出國報告（出國類別：考察）

澳洲精神醫療參訪計畫

服務機關：衛生福利部

姓名職稱：賴淑玲 科長

李炳樟 科長

賴德仁 理事長

張家銘 祕書長

派赴國家/地區：澳洲

出國期間：107 年 4 月 20 日至 107 年 4 月 29 日

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摘要

精神衛生法第 35 條規定略以，依精神病人病情輕重，有無傷害危險，提供精神醫療門診、急診、全日（急、慢性）住院、日間留院、社區精神復健及居家治療等不同之照護方式。

我國自 1985 年起開始推動精神醫療網計畫，業已完成精神醫療資源硬體建設及人力規劃，精神醫療急、慢性病床數有顯著增加，迄至 2017 年底，許可病床數已達全國醫療網每萬人口 10 床之目標。惟參酌世界各國精神病床發展趨勢、精神病人疾病型態的改變及藥物治療技術的進展，各國均朝向發展多元化的精神病人社區照顧模式及方案。

為因應未來精神照護社區化、提升民眾意識及重視人權，並強化社區精神照護網絡、促進社區精神病人之社區融合及追蹤關懷，亟需建立整體性及連續性之精神衛生照顧網絡，鑒於澳洲近年來社區精神照護體系建構之經驗，規劃赴澳洲考察，以建立精神病人分級方式與社區連續性照護模式，並強化精神病人照護及其權益之保障。

本次考察行程前往澳洲維多利亞省墨爾本-聖文生精神健康服務（St.Vincent Mental Health Service）屬下的工作單位、精神衛生法庭（Mental Health Tribunal）、Beyond Blue 及家庭暴力防治中心等相關機構，針對精神疾病社區連續照護及個案管理（含多重議題照顧個案）、危機處理及精神疾病強制住院、強制社區治療審查及人權保障、心理健康初級預防等議題，與當地醫療機構進行交流討論及學習各項社區精神病人連續照護服務，成果豐碩。

本次考察活動感謝台灣精神醫學會全力協助赴澳考察行程，熱心引薦澳洲墨爾本相關精神醫療及社區照護相關機構，使本次考察行程得以進行順利圓滿達成任務，讓我們對澳洲精神病人連續性照護對策有最近距離的觀察，並為雙方未來交流建立良好的互動關係，有利於臺灣制訂更好的精神疾病社區連續照護及個案管理政策。

目錄

壹、參訪背景

一、台灣精神醫療現階段的困境與挑戰

落實精神疾病防治與照護服務，為國家精神疾病的防治目標，其包括：強化精神衛生體系及服務網絡、強化精神病人緊急處置、強制治療及社區照護服務、落實社區精神病人管理及追蹤關懷、發展多元化精神病人社區照護模式、促進精神病人權益保障、充權及保護。

我國自 1985 年起開始推動精神醫療網計畫，業已完成精神醫療資源硬體建設及人力規劃，精神醫療急、慢性病床數有顯著增加，迄至 2017 年底，許可病床數已達全國醫療網每萬人口 10 床之目標。惟依據 WHO（2009）有關「提升精神衛生健康體系與服務」（Improving Health Systems and Services for Mental Health）之政策提及，最佳化精神衛生照護模式（WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health）（WHO, 2009）須針對各照護層級進行推廣提供精神病人連續一系列的服務，爰於規劃服務時應採全面綜合之方式以創造最佳的組合。

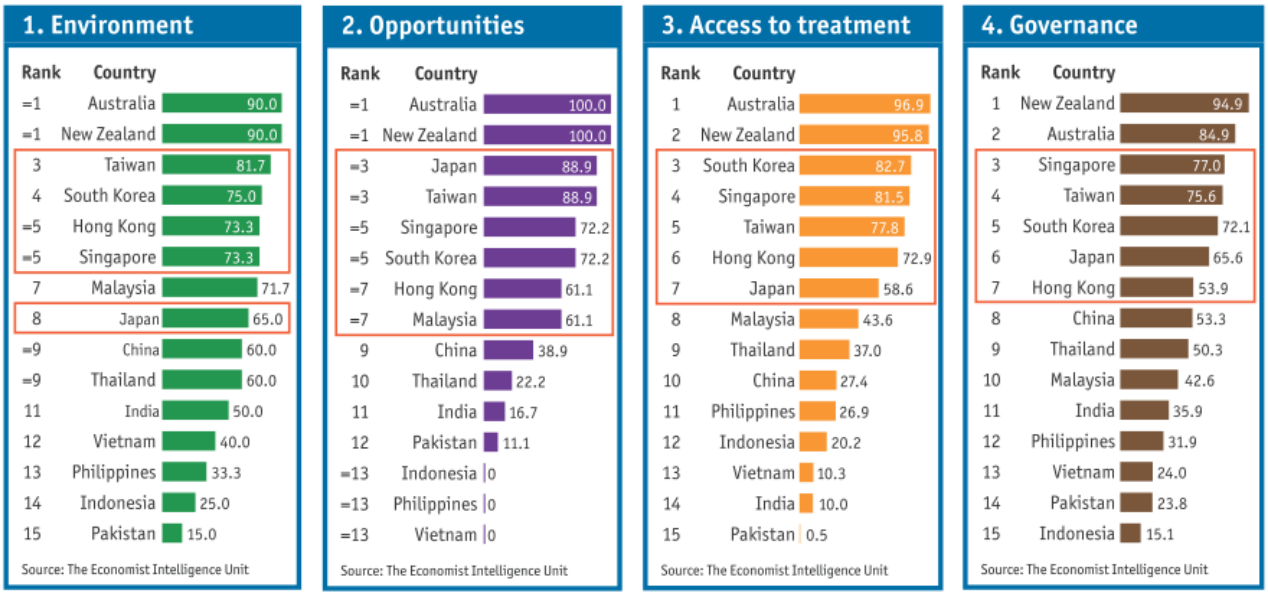
近年來，精神衛生業務雖已朝社區化推廣趨勢，並建置社區心理衛生中心、設立精神復健機構、出院準備計畫及社區關懷訪視制度。然而，要達到世界衛生組織「最佳化精神衛生照護模式」之目標，且目前精神醫療給付體系，仍偏重精神疾病住院支付，對精神病人社區照護支付投入較低且媒體對精神病人不適切報導，又造成社會大眾對精神疾病污名，造成無法發展多元化的精神病人社區照顧模式及方案，提供穩定社區精神病人病情的醫療及復健措施及支持網絡。

精神衛生法在 1990 年制定，於 2007 年 7 月 4 日修正施行精神衛生法，為保障精神病人人權，針對強制住院申請案件進行審查，新增第三者審查制度，成立「精神疾病嚴重病人強制鑑定與強制社區治療審查會」。惟近年國際上對人權的重視，人權團體質疑強制住院恐不符「身心障礙者權利公約」第 14 條規定，亦需有相關檢討與修法。

二、亞太精神健康和社會融入指數：台灣落後澳洲與紐西蘭

國際知名的經濟學人雜誌在 2016 年有一個特刊 [1]，評比亞太地區 15 個國家的精神健康和社會融入指數，分為四類：環境、可及性、機會及治理。在環境上，台灣的排名在第 3，次於澳洲與紐西蘭。在機會上，台灣排名第 4，次於澳洲、紐西蘭、日本。**在治療的可及性上，台灣排名第 5**，次於澳洲、紐西蘭、韓國、新加坡。在治理上，台灣排名第 4，次於紐西蘭、澳洲、新加坡。

整體而言，15 個國家的精神健康指數上，台灣排名第 3，次於澳洲與紐西蘭，優於新加坡、韓國、日本、香港，也勝過馬來西亞、中國、泰國、印度、菲律賓、越南、印尼、巴基斯坦。即便如此，台灣的總分（80.1 分）仍與第一名澳洲（94.7 分）、第二名紐西蘭（92.2 分）有很大差距。顯示台灣仍有相當可努力的空間，特別在社區精神醫療的發展上，應該向澳洲、紐西蘭多所學習。



基於以上的說明，台灣精神醫療現階段確實面臨醫院轉型到社區精神醫療的困境，也要應付未來聯合國國際人權公約的挑戰。而亞太地區台灣的精神醫療可向澳洲或紐西蘭學習，包括澳洲在精神醫療政策與機構的轉型、社區精神醫療連續性及分級服務、澳洲精神衛生法的運作與精精神醫療法庭、如何因應國際人權公約的經驗及心理健康早期預防與促進，都是值得我們參考。為了突破台灣精神醫療困境與挑戰，本年度以澳洲墨爾本當作我們的考察參訪的地區。

貳、參訪目的

一、瞭解澳洲的精神醫療政策沿革，以作為未來制定政策參考。

二、瞭解澳洲的社區精神醫療制度及其運作方式，以作為社區精神醫療制度規劃參考。

三、瞭解澳洲維多利亞精神衛生法、強制治療制度與人權公約關係，以做為精神衛生法修法參考及依人權公約精神做調整。

四、瞭解其他澳洲特殊精神處理機構與單位，例如超越憂鬱（Beyond Blue）及家庭暴力防治中心等機構，瞭解其推動心理健康促進及家庭暴力防治業務，作為國內推動業務參考。

參、考察人員與行程：

一、考察人員

姓名	服務機關	單位/職稱
賴淑玲	衛生福利部	心理及口腔健康司 科長
李炳樟	衛生福利部	心理及口腔健康司 科長
賴德仁	台灣精神醫學會	台灣精神醫學會 理事長
張家銘	台灣精神醫學會	台灣精神醫學會 秘書長

二、考察行程：

日期	行程
4 月 20 日	前往桃園機場搭乘中華航空出發
4 月 21 日	抵達墨爾本機場，轉乘至住宿飯店
4 月 22 日	參訪前說明會及與墨爾本當地專家學者餐敘，交流精神醫療經驗
4 月 23 日	1、The Footbridge Community Care Unit（Residential Rehabilitation Program） 2、North Fitzroy Prevention and Recovery Care（PARC） 3、Mental Health Tribunal
4 月 24 日	1、St. Vincent’s Hospital *Overview of St. Vincent’s Mental Health services community and inpatient setting *Focus on the Mental Health Act and involuntary treatment *Mental Health Acute Inpatient Service 2、Claredon Community Mental Health Service *Overview of Victorian Mental Health System *Continuing care team
4 月 25 日	與當地專家學者交流精神醫療經驗
4 月 26 日	1、Beyond Blue 2、Domestic violence centre
4 月 27 日	Melbourne School of Population and Global Health 參訪後意見交流與討論會
4 月 28 日	自墨爾本機場搭乘中華航空班機返台
4 月 29 日	返回台北

肆、參訪過程及所見所聞：

一、澳洲全國心理及精神醫療策略（National Mental Health Plan）沿革

澳洲的政治體制是聯邦制度，設立聯邦議會及六個州議會，兩個代表理事會。澳洲總督為澳洲的最高領導人，但重要的政治決定和大多數的國家權利被掌握在聯邦政府總理以及其內閣手中。6 個州分別是新南威爾斯州-首府雪梨；昆士蘭-首府布里斯本；南澳大利亞-首府阿德萊德；塔斯馬尼亞-首府霍巴特；維多利亞-首府墨爾本；西澳大利亞-首府伯斯；兩個領地則是：澳洲首都區-首府坎培拉；北領地-首府達爾文。

澳洲的人口 24,715,868，面積 7,686,850 Km^2，人口與台灣相當，但國土面積是台灣的 213.6 倍 [2]。

	澳洲	台灣
人口數	24,715,868（2018）	23,682,521（2018）
面積	7,686,850 Km^2	35,980 Km^2
GDP	1204.62 billion USD（2016）	529.58 billion USD（2016）
NHE 佔 GDP	10.3%（2015-2016）	6.3%（2016）
標準化自殺死亡率	11.7（2016）	12.3（2016）

為促進心理衛生，降低心理健康問題對個人、家庭與社區的衝擊及保障精神疾病病人的人權，澳洲各級政府衛生部門於 1992 年（聯邦、州、地方）共同簽署推動國家心理衛生政策，並自 1993 年開始第 1 期**國家心理衛生 5 年計畫，至今已推動 5 期國家心理衛生計畫，其各期國家心理衛生計畫推動重點及效績如下：**

（一）第一期全國心理及精神醫療計畫 1993-1998 （First National Mental Health Plan） [3]

其提供具體的政策架構與聯邦經費，並立基在「主流化」與「整合性」的共同目標，其具體成果有（1）精神醫療花費 6 年增加 30%，主要是在社區精神醫療花費增加 87%，但醫院精神醫療下降 8.5%。(2)精神醫療的床位由 5,802 床下降到 3,396 床（減少 42%）。（3）有關精神醫療機構的支出占精神醫療總支出比則由 49%下降為 29%。（4）綜合醫院佔所有急性精神病床佔床率由 55%提升至 73%。（5）精神醫

療使用者與照顧者參與醫療決定由 1994 年 33%增加到 1998 年 61%。（6）給予支持精神失能服務的 NGO 經費增加 200%。（7）24 小時社區住宿機構照護的床位增加 65%（由 824 床增加為 1363 床）。（8）有 48%的社區與綜合醫院經費的增加來自於原本精神醫療機構的關閉。

（二）第二期全國心理及精神醫療計畫 1999-2002 （National Action Plan for Promotion, Prevention, and Early Intervention for Mental Health） [4]

延續第一期計劃，並將精神醫療的政策重點，擴充到開業醫師與私人精神科醫師，也開始強調憂鬱症的重要性，並強調心理衛生促進與預防及早期介入等重點方向，並且持續改革心理衛生服務的結構，以及發展心理健康促進的實證模式，強調三個主要面向的工作，包括如下：

1、促進及預防：（1）心理衛生促進及預防（2）建立心理健康識能文件（3）學校心理衛生全國計畫（4）全國憂鬱行動計畫（5）自殺防治。

2、服務的改革與夥伴關係：（1）教育訓練（2）基層精神醫療（3）跨部門的連結。

3、品質與有效性（Quality and effectiveness）：（1）全國精神疾病調查（National Survey of Mental health and Wellbeing）（2）預後研究（3）立法保護權益。

（三）第三個全國心理及精神醫療計畫 2003-2008 （National Mental Health Action Plan: Ways forward） [5]

延續第二期計畫，強調全澳洲人民心理健康。訂定 34 個結果指標及 113 個關鍵指標，並特別在以下重點再延伸，包括：（1）使用者與照顧者（2）夥伴關係發展（3）精神醫療人力（4）特殊精神醫療服務（5）雙重診斷（6）服務不足的族群（7）品質促進與創新（8）有效性與當責性。

（四）第四期全國心理及精神醫療計畫 2009-2014 （National Mental Health Action Plan: An agenda for collaborative government action in mental health） [6]

採用一種群體健康的策略，此期國家整體計畫的對象是所有經驗不同階段心理衛生問題與心理疾病的民眾，包括其照顧者與家人，此期重點部份在（1）社會包容與復原（2）預防與早期接入（3）服務可及性、協同合作與照護連續性（4）品質改善與創新（5）當責信（過程評估與報告）

（五）第五期全國心理及精神醫療計畫 2017-2022 （National Mental Health and Suicide Prevention Plan） [7]

目前，已進入第五期的計畫之階段，此期重點包括（1）整合區域計畫及服務（2）有效自殺防治（3）對嚴重複雜的精神病人協同合作及支持（4）改善原住民及托雷斯海峽群島住民的心理健康及自殺防治（5）改善與精神病人照顧者的身體健康避免早期死亡（6）降低汙名與排斥（7）安全及有品質的精神醫療服務（8）確保系統有效性的運作與持續性改善

二、澳洲精神醫療系統

根據 Australia Mental Health Services, in brief, 2017 [8]，澳洲精神醫系統，包括三個部分：Mediare 給付的服務（開業醫師、精神科醫師、心理治療師）、精神醫療相關機構（公、私立醫院、社區精神醫療服務、住宿型精神醫療服務）、支持性服務（失能支持服務、遊民支持服務、精神醫療計畫）。

