–PARTNERSHIPS FOR PARTICIPATION

An essential component of the Board's advice is joined-up approach for people excluded because of mental illness.

Joined-up processes are not about consolidating funding or integrating services in a single department, agency or non-government organisation. It is about working smarter together with current and future resources. Effective joining-up begins by clearly identifying what is already being delivered, evaluating whether it could be more effectively delivered and, most importantly, aligning the delivery around people to get better outcomes.

The Board is aware, through its other references, that synchronising the various services that are already being provided to a person yields good results.

Agencies and programs in other portfolios already service many people with a mental illness. For example, we know that almost 2000 consumers of the community mental health services are Housing SA tenants. The Department for Families and Communities provides subsidies to the 400 consumers of community mental health services in supported accommodation facilities, some of whom would also be involved in support programs.

Joining up is about building on services already being delivered across government to ensure that they are co-ordinated and getting the results people want.

Families SA has funding arrangements with Child and Adolescent Mental Health Services around dedicated resources to prioritise access for children under Guardianship of the Minister. The diversion courts in the justice system are case-managing people who have a severe mental illness.

From the Board's own references, $28 million or 32% of total Social Inclusion Initiative funds have been identified as supporting people with a mental health problem.

In the homelessness reference, extensive profiling was undertaken across many of the projects. This showed that the proportion of people with a diagnosed mental illness ranged from 22% to 60%. Among these projects, those that provided case workers or case management–for example the tenancy support schemes in public housing and the multiple and complex needs projects–cited mental health and access to mental health services as one of the most significant barriers. Joining-up clearly needs to go both ways.

The most significant recurrent investment from the 2002 Drug Summit funding was in programs in the justice system. Given the prevalence of dual diagnosis in this population, people with a mental illness must be benefiting. It is estimated that around 20% to 25% of young people in the scope of the school retention programs would have underlying emotional and social wellbeing issues.

The Board is proposing five key partnerships involving 32 agencies, divisions or offices across state government and the Commonwealth. These are listed in Appendix 3. As the partnerships are developed, involvement of relevant non-government organisations will be essential.

The first focus for three of the partnerships (general health, justice and housing and social care) will be on the 400-800 people with complex needs.

There is a non-negotiable requirement for each partnership to consider and design scalable and sustainable options for country South Australia and effective strategies for Aboriginal people.

Partnership 1: Education, Employment and Training/Mental Health

The priority for this partnership was established clearly in the consultation, in which the overwhelming number of people talked about their dual aspirations for involvement in paid employment and increasing their disposable income. The goal for them is competitive employment—part or full-time work in the competitive labour market at award wages with supervision provided by personnel regularly employed by the business.

In Australia, 75-78% of people dealing with psychotic conditions do not participate in the labour force. The onset of psychotic conditions significantly disrupts education, employment and career development. Participation rates vary with the course of the illness. People with a single episode of illness have greater participation than those who have multiple episodes or whose illness has a chronic course.[55]

Increasing participation rates generally is a key strategy for Australia in dealing with the imbalance of revenue to expenditure as the population ages over the next ten to fifteen years.[56] Providing support services for groups traditionally excluded from competitive employment will be a more viable proposition in the future. The personal helpers and mentors

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[55] Harvey et al, *Disability, homelessness and social relationships among people living with psychosis in Australia*, Low Prevalence Disorders Study Group, National Mental Health Strategy, October 2002.
[56] Banks, Gary, *Policy Implications of an Ageing Australia*, Productivity Commission, 2005.

initiative funded under the COAG plan is a reflection of this shift in thinking by the Commonwealth.

Inter-sectoral collaboration is essential, but there is currently very little knowledge transfer between vocational rehabilitation and the clinical mental health sectors. Clinicians may have low expectations because they are not aware of what is feasible and vocational specialists can lose touch with the latest developments in mental health treatment. Treatment and vocational plans need to be co-ordinated and integration of vocational and clinical services appears to be achieving more effective results.[57]

The evidence from the centres of excellence overseas, monitored by the Board, is that we cannot rely solely on the marketplace. The system of co-operatives that has been part of the Italian economic system for many years has been an important element in the success of the mental health system in Trieste (Italy). Developing social firms and enterprises that want to employ people with a mental illness must be on the agenda.

The partnership should deliver a specification for situating the South Australian Public Service as an exemplary employer.

A future-looking case study:
Susan–possibilities from a joined-up response

Following a 'nervous breakdown' in 2006 and subsequent diagnosis with schizophrenia, Susan became unemployed and remained so for two years. She lacked the confidence to return to the workforce and felt that working would cause her too much stress and would trigger a relapse. In 2008, coordinated work by a Job Network provider, a case worker from the Commonwealth funded Personal Helper and Mentor program and staff of the state community mental health services allowed Susan to access the employment support services while also managing her mental illness. Susan gradually built her confidence and began working part time in a local business. Three years on and Susan now has a full time job and she is mentally stable. Her employer is aware of her illness and has received information and advice on how best to facilitate Susan's employment. Susan is confident, self-determining and feels as though she is once again living a fulfilling life.

