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Response to the National Consultation: Pathways of Recovery: Preventing Relapse

Dear Sir or Madam,

Thank you for providing the Mental Health Co-ordinating Council (MHCC) with the opportunity to take part in the National Consultation on 'Pathways to Recovery: Preventing Relapse', and to comment on the discussion paper.

MHCC is the state peak body for non-governmental organisations (NGOs) working for mental health throughout NSW. MHCC represents the views and interests of over 140 NGOs in the formation of policy, and acts as a liaison between the government and non-government sectors. Our member organisations specialise in the provision of rehabilitation services and support for people with a disability due to mental illness. In developing this submission, MHCC has consulted member organisations, and taken account of the views of consumers, carers and other stakeholders.

The MHCC welcomes the work of the National Mental Health Promotion and Prevention Working Party, and specifically the discussion paper 'Pathways of Recovery: Preventing Relapse'. The close attention now paid to relapse prevention, as a component of the recovery process, is timely and appropriate. As the peak body for the NGO mental health sector in New South Wales, we represent our members in strongly advocating for an increase in community services nationally, for people with mental health problems and disorders.

In making this submission, MHCC has used the format requested.

Question 1: What are your thoughts about the relapse prevention framework as presented in the discussion paper? Do you think it provides a good tool for developing recovery-focused services?

The commitment to giving relapse prevention a new profile is very much welcomed by MHCC. The detailed exploration of what is meant by relapse prevention, and advocacy of its inclusion as a component of the recovery process, is timely and appropriate. It represents an accessible way to improve mental health care in Australia, and thus lessen the burden of mental ill health on individuals, families, carers, and the wider community. The fact that consumers were centrally involved in the development of the framework, and are referenced throughout, gives it rigour and high credibility. Similarly, by including the experience of many carers in the evaluation, the framework is rooted in a practical understanding of support needs through the recovery process.

*MHCC is the peak
Body for mental health
Organisations in NSW*

Mental Health Co-ordinating Council- Response to the National
Pathways of Recovery: Preventing Relapse
The Mental Health Co-ordinating Council is funded by NSW Health

It is important to recognise that this is not new work. Many individuals and service providers have incorporated the work now being called 'relapse prevention' into their daily self-management routines, or work with consumers. NGOs working in mental health have focused on relapse prevention for a long time, and have become very skilled in the practice of it. Unfortunately the work and approaches developed within the sector have not been adequately evaluated and documented in many instances.

In Australia, rehabilitation and psychosocial support services have taken a secondary role to acute care, which is often pharmacologically driven. 'Because of the enormous pressure to discharge quickly, there is no time to reflect on acute and long-term management plans, often large doses of medications are used to achieve rapid changes, and there is next to nothing in the way of psychological therapies. What is worrying this patient, what pressures have they been under, who are they, what about their families? No one asks, there's no time.' (National Association of Practising Psychiatrists, quoted in Select Committee on Mental Health 2002 p.44). Although National Mental Health Plans have emphasised the need to focus on promotion, prevention, and early intervention strategies and services, and more recently have affirmed the need for and value of the recovery framework, there is much to be done to root this vision in services in the community, available to all.

It is appropriate to grasp this opportunity now, to structure a strong relapse prevention framework for use Australia-wide. If done well, this will facilitate the recovery pathway of consumers into the community. For this to happen, the nuts and bolts of relapse prevention need to be defined; the 'how, who and when' need to be elaborated, and the work needs to be rooted in Practice Guidelines. This will include how to recognise triggers; how to enable a consumer to identify their own needs at difficult times, and how to participate in establishing their own relapse prevention plan. It will include good discharge planning, linking consumers with community organisations, and effective follow up. The discussion paper presents a good foundation, but it is not yet a 'tool' for relapse prevention. This point will be expanded in a later section.

This new framework needs to be evaluated and reported, and the States and Territories need to be required to carry it out. Implementation of the framework will require an action plan and resource allocation if it is to have an impact on service delivery. Whilst we understand an action plan is in development at the National level, it will be necessary that detailed State implementation plans are also mandated as part of the overall strategy including funding implications, evaluation and reporting requirements.

a) What do you like about it?