Table 1: Overview of Australia's mental health care system

Medicare-subsidised services		
General practitioners	Psychiatrists	Psychologists
Specialised mental health care settings		
Public and private hospitals	Community mental health care	Residential mental health care services
Support services		
Disability support services	Homelessness support services	Mental health programs

在 2007 年報告，16-85 歲精神疾病病人，針對 1/3 病人評估中發現過去一年的精神就醫中有 70.8%是開業醫師、37.7%是心理師及 22.7%是精神科醫師

澳洲提供精神衛生服務的機構包括公立醫院、私立醫院、社區、NGO、私立診所。這些機構都受各州精神衛生法的管理，各機構設置需符合全國精神衛生服務標準。衛生部門會定期機構進行審核。精神衛生服務的提供機構主要有：區域精神衛生中心、社區衛生中心、醫院精神科（僅負責精神病的短期治療）。

另外澳洲的社區精神醫療制度建立在個案管理（case management）及綜合醫院精神科為核心的兩個主軸，整合社區精神醫療資源，強調持續性照顧，人性化、個別化且具有高度彈性的社區精神醫療制度。

嚴重精神病患原則上都會進入社區精神醫療的個案管理服務系統，平日由個案管理師負責追蹤，一旦病情不穩或症狀復發，需要住院治療，則轉介至該地區專責的綜合醫院精神科急性病房（澳洲稱為住院單位，inpatient unit），住院治療有一定的天數限

制，病情穩定的病患，經過評估之後出院，回到社區精神醫療服務系統，繼續由個案管理師追蹤，若個案持續穩定，日常生活功能佳，可以工作賺錢，有固定住所，也可以要求轉介至私人精神科開業醫師或一般開業醫師，但此類病患為數不多；而長期不穩定，且有自傷或傷人之虞，則轉介至安全性延長住院床位（被州政府指定的少數綜合醫院精神科病房），接受長期住院治療。

嚴重精神病患長期失能的復健治療計畫，根據病患個別情況，有工作人員前往居家服務型的（home-based outreach support），每日社會心理支持性的（psychosocial rehabilitation day program），有密集強化性的（residential rehabilitation program），以及針對家屬或照顧者的喘息治療（residential respite）。以下就其精神醫療體系及使用狀況說明如下：

（一）開業醫師 GP

在 2015-2016 澳洲**開業醫師**所提供服務中，有 12.4%是精神醫療相關服務，提供 18,000,000 次的精神醫療相關服務，在 medicare 所支付的精神醫療相關服務有 30.6%（3,200,000 澳元）是給**開業醫師**。而**開業醫師**治療的精神疾病前 5 名依次是憂鬱症、焦慮症、睡眠障礙、急性壓力反應、思覺失調症。

另外，在 medicare 所給付的精神醫療服務，給付最多是**開業醫師，**其次為其他心理師、臨床心理師、精神科醫師、其他醫療專業。

（二）住院型精神醫療服務 Overnight mental health-related hospital care

2015-2016 年，公、私立醫院有 244,934 次精神醫療住院。平均住院天數是 16 天。63.7%住院精神醫療有特殊服務。其中憂鬱症是提供特殊服務的最多的疾病主診斷。

（三）居家型的精神醫療服務 Residential mental health service

居家型的精神醫療是提供精神病人 24 小時的居家型的環境與服務，鼓勵病人自己對自己的日常生活負責，並提供心理社會復健服務。在 2015-2016 年有 5,840 人(7,727 次)接受居家型的精神醫療服務，總服務天數超過 307,000 天，有 19.4%是強制性的。思覺失調症是最主要的主診斷。54.7%的居家型精神醫療照護天數小於 2 週，5.4%是 3 個月到 12 個月。

（四）社區型精神醫療服務 Community mental health care services

2015-2016 年社區精神醫療服務 41 萬人（940 萬人次服務），有 1/7（13.5%）是強制性的。40.8%的病人(約 17 萬人)是中長期的治療(治療天數 92 日或更長)。

社區精神醫療服務患者中，最多的主診斷是思覺失調症。

（五）強制治療與治療環境

住院型精神醫療服務的強制比例最高（超過四成），其次是居家型的精神醫療服務（19.4%），最後是社區型的精神醫療服務（13.5%）。

（六）澳洲精神醫療相關數據

2015-2016 年全澳洲精神醫療總花費是 90 億澳幣（每人 373 澳幣），佔澳洲政府所有醫療花費的 7.7%。共有 230 萬人受到 Medicare 給付的精神醫療相關服務。提供精神醫療失能支持服務 96,330 人。2014－2015 年公立與私立醫院精神科的病床數有 9,577 床，社區居住型精神醫療病床數 2,471 床。全澳洲共有 3,131 位精神科醫師，20,834 位精神醫療護理師，24,522 位註冊心理師。

（七）澳洲的社區精神醫療服務

澳洲社區精神醫療服務設施，包括社區精神醫療診所（community mental health clinic），專責嚴重精神病患的追蹤及個案管理工作，其下分成持續照護團隊（Continuing care team，簡稱 CCT），專責病情穩定的個案，每位個案管理師至多服務 25 位個案；機動支援團隊（Mobile support team，簡稱 MST），專責病況不穩定或服藥配合度欠佳的個案，每位個案管理師至多服務 10 位個案，這類個案通常具有強制社區治療的身分（Community treatment order，CTO），需要個案管理師每日家訪 1 至 2 次，監督服藥配合度，或給予長效抗精神病藥物針劑；危機評估團隊（Crisis assessment team，簡稱 CAT），專責服務可能需要住院或者必須至急診室評估的個案，個案管理師服務的個案數不定，但個案管理師需要到綜合醫院急診室的精神科檢傷分類（triage）輪值。

三、維多利亞省精神醫療系統

維多利亞省位於澳洲東岸南部，全省現劃分為 79 個地方政府區域。維多利亞省乃澳洲大陸中幅員最小的省，但是總人口卻為澳洲第 2 多，僅次於新南威爾斯省。總人口是 626 萬人。維多利亞省面積僅佔澳洲總面積的 3%，但維多利亞省人口佔澳洲 1/4 [2]。

（一）維多利亞省精神醫療沿革 mental health reform [9]

1、第一期 1960 年至 1980 年：減少精神病床數，新的精神用藥引入使用及開始消費者權利運動。

2、第二期 1990 年至 2000 年：關閉精神醫療機構、建立社區基礎的臨床評估、治療

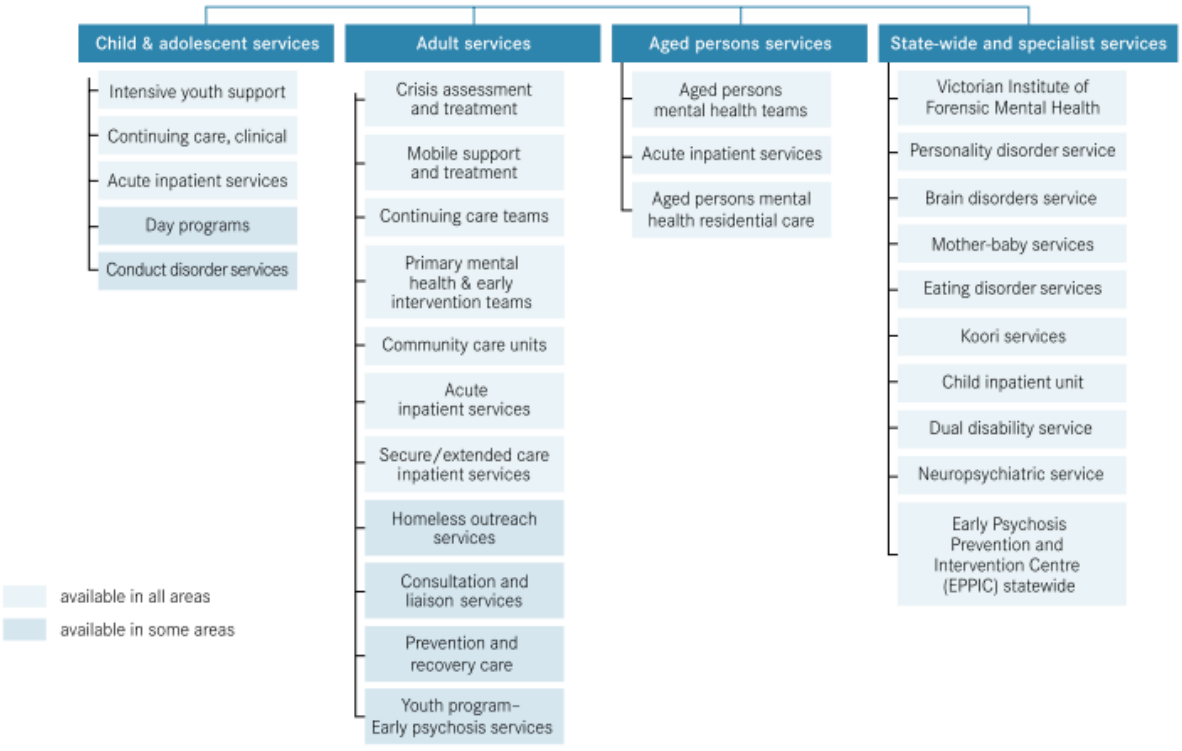
與復健系統及根據地理區域劃分精神醫療服務涵蓋範圍。

3、第三期 2000 年至 2017 年：建立早介入協助的特殊治療單位（例如 Prevention and Recovery Center, PARC）、更多的經費支持 NGO 部門組織（精神醫療社區支持服務（Mental Health Community Support service （MHCSS）, peak bodies）。

4、目前 2018 年：推動國家失能保險方案（National Disability Insurance Scheme,NDIS）支助社區失能支持服務，包括精神醫療的 NGOs （MHCSS）及改變消費者利用服務的方式與特別診所及 NGO 的互動。

（二）維多利亞省的精神醫療 Victorian Mental Health Services [9]

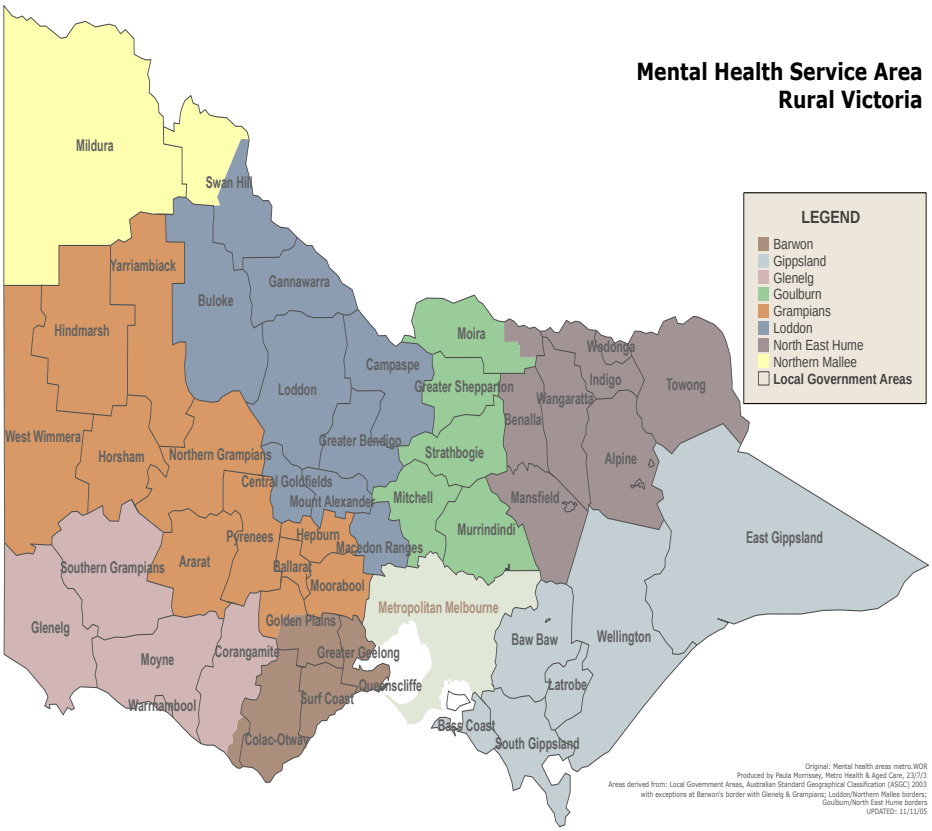
維多利亞省的精神醫療，基本的設計是分區、分年齡層、持續處理，省政府支付的特殊精神醫療服務提供包括社區與住院的照護，其公立精神醫療系統，在每區都有不同精神醫療機構（area-based clinical servies），負責兒童青少年（0-18 歲）、成人（16-64 歲）、老人（大於 65 歲）的精神醫療服務。有 21 家成人精神醫療服務（AMHS），17 家老人精神醫療服務，13 家兒童及青少年精神醫療服務（CAMHS），Orygen Youth Health 等。

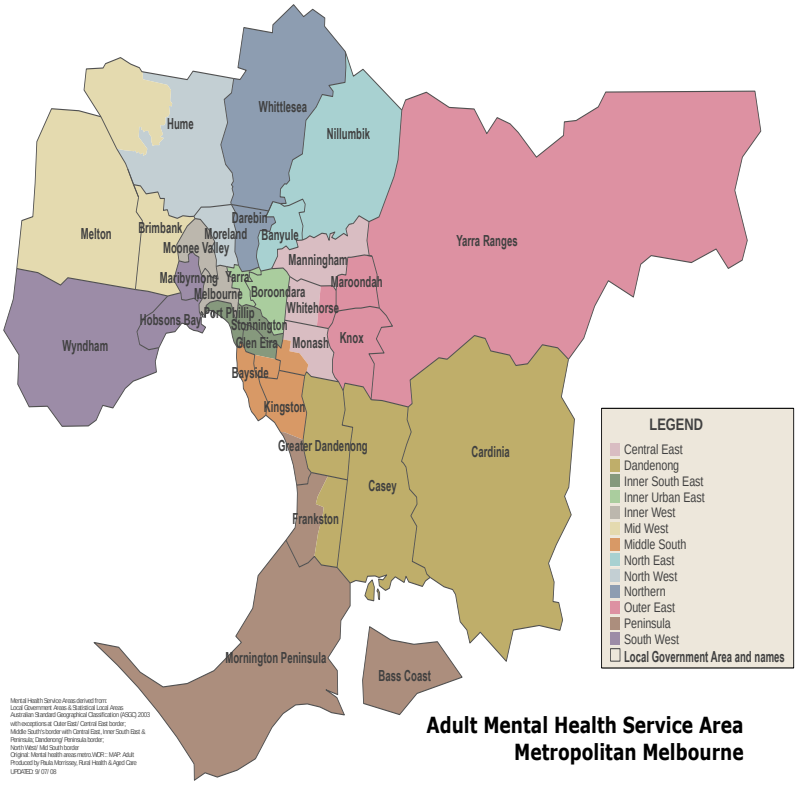


以成人為例就有：急性社區介入服務、急性住院服務、精神評估與計畫單位、保安延伸與住院服務、合併持續照護、照會聯繫接神醫療、社區照護單位、預防與復原照護、早發性精神病服務 Early psychosis（16-25 歲）及年輕預防與復原

照護 Youth PARC（16-25 歲）。

1、原則上民眾只能在他們的管轄區域內尋求醫療服務。有時民眾可能會由其他地區來尋求精神醫療協助。如果一個人跨區接受醫療，這人原本所在的成人精神醫療服務（AMHS）有責任要確保服務的連貫性。