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[57] Department of Health, United Kingdom, *Vocational services for people with severe mental health problems: Commissioning guidance*, February 2006.

Partnership 2: General Health/Mental Health/Drug and Alcohol Services

In the earlier information on the profile of people using mental health services, 44%—or just over 2100—indicated a substance misuse problem, 28% or 1360 people reported poor health and 21%—or just over 1000 people—reported dealing with a chronic disease. It is likely that there will be a strong crossover between the latter two.

We know that people with a severe mental illness are at risk of physical illnesses and conditions including coronary heart disease, diabetes, infections, respiratory disease, poor oral health and greater levels of obesity.

People with a mental illness show excess mortality from all causes of death, both natural and unnatural. Overall, people with mental illness have a 2.5 times higher mortality rate than the rest of the population, which is equivalent to a life expectancy in the 50-59 year age group. An Aboriginal person dealing with a severe mental illness is also disadvantaged by an already reduced life expectancy.

A key focus of this partnership must be to ensure that people with severe mental illness are recognised as a vulnerable group in need of a special focus across the health system. They need to be included in all major general health policies in South Australia.

There is a significant crossover of mental illness with diabetes and cardio-vascular disease and all of the identified risk factors of obesity, high blood pressure, physical inactivity, poor nutrition, high blood cholesterol, alcohol use and tobacco smoking.[58] Despite this, South Australia's chronic disease management framework does not give priority to mental health. This needs to be addressed.

Further, studies overseas have shown that people who use mental health services are much less likely than the general population to be offered physical health checks or to receive opportunistic advice on smoking cessation, alcohol, exercise or diet.[59] It is therefore imperative that more is done to link people with general practitioners so that more holistic care can be provided.

The GP Plus centres, announced by the government in the 2006-07 State Budget, provide an excellent opportunity to do this. The Board strongly supports the GP Plus strategy for identifying mental health

> People with a severe mental illness are very vulnerable to physical ill health and they need better general health care at all levels.

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[58] Department of Human Services, *Chronic Disease – Prevention and management opportunities for South Australia,* 2004.
[59] Department of Health, United Kingdom, *Choosing Health: Supporting the physical health needs of people with severe mental illness: Commissioning framework*, August 2006.

services as a potential service stream in centres. However, there is as yet no focus on people with severe mental illness as a vulnerable population needing improved access to primary health care.

Finally, Drug and Alcohol Services need to be a key partner in the focus on the 400-800 people with complex needs. Identity data matching across drug and alcohol inpatient services with other markers will be important to establish whether there are common clients.

A future-looking case study:
Simon–possibilities from a joined-up response

It is now 2011. Two years ago, Simon, aged 26, was admitted to the Emergency Department at the Royal Adelaide Hospital (RAH) for methamphetamine overdose. RAH staff referred him to mental health services for assessment of his apparent drug-induced psychosis. Simon was placed in a dual diagnosis program at Glenside where he received treatment for both his mental health and substance abuse conditions. Previously, Simon had accessed mental health services, but not drug and alcohol treatment. This had seen him cycle through the hospital system a number of times. Following his treatment at Glenside, Simon moved into community-based supported accommodation. Here he received treatment and support to avoid relapse in both his mental health and his drug addiction and treatment for Hepatitis C. Since beginning treatment, Simon's dental health needs have been addressed, which had deteriorated due to his drug abuse and Hepatitis C. He also now regularly sees a GP, which he had not done since childhood. After leaving Glenside, Simon had one relapse in his drug use, but a prompt response from a community team saw him quickly stabilised. He has since been 'clean' for the last 14 months and is an active member of Narcotics Anonymous.

Partnership 3: Child and Adolescent Psychological Wellbeing

Psychological health must be a top priority for existing partnerships in early childhood and school based initiatives.

There is increased interest and understanding across all sectors of the community about the importance of early childhood for the future of South Australia. The state has invested in a joined-up approach across government to early childhood services as a response to the demand for more consumer focused service delivery. Access and participation for children and families with additional needs is recognised as a key priority. In this context, the psychological health of children and young people should be seen as one of the state's top priorities.

Schools are already progressing initiatives that educate young people about mental health and mental illness. Partnerships with organisations like *beyondblue* are integral to this work. The Board believes that a holistic curriculum that delivers mental health education and prevention

messages integrated within existing programs and subjects–rather than as a separate add-on–is the ideal to be working towards.

The partnership will be based on the Department of Education and Children's Services and the Department of Health continuing to work towards delivering integrated services for young people who need more intensive interventions because of serious mental health or behavioural issues. This will necessarily mean changes for both systems. However, integration of the work of professional school-based counsellors with that of specialist mental health services, provided through Child and Adolescent Mental Health Services (CAMHS), will be essential.

The focus of the joined-up partnership in this area should be on:

- Describing the evidence-based policy framework for child and adolescent mental health services, including a definition of the proposed roles of specialist and primary health services and how they relate to schooling and social supports.

