DISCUSSION PAPER –

MENTAL HEALTH

CALLAN PARK MASTER PLAN

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About Professor Vaughan Carr

Vaughan Carr graduated in medicine from the University of Adelaide in 1973 and received his training in psychiatry at the University of Rochester (1974-78) and Yale University (1978-80) in the USA.

After 8 years as an academic psychiatrist at the University of Adelaide, he took up the position of Professor of Psychiatry at the University of Newcastle in 1989 and Director, Hunter Mental Health from 1997 to 2005. As Director of Hunter Mental Health, Professor Carr led a program of structural reorganisation, reform and renewal of mental health services in the Hunter Area based on mental health strategic plans, which he prepared in 1993 and 1996.

Vaughan was Founding Director of the Hunter Institute of Mental Health in Newcastle from 1992 to 1997. He was President of the Australasian Society for Psychiatric Research (ASPR) in 1997-98.

In 1996-2000 Vaughan initiated and lead the establishment of the Psychological Assistance Service, a clinical unit for the identification and treatment of young people at 'ultra-high risk' of developing psychotic disorders.

Vaughan has served on numerous Regional Grants Interview Committees and Grant Review Panels of the National Health and Medical Research Council (NH&MRC) since 1988, and has been the psychiatry representative on the Australian Drug Evaluation Committee of the Therapeutic Goods Administration (2004-06).

Commencing in 1999 Vaughan was Director of the Centre for Mental Health Studies, a multi-disciplinary organisation for research, education and service evaluation in mental health. He was appointed Scientific Director of the Schizophrenia Research Institute (formerly the Neuroscience Institute of Schizophrenia and Allied Disorders) in 2004 and the Institute's Chief Executive Officer in 2007.

In 2006 Vaughan was appointed Director of a new Priority Research Centre at the University of Newcastle, the Centre for Brain and Mental Health Research.

Professor Carr's research has been recognised by his peers through the award of the ASPR Organon Research Award (1987), the ASPR Novartis Oration (2003), and the ASPR Founders' Medal (2006).

In the past 10 years Vaughan has been a chief investigator on 41 NH&MRC and other research grants (total value $14.2 million). He is the lead chief investigator on a NH&MRC Enabling Grant for the establishment of a national schizophrenia research bank involving collaborators in four states.

Vaughan has co-edited two textbooks and has made contributions to a number of books, published proceedings and an encyclopaedia. He has over 150 publications in the areas of schizophrenia and other psychotic disorders, early psychosis, depression, post-traumatic stress, mental health care delivery in general practice, child psychiatry, cognitive neuroscience, mental health service evaluation, alcohol and drug abuse, psychotherapy and health economics.

In 2009 Vaughan resigned from the University of Newcastle to commence appointment as Professor of Schizophrenia Epidemiology and Population Health at the University of New South Wales.

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Mental Health

The history of mental health service provision at Callan Park

Callan Park began to be developed in 1873 as a lunatic asylum under the direction of Dr. Frederick Norton Manning. Manning designed the asylum as a stand-alone psychiatric facility based on the principles of the Kirkbride Plan, which promoted seclusion from suspected causes of illness in natural environments with extensive grounds and cultivated parks, away from pollutants and urban centres, with the intention of curing mental illnesses. These asylums aimed to replace cruder methods of coping with the mentally ill, such as confining them to prisons or poorhouses where they were often abused and their special needs were rarely met, and they revolutionised the treatment of the mentally ill in NSW.

Callan Park was initially a branch of the overcrowded Gladesville Hospital for the Insane, but in 1878 was proclaimed an independent institution known as Callan Park hospital for the Insane (later known as Callan Park Mental Hospital). Nearby Broughton Hall became a convalescence hospital for shell-shocked soldiers in 1915 before being transformed into Broughton Hall Psychiatric Clinic for voluntarily-admitted patients by Dr. Sydney Evan Jones in 1921. Callan Park and Broughton Hall continued to function as mental health facilities until their amalgamation in 1976 to become the 250 bed Rozelle Hospital. In April 2008, all Rozelle Hospital services and patients were transferred to Concord Hospital in accordance with national strategies regarding mental health reform that stated psychiatric facilities should be co-located with general hospitals. The Concord Centre for Mental Health (CCMH) currently contains 172 beds[1].