2、分區、分年齡層提供不同服務

3、特殊精神治療服務

4、2016-2017 年維多利亞省精神醫療照護相關數據

公立精神醫療資源使用者，共有 66,445 人（51,735 成人，10,723 兒童青少年、7,386 老人、751 司法病人）；11,337 人為社區支持服；36.6%是新使用者；服務 1.1%的維多利亞省人口；50.4%是女性；32.6%為鄉下；13.6%是文化種族多樣的族群；2.5%是原住民。轉介來源最多是急診（24.2%）、其他（21.8%）、急性醫療單位（21.5%），開業醫師（11.7%）、個案自行就醫（4.6%）。12.6 億澳幣花費在臨床服務、1.25 億澳幣在社區支持服務。**精神科醫師** 23-25%在公立機構工作，75-77%在私人機構工作。

四、聖文生醫院的精神醫療 St Vincent Mental Health Services [10-11]

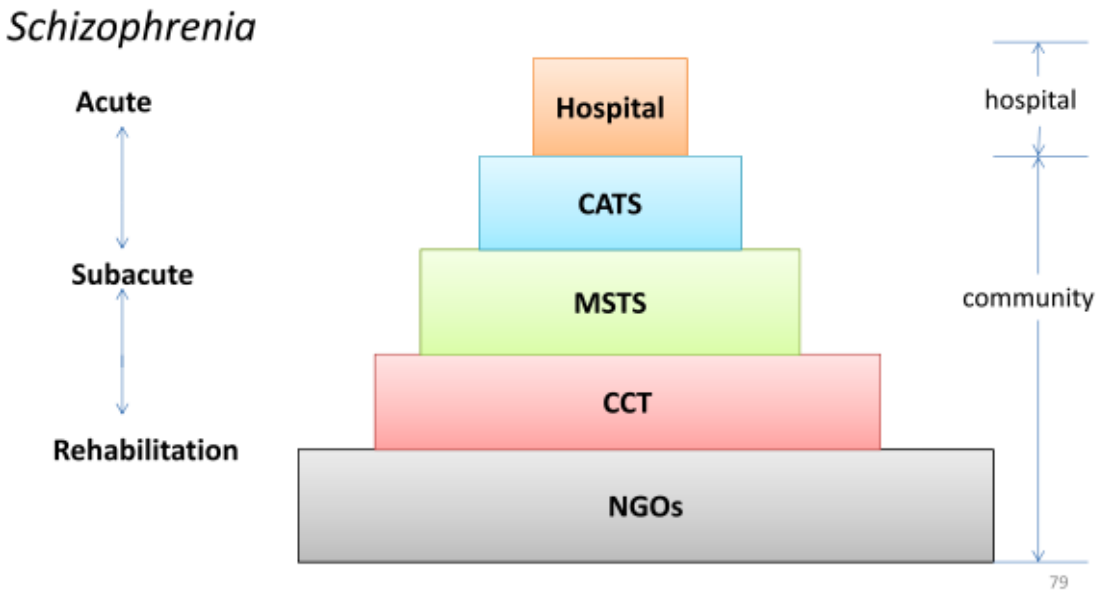
（一）聖文生醫院及其精神科的各種服務

聖文生醫院在墨爾本的市中心，是一個公立醫學中心級綜合醫院，總規模880床。除了各科的臨床服務外，也包括各種教學與研究。聖文生醫院的精神科（St. Vincent's Mental Health, SVMH） 是一個以社區為基礎的公立精神醫療服務單位，服務範圍涵蓋墨爾本市的內、東部。它包括急性精神科病床及機動性社區照護計畫。它也歸屬墨爾本大學，有許多的大學生、研究生、精神科醫師。強調以個案為中心的治療並聚焦在復原，整合醫院及社區服務，以一個跨精神醫療、一般醫療、與社會服務的網絡在服務範圍來運作。

整體而言聖文生醫院的精神醫療，包括社區為基礎的個案管理(case management）及綜合醫院精神科為核心的兩個主軸，強調持續性照顧，人性化、個別化且具有高度彈性的社區精神醫療制度，盡可能減少精神病患的住院。

在聖文生醫院中有急診、精神科的急性病房（Acute inpatient services）、精神檢傷(Psychiatric triage)，及一些特別的精神醫療服務(Body Image Eating Disorders Treatment and Recovery Service- BETERS, Victorian Dual Disability Service- VDDS, Mental Health Primary Intervention & Care Teams-MH PICT/ HOPE- Suicide Prevention）。

在社區中有一個中長期的社區醫療服務（Footbridge Community Care Unit）、一個短中期的預防及復原中心(North Fitzroy Prevention and Recovery Center, PARC），兩個社區精神醫療服務（Claredon Community Mental Health Service, Hawthorn Community Mental Health Service），各種的社區精神醫療團隊（危機評估與治療服務 Crisis Assessment and Treatment Service（CATS），機動支援團隊 Mobile Support Team（MST），持續照護團隊 Continuing Care Team（CCT）。



1、個案管理師

個案管理師的職責，主要在設定照護個案的復原目標、了解照護個案的個人強度、發掘照護個案的支持需求及參與並協助照護個案的治療計畫。

個案管理師的訓練課程，包括（1）個案管理與復健介紹（2）精神病理、臨床會談技巧與精神狀態檢查（3）嚴重精神病人的精神藥物、評估工具、臨床表現與物質濫用問題（4）心理社會介入，常用評估工具與預後評量（5）危機處理，嚴重精神病人與人格疾患的的精神醫療相關法律（6）復原取向的個案管理，個案管理師的角色，個別照護計畫（7）個別照護計畫，生理治療，社區生活技巧與職能復健（8）個別與家庭的溝通與諮商技巧（9）問題焦點治療（Solution-focused therapy），同儕專家服務，社區資源利用（10）警察的角色，與個案管理師的偕同工作。

2、精神檢傷分類 Psychiatric Triage [12]

維多利亞省有一個精神檢傷分類的指引與量表（Guideline of Statewide Mental Health Triage Scale），聖文生醫院精神科提供每周七日、24 小時皆有精神檢傷分類服務，負責評估被轉介的新個案。

其精神檢傷評估考量三個主要因素 Triage decision-making factors，分別為需求 need：個案需要的特定精神醫療服務；風險 risk：個案目前對自己與他人的風險；急迫性 urgency：精神醫療服務或其他服務反應的急迫性。

檢傷分類編碼 Triage Codes，分成 8 個等級，分別為：

- ◆ A 需要緊急服務（emergency services response）
- ◆ B 高急迫性的精神醫療服務（high urgency mental health response）
- ◆ C 急性精神醫療服務（urgent mental health response）
- ◆ D 半急迫性精神醫療服務（semi-urgent mental health response）
- ◆ E 非急迫性精神醫療服務（non-urgent mental health response）
- ◆ F 轉介其他服務提供者（referral to alternative provider）
- ◆ G 只要提供資訊/不須進一步動作（information only/No further action）

Mental Health Triage Scale

編碼/描述	回應型態到面對面接觸的時間	典型表現	精神醫療服務行動反應	進一步行動考慮
A **現在狀況危急自己或他人**	緊急服務 立刻轉介	● 藥物過量 ● 其他生理急症 ● 被襲擊 ● 自殺意圖/嚴重自傷 ● 暴力、威脅或持有武器	檢傷醫師告知急救人員、警察、消防	持續打電話直到緊急服務到達
B **非常高危險可能將傷害自己或他人**	高急迫性的精神醫療服務 在兩小時內	● 急性自殺意念/或有清楚與計畫的傷人風險/ 或有自傷或攻擊史 ● 非常高危險行為伴隨知覺/想法困擾,譫妄,失智,或衝動控制缺損 ● 由警察依照精神衛生法第十條進行評估	危機評估與治療服務或類等的面對面評估 並/或 檢傷醫師建議出席醫院急診（當危機評估與治療服務不能及時出現，或當個案需要急診評估治療）	在等待面對面的精神醫療服務的回應前，提供或安排個案及照顧者的支持（如 電話支持/治療；其他提供者回應） 在等待面對面的精神醫療服務的回應前，提供電話次級照會 如果情境改變建議打電話者回覆 如果適當可安排兒童/青少年的家長/照顧者的督導
C **高危險可能傷害自己或他人/ 或**	急性精神醫療服務 在八小時內	● 自殺意念/沒有計畫或過去自殺想法 ● 快速增加精神病症狀/ 嚴重情緒障礙 ● 高危險行為伴隨	危機評估與治療服務,持續照護或相等服務 （如 CAMHS 緊急反應）八小時內面對面評估 並	如上 獲取或證實/更多的資訊

編碼/描述	回應型態到面對面接觸的時間	典型表現	精神醫療服務行動反應	進一步行動考慮
		知覺/想法困擾,譫妄,失智,或衝動控制缺損 ● 無法自我照顧或獨立執行日常生活 ● 已知個案需要緊急介入以避免復發	危機評估與治療服務,持續照護或相等檢傷接觸以電話一小時內追蹤	
D **中危險傷害/ 顯著受挫**	半急迫性精神醫療服務 在 72 小時內	● 個案/照顧者因嚴重精神疾病而困擾（包含焦慮情緒/焦慮症）而無自殺危險 ● 早發性精神病症狀 ● 需要優先面對面評估去澄清診斷狀態 ● 已知個案需要優先治療或重新評估	危機評估與治療服務,持續照護或相等服務（e.g.CAMHS 個案管理師）面對面評估	
E **短期低傷害風險或 中風險但有高支持穩定因素**	非急迫性精神醫療服務	● 需要特別精神醫療評估，但在等候期是穩定且低傷害風險 ● 其他服務提供者能夠處理個案直到精神醫療約診（有或無精神醫療團隊電話支持） ● 已知個案須非緊急性重新評估,治療或追蹤	持續照護或相等服務（e.g. CAMHS 個案管理員）面對面評估	
F **不須精神醫療服務面對面回應而轉介**	轉介其他服務提供者	● 其他服務提供者（如 GPs,私人精神醫師,老人照顧評估服務）更適合個案現在需求 ● 輕微憂鬱/焦慮症狀/適應/或行為/或發展障礙 ● 老人早期認知改變	檢傷的醫師提供正式或非正式的轉介到其他服務提供者，或建議一個特別的服務提供者	促進與其他服務提供者約會（受到同意/私下需要）,特別是如果其他介入須及時

編碼/描述	回應型態到面對面接觸的時間	典型表現	精神醫療服務行動反應	進一步行動考慮
G **建議 或 只要資訊/** **服務提供者照會/** **精神醫療服務需要更多資訊**	只要提供資訊 / 不須進一步動作	● 個案/照顧者需要建議或討論的機會 ● 服務提供者需要電話照會/建議 ● 不須精神醫療或其他服務 ● 精神醫療服務可等待再進一步接觸 ● 需更多資訊（包含與精神醫療團隊討論）以決定是否精神醫療團隊要介入	如果需要，檢傷醫師可提供照會、建議或短期諮商 並/或 精神醫療服務經過電話收集進一步資訊	禮貌上透過電話接觸進行追蹤

（翻譯自 Mental Health Triage [12]）

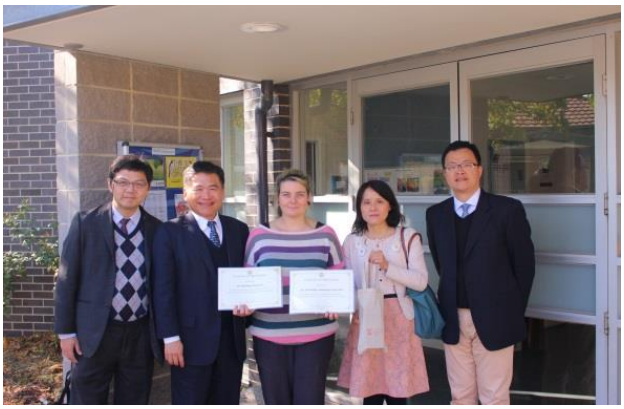
3、急性病房 Acute Inpatient Service（AIS）

聖文生醫院精神科有一個 44 床上下 2 樓的急性病床，包括 6 床的加護病床(Extra Care Unit, ECU），急性精神科病房以短期住院為主，一半以上在 2 周以內，有時也可能住到 3 個月到半年；住院最多的診斷仍是思覺失調症，合併甲基安非他命的比例不少。

4、Footbridge 社區照護單位（Footbridge Community Care Unit, CCU）

精神個案出院回到社區後可以到 CCU，其主要任務是提供居家住所及密集性的復健治療計畫，恢復病人原有日常生活功能，提升獨立生活能力。Footbridge 社區照護單位是一個有 20 床 24 小時中長期社區居住型的住宿機構，提供心理社會失能的精神病人，臨床照護與復健服務社區照護單位。

有各種生活和職能訓練團體，例如清潔，烹飪、康樂及運動團體等，工作人員定期帶個案外出購物逛街，走路搭車到市中心看電影等，個案入住的基本條件是不能太過混亂，能自行走路，毋需依靠輪椅或臥床，最久可入住 6 年。每 4 周有一床出院評估，調整周轉率。個案入住之後，有 4 周的密集評估，即所謂的觀察期，太過混亂或不遵守規範，4 週之後，不符入住條件，就必須辦理出院，有 2 人房、3 人房或個人房的單位，但共用客廳，衛浴，廚房及洗衣間，戶外有漂亮的庭院，種植各種花草。



5、預防與復原照護 North Fitzroy Prevention & Recovery Care（PARC）

PARC 是維多利亞省獨有的短中期的社區照護單位，協助個案精神症狀的預防與復原為目的，像家一樣的住宿單位，協助社區在地的精神病人所需要的額外支持協助，但不需要住院。在 PARC 中強調是一個「階梯向上、向下」（step up/step down）的服務，目標在社區中避免個案需要住院，也提供醫院出院個案回家前的協助。

6、社區精神醫療中心 Community Mental Health Center

以 Clarendon 社區精神醫療中心為例，它有多重功能，包括精神醫療檢傷、評估、照會與個案管理服務，並主動與開業醫師或私人精神科醫師分擔照護個案的工作。

在社區精神醫療中心，主要是有幾個主要團隊，包括：持續照護團隊 Continuing Care Team（CCT）、機動支援團隊 Mobile Support Team（MST）及危機評估與治療服務 Crisis Assessment and Treatment Service（CATS）。

- **持續照護團隊（Continuing Care Team，簡稱 CCT）**

  CCT 個案管理師的組成是多元的，包括社工師、護理師或是職能治療師，每位個案管理師至多服務 25 位個案；負責協助精神病情較為穩定，但仍有心理社會失能的個案、照顧者與社區單位，提供精神、心理、社會、功能與家庭的評估，解決他們的需求，連結各種資源包括開業醫師與失能復健與支持服務。會連結並協助出院後的支持，避免復發與促進復原。若有惡化與危機，會轉介緊急支持照護團隊。

- **機動支援團隊（Mobile Support Team，簡稱 MST）**

  MST 個案管理師的組成也是多元的，包括社工師、護理師或是精神科醫師，專責病況不穩定或服藥配合度欠佳的精神個案，提供較積極的評估與治療服務。每位個案管理師至多服務 10 位個案，這類個案通常具有強制社區治療的身分，需要個案管理師每日家訪 1 至 2 次，監督服藥配合度，或給予長效抗精神病藥物針劑。

- **危機評估與治療服務（Crisis Assessment and Treatment Service，簡稱 CATS）**

  CATS 主要的職責是針對在家或其他地方，有急性精神疾病個案，做危機處遇與短期的積極治療。CATS 會評估個案現在的精神狀態、精神疾病史、社會支持等，會與個案及照顧者一起合作。一般 CATS 是提供在家的積極治療、照顧與支持，不過有時住院是必要的，也會協助住院的安排、轉介與交通。有需要時，CATS 也常要與警察、緊急消防、酒精與藥物服務、兒童保護單位一起工作。

- **另外，其他特殊的團隊例如：**

  - **遊民精神醫療服務 Clarendon Homeless Outreach Psychiatric Service（CHOPS）**針對居無定所或無家可歸的個案，個案管理師服務的個案數不定，負責的個案有不少合併有藥酒癮的問題。