- Implementing existing early childhood programs (including antenatal programs) with a focus on mental health, ensuring that standard business planning and staff development and performance management processes focus on increasing the mental health promotion and prevention capacity of early childhood programs.

- Implementing processes for educating young people about mental health and mental illness within the existing curriculum, rather than an as add-on.

- Integrating school-based services with specialist mental health and wellbeing services in the community.

A future-looking case study:
Tim–possibilities from a joined-up response

When Tim had his first psychotic episode, just before his 17th birthday, he was admitted to the adolescent inpatient service at the Child, Youth and Women's Health Service and diagnosed with schizophrenia. During that stay his family received counselling and advice to facilitate a successful return to home. Following discharge, his CAMHS 'gateway' worker worked with Tim and his family on a plan for him to transition to the early psychosis service based at Glenside. His CAMHS and early psychosis case managers co-worked for six months to ensure that the transition ran smoothly. From then onwards, Tim received regular home visits from clinicians and allied health professionals from a community mental health team (CMHT) working from a comprehensive care and relapse plan. In addition to treatment for Tim, the CMHT also provided continuing support and advice to his family and his girlfriend.

Prior to returning to school he was able to do schoolwork while still at home through regular contact with the trained counsellor from his school. Upon returning to school he was able to take advantage of new SACE arrangements and complete his schooling over an extended period. Throughout this time the school counsellor and community mental health workers continued to work together to monitor his health and to ensure that he was able to continue his education successfully. Tim finished Year 12 last year, has commenced an undergraduate degree and his illness remains stable. He continues to receive regular visits from the CMHT and is now working with the team's vocational specialist to look for part time work.

Partnership 4: Housing/Social Care/Aged Care/Mental Health

From a social inclusion perspective, the therapeutic significance of having a stable place of one's own to live—a home—provides the foundation upon which to realise a person's desire and ability to make progress in other aspects of their life. It is not possible to deliver anything meaningful in the way of rehabilitation and recovery to people who either have no home or are in marginal accommodation.

A home is the foundation for people to move forward on their life goals supported by rehabilitation and recovery services.

The first focus must be on the 400-800 people who have complex needs. It is likely that some will be in insecure housing. Data matching will identify those who are a priority in this context. There may be social care agencies in the homeless sector working with some people. If these relationships are effective, then they should be drawn into the partnership.

Alignment of housing and social care

Housing is a key priority and joining up with clinical mental health, and social care services is essential to deliver the best outcomes.

There is an important relationship between support needs and accommodation in the stepped model of care. The modelling indicates that South Australia will need 150 24 hour supported accommodation places and 300 visited community places. As the intensity of the support increases, there is clearly value in clustered housing to ensure efficiencies in support service models.

Supported housing places where people are living in their own tenure should be the mainstay of the system.

It is estimated that there are almost 2000 people using community mental health services living in public or social housing. The security of the tenure is not known. It is likely that some will be at risk and would benefit from a joined-up response to maintain their housing.

The Board is aware that the key state agency partners (Department for Families and Communities and the Department of Health) are already engaged in a process that is looking at the relationship between psychiatric disability support services and psychosocial rehabilitation services in the NGO sector. The Board does not want to pre-empt that process other than to observe that:

- Historically, community services and mental health services have had a difficult relationship with each sector concerned, with some cause, that the other service sector is unresponsive.
- The Department for Families and Communities has mechanisms for contracting with the non-government and it is not efficient for the Department of Health to duplicate them.
- A specification that protects the integrity of both agencies' investment would seem to be a good starting point for the re-contracting process recommended by the Board.

The stepped model of care relies on the elements of the system being in balance. The alignment of community mental health services, support and housing around a consumer is critical to achieving their recovery goals.

Mental health services for older people are the least well developed in South Australia and are out of touch with contemporary policy. The state must shift to an aged care/shared care model for residential services and there must be a clear framework. The partnership also needs to advance the Board's recommendations for a strategic investment and development plan for earlier intervention outlined in the previous section.

Effective partnerships are needed to modernise South Australia's mental health services for older people.

A future-looking case study:
June–possibilities from a joined-up response

June, aged 46, has had difficulty maintaining accommodation for the past twenty years. She has a long history of failed tenancies in both the public and private rental housing systems. June has diagnosed agoraphobia and generalised anxiety disorder (GAD), the acuity of which increases markedly whenever she has to move to a new residence. Three years ago June was identified through a supported tenancy program as being at high risk of falling out of the housing system completely. The program initiated the services of a community mental health team to provide June with treatment for her agoraphobia and GAD. June was moved from a three-bedroom house with a large backyard, into a more manageable, supported single bedroom apartment. The housing support workers assist June to manage her new home and have referred her for advice on budgeting. June's mental state is more stable and she receives regular visits from community mental health teams. On the infrequent occasions that June requires it, the housing support workers activate a system through

which they initiate more intensive treatment for her. June feels much more comfortable in the knowledge that she can access support whenever she needs it. June has now been housed in her unit for two and a half years, her longest tenancy in over a decade.