The evolution of mental health service provision, current frameworks and future directions

From institutionalisation to community care

In Australia and other developed countries the management of people living with a mental illness predominantly consisted of custodial care up until the 1970s. Beginning as early as the 1950s, stand alone psychiatric hospitals, or asylums, were criticised as being degrading, humiliating and in violation of basic human rights (for example see Goffman, 1961 and the Office of Psychiatric Service Audit, 1992).

[1] CCMH contains a 30-bed older persons unit, two 24-bed acute adult unit, a 10-bed IPCU and 10-bed male HDU, 12-bed female HDU, two rehabilitation units (35- and 15-beds) and a 12-bed adolescent unit.

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With the development of new pharmaceutical treatments the need for physical restraints and custodial care was all but eliminated resulting in pressure to close stand-alone psychiatric hospitals. Subsequently, in 1983 the Richmond inquiry into health services for the psychiatrically ill and developmentally disabled recommended a reduction in the number of beds in the large psychiatric hospitals in parallel with the provision of alternative community care to reduce stigma and improve the quality of treatment and social integration of consumers.

> "Fundamental to the Richmond Report philosophy was the notion of a network of community based services including hospital care, health teams, supported houses, rehabilitation services and crisis care." (Out of Darkness into Light, The Richmond Report, Speech notes, May 2003 Symposium, by David Richmond AO).

A commonly cited example of successful community care is the work of psychiatrist Franco Basaglia in Trieste, Italy. From 1971 Basaglia transformed the hospital in Trieste replacing it with a network of alternative community services. The grounds were opened up, restraints and electro-convulsive therapy were eliminated, staff were trained to abandon their role as guardians and consumers were engaged in a rehabilitation process that involved meaningful activity and social interaction (see Dell'Acqua, 1995 for a review).

In Australia a National Mental Health Strategy was developed and endorsed in 1992. The strategy has been reaffirmed a number of times since 1992 and the fourth, most recent National Mental Health Plan was released in 2009 (Commonwealth Department of Health and Aging, 2009). A consistent priority of the National Mental Health Strategy was first, to downsize and close stand-alone psychiatric hospitals as part of a community-oriented system of care, while providing inpatient care, where necessary, for people with a mental illness in psychiatric units co-located with general hospitals; and second, to expand treatment and support services to assist people affected by mental illness living in the community. These services include clinical care provided by health professionals working outside hospital settings (referred to as 'ambulatory care services'), residential services and a range of support programs provided by non-government organisations (NGOs). The COAG National Action Plan on Mental Health 2006-2011 sets out how NGO services are incorporated into the National Mental Health Strategy. (see also the NSW Health publications: *Community Mental Health Strategy 2007-2012* and *Housing and Accommodation Support Initiative (HASI)*).

Despite prioritising community care, the National Mental Health Report (NMHR; 2007) found that while there has been a reduction in non-acute beds, the development of specialised community-based residential services has been inadequate. Furthermore, many believe (for example, Groom, Hickie & Davenport, 2003) that investment in the specialist hospital, community and accommodation services that are essential for supporting people with a mental illness has been far from adequate with reportedly only 35% who need community services having access to them.

The recovery model and consumer empowerment

In recent years there has been a movement towards delivering mental health services from a recovery oriented framework. The concept of recovery has been

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defined in multiple ways; however, principles of the model generally include: 1) Hope for recovery; 2) Healing, and defining oneself as separate from the illness; 3) Empowerment and self-determination through active participation; 4) Connection with oneself, relationships and the community; and 5) Human rights (see Jacobson & Greenley, 2001). The definition developed by Patricia Deegan, a consumer, that is cited in the National Mental Health Plan, is:

> *Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges. It is not a perfectly linear process. At times our course is erratic and we falter,*
> *slide back, regroup and start again… The need is to meet the challenge of the disability*
> *and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work and love in a community in which one makes a significant contribution.*