- **自殺防治服務 HOPE （Suicide Prevention）**：HOPE 團隊主要的協助對象是曾經出現在醫院的自殺企圖者，目標在降低自殺企圖與相關行為造成個案、照顧者與家庭的困擾，提供家訪介入協助，也包括轉介回醫院的服務。
- **精神醫療-初級介入與照護團隊 Mental Health－Primary Intervention & Care Team 簡稱 MH-PICT**：MH-PICT 團隊提供對於管轄區域內 GP 的教育與支持，特別是常見的焦慮與憂鬱疾病病人，MH-PICT 團隊可能會直接參與評估或治療，或協助與精神醫療及其他支持系統資源，或透過被動照會提協助。

五、Mental Health Act 2014 （Vic） [13]

（一）維多利亞精神衛生法簡介

澳洲各州都有自己的精神衛生法（Mental Heath Act, MHA），例如本次造訪的墨爾本所在的維多利亞省，就有自己的精神衛生法（Mental Health Act 1986（Vic）, Mental Health Act 2014 （Vic））。隨著這幾年國際上對人權的重視，包括 United Nations Principles for the Treatment of Persons with Mental Illness 1991 （UN Principles），及 United Nationas Convention on the Rights of the persons with Disabilities 2008（the CRPD），各州的精神衛生法也有更新或調整以符合國際要求。

單以 Mental Health Act 2014（Vic）而言，就有 17 部分 150 頁。幾個重要部分值得參考學習。例如：

第三部分:人權保護:提到有病人的權利與限制,還有保護人(Nominated Person)的角色等等。

第四部份：強制病人（Compulsory Patients）：提到有強制評估（Assessment Orders）、法院強制評估(Court Assessment Orders)、暫時強制治療(Temporary Treatment Orders）、強制治療（Treatment Orders）等的條件、程序與時間等等。

第八部分：精神衛生法庭（Mental Health Tribunal）：提到精神衛生法庭的建置、成員、管理、程序與規則等等。

第九部分：社區訪員（Community Visitors）：提到社區訪員的職責與功能。

第十一部分：保護病人（Security Patients）：提到法院強制保護治療（Court Secure Treatment Orders）、強制保護治療（Court Secure Treatment Orders）的規定要件等。

第十二部分：司法病人（Forensic Patients）：規定犯罪的精神病人等事項。

（二）強制病人 Compulsory patient [15]

其基本原則尋求最少及最短使用（minimize the use and duration）強制治療，去以確保最少限制與侵犯（least restrictive and least intrusive)。其執法者（Authorised person)，可為緊急救護、警察、受雇在特定精神醫療服務（designated mental health services）或精神醫師的醫療人員，並在 2014 年精神衛生法規範執法者在執行過程可以搜索、拘捕、搜身、使用器具做身體約束及運送個案到特定精神醫療機構。

指定精神科醫師（Authorised psychiatrist）可以對其他註冊醫療人員（registered medical practitioner）所做的強制評估（Assessment Order)，進行檢視並延長強制評估（Assessment Order)、決定強制暫時治療（Temporary Treatment Order）及有權力撤銷強制評估（Assessment Order)。

1、強制評估（Assessment Orders）

其強制評估要件為個案顯然有精神疾病（appear to have mental illness)、個案明顯有立即治療的需要，以去預防他的身心狀況嚴重惡化，或嚴重傷害自己或他人。可由註冊的醫療人員或精神醫療人員或精神醫療服務機構來決定，其強制時間在社區-最長 24 小時；醫院-24 小時，若個案在醫院（指定精神科醫師或代表精神科醫師可以延伸兩次，最長 72 小時)。

2、暫時強制治療（Temporary Treatment Order）

暫時強制治療的標準為有精神疾病的人、需要立即治療去預防嚴重惡化身心狀況或嚴重的傷害自己或他人，病人被強制治療，治療可以立即提供強制以最小限制的方法立即治療個案。由指定精神科醫師（Authorised psychiatrist）決定，不論是社區或住院暫時強制治療最多 28 天。兒童（18 歲或以下的人）為 14 天。

3、強制治療（Treatment Order）

在執行暫時強制住院法令的最後一周，由指定精神科醫師（authorised psychiatrist）再次替病人進行診察，並決定該強制是否需要繼續，並依臨床評估決定病人是以社區或住院治療，如需要向精神衛生法庭（Mental Health

Tribunal）提出申請，由精神衛生法庭（Mental Health Tribunal）決定，其強制時間在社區（成人最長 12 月；小於 18 歲最長 3 月)；住院（成人最長 6 月；小於 18 歲最長 3 月)，一旦不符合強制治療標準，指定精神科醫師（authorised psychiatrist）需要立即撤銷強制治療。

4、Mental Health act and human right [16]

本次考察的目的之一，是瞭解澳洲如何因應國際人權公約的要求。澳洲人權委員會有出版 Mental Health Legislation and Human Rights，對於各省的精神衛生法與國際人權公約的參考，可以供我們參考。不過據我們得到的訊息是，由於瞭解到國際人權公約與澳洲現行各精神衛生法有相當的牴觸衝突，所以國際人權公約部分的條文是保留未簽署的。

六、精神衛生法庭 Mental Health Tribunal （Vic） [17]

精神衛生法庭是維多利亞省因應 2014 年精神衛生法(Victorian Mental Health Act 2014）所設計的一個獨立的法庭，主要的功能在決定精神病人強制治療（compulsory mental health treatment）是否符合維多利亞精神衛生法所制訂的要件。如果個案的條件符合法律規定，精神衛生法庭會就會許可其強制治療（Treatment Order)，保護精神病人的權利與尊嚴。其主要審查項目如下：

- 強制治療（Tratment Order）許可指定精神科醫師可以在一定時間及在指定精神科機構，對於精神病人提供強制治療（住院或社區)。
- 檢視各種的強制治療（Treatment Orders）並執行聽證去撤銷強制。
- 決定被強制治療的精神病人或小於 18 歲是否電痙攣治療（ECT)。
- 決定精神疾病的犯人轉移到指定精神機構治療。
- 負責審查轉移病人到其他精神醫療機構。
- 負責審查精神疾病的神經外科手術。

（一）強制治療（treatment order）之審查時機及程序

1、指定精神科醫師所決定暫時強制治療僅能強制病人 28 天，所以精神衛生法庭必須在 28 天結束前舉行聽證會，決定個案的狀態是否符合強制治療（Treatment Order）的標準。

2、精神衛生法庭在決定強制治療（Treatment Order）前，需確認個案符合所有治療的標準。包括：個案有精神疾病、需要立即治療以預防身心健康嚴重惡化或嚴

重傷害自己或他人；可立即提供必要及最小限制治療，使病人得到完善治療。

3、精神衛生法庭在聽證會時，須依據當時情境判定強制治療是強制社區治療（Community Treatment Order）或是強制住院治療（Inpatient Treatment Order）。也會決定強制治療（Treatment Order）的時間。最長強制社區治療是 12 個月，最長強制住院治療（Inpatient Treatment Order）可以到 6 個月。若個案小於 18 歲，不論哪種強制治療（Treatment Order）最長是 3 個月。

4、要區分強制治療的時間，與病人強制住院的時間。多數而言前者會大於後者，意思是若強制仍是必要，病人離開醫院仍能在社區以強制社區治療（Community Treatment Order）繼續治療。

5、精神衛生法庭可以在任何時刻撤銷被判定強制暫時治療（Temporary Treatment Order）或強制治療之情境與時間。

（二）精神衛生法庭的聽證會（hearing）

1、精神衛生法庭的一般部門，可以執行聽證會並做強制暫時治療法律決定，聽證會由三個人組成，包括司法人員（legal member）、精神科醫師或登記醫療人員（registered medical practitioner member），及社區人員（community member）。其中司法人員是主席。

2、精神衛生法庭的特別部門，會對 ECT 及神經外科手術執行聽證會病做法律決定。聽證會由三個人組成，包括：司法人員（legal member）、精神科醫師，及社區人員（community member）。其中司法人員是主席。

3、2016-2017 年維多利亞精神衛生法庭的聽證會執行狀況 [18]

（1）聽證會執行 7,818 件，62 件是再續執行。其中 5,925 件是決定強制治療（75.8%）。371 件是撤銷強制治療/暫時強制治療。590 件是許可 ECT 谷療，100 件是否決 ECT 治療。

（2）聽證會結果許可強制社區治療（Community Treatment Order）有 3,423 件（54%），強制住院（Inpatient Treatment Order）有 2,502 件（40%），6%撤銷暫時強制治療（Temporary Treatment Order）。另有 351 件是緊急的 ECT，237 件是標準的 ECT 是被許可。

（3）強制社區治療（Community Treatment Order）的時間，最多的是 40-52 週（46%），其次是 14-26 週（39%）。強制住院治療（Inpatient Treatment Order）的時間，最多的是 21-26 週（68%），其次是 7-13 週（20%）。

（4）共有 688 件 ECT 相關審查，其中核准強制 ECT order 有 85%，不同意的有 15%。不同意理由最多的是可以用較不限制的方式治療（53%），其次是病人有能力被告知後決定（41%）。

（5）聽證會執行的形式，直接與本人接觸（76%），視訊 24%，電話<1%。

七、Beyond Blue [19]

Beyond Blue 於 2000 年 10 月成立，是澳洲知名從事憂鬱防治及心理健康促進的非營利性組織。致力於協助處理憂鬱、焦慮及相關精神疾病。透過與醫療機構、學校、職場、大學、媒體與社區組織的合作，協助憂鬱及焦慮患者覺察症狀、處理疾病，也降低相關精神疾病的污名化。該機構深獲澳洲聯邦政府、州政府及地區政府以及民眾、corporate Australia 和 Movember 等機構的支持。目前員工有超過 1 百人以上。beyondblue 標識-蝴蝶，呈現溫柔的蝴蝶釋放沉重和黑暗，飛向陽光，傳播信心。Beyond Blue 對澳洲心理健康工作及方案制定有重要影響，超過 87%澳洲民眾認識

它現在的主席，是 The Hon Julia Gillard AC ，她是澳洲前總理。

與我們說明介紹的是 Prof Grant Blashki，他也是墨爾本大學的副教授，家庭醫科醫師。他目前也是 Beyondblue 的 clinical advisor。負責給予這個組織專業臨床的建議。

強調現在澳洲有 2 百萬人有焦慮、2 百萬人有憂鬱，每日有 8 人結束生命。終其一生，澳洲每 3 個女性有一人有焦慮、每 6 個女生有一人憂鬱。澳洲每 5 個男性有一人有焦慮、每 8 個男生有一人憂鬱。Beyondblue 致力於各個層面的大眾推廣，也建立了許多的教材、推廣品、網站，與不同分眾的策略與作法，值得台灣學習。

Beyond Blue 宗旨：1、提升社會大眾對心理健康的覺察 2、讓大眾更友善看待心理疾患、去汙名化。3、促進民眾能在對的時間得到有效支持與服務的機會。4、使用最佳的商業操作，去傳遞整合及以證據為基礎，形成有效的行動，減緩心理疾患帶來的影響。

Beyond Blue 創意防治方案

1、Way Back Support Service [20]

Way Back Support Service 是 beyondblue 對於自殺企圖者提供 3 個月非臨床的關心與實際的支持。提供個案醫院出院後鼓勵與支持及協助的計畫，使個案能安全並回到相關就診與得到社區支持，協助個案連結支持網絡。

2、Mind Matters [21]

Mind Matters 是校園精神健康的行動計劃，目的在促進年輕人的精神健康與健全。這也是一個網絡工作，建構自己的校園精神健康策略時，可依他們獨特的情境提供結構、引導與支持。其有 4 個主要的內容 C1 正向校園社區 C2 學生技巧與復原力（resilience）C3 父母與家庭 C4 支持有精神困難的學生。

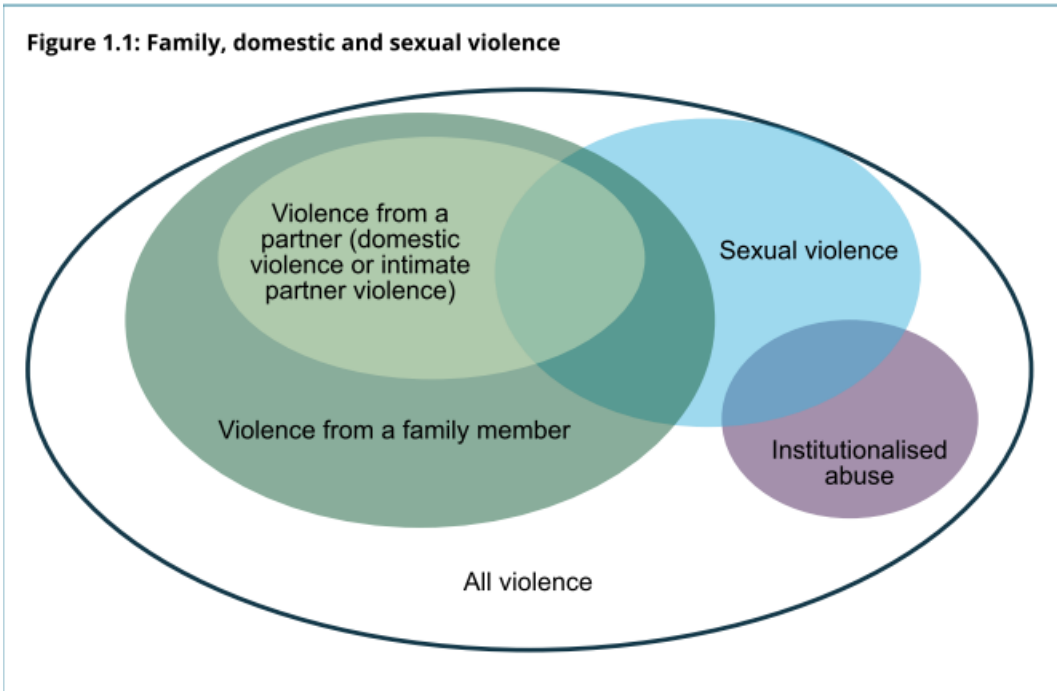
3、Heads UP [22]

Heads Up 是精神健康職場聯盟與 beyondblue 一起發展的。Heads Up 呼籲企業領袖去承諾並開始推動職場的行動。鼓勵每個在職場的個人扮演自己的角色，去創造工作環境的精神健康，自我照顧自己的精神健康，並關心周遭的同仁。澳洲研究發現，沒有治療的精神疾病每年造成企業損失 109 億澳幣，分析並發現，每投資 1 元澳幣在職場的精神健康，可以對企業造成回收 2.3 元澳幣的好處。

八、家庭暴力

（一）澳洲家庭暴力概況［23］

澳洲統計大於 15 歲以上的女性，每 6 個有一個曾經歷過現在或過去伴侶的身體或性暴力，每 4 個有一個會有曾經歷過現在或過去伴侶的情緒暴力，每 5 個有一個曾經歷過性暴力，而 2012-2013 及 2013-2014 有 99 個女性因現在或過去伴侶的暴力而死亡。強調暴力有很多種，機構的暴力、性的暴力、家庭成員的暴力、親密關係的暴力。



（二）2010-2022 澳洲有降低女性與孩童暴力的全國計畫，[24]

1、第 1 期行動方案 First Action Plan, 2010-2013

2、第 2 期行動方案 Second Action Plan, 2013-2016

3、第 3 期行動方案 Third Action Plan, 2016-2019

（三）維多利亞省也有自己的暴力防治策略 （Free Violent, Victoria） [25]