Partnership 5: Justice/Mental Health

The increased prevalence of mental illness amongst people cycling through the criminal justice system has been discussed previously as a worldwide phenomena.[60]

Aboriginal people are 13 times more likely to be in contact with the criminal justice system and are over-represented in these high prevalence rates. Nationally, incarceration rates for Aboriginal and Torres Strait Islander women have more than doubled in the last ten years.

The prevalence of mental health problems in women generally is significantly greater, linked to the fact that three quarters of female prisoners are illicit drug users and are incarcerated for drug and drug-related crime.[61]

The first focus for this partnership is on the 400-800 people with complex needs. The court diversion scheme operating through the Magistrates Mental Impairment Court can provide a useful re-entry point for people with complex needs who have been lost to follow-up by community mental health services. This scheme performs or organises mental health assessments, gathers information and presents a comprehensive report to the court with recommendations. All defendants coming before the courts have the right to due process. A person charged with an offence may deem it to be in their best interests in particular circumstances to refuse diversion and instead opt for their case to be heard in the normal way under the criminal justice system.

Currently, health services for prisoners have three components: primary care (with general practitioners being responsible for physical health and routine mental health complaints), specialist forensic (providing specialist mental health care) and social work, psychology and addiction services (which are broadly responsible for prisoners' other mental health needs). There needs to be greater co-ordination and, where appropriate, integration of clinical services with social work, psychology and addiction services.

This partnership must leverage off existing relationships to deliver more integrated services for people with complex needs.

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[60] Corrective Services Administrators Conference, unpublished paper *Prisoners with Mental Health Problems*, 2006.

[61] Australian Health Ministers Advisory Council, Standing Committee on Aboriginal and Torres Strait Islander Health, *Policy Guidelines for the Provision of Aboriginal Custodial Health*, 2004.

A future-looking case study:
John–possibilities from a joined-up response

12 months ago, John, aged 23, was charged with carrying an offensive weapon and was referred to the Mental Impairment Court by police. John suffers from psychosis, antisocial personality disorder, has high levels of paranoia and aggressive behaviour. He has a history of chronic substance use and youth offending. Through a joined-up approach from the social inclusion justice partnership agencies, John underwent psychiatric assessment and was placed on supervised bail conditions with access to a forensic psychiatrist. Over the next five months John underwent treatment for his psychosis, maintained his own accommodation with the help of housing support services and adhered to his bail conditions. Through intervention from drug and alcohol services, he significantly reduced his substance misuse. At his final review the charges against him were withdrawn due to his treatment adherence and the cessation of his criminal behaviour. John currently has a stable mental state and decreased levels of anxiety, paranoia and suspicion. He lives in stable accommodation, is job ready and has regular psychologist visits to manage his illness.

Conclusion

In recommending these partnerships, the Social Inclusion Board is aware that joined-up work is demanding, but also that it delivers results. The focus should be on people with the greatest need who can benefit most from such activity. It will only succeed if it is supported at the highest levels in government agencies and non-government organisations. The oversight of joined-up work by an inter-ministerial committee will be essential.

Recommendation 36:

The five mental health partnerships for joined-up government that have commenced work should continue. Completing their agendas to deliver co-ordinated and, where required, integrated responses to mental health issues are essential to the stepped system of care.

Recommendation 37:

Reporting on the progress of the partnerships should be formalised through the establishment of an inter-ministerial committee, chaired by the Minister for Mental Health and Substance Misuse and supported by senior officials.

7. TACKLING STIGMA AND DISCRIMINATION

'Stigma erodes confidence that mental health disorders are valid, treatable conditions. It leads people to avoid socialising, employing or working with or renting to or living near people who have a mental health disorder…stigma tragically deprives people of their dignity and interferes with their full participation in society.' [62]

Stigma is pervasive and will only be tackled when people with a mental illness are socially included.

Stigma and discrimination against people with mental health problems is pervasive. Campaigns against discrimination have their place, but they cannot and should not be the limit of South Australia's effort. In order to be included, people with mental illness require social capital—the expressions of trust and reciprocity on which a life can be built. Social capital means the networks, social ties and mutual obligations that we accumulate over time and can be drawn upon and used in a way that produces personal, economic and social gain. They are a shared or group-held social resource.

How can government contribute?

At the first level, a community awareness campaign on the changes to the Equal Opportunity Legislation to protect people with a mental illness from discrimination will be essential to support the passage of the Bill and the changes to the Equal Opportunity Act.

'An Open Mind' will be the banner for campaigns to educate and promote positive messages to the broader community.

A targeted approach will be more effective and manageable and, in the first instance, the focus should be on employment, accommodation and education as the three areas in which discrimination has significant impact on people's lives.

At the second level, an ongoing 'slow stream' public health campaign under the banner of 'An Open Mind' will educate the community on the facts of mental illness and the promotion of positive messages and images.