- **Consumers at the Centre:** The recognition that consumers need to be at the centre of their own care planning and self management, and that all mental health services need to work within frameworks which enable them to support the empowerment of consumers, as well as to 'aim to reduce the clinical manifestations of illness' (p.67).
- **Starting early:** The recognition that planning for relapse prevention should start early in treatment, and involves the consumer and (if the consumer welcomes this) all those in his or her network, including carers and family members, rehabilitation support services, NGOs, GPs, and mental health service staff.

- **Access to Services:** The recognition that all services (including hospital based services, GPs, community based services, NGOs) need to be involved in the relapse prevention strategy, and to work together to enable consumers to get the most appropriate help at any time. The report recognises that many approaches are helpful, and uses a holistic model, rather than a single approach.
- **Flexibility of Services:** The acknowledgement that there is a need for more flexibility of services, and particularly 'a middle level of service response', which would include supported accommodation options for people who are becoming unwell again but do not require hospitalisation. (p.42).
- **Discharge planning:** The recognition that the lack of good discharge planning may lead to the consumer being readmitted to hospital (p.43), and further damaging their long term possibilities for well-being. The cost implications for the individual, carers, health services and community generally are significant.
- **Validation of NGOs:** The recognition given to 'the immense value of non-governmental organisations and support groups in providing alternative services that are otherwise unavailable' (p.48) is very welcome. MHCC has been aware of the lack of services for people requiring longer-term care and rehabilitation in the community, for many years. Since the Richmond Report (1983), and further supported in the Burdekin Inquiry (1993), and the Inquiry into Mental Health Services in NSW (2002), there has been general agreement that the provision of these services is most appropriately situated in the non-government community based sector.
- **Hopeful outcomes:** The acknowledgement of the shift to more hopeful expectations of the outcome, for people affected by serious mental health problems.
- **Empowering message:** The value of the empowering and hopeful message conveyed by the report.
- **Importance of family and Carers:** Acknowledgement of the crucial importance of family and carer support to many consumers, and the importance of support being available to family members and carers.
- **Recovery Framework:** The fact that the work of relapse prevention is located within a recovery framework. The significance of the recovery approach is acknowledged in the National Mental Health Plan 2003-2008.
- **Developing an evidence base for relapse prevention:** The recognition of the need to develop this, in respect of work towards relapse prevention carried out in all sectors
- **Illness self-management:** The fact that links are made to strategies for illness self-management in the field of chronic illness (p.39).
- **Promotion, Prevention, Early Intervention:** Recognition of the ongoing importance of Promotion, Prevention, and Early Intervention, as developed for the Second National Mental Health Plan.

b) What don't you like about it?

- **Relapse prevention is a negative term:** Some consumers and carers find the term to have negative connotations, and to inappropriately locate the consumer within a medical framework. We have suggested alternative terms: 'Strategies for supporting wellness' or 'Recovery strategies'. Through holding the concept of wellness, and maintaining hope, identified as so important by consumers, these terms have a better fit within a recovery framework.
- **High expectations of GPs:** Concerns exist amongst MHCC member organisations, about the expectations which the framework places on GPs. Factors which cause concern include the decline in bulk billing, the newness of specialist mental health training for GPs, and their lack of specialist support. 'GPs report that they are poorly supported by specialist care services and evidence from practice reviews indicates major deficits in the quality of care they can provide. (Groom et al 2003, p3)

c) Are there any gaps in the framework?