Priorities stated in the most recent National Mental Health Plan include protection from human rights abuses, destigmatisation of mental illness and improvement of consumer empowerment and participation. It proposes that service providers should be accountable to consumers at all levels of the mental health system and provide an avenue to identify and resolve deficiencies in service quality that, historically, compromised the rights of people with a mental illness. It also proposes to improve social inclusion through the development of stable accommodation options, opportunities to participate in employment and education, and improve primary care and mental health services in the community. For more information see NSW Health publications: *NSW Consumer and Carer Mental Health Framework for Participation and Prevention* and the *Mental Health Consumer Perceptions and Experiences of Services Initiative (MHCoPES).*

However, despite the development of Consumer Advisory Committees (CACs) and attempts to generate a recovery-oriented culture in mental health services, many consumers have concluded that while progress has been made in improving consumers' rights and consumer and carer participation, full and meaningful participation has not yet been achieved, particularly in individual treatment decision-making.

Early intervention

Early intervention is the early detection of emerging signs and symptoms of mental illness to enable timely, effective and appropriate treatment that aims either to prevent diagnosable illness or reduce disability and improve the outcomes associated with mental illness. Early intervention activities are generally conceptualised as actions early in life, early in illness and early in episode.

With three quarters of all mental disorders appearing before the age of 25 (Australian Bureau of Statistics, 2008) and an increasing body of evidence to support early intervention activities, there has been a recent emphasis on rethinking our mental health system with a renewed focus on young people and early intervention. The National Mental Health Plan has specified action aimed at building resilience, raising community awareness and treating mental illness as early as possible to reduce long-term disability. Consequently, these reforms have seen the emergence of youth

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and early intervention teams within community mental health services and further growth of services like Orygen Youth Health (http://oyh.org.au/) and the HeadSpace (http://www.headspace.org.au/) network of services. For more information on early intervention see the Commonwealth Department of Health and Aging publications: *Promotion, Prevention and Early Intervention for Mental Health: A Monograph*, and the subsequent *National Action Plan on Promotion, Prevention and Early Intervention in Mental Health*.

Advocates of early intervention, however, argue that access to and quality of mental health care lags behind mainstream health care and this gap is widest for young people who fall between the child/adolescent and adult services. They have called for further development and funding for services that specialise in working with children, young people and their families.

State and Federal government funding for mental health services

According to the 2007 National Mental Health Report, spending on mental health in 2005 was $3.9 billion, an 85% increase in real terms since 1993. Australian Government spending was $1.38 billion, states and territories $2.38 billion and private health insurers $163 million, an increase of 149%, 67% and 18% since 1993, respectively. However, despite this increase in spending Australia's total percentage of health spending allocated to mental health remains below many comparable developed countries. For example, the 2001 World Health Report found that the portion of the health budget allocated to mental health was 6.5% in Australia (note – increased to 6.8% in 2005), 11% in New Zealand, 7% in the Netherlands, 11% in Sweden, 6% in the USA, 10% in the UK, and 11% in Canada.

In terms of progressing towards community-based care, spending by states and territories on community based mental health services increased by 185% or $777 million between 1993 and 2005. In 1993, of state and territory mental health spending, 29% was dedicated to caring for people in the community. By 2005, the community share of total mental health expenditure had increased to 51%. From 1993 to 2005 there was reportedly an increase in health professionals employed in state- and territory-funded ambulatory care mental health services and increased funding to non government organizations (NGOs) to provide mental health services, including community support services for people with psychiatric disability.

Despite reported increases in mental health funding, the recent Council of Australian Government's (COAG) meeting generated united condemnation from those working in the sector who expressed disappointment in the Federal Government's lack of funding for mental health. There were expectations that a major funding announcement on mental health would be part of the deal, however, of the extra $5 billion put on the table for health services, only $174 million was set aside by the Rudd Government for mental health (see COAG publication: A National Health and Hospitals Network for Australia's Future Delivering the Reforms, released 7 July 2010).