At the third level, government must be situated as an exemplary organisation. Every day there are thousands of interactions between people with a mental illness and services, both those in the mental health system and those across government. Every respectful interaction sends the message that people can belong and participate. Every time people feel they have real choices, they receive the message that they have the right to participate in decision-making.

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[62] Department of Health and Human Services, *Surgeon General's Report on Mental Health*, Washington 1999.

Every productive partnership between agencies signals that we are prepared to work together to provide the foundations–housing, employment, support—on which people can build their social capital.

The public sector is a major employer in South Australia–every manager who is open and flexible around employment and every employee who welcomes and supports people with a mental illness into and in the workforce reinforces the fact that people dealing with a mental illness can belong and participate in our world of work.

The government also commissions significant services in other sectors. The way in which we commission, the frameworks we use and the accountabilities we demand should all reflect our commitment to social inclusion. The key relationship in programmed services continues to be between the public funder and the service provider. Consumers and other end users are systematically excluded from the financial and accountability relationships. Changing that relationship sends the message that our service systems are truly people-centred.

Government can use both its employment and its procurement processes to advance social inclusion for people with a mental illness.

How can community leaders contribute?

Community leaders who challenge stigma and discrimination against people with a mental illness promote the norms and values of a socially inclusive society.

Community leaders and people with high profiles, who have a mental health problem and are open about it, communicate that a person cannot and must not be defined by their illness. They change perceptions about the stereotypes of mental illness and encourage other people to disclose.

Community leaders can challenge stereotypes and the media can help shape public opinion and perception around the plan and promote the benefit for people affected by mental illness.

How can the media contribute?

The Board has developed a broad-based plan that will make mental health services more effective. The media will be a major channel of communication for the plan. Media has the ability to shape public opinion and perception. Balanced, accurate and sensitive reporting will be critical to the community gaining a genuine understanding of the plan. Ultimately, it will be a key contributor to its success.

How can each of us contribute?

The evidence suggests that positive personal contact is the best counter to stigma and discrimination. At the neighbourhood level, each of us as neighbours, shoppers, members of faith communities, parents and sports people have opportunities to change our perceptions and our actions. For people with a mental illness, the local relationships such as being a customer of the deli or supermarket, a resident serviced by the post office or a member of the library or a local sporting club are the mainstays of social inclusion.

Every action in the plan moves us forward on our social inclusion agenda. Glenside symbolises South Australia's break with the past and the hope for a new future.

The Social Inclusion Board views its plan not as a strategy for system change, but as a contribution to social inclusion. Every action in the plan that is effectively implemented moves South Australia forward on its social inclusion agenda.

And in that context, the structural and cultural renewal of the Glenside site is the symbolic break with the past and the hope for a new future that South Australia needs to complete its transformation.

Recommendation 38:

The South Australian Government should develop two campaigns:
- A targeted awareness campaign on the changes to the Equal Opportunity Legislation to protect people with a mental illness from discrimination.
- A 'slow stream' public health campaign under the banner of 'An Open Mind' to educate the community on the facts about mental illness and promotion of positive messages about people dealing with mental illness.

Recommendation 39:

An across government action plan should be developed and implemented to ensure that the South Australian Government is an exemplary organisation in managing the psychological wellbeing of employees and in the employment of people with mental health issues.

IMPLEMENTING THE PLAN–MAKING IT HAPPEN

This report has described a vision for changing how we think about mental health and how we deliver mental health services, but producing policy advice is only one step in the process of achieving change. To make the proposed vision a reality–to produce real benefits for individuals, families and service providers–the recommendations in this report must be implemented. This will involve a challenging process of transition and transformation.

It is recommended that the Department of Health have primary responsibility in implementing the Board's recommendations. However, as indicated throughout the report, real change and a lasting impact can only be achieved if implementation happens in partnership. A joined-up approach is required and must include other government agencies, the non-government sector, people who work in the sector and, most importantly, people who need mental health services and their carers and families.

The vision must translate into a transformed system through a joined-up approach with meaningful input from consumers and carers.

It is essential for the effective implementation of the Board's advice that the recommendations are seen as interrelated and interdependent and that they are implemented as a complete plan. It is also essential that consumers and carers have meaningful input into the implementation process at all levels. The Board's experience is that, while consumers and carers share much in common, there are also differing viewpoints. Separate mechanisms will ensure the integrity of the advice from both perspectives.

Recommendation 40:

The South Australian Government should implement the Social Inclusion Board's Plan of Action for the reform of the mental health system over five years.

Recommendation 41:

In planning for the implementation of the Board's recommendations, the Department of Health must ensure that consumers, carers and families have meaningful input at all levels.

Change is always challenging. Implementing the vision in this report is as much about changing culture as it is about changing structures. Engaging the hearts and minds of all partners is crucial.

The Social Inclusion Board is convinced that the South Australian mental health system has the willingness and ability to meet this challenge. In partnership we can make it happen.

Glossary of terms

Acute care
Short-term medical treatment, usually in a hospital, for patients having an acute illness, which generally exhibits a rapid onset followed by a short, severe course.