暴力的三級預防

	初級預防	次級預防 （早期介入）	三級預防 （反應）
這是甚麼?	在暴力前預防暴力發生	早期介入預防暴力再發生	預防長期因暴力而受傷
該聚焦甚麼?	以民眾為整體，暴力行為發生因所在的環境有不同，解決可能導致暴力或縱容暴力發生的因素	高風險的加害者或受害的個人或團體及造成風險	讓受暴力影響的系統、組織或社區，有能力反應處理並處理加害者
該做甚麼?	建立社會結構、常規、與行動，去預防暴力發生或減少暴力發生的風險	挑戰會使個人增加或促發暴力的因素	用展現對於暴力的當責性，與支持女性有權利與復原

（翻譯自[25]）

（四）DV-Alert [26]

DV-Alert 是一個澳洲特別針對家庭暴力的防治組織，在澳洲各地舉辦工作坊，提供有品質與文化敏感度的家庭暴力防治的教育訓練課程，以協助這些因家庭暴力的受害者，強調三個 R 的重點，包括：辨識（recognize）、反應（response）、轉介（refer）。

伍、澳洲與台灣精神醫療機構、社區照護與強制治療的差異

（一）澳洲與台灣的的精神照護機構分布

<table>
<tr><td colspan="6">台灣</td><td colspan="6">澳洲</td></tr>
<tr><td colspan="6">426
機構</td><td colspan="6">1,591
機構</td></tr>
<tr><td>22
社區心衛中心</td><td>203
復健機構</td><td colspan="2">129
私立醫院</td><td colspan="2">72
公立醫院</td><td>1,197
社區心衛中心</td><td>167
復健機構</td><td>66
私立醫院</td><td colspan="2">161
公立醫院</td></tr>
<tr><td></td><td></td><td>92
私立醫院精神科</td><td>37
私立精神醫院</td><td>63
公立醫院精神科</td><td>9
公立精神醫院</td><td></td><td></td><td></td><td>144
公立醫院精神科</td><td>17
公立精神醫院</td></tr>
<tr><td></td><td></td><td>2906
床</td><td>7,266
床</td><td>5,126
床</td><td>5,671
床</td><td></td><td></td><td>2,754
床</td><td>5,310
床</td><td>1,698
床</td></tr>
<tr><td></td><td>5,917 床
住宿型
（2,435
日間型）</td><td colspan="4">20,969 床</td><td></td><td>2,383
床</td><td colspan="3">9,812 床</td></tr>
</table>

1、澳洲與台灣人口相當，但面積是台灣的兩百多倍。上表呈現的是澳洲與台灣在精神醫療機構分布的差異。台灣有 426 家精神照護機構、澳洲有 1,591 家精神照護機構，其中社區心理衛師中心台灣只有 22 家，澳洲卻有 1,197 家。澳洲顯著有較多比例的社區心理衛生中心（1,197/1,592=75.2%），相較於台灣只有（22/426=5.2%）。

2、台灣與澳洲住院床位與分佈

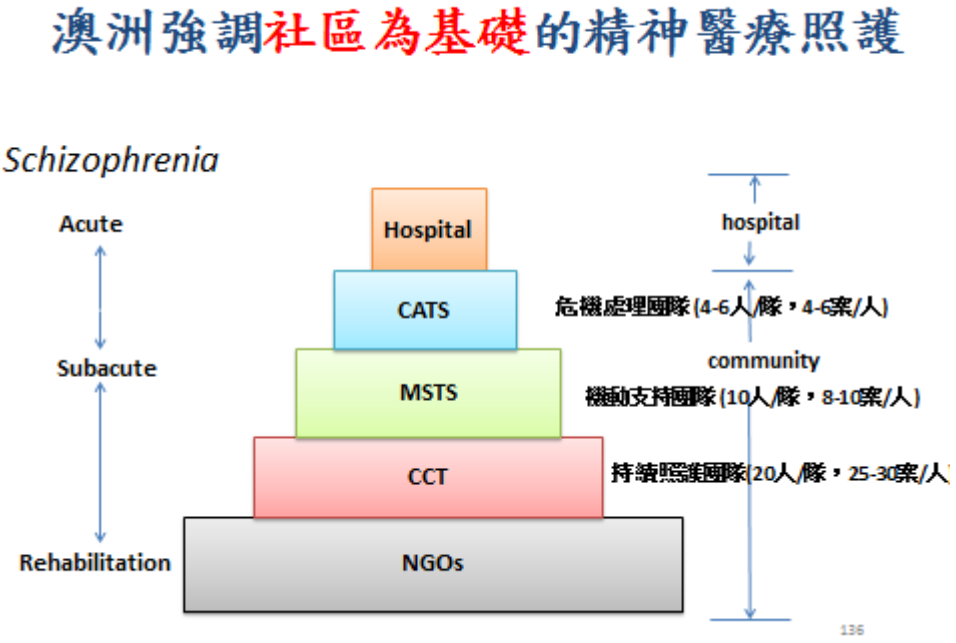
（1）台灣住院精神科床位，分布在 72 家公立醫院（9 家公立神科醫院、63 公立醫院精神科）、129 家私立醫院（37 家私立精神科醫院、92 家私立醫院精神科）。共提供 20,969 張住院床位。

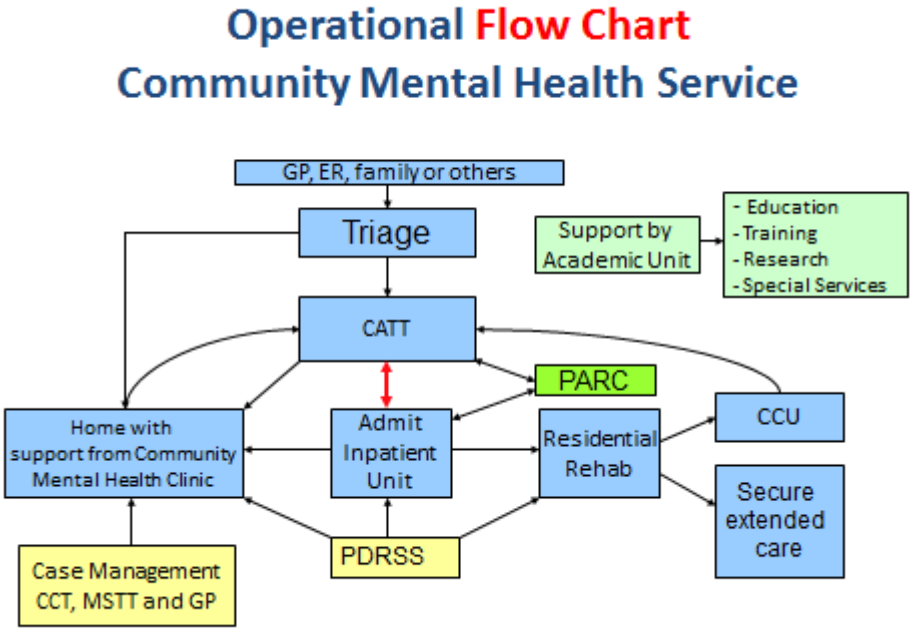
（2）澳洲精神科住院床位，分布在 161 家公立醫院（17 家公立神科醫院、144 公立醫院精神科）、66 家私立醫院。共提供 9,812 張住院床位。

（3）台灣精神科住院床位數，是澳洲精神科住院床位數的兩倍多。澳洲精神專科醫院總床位數，僅佔所有精神科總住院床位數的 17.3%，大多數（82.7%）的精神科床位是在公、私立綜合醫院之中。澳洲精神科住院病床多數回歸綜合醫院精神科。台灣大型化的精神專科醫院仍然不少，佔台灣所有精神科總床位數的

61.7%，公、私立綜合醫院精神科床位數占 38.3%。台灣精神科住院病床在精神專科醫院的仍較綜合醫院的多。

（二）澳洲與台灣的精神科社區照護的差異





1、澳洲較台灣更強調以社區為基礎的精神醫療照護

澳洲有較完整的社區精神照護團隊，駐點在社區心理衛生中心，以個案管理師為核心，與醫院密切合作。包括持續照護團隊（CCT，一隊 20 人，每人 20-35 案）、

機動支援團隊（MST，一隊 10 人，每人 8-10 案）、危機處理團隊（CAT，一隊 4-6 人，每人 4-6 案），依個案的狀況做分工設計。

2、澳洲強調持續性、流動性的精神照護。精神病人依照不同病情狀況，有不同的單位處理。

（1）精神檢傷（Psychiatric Triage）是重要的把關者，評估個案的嚴重性、緊急性、需求性，決定是否要將開業醫師或急診轉來的個案，納入精神醫療照護系統。

（2）危機處理團隊（CATT）是重要要的轉銜樞紐，負責控制協調要住醫院急性病房或是在社區居家或社區單位住院照護，CATT 也會積極穩定個案避免需到醫院住院。有時個案在醫院急性病房只會短期住院、仍有症狀而出院，出院後的個案也會轉給 CATT 團隊，讓其處理後再轉給社區居家或社區住院照護。

（3）社區有 PARC、CCU、residential rehabilitation unit 可以短、中期住宿協助。也可以回家或看社區診所，有 CCT、MST 等社區團隊會協助。

（4）PDRSS（Psychiatric disability rehabilitation and support services），大多是由 NGO 組織負責。PDRSS 團隊與醫院、社區與家庭建立關係與合作、早期介入，以盡早協助功能的支持與復健。

（5）學術單位提供教育、訓練與研究，支援並支持所有精神醫療照護系統的運作。不論在醫院或社區的工作者，都可以與學術單位合作，也提升他們的角色地位。

（三）澳洲與台灣的強制醫療

<table>
<tr><th colspan="2"></th><th>澳洲（維多利亞省）</th><th colspan="2">台灣</th></tr>
<tr><td colspan="2">審查單位</td><td>精神衛生法庭</td><td colspan="2">審查會</td></tr>
<tr><td colspan="2">審查單位組成</td><td>3 人（精神科醫師、司法人員、社區人員）</td><td colspan="2">7 人（專科醫師、護理師、職能治療師、心理師、社會工作師、病人權益促進團體代表、法律專家及其他相關專業）</td></tr>
<tr><td colspan="2">強制種類</td><td>（a）強制評估（社區、住院）
（b）強制暫時治療（社區、住院）
（c）強制治療（社區、住院）</td><td colspan="2">（a）強制鑑定
（b）強制治療（住院、社區）</td></tr>
<tr><td colspan="2">強制住院治療數</td><td>2,502（2016 年）</td><td colspan="2">752（2016 年）</td></tr>
<tr><td colspan="2">強制社區治療數</td><td>3,423（2016 年）</td><td colspan="2">58（2016 年）</td></tr>
<tr><td rowspan="3">強制
鑑定
（評估）</td><td>條件</td><td>個案顯然有精神疾病；
需要立即治療去預防：嚴重身心健康惡化；或嚴重傷害自己或他人；</td><td colspan="2">嚴重病人（現實脫節之怪異思想及奇特行為，致不能處理自己事務，經專科醫師診斷認定者）傷害他人或自己或有傷害之虞，</td></tr>
<tr><td>決定者</td><td>註冊的醫療人員或精神醫療人員或精神醫療服務機構來決定</td><td colspan="2">兩位指定專科醫師</td></tr>
<tr><td>時間</td><td>社區－最長 24 小時
住院－最長 72 小時含交通</td><td colspan="2">2 日內</td></tr>
<tr><td rowspan="3">暫時
強制
住院
（社區）</td><td>條件</td><td>個案有精神疾病；
需要立即治療去預防：嚴重身心健康惡化；或嚴重傷害自己或他人；</td><td colspan="2" rowspan="3">無</td></tr>
<tr><td>決定者</td><td>指定精神科醫師</td></tr>
<tr><td>時間</td><td>醫院或社區皆為 28 天</td></tr>
<tr><td rowspan="3">強制
住院
（社區）</td><td rowspan="2">條件</td><td rowspan="2">暫時強制住院者
個案有精神疾病；
需要立即治療去預防：嚴重身心健康惡化；或嚴重傷害自己或他人；</td><td>強制住院</td><td>強制社區治療</td></tr>
<tr><td>嚴重病人（現實脫節之怪異思想及奇特行為，致不能處理自己事務，經專科醫師診斷認定），有傷害他人或自己或有傷害之虞</td><td>嚴重病人，不遵醫囑至其病情不穩或有生活功能退他之虞</td></tr>
<tr><td>決定者</td><td>精神健康法庭</td><td>2 位指定專科醫師認定後送審查會</td><td>1 位專科診斷後送審會</td></tr>
<tr><td>時間</td><td>社區（成人最長 12 月）
住院（成人最長 6 月）
小於 18 歲最長 3 個月</td><td>住院最長 60 日，得再申請延長 60 日</td><td>第 1 次強制社區治療 6 個月；延長強制社區治療 1 年</td></tr>
</table>

（一）台灣的強制醫療較澳洲為嚴格

1、台灣的精神衛生法分為強制鑑定與強制治療二種，強制治療須送審查會決定。

2、審查會的組成為七人（專科醫師、護理師、職能治療師、心理師、社會工作師、病人權益促進團體代表、法律專家及其他相關專業）

3、強制條件：嚴重病人（現實脫節之怪異思想及奇特行為，致不能處理自己事務，經專科醫師診斷認定者），且有傷害他人或自己或有傷害之虞。

4、需先由要 2 位指定專科醫師鑑定，鑑定後再向審查會申請許可。

5、台灣 2016 年僅有 752 件強制住院治療，58 件強制社區治療。

（二）澳洲維多利亞省的強制治療較台灣寬鬆、彈性但積極

1、維多利亞省的精神衛生法，分為強制評估、暫時強制治療與強制治療，僅有強制治療要送精神衛生法庭。

2、強制鑑定要件為個案顯然有精神疾病；需要立即治療去預防嚴重身心健康惡化或嚴重傷害自己或他人。僅須註冊的醫療人員或精神醫療服務機構內精神醫療人員決定，未必需要精神科醫師。

3、暫時強制治療要件為個案有精神疾病；需要立即治療去預防身心健康嚴重惡化或嚴重傷害自己或他人；須為指定精神科醫師才能決定。可決定暫時強制治療 28 天。

4、強制治療要件為暫時強制治療 28 天結束前，精神衛生法庭要舉行聽證會，決定強制治療。精神衛生法庭組成為 3 人（精神科醫師、司法人員、社區人員）。可決定 1 年的強制社區治療或半年的強制住院治療。

5、澳洲維多利亞省 2016 年就有 2,502 件強制住院治療，3,423 件強制社區治療。

陸、心得及建議

一、心得：

此行的目的在考察（一）澳洲的精神醫療政策沿革、（二）澳洲的社區精神醫療制度、（三）澳洲精神衛生法與人權公約、（四）其他澳洲特殊精神處理機構與單位。許多的所見所聞，確實值得台灣做參考。

（一）在精神醫療政策方面：澳洲在上個世紀末就已經開始積極地去機構化，並發展社區精神醫療。配合澳洲國家精神醫療政策改變，減少慢性精神醫院的床位、增加精神科位於綜合醫院的床位數，增加消費者參與，並鼓勵補助 NGO 負責許多精神失能支持的方案。

（二）在社區精神醫療方面：澳洲強調以社區為基礎的的精神醫療照護。各地都有社區心理衛生中心及以個案管理師為基礎的社區照護團隊。強調連續性、持續性、流動性的照護，依個案的嚴重、急迫、需求做不同的分工。個案回歸社區需要個案管理師（case manager）的密切追蹤及協助，包括服藥配合度，住所安排，職能訓練，職場工作轉介等，醫療人員的角色單純化，與精神病患及其家人的關係可改善，純粹站在協助病人的立場，卸除機構化過程中的醫療人員、照顧者、家人的多重角色。

（三）在精神衛生法、精神衛生法庭與人權公約：澳洲較為寬鬆與彈性也較積極。賦予精神醫療人員較大的權限與空間，未必一定要嚴重病人傷人傷己才能強制治療。有精神疾病、有可能造成身心狀況惡化或傷人傷己的風險，精神科醫師一名即可暫時強制治療 28 日。28 日以上才要精神衛生法庭審查。維多利亞省是台灣四分之一人口數，2016 年的強制住院與強制社區治療就有 5,925 件，而台灣只有 610 件。可是在人權公約上他們反而是保留的。