- **An Assessment Tool:** A tool is needed which will enable mental health care staff to make a realistic appraisal, with a consumer, of factors which have an impact on their opportunities to recover, and what may hold them back. It needs to address (amongst other things) their self regard, physical health, how they are seen by intimate partners, family members and friends, and the health of these relationships for the consumer; their capacity for social contact; accommodation options; opportunities to take part in worthwhile activities or employment; and life skills. A tool such as this will give meaning to the relapse prevention framework, and will lead into the detailed planning framework, which must underpin it.
- **Acknowledging that relapse prevention is not for all consumers:** There is a need to recognise that some consumers will not be ready to embrace the concept of recovery. It must be recognised that recovery is a very individual process, and (as indicated above) a realistic appraisal of opportunity and expectations needs to take place.
- **Explanation for exclusion of some diagnoses:** The strategy is targeted at the so-called major mental illnesses and fails to include personality disorders or dual diagnosis (in relation to both substance misuse and intellectual disability). These groups require some of the most intensive work around relapse prevention and should not be excluded. Some explanation as to their neglect in respect of the strategy is required. If these groups meet the criteria for admission to mental health facilities they should be included in a relapse prevention strategy. We suggest they should be included in Population Groups with Special Needs (p.49), and their needs of the strategy in relation to relapse prevention documented.
- **Detailed exploration of the work of NGOs:** The evidence base for the work of NGOs, in relapse prevention, rehabilitation and recovery, needs to be sought out and incorporated into the report. NGOs have approaches which are innovative and creative in working with their target groups but have difficulty attracting research funds to substantiate outcomes. In NSW the situation is particularly acute, as the NGO sector has never been adequately funded, and the state provides less than any other state for the

development of community based mental health services in the non-government sector. (National Mental Health Report 2000.) A fuller exploration of the role of NGOs in this work needs to be included under Access and Early Intervention, the third of the 4 A's, where the roles of GPs, case management, and the acute and specialist mental health care system are explored. In the final section of the report, 'Issues for Consideration', the NGO sector is included under 'providers of non-clinical psycho-social and psychiatric rehabilitation support services'. However, unless NGOs are acknowledged and validated in the work they are doing, there is little chance that the framework advanced for preventing relapse will be able to fulfil its potential. A consultation concerning community priorities for the Nation Mental Health Policy for 2003-2008 carried out by the Mental Health Council of Australia recorded: 'Various respondents including GPs raised the importance of NGOs in delivering various services and providing a more holistic approach by being able to include counselling, advocacy, public education, workshops, referrals and social and support groups.' (Groom et al, p.17).

- **Support to Carers:** The role of family members and carers currently being taken, and likely to continue, in relapse prevention is acknowledged, but the problematic nature of this is not sufficiently documented. Carers regularly inform MHCC (MHCC Carers Working Group, which meets monthly) of the lack of support to them from mental health services and the stresses and difficulties this places on them. Carers often find themselves holding a role which is best performed by mental health support staff. Training for carers in strategies for relapse prevention should be incorporated in the document, to give support to them in maintaining consumers in the community, and in advocating for assistance from mental health services.
- **Advocacy for a protocol in Discharge Planning:** Development of a protocol which (with the consumers permission) includes NGOs in information exchange plans following discharge, would ensure that essential information held by NGOs about a persons' well-being and relapse triggers, highly relevant to their individual plan, was not ignored by default.
- **A strategy to address culture change:** A clear strategy is needed to address culture change issues in the medical and nursing and allied health professions. The report acknowledges the damaging impact on consumers, of stigmatising attitudes held by health service staff (such as the expectation that they will not recover, or will be dangerous), and the urgent need for change. 'Attitudes toward the recovery of people with mental illness were especially negative in acute mental health care settings'. (P.43). 'Persons with mental illness report ongoing abuse within hospital forms of care...Overt abuse is reported to occur within emergency departments and other acute care settings of general hospitals.' (Groom et al 2003, p.4) Addressing these issues needs to be acknowledged as the responsibility of federal and state health service leaders, and an action plan needs to be developed. This could include a review of training content of professional health related courses, and consideration of the values base for this work.
- **The needs of forensic patients:** The framework needs to address the needs of these consumers, 73% of whom have been admitted to a mental health unit prior to being placed in prison. (Henderson, 2003). MHCC feels that exit and transition planning is an essential part of comprehensive

treatment and care. We advocate strongly that this planning should include linking the person to community based treatment and support. Special services need to be established in the community such as early intervention strategies (i.e. court diversion programs; community supported rehabilitation; housing, and vocational programs). These programs should include experienced forensic case managers who support and recognise transitional needs, ensuring maximum potential for recovery and rehabilitation into the community and prevention of relapse.