Catchment
The geographical area and its population that is serviced.

Clinical
Related to the treatment of a disorder.

COAG
Established in 1992, the Council of Australian Governments (COAG) is the peak intergovernmental forum in Australia. COAG comprises the Prime Minister, state premiers, territory chief ministers and the President of the Australian Local Government Association (ALGA). The role of COAG is to initiate, develop and monitor the implementation of policy reforms that are of national significance and which require co-operative action by Australian governments.

Community mental health
Those services and teams that are delivering care outside of hospital settings across the child and adolescent, adult and older people sectors.

Contracting
The process whereby government purchases services from other sectors based on agreed specifications, resources and accountability arrangements.

Country South Australia
The geographic area and its population outside of the Adelaide metropolitan area.

De-institutionalisation
Refers to the process of discharging long-term patients from psychiatric hospitals and other long-term facilities so that they can live in the general community.

Forensic services
Specialised services for people who have a mental illness and are in contact with the courts or the corrections system.

Full time equivalent
The percentage of time a staff member works represented as a decimal where 1 equals full time.

Mental health
Mental health is not simply the absence of mental illness. It is a state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential.

Mental illness
Mental illness is a clinically diagnosable condition (or disorder) that significantly interferes with an individual's cognitive, emotional or social abilities.

Intermediate care
A range of service types with the common aim of providing short-term substitutes for acute admissions or hospital stays.

Inpatients
People receiving care in hospital settings.

Joined-up government
Agencies across government working together to deliver benefits for particular people or interest groups whose needs span more than one portfolio.

Mainstreaming
The transfer of beds from stand-alone psychiatric hospitals to psychiatric wards in general hospitals.

Non government organisations (NGO)
In the context of the report, refers to those organisations in the not for profit or for profit sector who are contracted to deliver services for people with a mental illness.

Psychotic conditions
A diverse group of illnesses that are characterised by fundamental distortions of thinking, perception or emotional response and include schizophrenia, bipolar affective disorders and delusional disorders.

Psychosocial rehabilitation
Practice that encourages people to participate actively with others in working on their mental health and social competence goals. The process emphasises wholeness and wellness and has a comprehensive approach to the delivery of vocational, residential, social/recreational, education and personal adjustment services.

Recovery
A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life.

Shared care
In the context of this report, shared care refers to arrangements where practitioners from the primary care and specialist sectors work co-operatively to achieve positive outcomes for a person or group.

Social capital
The networks, social ties and mutual obligations that are accumulated over time and can be drawn upon and used in a way that produces personal, economic and social gain. They are a shared or group-held social resource.

Specialist services
In the context of this report, specialist refers to the secondary and tertiary services that are the state funded component of mental health services.

Stepped care
A service system that is organised as a range of steps from the least intensive to the most intensive. The system is balanced by ensuring there is sufficient capacity at each of the less intensive service steps so as to limit the need for more intensive options. Costs are likewise graduated across the steps from the least expensive to the more expensive.

APPENDIX 1: Social Inclusion Board members

Monsignor David Cappo (Chair)

Ms Amanda Blair

Mr Mark Butler

Prof Bettina Cass

Mr Bill Cossey

Prof Graeme Hugo

Ms Ingrid Marshall

Mr Alwyn McKenzie

Ms Tanya Smith

Prof Roger Thomas

Mr Brenton Wright

APPENDIX 2: Reference Group and Panel Members

Reference Group

Cappo, Monsignor David   **(Chair)**

Belperio, Dorothy, Ms	The Richmond Fellowship of SA
Blieschke, Jeremy, Mr	Social Inclusion Unit
Bonner, Rob, Mr	Australian Nursing Federation
Brayley, John, Dr	Department of Health
Bria, Robert, Mr	Social Inclusion Unit
Buckskin, Mary, Ms	Aboriginal Health Council of South Australia
Butler, Mark, Mr	Social Inclusion Board
Chhabria, Belinda, Ms	Department of the Premier and Cabinet
Colbung, Kerry, Ms	Department of Health
Cossey, Bill, Mr	Social Inclusion Board
Devlin, Janet, Ms	South Australian Divisions of General Practice
Dodd, Zell, Ms	Southern Adelaide Health Service
Fielke, Ken, Dr	Rural & Remote Mental Health Services
Fisher, Jane, Ms	Council on the Ageing South Australia
Frost, Peter, Dr	South Australian Divisions of General Practice
Harris, Geoff, Mr	Mental Health Coalition of South Australia
Hundertmark, James, Dr	Royal Australian & New Zealand College of Psychiatrists
Johnson, Bob, Mr.	Country Consumer
Laubsch, Sam, Ms	Youth Affairs Council of South Australia
Lawrie-Smith, April, Ms	Department of Justice
Maguire, Madge, Ms	Catherine House Inc
Martinez, Lee, Ms	Department of Health
Miliotis, Natasha, Ms	Mental Illness Fellowship of South Australia
Oxlad, Lindsay, Mr	Public Service Association
Panter, David, Dr.	Department of Health
Rozenbilds, Ute, Dr	Royal Australian and New Zealand College of Psychiatrists
Saltis, Johanna, Dr	Australian Psychological Society of South Australia Branch
Sanders, Cathy, Dr	South Australian Divisions of General Practice
Smith, Tanya, Ms	Social Inclusion Board
Steeples, Tom, Mr	Health Consumer Alliance
Thomas, Roger, Mr	Social Inclusion Board
Upton, Sue, Ms	Helping Hand Aged Care Inc
Waterford, David, Mr	Social Inclusion Unit
Warmington, Rosemary, Ms	Carers Association of South Australia Inc
Whitehorn, Jill, Ms	Social Inclusion Unit
Winefield, Helen, Dr	Australian Psychological Society South Australia Branch
Wright, Brenton, Mr	Social Inclusion Board
Yates, Ian, Mr	Council on the Ageing South Australia