Service providers have argued that the best way to reduce pressure on emergency wards and hospital beds is to improve treatment in the community for people with

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mental illness and thereby avert the need for hospitalisation. For further reading see the Mental Health Council of Australia's 2003 report *Out of hospital, Out of mind!*

Current mental health services in the inner west

Current mental health services in the inner west include community based services at Camperdown, Croydon, Glebe, Marrickville and Redfern. These services offer intake, assessment and triage, and the following treatment and support services:

- Mental health assessments
- Support, advice, counseling and case management
- Information and support for family, friends and carers
- 24 hour Acute Care Service Child and Family team for school aged children with a mental illness (Marrickville)

Acute, adolescent, older person and rehabilitation inpatient services are provided by the Concord Centre for Mental Health and the Royal Prince Alfred Hospital (RPAH) Missenden Psychiatric Unit. RPAH also has an Eating Disorders Program with inpatient, day patient and outpatient services.

Complementary programs include:

- *Housing and Accommodation Support Initiative (HASI).* HASI provides accommodation and support for people with a range of levels of psychiatric disability. Under this partnership the Mental Health Service provides the clinical support, an NGO provides the non-clinical support and a community housing association provides the accommodation.
- *Headspace – Youth Mental Health Initiative.* Headspace provides a range of mental health services aimed at young people between the ages of 12 and 25. It is linked with GPs and has a focus on early identification and intervention.
- *AfterCare.* Aftercare offers services to people in the community with mental illnesses, which includes helping people build on their independence, strengthening family and friendship networks, facilitating social and recreational activities in the community and supporting people in their vocational and educational pursuits.
- *We help ourselves (WHOS).* WHOS is a drug and alcohol recovery service that provides residential services, counseling, education and support, and skills development.
- *Mental Health Coordinating Council (MHCC).* MHCC is the peak body for community mental health organizations in NSW. They advocate and represent the sector's views, build sector capacity, facilitate change through policy initiatives, engage in research activities, provide training and promote recovery-oriented approaches.

Mental health service providers in the area identify a lack of appropriate residential services to ease the transition between acute care and the community as one of the most significant gaps in current service provision. Services providing vocational and educational opportunities for consumers and primary care services (including consistent access to GPs and health facilities, consumer education regarding physical health and wellbeing and GP training programs regarding common conditions in consumers) have also been identified as currently inadequate.

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Strengths Callan Park brings to the provision of mental health services

There are several strengths regarding the development of mental health services at Callan Park. First, there is community support for the return of some mental health services. Therefore any master plan must be prepared to consult with, and represent the interests of members of the local community. Second, there are a number of established community services (e.g., Aftercare, We Help Ourselves) in the area that could be supported to provide a broad centralised range of coordinated care for consumers. Third, Callan Park consists of extensive grounds and landscaped gardens that could be utilised to facilitate both mental and physical wellness in mental health consumers (see NSW Health publication: *The effect of the built and natural environment of Mental Heath Units on mental health outcomes and the quality of life of the patients, the staff and the visitors, Chapter 6*). Fourth, the Callan Park (Special Provisions) Act 2002 specifies public or private health services are one of the allowable uses on the site.

Factors potentially acting against the provision of mental health services at Callan Park

Current State and Federal funding for mental health services, which are guided by the National Mental Health Strategy, may constrain the types of services that can be offered at Callan Park.

Also the size and configuration of the existing infrastructure may not be suitable for adaptation to modern mental health service provision. This particularly relates to the development of acute or subacute inpatient facilities that, under current policy guidelines, would need to be co-located with a general hospital (ie, acute beds), and ought to include individual rooms with ensuites, have adequate space for recreation and communal activities (including outdoor space), group and individual therapy rooms, and appropriate office and interview space, all with high level security. Associated support infrastructure also needs to be extensive and consequently a hospital facility would have a large footprint on the site. It is open to question whether a hospital that fits the guidelines of the current National Mental Health Strategy could be provided within the footprint and building envelopes that exist on the site, as is required by the Callan Park (Special Provisions) Act 2002. This, however, needs to be tested through the master planning process before any final recommendations are made as possibilities may exist for a smaller campus style facility.

For supported accommodation options, some existing buildings may be suitable if appropriately refurbished (eg, for supported group-based living), but others may need to be purpose built (eg, for sole-occupant independent living). Achieving new, purpose built buildings would require careful consideration of which (if any) existing buildings could be removed under the guidelines of the Callan Park (Special Provisions) Act 2002 to achieve the necessary footprints and envelopes to suit the new requirements.