（四）在其他特殊精神醫療機構及處置：Beyondblue 在憂鬱、焦慮、自殺議題的的積極與成就，還有幾個在校園、職場的特殊方案，與利用各種現代電子媒介社群的協助模式，都讓我們印象深刻。家暴議題上，由國家、地方都十分重視，並有完整統計分析與行動方案，也是值得學習的。

綜合這些見聞與學習，台灣未來在精神醫療政策精進、社區精神醫療發展與建置、精神衛生法的修法與人權公約的應付、其他特殊精神議題的處遇協助，都值得參考澳洲的經驗，讓整體的精神醫療能夠更完整進步，也有助於社會安全網的穩定。

二、建議：

（一）重新盤點精神照護及精神病人社區照護資源，投入更多經費於社區精神照護並檢討現行給付標準，提升社區給付標準（含出院準備、居家治療及強效針劑），並整合醫療（含公務預算及健保給付）、社福、勞政、教育及民間團體資源，以區域及社區為基礎的全人社區精神照護管理，強調連續性、持續性、流動性的照護，依個案的嚴重、急迫、需求做不同的分工，在既有基礎上，基於資源和現實情形制度適度整合社區心理衛生中心及以個案管理師為基礎的社區照護團隊。

（二）重新檢討社區關懷訪視員之制度，含教育訓練制度、訪視人力、訪視重點、資源轉介及人力留任等制度。

（三）檢討精神病人強制住院制度，需同時兼顧精神病人就醫權及人權，適度調整現行審查制度。

（四）建議與國家衛生研究院結合，訂定相關成效指標，編印心理衛生及精神衛生年報，做為資料彙整，編纂當年度中央、地方及民間團體重要的工作發展，並推動工作進行客觀記載及系統性整理與分析。

（五）初級預防是我們未來需重視的工作，我國精神醫療人力目前重點仍放在醫院/診所之病人。而學生、職場員工、孕婦之心理健康促進需有更系統性之策略，我們需要向澳洲學習其系統性之策略，若能增加學生之抗壓性、情緒管理，人際關係，必能減少在校之霸凌、憂鬱及自殺、暴力等事件。

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Information about your rights & responsibilities as a resident responsibilities

All consumers, visitors, and staff have a right to a safe environment at The Footbridge CCU.

This means everyone needs to:

- Keep the shared living areas clean.
- Use the "in/out" board to let staff know when they are leaving and when they will come back to The Footbridge.
- Let staff know when they have visitors at The Footbridge. Visitors need to sign the Visitor's book at the start and end of each visit. Visiting hours are until 8.30pm every day.

We will not tolerate any:

- Intimidation - verbal or physical
- Violence - the police will be called if there is violence to people or damage to property.

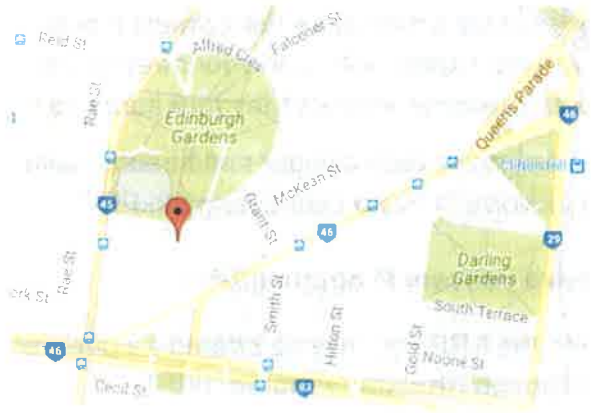
This is called a Zero Tolerance policy

How to contact Footbridge Community Care Unit

Speak to your case manager if you want to be part of the program at Footbridge.

Your case manager and carer, family or friend can take you on a tour of Footbridge

On this tour you can ask any questions you like about the program.



Footbridge Community Care Unit
540 Napier Street,
North Fitzroy VIC 3068
Tel: 9481-5644
Fax: 9481-4193

ST VINCENT'S HOSPITAL MELBOURNE

enVision2025

Footbridge Community Care Unit (CCU)

540 Napier Street, North Fitzroy

What is Footbridge?

Footbridge Community Care Unit is in Fitzroy North, and is a 20 bed mental health residential recovery program. It is staffed 24 hours a day. It has a multidisciplinary team that provides clinical care and case management using a strengths-based approach. This shared living environment supports people to achieve their recovery goals; build on everyday living skills; and develop links in the community.

Who comes to The Footbridge?

Individuals who experience mental illness and who would benefit from a period of intensive support to achieve their recovery goals.

Recovery Review Program (RRP)

This RRP is a short term program where you stay at Footbridge and work with different members of the team to:

- Identify your personal recovery goals
- Identify your personal strengths
- Explore your support needs
- Involve you in planning your treatment

At the end of the program we will arrange a time with you, your carer/family, and your treating team to discuss recommendations for your future care.

Your community case manager and treating team will stay involved in your care during the RRP.

Intensive Recovery Program (IRP)

Following the RRP you may be offered a placement in the Intensive Recovery Program (IRP).

The IRP is a longer term program, the length of stay is determined by yourself and the treating team.

During this time your care will be transferred to Footbridge, and you will be appointed a case manager who will work alongside you during your stay. The IRP provides an opportunity for individuals to access a range of health care professionals and resources to support their recovery goals.

A Message for Carers and Family members

We believe that carers and family members have an important role in the consumer's time at Footbridge. St Vincent's Mental health also offers a range of services for carers such as:

- Families where a Parent has a Mental Illness
- Children of Parents with a mental illness
- Carer Consultant
- Tandem Carers Fund

Please speak with your case manager for more information.

Mental Health Tribunal

Mental Health Tribunal Service Charter

The Mental Health Tribunal (the Tribunal) is an independent statutory tribunal established under the *Mental Health Act 2014*. The Tribunal is an essential safeguard under the Act to protect the rights and dignity of people with mental illness.

Purpose of our Service Charter

- Outlines our vision, values and goals
- Advises what services you can expect from the Tribunal
- Outlines our service standards
- Explains how you can give us feedback on any aspect of our service

Functions of the Tribunal

The primary function of the Tribunal is to determine whether the criteria for compulsory mental health treatment as set out in the *Mental Health Act* 2014 apply to a person. The Tribunal makes a Treatment Order for a person if all the criteria in the legislation apply to that person.

The Tribunal will also determine:

- Whether electroconvulsive treatment (ECT) can be performed on a person if they are considered to not have capacity to give informed consent to ECT, or if they are under the age of 18.
- A variety of matters relating to security patients.
- Transfers of treatment to other mental health services.
- Applications to perform neurosurgery for mental illness.

Vision

The Tribunal's vision is:

Promoting rights by ensuring the participation of people with mental illness and their carers in decision making.

Values

We are:

- accessible
- collaborative
- responsive and solution focused
- respectful of diversity and individual dignity
- accountable and professional
- committed to learning and improvement

Goals

The Tribunals' goals are:

- **Participation** – maximising opportunities of consumer and carer participation.
- **Excellence in Tribunal Practice** – embedding best practice in all aspects of our operation.
- **Building Excellence in Mental Health Law** – promoting transparency in decision making and contributing to the implementation and development of the Mental Health Act.

Last Updated: February 2015

Level 30, 570 Bourke St, Melbourne Victoria 3000 Australia
T +61 3 9032 3200 F +61 3 9032 3223 T 1800 242 703 (Toll-free)
E mht@mht.vic.gov.au W mht.vic.gov.au

State Government Victoria

Tribunal Services

The Tribunal provides the following services:

- Scheduling and conducting hearings, primarily to consider compulsory treatment, and ECT.
- Providing written notices of hearing to parties and compulsory notification persons as soon as practicable.
- Responding to enquiries from parties including consumers, carers, legal representatives and mental health service providers.
- Where the Tribunal has determined to make an Order, take steps to give a copy of the Order to parties and compulsory notification persons as soon as practicable after the Order is made.

Tribunal Staff Service Delivery Standards

Our service standards describe the level of service we aim to deliver. These standards will be measured regularly through internal monitoring procedures and by monitoring the feedback you provide.

- Where a consumer is made a compulsory patient we will list a hearing within the legislative time requirements.
- We will notify consumers, nominated persons and other parties of hearings as soon as practicable.
- The office will be attended from 9.00 am to 5.00 pm each business day.
- Staff will identify themselves by their preferred name.
- Staff will be contactable by email, telephone, and/or in person during business hours.
- Enquiries will be attended to promptly and the enquirer will be treated fairly, reasonably and with courtesy.
- Email enquiries will be acknowledged on receipt and will be responded to within 2 business days. Where your request cannot be finalised within 2 business days you will be advised of the expected time frame for resolution.
- We will answer 95% of telephone calls within 1 minute. Where a voice mail message is left we will respond to that message within one business day.
- Wherever practicable, if it is not possible or appropriate to assist a person making an enquiry, staff will provide information regarding agencies which may be able to assist.
- We will collect, store, use and disclose your personal information only for the purposes of the work of the Tribunal and in accordance with the *Mental Health Act* 2014.

Feedback

To provide feedback or make a complaint please see the feedback and complaints handling process on our website or complete the online feedback form through our website at www.mht.vic.gov.au

How to Contact Us

Mental Health Tribunal
Level 30, 570 Bourke Street
Melbourne, Victoria 3000

Telephone: (03) 9032 3200

Toll free for Victorian country callers: 1800 242 703

Email: mht@mht.vic.gov.au

Website: www.mht.vic.gov.au

Last Updated: February 2015

The role of the Victorian Mental Health Tribunal under the *Mental Health Act 2014* (Vic)

Matthew Carroll
President – Mental Health Tribunal

23 April 2018

Mental Health Tribunal

Issues to be covered

1. The Tribunal's functions under the Act
2. The Tribunal's solution-focused approach to the conduct of hearings
3. Future focus

Key principles of the MH Act

- Voluntariness preferred
- Recovery and community participation
- Preferences should be respected
- Allowing people to make choices involving a degree of risk
- Rights, dignity and autonomy to be promoted
- Holistic approach
- Carers recognised, respected and involved

Treatment Orders

- Sequence of Orders
- Types of Orders
- Length of Orders
- Triggers for Tribunal hearings

Criteria for Treatment Orders

Section 5:

- The person *has* mental illness;
- Because the person has mental illness the person needs *immediate treatment* to prevent *serious deterioration* in their mental or physical health or *serious harm* to themselves or another person;
- *Immediate treatment will* be provided if they are subject to an order;
- *No less restrictive means reasonably available* to enable immediate treatment.

Key Statistics – Treatment Orders

	2014/15	2015/16	2016/17
ITOs made	2324	2485	2502
CTOs made	2588	3120	3423
Orders revoked	417	358	371

Electroconvulsive Treatment

- Why does the Tribunal have a role in relation to ECT?
- When does an application have to be made to the Tribunal?
- How the Mental Health Act defines capacity
- The form of an ECT Order made by the Tribunal

Criteria for ECT Orders – adult compulsory patients

Section 93 and 96:

The person must not have the capacity to give informed consent to ECT and there is no less restrictive way for the person to be treated.

Considerations relevant to the less restrictive test include:

- the person's views and preferences re ECT and beneficial, alternative treatments;
- content of an advance statement;
- views of any nominated person, carers, guardians;
- the likely consequences of ECT not being used;
- any second opinion that has been provided.

Key Statistics – ECT Orders

	2014/15	2015/16	2016/17
ECT Orders made	550	620	588
ECT applications refused	68	86	100

Solution-focused hearings

A solution-focused approach

Characteristics of a solution-focused approach to hearings:

- Exploratory rather than directive.
- Constructive and respectful questions and discussion.
- Informed by the preferences and views of consumers and also the views of a nominated person and/or carer/s.
- Informed but not defined by the reality of available services.
- Agility and containment.

But none of these principles detract from the need for rigour. Solution-focused discussions may at times be difficult.

The future

1. Tailored approaches to hearings
2. Developing our skills and ability to engage parties and promote participation
3. Ensuring consistency
4. Developing our own and others' understanding of the Tribunal's role in relation to treatment

Asia Australia Mental Health

Victorian Mental Health Service System

Overview of the Victorian Mental Health System

Key questions to be covered:

- What are the principles of mental health service delivery in Victoria?
- What are types of services are available for people with a mental illness and who provides these services?
- How do we know if we are making a difference in people's lives?
- How can we understand consumer outcomes?
- What are the changes/reforms planned for the future?

Asia Australia Mental Health

Mental Health Services in Victoria

Mental health services in Victoria can be accessed through GPs and other primary care providers, but people who are seriously affected by their illness can be referred to the specialist mental health service system.

Generally the impact or severity of the condition, rather than a specific diagnosis, triggers access to specialist mental health services.

Specialist mental health services in Victoria are divided into two service delivery types:

- Clinical Services focus on assessment and treatment of people with a mental illness. These services are called Area Mental Health Services and are managed by hospitals.
- Non-clinical services (NGOs) are called Mental Health Community Support Services (MHCSS). These focus on activities and programs that help people manage their own recovery and maximise their participation in community life.

Both clinical and non-clinical services operate within geographically defined catchment areas

Asia Australia Mental Health

Principles of mental health service delivery in Victoria

- Comprehensive and equitably distributed services
- Continuity of care through case-management
- Mental health services delivered with general health services (`mainstreaming')
- Integration of hospital-based and community care
- Focus on those with `serious mental illness'

Asia Australia Mental Health

Mental Health in Victoria – Historical Overview

First Two Phases of Reform

- First phase: *1960's to 1980's*
  - Reduction in hospital bed numbers with the introduction of psychotropic medications
  - Emergence of consumer rights movement
- Second phase: *1990's to 2000's*
  - Closure of psychiatric institutions
  - Community-based system of clinical assessment, treatment and rehabilitation
  - Services delivered geographical catchment areas

Asia Australia Mental Health

Mental Health in Victoria – Historical Overview

Next 2 Two Phases of Reform

- Third phase: *2000 to 2017*
  - Positioning specialist clincial programs to intervene earlier and provide alternatives to acute inpatient care (e.g. PARC)
  - More funding to the NGO sector (MHCSS, peak bodies)
- Current phase: *Piloted 2016 – current*
  - National Disability Insurance Scheme (NDIS) now funding community disability support services which include MH NGOs (MHCSS)
  - Significant change in the way consumers access these services and the way specialist clinical services and NGOs interact

Asia Australia Mental Health

De-institutionalisation

Mental Health Act Victoria 1986

- Right of person with a mental illness to be treated in the "least restricted environment"
- Right of person with a mental illness to live in the community
- Involuntary hospitalisation and Community Treatment Orders

Asia Australia Mental Health

Victorian Mental Health Reform 1992 Onwards

- 1992 Release of First National Mental Health Strategy and Plan
- 1996 Integration of mental health services with general health services
- 1994-1999 Closure of all large psychiatric institutions

Asia Australia Mental Health

How did the reform it take place?