Consumers, Carers & Advocates Advisory Panel

Wright, Brenton, Mr   **(Chair)**

Burgess, Anne, Ms	Equal Opportunity Commission
Di'Orio, Mirella, Ms	Disability Action
Doogue, Barbara, Ms	NORCAG
English, Lyn, Ms	Panic Anxiety Disorder Association
Harley, John, Mr	Office of Public Advocate
Haynes, Coralie, Ms	Flinders Medical Centre Mental Health Consumer Group
Hilton, Michelle, Ms	ASEC (Youthink)
Kluzek, Ben, Mr	Eating Disorder Association of South Australia Inc
Laubsch, Sam, Ms	Youth Affairs Council of South Australia
Mason, Paola, Ms	Children of Mentally Ill Consumers
Miliotis, Natasha, Ms	Mental Illness Fellowship of South Australia Inc
Parry, Trevor, Mr	Noarlunga Mental Health Consumer Group
Potter, Reg, Mr	Consumer & Carer Advisory Council covering Glenside Campus & Eastern Mental Health Services
Rigney, David, Mr	Disability Advocacy & Complaints Service
Seiboth, Joy, Ms	Association of Relatives & Friends of the mentally Ill
Slocombe, Colin, Mr	Obsessive Compulsive Disorders Support Group
Smith, Ann, Ms	Flinders Medical Centre Mental Health Consumer Group
Smith-McCue, Dy, Ms	Youth Think (Child & Adolescent Mental Health Service
Steeples, Tom, Mr	Health Consumer Alliance
Stocco, Denis, Mr	Mood Disorders Association of South Australia
Van de Ven, Michelle, Ms	Mood Disorders Association of South Australia
Warmington, Rosemary, Ms	Carers Association of South Australia Inc
Waterford, David, Mr	Social Inclusion Unit
Whitehorn, Jill, Ms	Social Inclusion Unit
Yates, Ian, Mr	Council on the Ageing South Australia

Management Panel

Cossey, Bill, Mr   **(Chair)**

Beltchev, George, Mr	Department of Health
Bosio, Anne, Ms	Department of Further Education, Employment, Science and Technology
Brayley, John, Dr	Department of Health
Caudrey, David, Mr	Department for Families & Communities
Cappo, David Mons	Commissioner for Social Inclusion
Cusack, Lynette, Ms	Drug & Alcohol Services South Australia
Diamond, Mark, Mr	Department of Health
Dow, Alastair, Dr	Department of Education & Children's Services
Durrington, Learne, Ms	Department of Health
Evans, Keith, Mr	Drug & Alcohol Services South Australia
Fahy, Bryan, Mr	South Australian Police
Goodes, Tim, Mr	Attorney General's Department
Komorek, Marie, Ms	Children, Youth & Women's Health Service
Leggett, Mark, Mr	Department of Health
MacDonald, Gerard, Mr	Department of Treasury & Finance
Miller, Sandy, Mr	Department of Health
Mondy, Gail, Ms	Children, Youth & Women's Health Service
Panter, David, Dr	Department of Health
Rafalowicz, Eli, Dr	Southern Adelaide Health Service
Reid, Simonne, Ms	Department of Health
Severin, Peter, Mr	Department of Correctional Services
Smith, Tanya, Ms	Office of the Executive Committee of Cabinet
Waterford, David, Mr	Social Inclusion Unit
Whitehorn, Jill, Ms	Social Inclusion Unit
Wildash, Helen, Ms	Department of Education & Children's Services
Wilson, Liz, Ms	Department for Families & Communities