2. What other experiences have you had with relapse prevention and tools for relapse prevention? How did you find them? What difference did it make?

Through its members, wider involvement in the sector, and participation in consultations, MHCC is aware of approaches to relapse prevention, which are currently in use. A common theme is that they provide a way of facilitating engagement with a person with mental health difficulties, to help motivate them towards contact and community involvement, and provide the structure and organisation which many people with mental health problems have difficulty achieving alone. Much of the work of NGOs in this area is about simple daily life activities, which can be overlooked, but make all the difference in enabling someone to motivate themselves to find enjoyment and purpose.

Following are selection of a few services and programs with a focus on relapse prevention:

- **Connection with family:** Several MHCC member agencies stressed the protective value of connection with family, both as an important component of recovery, and in preventing relapse. The observation was made that those people who had strong family support had a much greater chance of recovering. The Schizophrenia Fellowship (NSW) is conducting a research study designed to evaluate the role of family members, and connections with family, in the recovery process. 'There is currently little information available about what life is like for those living with and supporting individual's recovering from psychosis. Family members, carers or supporters are considered to be a crucial part of the recovery process.' (Schizophrenia Fellowship, 2005 www.sfnsw.org.au). Family support can represent continuing care, ongoing connection to people, a trusting relationship, a social and activity network, and strong advocacy. Family members are likely to be alert to changes in behavior and to relapse triggers, and willing to act when these are noticed. Their involvement in detailed relapse prevention planning, with the consumers' consent, can ensure that a sound strategy is developed. Pathways, a New Zealand based organisation, encourages and welcomes family members to become involved. 'The involvement of family/whanau, friends and partners is integral to Pathways service....You may be invited by the person you know to help create their plan, you may also have a support role in the plan itself.' A parent states 'People listen and there's huge respect for families. This is a very well run organisation.' (Pathways Trust, undated).
- **Individual Support Plans:** care plans, used by key workers in many NGOs in NSW, are used to support consumers in their individual recovery pathway. They enable worker and consumer to become more aware of factors which impact on the consumers' wellness or un-wellness, to anticipate and plan for the future, and to make plans for times when they are experiencing difficulties.

- **Aftercare:** This organisation has worked with people with mental health problems and disorders for nearly 100 years, to assist them to live and participate in the community. It can be assumed that much work has a relapse prevention aim, although the detailed work towards this end is not documented. One program provides 24-hour support and care to former boarding house residents with complex needs through individualised programs. Family contact is a vital part of this service and residents are encouraged to visit as often as they wish. Each person has access to a day activity of their choice within their chosen community. At Kirunda Adolescent Service, young people who have become isolated from their families and who have developed mental disorders are assisted with family re-union, schooling and other skills training while learning about how to live with the disabling effects of their disorders. Adolescents are encouraged to participate in structured activities with school, work or TAFE attendance during the day. Regular individual reviews provide an opportunity to discuss performance and look to areas requiring more encouragement. The service is an integral part of mental health services in Western Sydney Area Health Service.
- **Community Inclusion Project:** This is a project created by Kaiyu Enterprises, from an awareness of studies which ‘showed that social integration has a reliable positive influence on people’s mental health.’ (Norath 2004). The project was set up to enable people with a psychiatric disability to integrate with mainstream community organisations. Normalisation and acceptance on a reciprocal basis were the concepts behind the project, which introduced a consumer to community activities of interest to them, and then matched them with a volunteer who also participated. In commenting on the project outcomes, Norath indicated that the consumer would benefit in the development of social skills, reduce isolation, improve self-esteem and provide more choice. (Also documented by Hallinan and Courteney 2003.)
- **SANE Australia:** ‘The Sane Guide to Staying Alive’ has been developed as a resource for people with mental illness who feel suicidal at times (SANE Australia 2004). Written in a very accessible and attractive style, it covers getting to know your warning signs, finding support, planning action to help yourself, and getting your life back on track after a suicide attempt.
- **The Clubhouse Model:** This is an empowering model of rehabilitation in the community, with a non–medical focus. Pioneer Clubhouse (www.ans.com.au/-pioneer/index.html) is one of a number of Clubhouses in Australia, which are part of an international movement, and enable members to achieve their own personal goals in a supportive environment. Through building confidence and self-esteem, developing skills and friendships, and taking part in a work ordered day, members are supported on their recovery pathway. Clubhouses enable individuals to put into practice their own recovery and relapse prevention plans, whilst having a place in a community. Loyalty and commitment to the organisation often result from the experience of acceptance and belonging.
- **Children whose parents have a dual diagnosis:** In presenting her work on policy and practice effecting children and families where a parent has a dual diagnosis, Heggarty described a project model which incorporates both supports to workers (such as a training package, practice guidelines and protocols, and consultation on complex cases), and supports for families (such as specific information, the development of appropriate support