- Staff training and preparation for move from large hospitals to community services
- Education of families
- Preparation of patients to make the move to the community

Asia Australia Mental Health

Mental Health Act 2014

- Establish a recovery-oriented framework and embed supported decision making
- Compulsory treatment orders – minimise the duration of compulsory treatment
- Increase safeguards to protect the rights and dignity of people with mental illness
- Enhance oversight and encourage service improvement

www.health.vic.gov.au/mentalhealth/mhactreform.pdf
www.health.vic.gov/mentalhealth/publications

Asia Australia Mental Health

Framework for Recovery-oriented Practice (Victorian Government 2011)

- Promoting a culture of hope
- Promoting autonomy and self-determination
- Collaborative partnerships and meaningful engagement
- Focus on strengths
- Holistic and personalised care
- Involving family and other support networks
- Community participation and citizenship
- Responsiveness to diversity
- Reflection and learning

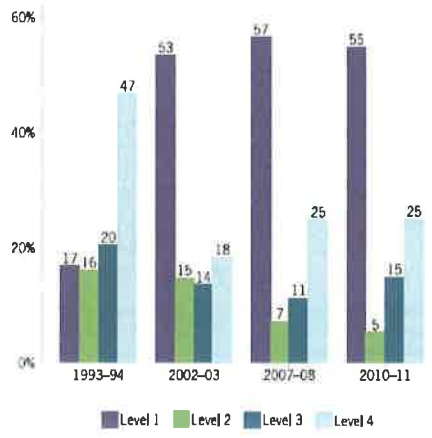
Asia Australia Mental Health

www.health.vic.gov/mentalhealth/publications

Consumer representation

- Level 1
  - Consumers on management committees
  - Consumer advisory committees
- Level 2
  - Consumer advisory committees in some areas of service
- Level 3
  - Consumers on broader advisory committees which represent a wide range of stakeholders and interests
- Level 4
  - Consumers not represented, but encouraged to meet with senior representatives of organisation

Figure 40
Consumer committee representation within mental health service organisations, 1993-94 to 2010-11[a]



Victoria's 10-year mental health plan

- Our goal is that all Victorians experience their best possible health, including mental health. We want to create a healthier, fairer and more inclusive society. That means good mental health for everyone, particularly people who are disadvantaged and vulnerable. We want people living with mental illness to receive the same respect and have the same opportunities as everyone else

Asia Australia Mental Health

Table 1: Victoria's 10-year mental health plan – outcomes

Vision	ALL VICTORIANS EXPERIENCE THEIR BEST POSSIBLE HEALTH, INCLUDING MENTAL HEALTH
Domains	**Outcomes**
Victorians have good mental health and wellbeing	1. Victorians have good mental health and wellbeing at all ages and stages of life 2. The gap in mental health and wellbeing for at-risk groups is reduced 3. The gap in mental health and wellbeing for Aboriginal Victorians is reduced 4. The rate of suicide is reduced
Victorians promote mental health for all ages and stages of life	5. Victorians with mental illness have good physical health and wellbeing 6. Victorians with mental illness are supported to protect and promote health
Victorians with mental illness live fulfilling lives of their choosing, with or without symptoms of mental illness	7. Victorians with mental illness participate in learning and education 8. Victorians with mental illness participate in and contribute to the economy 9. Victorians with mental illness have financial security 10. Victorians with mental illness are socially engaged and live in inclusive communities 11. Victorians with mental illness live free from abuse or violence, and have reduced contact with the criminal justice system 12. Victorians with mental illness have suitable and stable housing
The service system is accessible, flexible and responsive to people of all ages, their families and carers, and the workforce is supported to deliver this	13. The treatment and support that Victorians with mental illness, their families and carers need is available in the right place at the right time 14. Services are recovery-oriented, trauma-informed and family-inclusive 15. Victorians with mental illness, their families and carers are treated with respect by services 16. Services are safe, of high quality, offer choice and provide a positive service experience

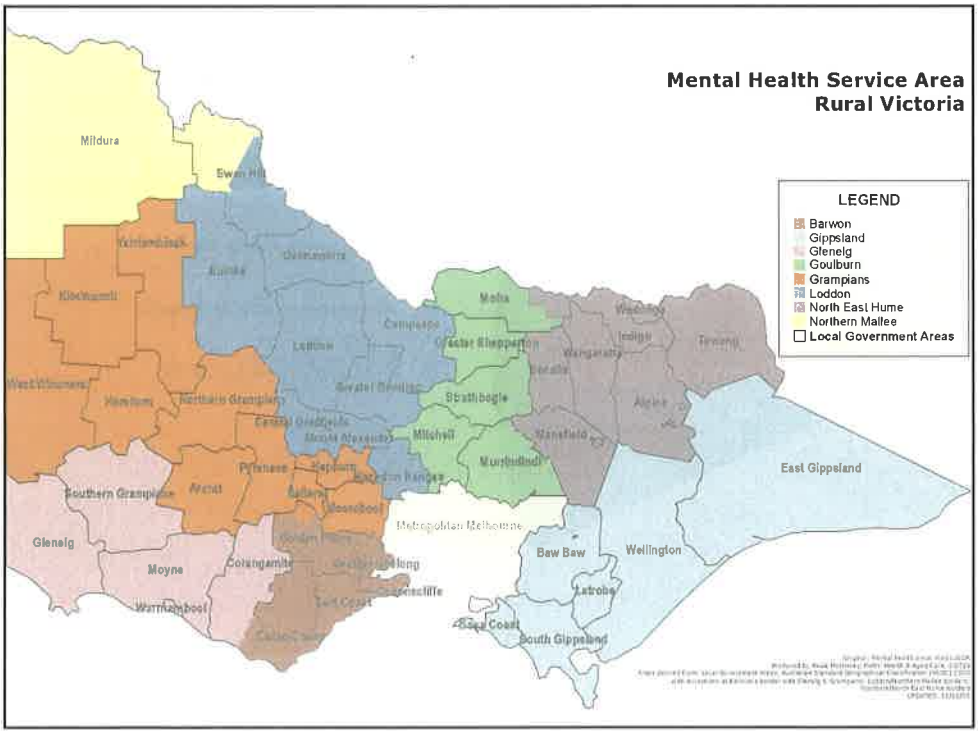
Victorian Mental Health Services

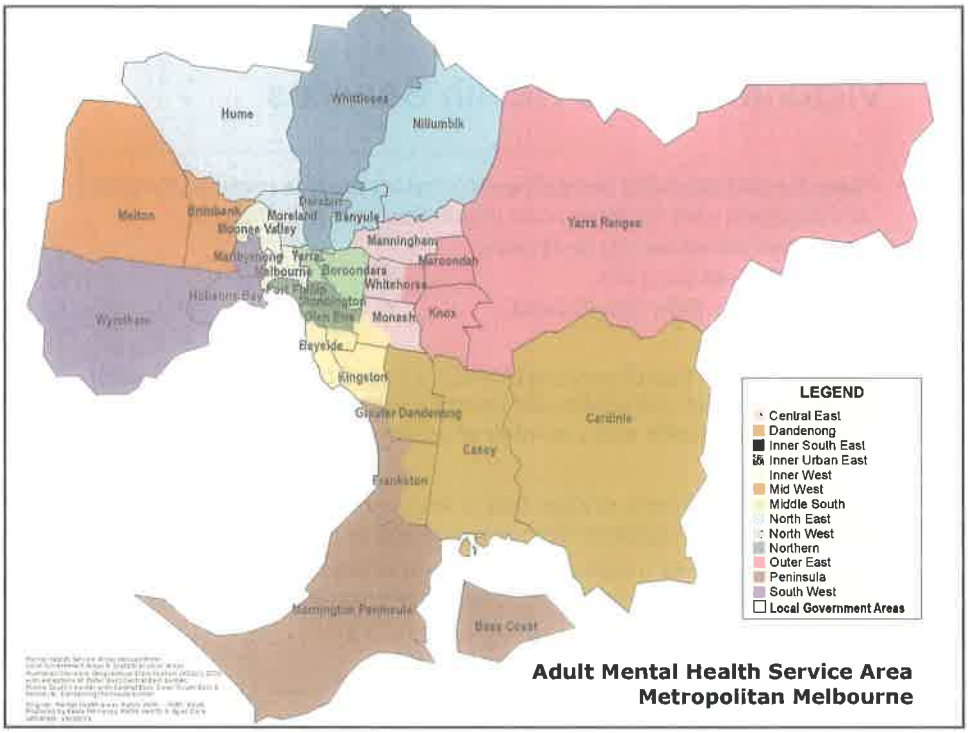
- State-funded specialist mental health services provide community-based and inpatient care for three main population groups in Victoria:
  - children and adolescents (0–18 years),
  - adults (16–64 years) and
  - older people (older than 65 years).

- 21 adult mental health services (AMHS), 17 aged persons mental health services, 13 child and adolescent mental health services (CAMHS), Orygen Youth Health and a number of youth services statewide.

- People can only access the services in their catchment area. Some people use mental health services from several areas or regions.
- If a person receives treatment from an 'out of area' service, the AMHS in the person's area of origin is responsible for ensuring service provision and continuity of care.

Asia Australia Mental Health

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Glen Eira
Greater Dandenong
Cardinia
Casey
Frankston
Mornington Peninsula
Bass Coast
LEGEND
Central East
Dandenong
Inner South East
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Adult Mental Health Service Area
Metropolitan Melbourne

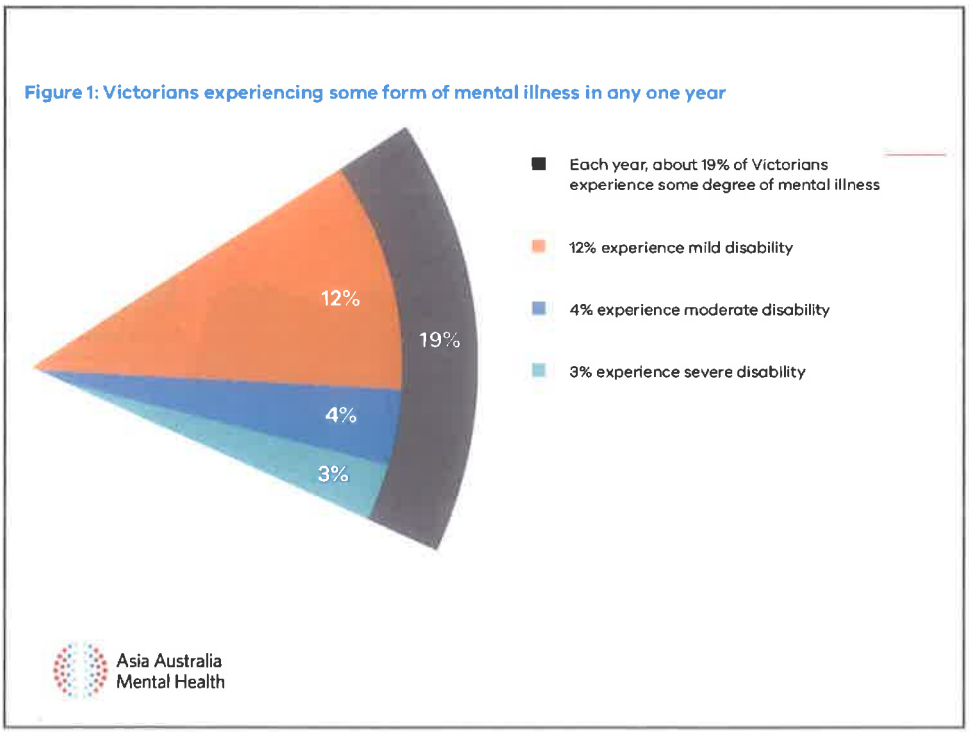


Figure 1: Victorians experiencing some form of mental illness in any one year
12%
19%
4%
3%
Each year, about 19% of Victorians experience some degree of mental illness
12% experience mild disability
4% experience moderate disability
3% experience severe disability
Asia Australia Mental Health

WHO RECEIVES PUBLIC MENTAL HEALTH TREATMENT?

66,445 registered clients

36.6% new clients

1.1% of population

50.4% women

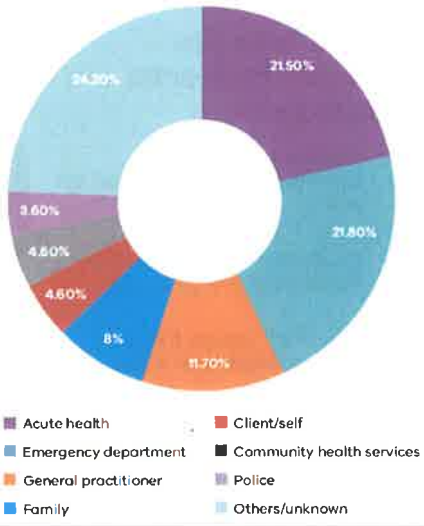
32.6% rural

13.6% CALD

2.5% Aboriginal or Torres Strait Islander

How do clients use clinical services in Victoria?

Source of mental health referrals, 2016–17

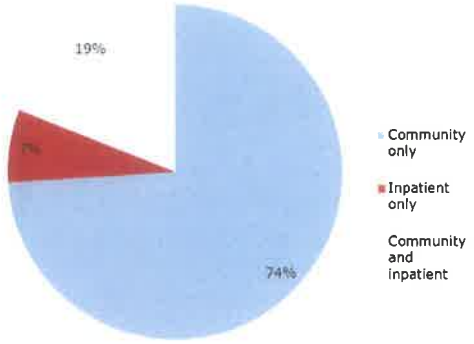


Community-based Service Delivery

Asia Australia Mental Health

How do clients use clinical services in Victoria?

- Most clients use **community** mental health services
  - Averaging 14.5 hours of community contact per client per year
  - Fewer than 25% of clients are inpatients in any given year
  - Only 0.5% receive 5 or more acute admissions in a year



Asia Australia Mental Health

Most important drivers of a positive overall experience (based on YES survey data 2016)

OUTCOME: Victorians with mental illness, their families and carers are treated with respect by services

A statistical analysis was undertaken to better understand what drives positive experiences of clinical services. The single largest factor driving a positive overall experience was *staff showing respect for your feelings*. 'Feeling respected' was in turn influenced by *feeling welcome, staff making an effort to see you when you wanted, staff showing hopefulness for the future, respect for individual values and feeling safe* (see Figure 2).

Asia Australia Mental Health

Victorian Mental Health Services- **responsibilities**

High-quality mental health services in Victoria support people with a mental illness by providing

- acute,
- subacute,
- specialist,
- residential and inpatient community services, and
- community support services.

These services provide people with a mental illness with the best treatment and care possible to support their long-term recovery goals and participation in community life.

- Government, non-government and private organisations in hospitals and in the community provide these services.

Asia Australia Mental Health

Victorian Mental Health Services- **funding**

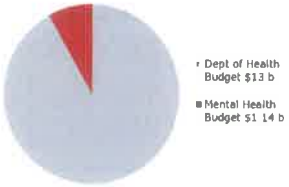
- The Victorian Government is responsible for the funding, delivery and management of specialised acute, sub-acute and residential public mental health services in hospital and community settings.
- It also funds Mental Health Community Support Services (MHCSS) that are delivered by non-government organisations to provide a range of rehabilitation and support services for people with a psychiatric disability arising from a mental illness.
- Through Medicare and the Pharmaceutical Benefits Scheme, the Commonwealth Government funds general practitioners, private psychiatrists and allied health professionals in the primary care sector, to provide mental health treatment and support.
- The Commonwealth Government also funds psychosocial support programs that assist people with a mental illness.