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Opportunities for strengthening mental health services at Callan Park

In the last 20 years there have been a number of reforms in mental health service provision. These reforms have redefined the types of services provided and have resulted in a rise in the number of NGOs providing community services in the area of mental health. Callan Park presents a unique opportunity to develop on-site mental health services that fit with current policies and evidence-based frameworks.

Potential to unite local community services (including NGOs) and community mental health services to maximise social inclusion

In order to facilitate service access, coordination and continuity of care, a key priority outlined in the COAG *National Action Plan on Mental Health 2006-2011* was to enhance non-clinical services provided by non-government organisations (NGOs). Developing mental health non-clinical services on Callan Park presents the potential to integrate existing community services that have been developed under this plan by generating interagency links to provide coordinated and continued care across health and social domains.

Potential to develop a mental health services in consultation with the community and consumers

Developing mental health services at Callan Park through a master planning process presents an opportunity to represent the interests of the community and consumers regarding what they perceive to be the vital services required for the area through consultation.

Specific opportunities

Intensive support to families

With a distinct lack of carer support services being a recognised area of need, and psychoeducation and support to families and carers is known to be effective in reducing stress and reducing consumer relapse and rehospitalisation, there is the opportunity to develop family and carer support services. This may potentially involve a resource and information centre and the development of web-based interventions with email and telephone support from personnel on the site, thus promoting broad geographic accessibility to the service.

Improving employment opportunities and outcomes

Consumers have expressed a lack of employment opportunities for those experiencing a mental illness. Realising that the development of skills improves independence and confidence and facilitates community involvement there is the potential to provide services and programs to enable more consumers to access employment and further education. These may include vocational rehabilitation services including work readiness and vocational training through TAFE or other education programs located on the site (e.g., food preparation and serving, computer skills, time management) prior to individual placement and support (IPS) and access to supported employment programs, co-operatives and possibly partnerships with local or on-site services to facilitate movement into the open labour market.

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Increased and improved accommodation options

With an increased risk of homelessness and an already high number that are homeless or in temporary, unstable or substandard accommodation, there is an opportunity to provide supported residential care services for mental health sufferers. This may be in the form of supported small-medium group accommodation, more independent, single occupant housing (e.g., HASI packages varying across the spectrum from low to high levels of support) or transitional residential services that aim to equip consumers with the skills they require to live independently using a recovery-oriented approach. For further reading see *The Road Home: Homelessness white paper* and *COAG National Partnership Agreement on Homelessness.*

Better options for younger people seeking mental health services

There is a significant amount of research that promotes the development of early intervention services. Given this, the current media coverage regarding the lack of opportunities for young people to access appropriate services, and a Federal Government commitment to fund youth focused services, there is the opportunity to provide a youth mental health service. This may include Early Psychosis Prevention and Intervention Centres (EPPIC)-style facilities with supporting acute/subacte beds (Orygen-style service) or Headspace Youth Health facilities.

Primary health care services for consumers (Wellness and Lifestyle Centre)

Primary health care is particularly important because people suffering from mental health problems experience significantly higher rates of physical illness. Even after accounting for death by suicide, people with mental disorders have considerably elevated mortality rates due to a range of physical diseases, for which their access to medical care is typically suboptimal. There is therefore the potential to develop a centre of excellence that deals specifically with physical health issues commonly experienced by mental health consumers (e.g., diabetes, metabolic syndrome, obesity, cardiovascular diseases). The facility may include primary (medical) care services, prevention (exercise, diet, fitness) and healthy lifestyle promotion (recreation, artistic and other creative endeavour, sport and social engagement) to promote overall wellbeing and improved quality of life. In addition to medical doctors (general practitioners), the facility would be serviced by sports and exercise specialists, physiotherapists, occupational therapists, nutritionists and psychologists in providing programs of care that may utilise the extensive grounds and sporting facilities at Callan Park.