networks, and the recruitment of specialist carers). This model, and much work carried out with families at risk, is intended to strengthen protective factors, increase awareness of risks, and put in place protective plans if risks increase. (Heggarty, 2004, on MHCC web site: www.mhcc.org.au)

- **New Zealand Model:** The Mental Health Commission (www.mhc.govt.nz) leads the recovery-oriented philosophy underpinning mental health services in New Zealand. 'Our vision is for New Zealand to be a place where people with mental illness have personal power, full participation in their communities and access to a fully developed range of recovery-oriented services.' (Mental Health Commission web site, 2005.) It publishes a range of accessible and attractive booklets for consumers, giving information about mental health services. An example is 'Oranga Ngakau: Getting the most out of mental health services: a recovery resource for service users' (Mental Health Commission 2003). Although not exclusively focused on relapse prevention, this publication advises consumers, in supporting their own recovery, to learn their early warning signs, and not be demoralised if they have to use services again. It recognises that some services which can be offered, such as support in the home, are particularly important if the consumer is at risk of having a crisis. There is an explicit recognition of the importance of connection to others, good information, and that recovery is an individual process.
- **Pathways Trust:** This New Zealand organisation describes itself as a recovery oriented support organisation providing accommodation, supported employment, and many opportunities for participation. Its work with consumers is focused around several objectives: working together to achieve your goals; one to one support; and creating a plan. 'Identifying signs or any changes which affect your wellness' is a part of working together. A regular, scheduled review is held after four weeks, and then at eight or twelve weekly intervals, to ensure that support is provided in the best way possible for each individual, and that information is exchanged and recorded. (www.pathways.co.nz)
- **NT Life Promotion Program:** This is a community program in Northern Territory working with members of the aboriginal community who have been affected by suicide. It provides a collaborative and integrated approach to life promotion, suicide prevention, intervention, postvention and bereavement support utilising a community development and capacity building framework. (Listed under National Suicide Prevention Strategy, Community Programs www.community-life.org.au)

Question 3: What needs to happen to ensure relapse prevention becomes standard practice in mental health services?

As indicated above, there are many possible approaches to relapse prevention, as there are to promotion and preventative work. Some of the stages in implementation are as follows:

- **Implementation of the National Mental Health Plan:** In the current plan it is stated that 'Those who do experience mental health problems and mental illness....should have access to a range of high quality and effective inpatient and community services,These services should provide continuity of care, adopt a recovery orientation and promote wellness.' (National Mental Health Plan 2003-2008, p 4.) There is a need for an

evaluation of the NMHP which would address implementation of these commitments.