Non-Government Organisations Advisory Panel

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Ballestrin, Darryl, Mr	GROW (South Australia) Inc
Belperio, Dorothy, Ms	The Richmond Fellowship of South Australia
Biven, Andrew, Mr	South Australian Network of Drug & Alcohol Services
Brown, Josephine, Ms	Neami Port Adelaide
Buckskin, Mary, Ms	Aboriginal Health Council of South Australia
Cleary, Terry, Mr	Anglicare South Australia Inc
Duncan, Jennifer, Ms	SACOSS
Dunn, Midge, Ms	Life Without Barriers
Fitzpatrick, Colleen, Ms	Lutheran Community Care
Graham, Colin, Mr	Aboriginal Health Council of South Australia
Grogan, Karen, Ms	South Australian Council of Social Services
Harris, Geoff, Mr	Mental Health Coalition of South Australia
Horsnell, Jan, Ms	Anglicare, South Australia Inc
Klun, Viv, Ms	Isolated Persons Project of Norwood
Lowe, Steve, Mr	Clubhouse South Australia
Marks, Sue, Ms	Roofs South Australia
McGrath, Bernadette, Ms	Supporting Survivors of Torture & Trauma
McGuire, Madge, Ms	Catherine House Inc
Millar, Sean, Mr	Neami Port Adelaide
Schwarz, Peter, Mr	Recreation Link-Up Program, Young Men's Christian Association
Senior, Paul Mr	Centacare Catholic Family Services
Smith, Sonia	Isolated Persons Project of Norwood
Steinfort, Patrick, Mr	Peer Support Foundation Victoria
Upton, Sue, Ms	Helping Hand Aged Care Inc
Warner, Peter, Mr	Uniting Care Wesley Port Adelaide
Waterford, David, Mr	Social Inclusion Unit
Whitehorn, Jill, Ms	Social Inclusion Unit
Wilson, Robert, Mr	Baptist Community Services (South Australia) Inc
Young, Bev, Ms	Southern Cross Care South Australia Inc

Workforce and Professions Advisory Panel

Butler, Mark, Mr   **(Chair)**

Barkway, Pat, Ms	Australian & New Zealand College of Mental Health Nurses
Bonner, Rob, Mr	Australian Nursing Federation
Cain, Chris, Dr	Australian Medical Association South Australia Inc
Cooper, Steph, Dr	South Australian Salaried Medical Officers Association
Dhillon, Rohan, Dr	South Australian Salaried Medical Officers Association
Gilbert-Hunt, Sue, Ms	Australian Association of Occupational Therapists, South Australia
Hare, Jon, Mr	Psychologists Association of South Australia
Keeler, Ngara, Ms	Convenor, Aboriginal Health Workers Forum
Leow, Steven, Dr	Royal Australian College of General Practitioners
Oxlad, Lindsay, Mr	Public Service Association
Pegram, Robert, Dr	Royal Australian College of General Practitioners
Rozenbilds, Ute, Dr	Royal Australian & New Zealand College of Psychiatrists
Rugen, Connie, Ms	Australian Association of Social Workers
Sanders, Cathy, Dr	South Australian Divisions of General Practice
Waterford, David, Mr	Social Inclusion Unit
Whitehorn, Jill, Ms	Social Inclusion Unit
Winefield, Helen, Dr	Australian Psychological Society South Australia Branch

APPENDIX 3: Partnerships for joined-up responses

Partnership 1: Education, Employment and Training/Mental Health

Department of the Premier and Cabinet—Social Inclusion (COAG)
Department of the Premier and Cabinet—Aboriginal Affairs and
Reconciliation
Department of Health—Mental Health Unit
Department of Further Education, Employment, Science and Training
Commonwealth Department of Health and Ageing—Mental Health
Commonwealth Department of Human Services—CentreLink
Commonwealth Department of Employment and Workplace Relations

Partnership 2:General Health/Mental Health/Drug and Alcohol Services

Department of Health
Department of Health—Aboriginal Services Division
Commonwealth Department of Health and Ageing—Primary Health
Care
Regional Health Services—General and Mental Health
Drug and Alcohol Services SA
Office for Women
Department of the Premier and Cabinet—Social Inclusion Unit
Department of the Premier and Cabinet—Aboriginal Affairs and
Reconciliation

Partnership 3: Child and Adolescent Psychological Wellbeing

Child and Adolescent Mental Health Services
Child, Youth and Women's Health Service
Department of Education and Children's Services
Department for Families and Communities
Families SA
Department of the Premier and Cabinet—Social Inclusion Unit
Department of the Premier and Cabinet—Aboriginal Affairs and
Reconciliation
Office for Youth

Partnership 4: Housing/Social Care/Aged Care/Mental Health

Department of Health - Mental Health
Department for Families and Communities—Disability Services
Department for Families and Communities—High Need Housing

Department for Families and Communities—Office for the Ageing
Housing SA
Community Housing
Regional Mental Health Services
Commonwealth Department for Families and Community Services and
Indigenous Affairs (FACSIA)
Commonwealth Department of Health and Ageing (DoHA)—Aged Care

Partnership 5: Justice/Mental Health

Attorney-Generals Department
SA Police
Department of Correctional Services
Courts Administration Authority
Department of Health—Mental Health
Department of Health—Aboriginal Health Division
Department of Health—Prisoner Health Services
Drug And Alcohol Services SA
Regional Mental Health Services
Department of the Premier and Cabinet—Social Inclusion Unit
Department of the Premier and Cabinet—Aboriginal Affairs and
Reconciliation

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