Services for forensic mental health consumers and legal assistance for consumers

According to Ian Pike, NSW Parole Authority, there are a significant number of people in custodial institutions who have mental or psychiatric disorders. For instance, about 41% of all inmates have had contact with a psychiatrist or doctor for some mental health problem. And of those, at the time they enter custody, there are about 15% who are prescribed psychiatric medication. Results of a screening survey in 2001, found that 27.5% of the inmates met diagnostic criteria for schizophrenia, 19.5% for bipolar disorder and 48.1% for depression. This highlights the potential to provide mental health and rehabilitation services for forensic mental health consumers who are inevitably part of the community. Another opportunity is to develop a specialised service that provides legal assistance and advice to people with a mental illness. There is also the possibility of providing clinical forensic

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evaluation services on the site to supplement existing local Area Mental Health Services.

Education and training facilities for mental health service providers

As the need for mental health services grows, the need increases for mental health clinicians with specific skills. With existing education and training facilities on the site there is the potential for further development of education and training facilities and programs. This may include multi-disciplinary education, consumer and carer workshops, psychiatry training and community education. This could potentially be achieved with the NSW Institute of Psychiatry establishing a satellite site at Callan Park in addition to the Institute's main campus at Cumberland Hospital in Parramatta.

Inpatient facilities

The development of inpatient facilities depends on a number of factors including Commonwealth and State policy and funding, and the ability to meet the specific architectural requirements of a modern inpatient facility. There is potentially an opportunity to develop some form of inpatient facility funded by either the private or public sector or both. Possible considerations include forming a centre of specialised expertise for voluntary tertiary referrals from across the State that may contain:

- short term, subacute beds for stabilisation, monitoring, diagnostic evaluation, special investigations, therapeutic procedures, and special medication commencement
- medium term, rehabilitation beds for medium term stabilisation and intensive rehabilitation
- a mix of private and public beds
- adjacent supported or independent accommodation facilities for consumers needing hospital level care but who live at a distance and require daily access to on-site rehabilitation services (e.g., vocational rehabilitation programs, Wellness and Lifestyle Centre)

Research facilities

There is the potential to develop specialised research facilitates. Specific possibilities include research centres focussing on rehabilitation psychiatry, clinical trials, and mental health economics. There are currently national research gaps in each of these areas and the nature of mental health services proposed here for development on the Callan Park site would fit well with research in these particular domains, and the research presence would, in turn, enrich and strengthen the mental health services on offer.

Expectations and moving ahead

Initially, further consultation with stakeholders, including the community and already established NGO service providers, is required to further establish the current profiles of service provision and expectations. Similarly, consultation with consumers (e.g., consumer groups and area consumer representatives) regarding their expectations and perceptions of what mental health services are needed locally is required.

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Further consultation is required regarding the above-mentioned specific opportunities and related evidence-based practices. Consultations around governance and funding are also required.

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Consultations to date include:

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- Victor Storm, Director, Sydney South West Area Health Service Mental Health, Drug and Alcohol programs
- David McGrath, Director, NSW Health Mental Health, Drug and Alcohol Programs
- Douglas Holmes, NSW Consumers Advisory Group
- Ros Montague, NSW Institute of Psychiatry
- Garth Popple, We Help Ourselves
- Friends of Callan Park

Further Reading:

- NSW Health Policy directives, guidelines and publications:
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    - NSW: A new direction for mental health. NSW Health.
    - NSW Community Mental Health Strategy 2007-2012
    - NSW Consumer and Carer Mental Health Framework for Participation and Prevention
    - Mental Health Consumer Perceptions and Experiences of Services Initiative (MHCoPES).
    - Physical Health Care of Mental Health Consumers: Guideline
    - The effect of the built and natural environment of Mental Heath Units on mental health outcomes and the quality of life of the patients, the staff and the visitors, Chapter 6
- Commonwealth Department of Health and Aging:
    - National Action Plan on Promotion, Prevention and Early Intervention in Mental Health
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Glossary

Acute: A short and severe stage of an illness or condition.

Acute Intervention: Intervention aimed to change the course of a mental health condition during the acute phase of the illness.

Advocacy: Active support (or argument) for a cause.