- **Training and attitude shifts of mental health staff** at all levels needs to incorporate relapse prevention and recovery strategies and philosophy. This has happened in New Zealand, and created a vibrant, participatory sector. Training for staff in assessing consumers in a realistic way, and in identifying risk and relapse triggers needs to be developed. This needs to be recognised as new work, even though it has long been regarded as essential in good mental health care by many staff. As reported in the Inquiry into mental health services in New South Wales (NSW Legislative Council, 2002), and as discussed in the Consultation (26th November 04) there is extensive concern about attitudes held by clinical staff towards people with mental health difficulties. The report states 'A great deal of emphasis needs to be put on changing attitudes in acute settings.' (p.43). Staff employed by health services need to have opportunities of contact with NGOs and consumers when they have moved through the acute phase, and are living and participating in the community.
- **Assessment Tool:** as described under 1c.
- **Partnerships across the sectors:** The interdependency between government sector health services and services provided by community based organisations needs to be accepted and recognised by all parties. The mental health sector needs to engage in ongoing planning and liaison, and partnership with consumers, carers, and community organisations. In 'Framework for Rehabilitation in Mental Health', NSW Health indicated that the state sector should provide clinical rehabilitation services, and the NGO sector should provide 'disability support' services. (NSW Health 2002.) This is an unrealistic and unproductive separation and distinction, placing constraints on the NGO sector and defining its work as 'non-clinical'. In practice many NGOs employ clinical staff with expertise to make clinical assessments and design care plans informed by an understanding of clinical interventions. The NGO sector needs to continue to work towards recognition of this. The essential nature of partnerships between the sectors is outlined in the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000 (p.50).
- **Discharge planning** needs to be put in place for all consumers. The lack of this is an extraordinary oversight, as is the statement 'When discharge plans were part of routine practice, they were often delayed by several months after the discharge.' (p.43) Planning for follow up in the community may make the difference between a consumer being supported in their recovery process, and re-entering hospital or acute care. Discharge planning involves making links into the community, and addressing accommodation, social support, information, and advocacy needs. It should involve agencies which specialise in providing support through employment programs. Discharge planning is crucial in ensuring a smooth transition for a consumer, at a time of risk for them. Continuing Care pathways need to be developed, with clear partnership arrangements, between providers in state and NGO sectors. Clear communication is essential in ensuring continuity of care for consumers. The value of good discharge planning is likely to be seen in a lessening of hospital stays, as consumers are linked to supports in the community. Preventing relapse is highly cost effective.

- **Recording of Readmission:** Currently mental health services are only required to collect statistics on readmission within 28 days of discharge. As MHCC recommended to the Inquiry into Mental Health Services in NSW, 'the availability of readmission data at three, six and twelve month intervals would enable NSW Health and the NGO sector to assess more fully the extent of the 'revolving door' syndrome. Analysis of these data would assist health planners to identify factors, interventions or services that could prevent readmission.' (Select Committee on Mental Health, 2002,p.45). This point became Recommendation 4: that data should be collected as advocated by MHCC, 'to assist in the planning of services with a relapse prevention focus.' (p. 46).
- **Consumers and Carers:** There is a wealth of experience, among consumers, carers, and service providers, about relapse prevention. Consumers who currently use tools and strategies, which help them be alert to risk factors for their continuing mental health, need to be acknowledged, and enabled to pass their learning on to others.
- **Respite services,** for carers and consumers, such as that provided by Westworks, in NSW. This program offers respite generally for a few hours each week, enabling a carer to have planned time for activities outside the home. Trained support workers who all have personal experience of mental illness staff this scheme. Testimonials from carers indicate its value: 'For our son, it meant that people came faithfully each week just to sit and talk. These people have recovered from mental illness themselves and understand what he was going through. He could relate to them very well – he knew they understood and they could say things that encouraged him. As a carer it was wonderful to meet people who had been down the dark tunnel and had come through.' (Westworks, undated.) Respite care is important to both consumers and carers, and provided both with new opportunities, such as making new social contacts. Having access to a respite service can be seen as a protective factor, and can be part of a relapse prevention plan.
- **Promotion, Prevention, and Early Intervention:** The Action Plan, which accompanied A Monograph 2000, needs to be evaluated and updated. The high value of promotion and prevention programmes is widely recognised.
- **Funding and Policy:** 'The link between effective rehabilitation, relapse prevention and shorter duration of psychiatric inpatient stays has been identified in several studies. Studies of psychosocial rehabilitation (skills training and supported employment), for example, have shown an average reduction of more than 50% in cost of care due to reduced hospitalisations.' (NSW Health 2002). A strong lead needs to be taken by the Australian Government Department of Health and Ageing to ensure that the work of the discussion paper, and the messages of policy documents such as that quoted above, lead to changes in clinical practice. Although relapse prevention planning should be seen as the bread and butter of both acute and non-acute services, new ways (and new money) may need to be found to enable it to become a standard part of clinical work.
- **A tool kit** is needed, to guide organisations in planning relapse prevention strategies. An NGO could develop a 'Planning for Wellness' or 'Strategies for supporting wellness' pack, drawing on tools such as 'The Sane Guide to staying alive' (SANE Australia 2004). This could be available to all, on a web site.