Anxiety Disorders: Anxiety and worry are a normal part of everyday life. Most people get anxious in everyday situations such as at work, at sporting events or before an interview. When a person is worried continuously in particular situations they may be suffering from an anxiety disorder. Often a person with an anxiety disorder fears that a relative or themselves will become ill or have an accident or they worry about money or work.

Carer: a relative or other person with whom the person with a mental illness has a close relationship and who is affected and concerned by the consumers illness. They may also be actively involved in the provision of care

Case Manager: A staff member who is usually based in a community mental health service who will act as a guide to help you towards recovery. They are responsible for looking after your interests when you are a consumer using public mental health services.

Case Management: This is a service that links, mobilises, coordinates, monitors, and reviews services and resources for the consumers of the mental health services.

Cognitive Behavioural Therapy: A form of therapy that is designed to change the mental images, thoughts and though patterns to help consumers overcome emotional and behavioural problems.

Community: Group of people living in one place or sharing the same background for example the same religion, ethnic origin, profession.

Community mental health teams: Teams which may include: social workers; community psychiatric nurses; consumer and carer consultants; peer support workers; occupational therapists; psychologists and psychiatrists; and Aboriginal mental health workers. Community mental health teams provide a range of services in the community including: individual treatment programs; family interventions; short and long term support; and psycho-education.

Consumer: A person with a mental illness who uses mental health services.

Consumer consultants: Consumers who are employed to advise on and facilitate service responsiveness to people with a mental health problem or mental illness and the inclusion of their perspectives in all aspects of planning, delivery and evaluation of mental health and other relevant services.

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Day programs: Programs providing individual or group centre-based activities on a whole or part-day basis. They include but are not limited to: assessment; assertive life skills training; activities programs; diversional therapy; and pre-vocational training.

Day patient: Person accessing day programs.

Diagnosis: Identifying an illness by looking at the pattern of symptoms that a person describes or is experiencing.

Disability: The effects of mental illness which severely impair functioning in different aspects of a person's life such as the ability to live independently, maintain friendships, maintain employment and to participate meaningfully in the community.

First Episode Psychosis: The first time that a consumer experiences a mental state where there is distortion in, or a loss of contact with reality.

Forensic mental health services: Services providing assistance to people who experience mental illness and are in contact with the adult criminal and juvenile justice systems.

Mental Health Assessment: A measurement or evaluation of the consumers' mental health including their social, emotional and behavioural functioning.

Mental illness: A clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD).

Non-government mental health sector: Private, not-for-profit, community-managed organisations that provide community support services for people affected by mental health problems and mental illness. Non-government organisations (NGOs) may promote self-help and provide support and advocacy services for people who have a mental health problem or a mental illness and carers or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, day programs, prevocational training, residential services and respite care.

Promotion and Prevention: Refers to interventions that occur before the initial onset of a disorder to prevent the development of a disorder. Any action taken to maximise mental health and well being among populations and individuals.

Psychosis: Refers to a mental state in which a person experiences distortion in or a loss of contact with reality.

Referral: To send or direct a person to another service or specialist for further treatment.

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Rehabilitation: Programs which are designed to strengthen individual skills to assist recovery and to develop the environmental supports necessary to sustain the individual as actively and independently as possible in a community setting and prevent hospitalisation. Services, including basic life, prevocational, vocational, recreational, or social, for persons with severe and persistent mental illness.

Social inclusion: Refers to policies which result in the reversal of circumstances or habits which lead to social exclusion. Indicators of social inclusion are that all Australians are able to: secure a job; access services; connect with family, friends, work, personal interests and local community; deal with personal crisis; and have their voices heard.

Supported accommodation: Decent, safe, and affordable community-based housing combined with non-clinical and clinical supports and services which enable people with mental health problems and mental illness to live independently in the community. This also applies to people who may need 24 hour clinical support in a residential (long-stay inpatient) setting rather than an institutional setting.

Symptoms: A change in a person's physical, behavioural or mental state indicating that a person is not functioning normally or an illness is present.

Treatment: The use of medication, rehabilitation and a team of mental health professionals, as well as yourself to help in the recovery from a mental illness.

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