- **National Mental Health Standards:** This framework needs to be incorporated into National Mental Health Standards, and regularly evaluated.

4. How will we know that relapse prevention has become standard practice? What sort of indicators and measures will show that we have relapse prevention as standard practice in a recovery focused mental health system?

- **Reduced hospital admissions:** This will be evident from the enhanced data collection (see Recording of Readmission's above.)
- **High Consumer Satisfaction:** A high level of consumer satisfaction with the Recovery focused mental health system, and the relapse prevention strategy will be evident in the results of Mental Health Outcomes and Assessment Tools (MH-OAT), and measures used to assess consumer satisfaction by NGOs.
- **Discharge Planning is being undertaken:** Acute care services will have taken on the responsibility for undertaking discharge planning, which will include relapse prevention. Clinical staff recognise the importance of talking to patients about triggers, recognising risks and protective factors, and having a plan. Consumers, and if wished, carers, will be regularly involved in making plans which anticipate needs in the event of relapse, and involve specific actions, such as making social contact, decreasing stress, increasing medication, or seeking extra support. A referral structure exists to enable increased care at times of risk and stress.
- **Clear role for NGOs:** A clear role for NGOs in relapse prevention plans for consumers with whom they are involved, is valued across health services. Strategies for managing emerging symptoms and understanding triggers when consumers are supported in the community are clear, and services are able to increase support or make appropriate referrals at these times. Clinical services recognise the value of NGOs and the services they provide, in assisting consumers to remain well in the community.
- **NGO services are respected and financially secure.** The losses, which occur when a well functioning community service is closed or curtailed, are a thing of the past.
- **Assertive case management:** This is more widely used in the community at times of stress for consumers, and is well integrated with acute care services, and NGO services.
- **Promotion, Prevention and Early Intervention:** A strong PPEI framework exists, and has enabled significant lessening in the need for acute care and hospital based services.
- **Reduction in Suicide:** The National Suicide Prevention Strategy is shown to be effective, through a reduction in the occurrence of suicide.
- **Self Help Materials are widely used:** Information and Self help materials, such as those produced by The Centre for Mental Health Research (Mental Health First Aid, BluePages, etc) and by NGOs (SANE Guide to Staying Alive), are widely used and have led to more competence in the community,

and throughout Human Services, in responding to people with mental health difficulties.

- **Carers are comfortable with their role:** Carers are well equipped to act and react to signs of concern, if this is their role in the consumers' plan.
- **Awareness of harmfulness of stress:** There is more awareness in the general community of the need to reduce stress, and its impact on mental health.
- **Responsible media interest:** Members of the media approach mental health issues from a responsible and non stigmatising position.
- **International Respect:** There is a high level of respect for Australia's Mental Health system amongst colleagues in other countries.

Thank-you for seeking the involvement of the NSW Mental Health Coordinating Council in this National Consultation. We look forward to the outcome with great interest, and to participating in future consultations.

Yours Sincerely,

Jenna Bateman,
Executive Officer.

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