Asia Australia Mental Health

Victorian Mental

(8.8% of heal

Victorian 2012 - 2013 Health Budget

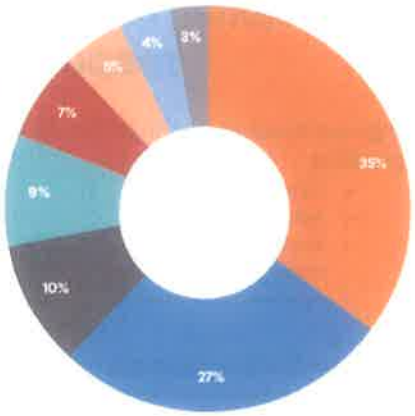


GOVERNMENT ROLES AND RESPONSIBILITIES IN MENTAL HEALTH

Nationally, approximately $8 billion is spent on mental health in Australia every year. Of this, around 60 per cent ($4.8 billion) is spent by state and territory governments, 36 per cent ($2.9 billion) by the Commonwealth and four per cent ($309 million) by private health insurance funds.[10]

Asia Australia Mental Health

Figure 2: 2015–16 mental health expenditure by service type



The Victorian Government invested $1.14 billion in clinical mental health services in 2015–16 and $128 million in MHCSS (see Figure 2)

Table 2: Victoria's clinical mental health workforce, 2012–13 to 2014–15[14]

Workforce type	2012–13	2013–14	2014–15
Psychiatrists, registrars and medical officers	704	734	771
Nurses	3,727	3,877	4,028
Allied health professionals	1,299	1,381	1,404
Administrative and clerical staff	493	459	546
Consumer workers	19	16	19
Carer workers	19	18	19
Domestic staff	173	161	152
Other personal care staff	233	237	214
Total	6,667	6,882	7,153

VICTORIA'S PUBLIC MENTAL HEALTH SERVICE SYSTEM

AREA-BASED CLINICAL SERVICES*

CHILD AND ADOLESCENT SERVICES (0–18 YEARS)**

- Acute inpatient services
- Autism assessment
- Consultation and liaison psychiatry
- Continuing care
- Day programs
- Intensive mobile youth outreach services
- School-based early intervention programs

ADULT SERVICES (16–64 YEARS)**

- Acute community intervention services
- Acute inpatient services
- Psychiatric assessment and planning units
- Secure extended care and inpatient services
- Combined continuing care
- Consultation and liaison psychiatry
- Community care units
- Prevention and recovery care (PARC)
- Early psychosis (16–25 years)
- Youth PARC (16–25 years)

AGED PERSONS SERVICES (65+ YEARS)

- Acute inpatient services
- Aged persons mental health residential services
- Aged persons mental health community teams

Asia Australia Mental Health

STATEWIDE SPECIALIST SERVICES

- Aboriginal services
- Brain disorder services
- Dual diagnosis services
- Dual disability services
- Eating disorder services
- Mother and baby services
- Neuropsychiatry
- Personality disorder services
- Torture and trauma counselling
- Victorian Institute of Forensic Mental Health (Forensicare)
- Victorian Transcultural Mental Health

MENTAL HEALTH COMMUNITY SUPPORT SERVICES

Services include individual support packages, youth and adult residential rehabilitation, supported accommodation, planned respite, Aboriginal programs, mutual support, self-help and community support services.

* *Delivery of activities varies between area mental health services. Some services have separate teams for the various activities; others operate 'integrated teams' performing a number of different functions.*

** *All child and adolescent and adult services are expected to respond to the needs of youth (16–25 years).*

Asia Australia Mental Health

References

1. *www.health.gov.au/mentalhealth*

Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and services 2015

2. *https://www2.**health.vic.gov**.au/**mental-health***

Victoria's 10-year Mental Health Plan 2015

https://www2.health.vic.gov.au/mentalhealth/priorities-and-transformation/mental-health-priorities-for-victoria

Asia Australia Mental Health

ST VINCENT'S HOSPITAL
MELBOURNE

ASPIRE ACHIEVE INNOVATE

Orientation Package

Orientation Package

The aim of the Orientation Package is to provide new staff, graduates, student nurses and student occupational therapists with information relating to St Vincent's Mental Health Service (Melbourne).

Table of contents

Service Description

St Vincent's Adult Mental Health Service and St George's Aged Psychiatry Services (Melbourne)

The St Vincent's Mental Health Service was established in September 1995 as part of the reforms documented in the National Mental Health Policy and Plan, 1992. This led to the mainstreaming of mental health services with the wider health system.

The aim of the policy is an increasing emphasis on a local integrated system of psychiatric care which promotes continuity of care for each individual, treatment in the least restrictive setting, consultation with patients and families, and links with local providers of disability support services and primary and specialist health care providers both in general practice and specialist services.

Target Population

The Services' priority is the provision of mental health services to consumers who

- Experience serious mental illness and associated disability - including acute and/or long-standing psychotic disorders, mood and anxiety disorders, and people with severe personality disorder.
- Live in the local catchment area - Cities of Yarra and Boroondara
- Are above the age of 16 to the age of 64 years for Adult Mental Health Services and above the age of 64 for St George's Aged Psychiatry Services.

Also included are those people who are referred because they have particular needs and may live outside the catchment area e.g. Koori, dual disability (mental illness with intellectual disability) homeless individuals who would otherwise fall between services and Dual Diagnosis (Mental illness with drug & alcohol issues).

Characteristics of the Consumer Group

The total sector population is approximately 225,000. The current adult population serviced by the Clarendon Community Mental Health Service is around 80,000 and by Hawthorn Community Mental Health Service around 145,000.

In the inner city sectors there are particular demographic features which are considered in service planning and delivery. Firstly, there is a high prevalence of people from non-English speaking backgrounds (NESB). Within the Inner Urban East area 27.4% of the consumer group are identified as being from NESB, and of these 14% have a preferred language other than English. Many nationalities are represented with consumers speaking over 20 community languages. The main nationalities represented are: Vietnamese, Greek, Malaysian, Serbo-Croatian, Italian and Chinese.

Secondly, this area is characterised by a particularly high prevalence of psychiatric disorder, homelessness and social disadvantage. Many people in this area are deprived and socially isolated. Additionally, there is a high rate of co-morbid drug and alcohol use disorders. This requires the services to give much attention to appropriate and accessible services to a diverse range of people.

Services Provided

Triage and Referrals (including crisis)

The catchment areas for both Clarendon and Hawthorn Clinics have now employed a 1300 number for improved access to mental health services across our sector. This number operates on a 24 hour basis and will assist people who are in crisis or people wishing to make a referral to our service with a central point of contact. That number is: 1300 558 862. The Triage and referral service operates from the emergency department which also provides a central location for accepting referrals from potential patients who arrive via the emergency department.

Existing clients of either Clarendon or Hawthorn Clinics can continue to make contact with a duty worker at their respective clinics during business hours. Current clients of both Hawthorn and Clarendon Clinics can contact the Duty Worker by using the following numbers: During office hours (Mon to Fri 9.00am - 5.00pm) Hawthorn 03 9882 9299 and Clarendon on 03 9417 5696.

SVMHS has developed an integrated approach to mental health services, which focuses on continuity of care. This is achieved through team structures operating from the Sector Services of Clarendon Community Mental Health Centre and Hawthorn Community Mental Health Centre, the Community Care Unit, the Inpatient Unit and through consumer / carer participation.

Crisis Assessment and Treatment Service (CAT)

A component of an Adult Area Mental Health Service which is available 24 hours a day to provide community based assessment and treatment for people experiencing psychiatric crisis. CAT services aim to prevent unnecessary hospitalisation, by providing treatment in the person's own environment such as in their home but may also work within emergency departments of hospitals. CAT services provide urgent assessment and will arrange inpatient admission if this is the most suitable treatment option. In providing treatment, CATS utilises all the clients' existing supports and works collaboratively with other health professionals who are involved in their care.

Access to CATS is through the referral mechanisms as outlined above (Triage).

Case Management Services:

Case management is a core clinical function that aims to ensure the consumer receives the best possible treatment and support through the identification of their needs, planning individual goals and strategies and linkages to appropriate services.

A case manager is a mental health professional employed by a community mental health service that has the primary responsibility for case management of a particular client. The case manager may be a social worker, psychiatric nurse, consultant psychiatrist, occupational therapist, medical officer or psychologist.

Clinical Case Management Policy:
http://intranet/Policies/Mental%20Health%20Adult%20Policies/Clinical%20Case%20Management%20Policy.pdf

Clarendon Community Mental Health Centre

This clinic provides services to people with serious mental illness that live within the City of Yarra (incorporating the suburbs of Fitzroy, Clifton Hill, Abbotsford, Collingwood, Richmond, and East Melbourne). Functions include taking Duty calls regarding existing clients of the service, non urgent assessment and secondary consultations. Case management services providing rehabilitation, with a focus on shared care arrangements. MSTS provides assertive outreach to clients who are difficult to engage and have associated complex needs. CHOPS provide services to clients who are or who have a risk of homelessness due to mental health problems. EARLY PSYCHOSIS PROGRAM provides services for the treatment of people who are experiencing their first episode of psychosis. The clinic is staffed by a range of disciplines including nursing, occupational therapists, psychologists, psychiatrists, social workers, and training psychiatric registrars. Telephone 03 9417 5696 Facsimile 03 9417 1231

Hawthorn Community Mental Health Centre

This clinic provides services to people with serious mental illness in the City of Boroondara (the suburbs of Ashburton, Ashwood, Balwyn, Burwood (part), Camberwell, Canterbury, Glen Iris (part), Hartwell, Hawthorn, Kew, and Surrey Hills). Functions include taking Duty calls regarding existing clients of the service, non urgent assessment and secondary consultations. Case management services providing rehabilitation, with a focus on shared care arrangements. MSTS provides assertive outreach to clients who are difficult to engage and have associated complex needs. CHOPS provide services to clients who are or who have a risk of homelessness due to mental health problems. EARLY PSYCHOSIS PROGRAM provides services for the treatment of people who are experiencing their first episode of psychosis. The clinic is staffed by a range of disciplines including nursing, occupational therapists, psychologists, psychiatrists, social workers, and training psychiatric registrars. Telephone 03 9882 9299 Facsimile 03 9882 9637

SECU Diversion and Complex Care Program

The SECU Diversion and Complex Care Program is a high intensity, recovery focused, support package aimed at promoting engagement with local community services, offer alternatives to admission to the Acute Inpatient Service (AIS) and Secure Extended Care Units (SECU). These packages can also support complex consumers already admitted to the AIS to transition into the community as an alternative to SECU.

Aimed at Consumers who experience unrelenting and sever symptoms of mental illness, have issues with; alcohol and other substances; acquired brain injury (ABI); re-occurring homelessness; and exhibit challenging/aggressive behavior – all impacting on their ability to engage therapeutically with mental health services. They could have, or be at risk of police/forensic service involvement, have multiple presentations to the AIS/ED, may be subject to the Mental Health Act (MHA 2014).

Footbridge Community Care Unit

*see details on page 17

MH PICT (Mental Health Primary Intervention Team)

provides a range of primary care services aimed at supporting consumers in the community as well as primary care providers. MH PICT provide education and support to primary health care providers regarding the treatment of people with high prevalence disorders (e.g. anxiety, depression) and young people at risk of developing mental illness

HOPE (Suicide Prevention)

The HOPE (Suicide Prevention) Team is part of PICT (Primary Intervention and Care Team) and is funded until June 2020. (HOPE: Hospital Outreach Post-suicidal Engagement). The team are trained in the CAMS (Collaborative Assessment and Management of Suicidality) model.

Adult Acute Inpatient Services:

St Vincent's Inpatient Mental Health Unit is located at 46 Nicholson Street, Fitzroy. The Unit is divided into two floors, Ground Floor (Hawthorn) and First Floor (Clarendon). Each of the units serves a separate geographical location. A total number of 44 beds have been allocated for the entirety of the two catchment areas.

The Unit operates on a Primary Nursing model as defined by the World health Organisation.

Ground Floor (Hawthorn) Telephone 9288 4416-7

The Ground Floor Unit consists of 22 beds. The breakdown of bed allocation is as follows:

- three extra care beds (ECU),
- five statewide Koori beds
- 15 open ward beds

Catchment Area: Ashburton, Auburn, Balwyn, Box Hill North (part), Burwood (part), Camberwell , Canterbury, Deepdene, Greythorn, Glen Iris Upper, Hartwell, Hawthorn East, Hawthorn, Kew East, Mont Albert (part), Balwyn North, Surrey Hills (part).

First Floor (Clarendon Unit) Telephone 9288 4674-5

The First Floor Unit consists of 22 beds. The breakdown of bed allocation is as follows:

- three extra care beds (ECU)
- 19 open ward beds

Catchment Area: Area is divided into two teams: Lions and Tigers. Lions include Fitzroy, Nth Fitzroy, Clifton Hill, Alphington, and Fairfield. Tigers include Richmond, Collingwood, East Melbourne, Abbotsford, and Burnley.

Prevention and Recovery Centre (PARC)

PARC is a 10-bedded unit for consumers of SVMH. The PARC program is run in collaboration with Wellways and provides short to medium term residential support for people with a mental illness. It is a 'step-up/step-down' service aimed at supporting people in the community to prevent unnecessary hospital admission and provides additional support to people being discharged from hospital before they go home.
Referrals & Contact Details | Katherine Davies/Anna Lanyon | Ph: 8481 3804 / 0408 052 782

Forensic Clinical Specialist Program

The Forensic Clinical Specialist Program (FCSP) was established in 2010. Its primary purpose was to boost the capability of the adult mental health workforce to assess, treat and support people with severe mental illness who are high-risk, violent or aggressive and may have a forensic/criminal history. The program was also intended to improve pathways from prisons, courts and corrections to mental health care.

What the Forensic Clinical Specialist Program can provide

- Support and advice about working with consumers who have been involved with the criminal justice system or who are at risk of offending;
- Input with risk assessment and risk management documentation;
- Co-ordination of High Risk Review Panels;
- Conduit of communication between SVMH, courts, prisons, corrections & Forensicare;
- Support and information about consumers on Non-Custodial Supervision Orders or Custodial Supervision Orders;
- Advice and assistance around navigating the criminal justice system;
- Facilitating referrals to Forensicare;
- Specialised forensic mental health assessments around violence, general offending, stalking, sexual offending, threateners and psychopathy;
- Secondary consultations; and
- Training and capacity-building for SVMH and local Mental Health Community Support Services (MHCSSs).

Early Psychosis Program

The Early Psychosis Program is one of the strategic directions for SVMH and has provided an impetus for detailed consideration of local and international guidelines and how they can be best implemented within the service. It is recognised that the implementation of the SVMH guidelines

will have significant implications for the delivery of services to these clients. Further, it is acknowledged that implementation of the model will require close monitoring to ensure its ongoing development.

Consultation-Liaison Psychiatry Service

The Consultation-Liaison Psychiatry service forms part of the St. Vincent's Mental Health Service and provides consultation and liaison services to the treating teams and wards of the general hospital. The service operates within business hours, covered after hours by the on call Psychiatric Registrars and Psychiatrists.

Services provided include:

1. Assessment and treatment of patients with altered mood, thought, perception, behaviour or unexplained physical symptoms where the treating team is concerned that an underlying psychiatric or psychological problem may be the cause. Follow-up for referred patients is organised as required through referral to mental health services based in the community, private psychiatrists or transfer to inpatient psychiatric services.
2. Assessment of patients attending the Emergency Care Centre who are outside the age range and place of residence for St. Vincent's Adult Area Mental Health Service.
3. Secondary consultation and provision of information about psychiatric disorders, treatments, mental health services, the Mental Health Act and other relevant legislation, and advice on the management of difficult behaviours, to general hospital staff.
4. Support and monitoring of patients of the St. Vincent's Mental Health Service who require admission to the general (non-psychiatric) wards for medical/surgical treatment.
5. Education of staff on mental health related issues.

The Consultation-Liaison Psychiatry Service consists of 2 Psychiatric Registrars (2.0 EFT), 1 Psychiatric Nurse (1.0 EFT) 5 part-time Psychiatrists (1.0 EFT), a part-time Psychologist (0.2 EFT) and an Administrative Assistant (0.2 EFT).

A rotational system provides intake for referrals to the Consultation-Liaison Psychiatry Service. The Psychiatric Registrars share this role during business hours and receive referrals from medical-surgical units within SVHM. Some referrals are received directly by Consultation-Liaison Psychiatrists but the majority are received through the registrars. The nurse also receives requests from staff for consultation in relation to patient care and is available via the paging system during business hours.

Referrals are initiated by paging the Psychiatric Registrar on for Consultation-Liaison Psychiatry through the switchboard. A written request for consultation is preferred before assessment of the patient is undertaken. The "Consultation Form" (red edged St. Vincent's form available on all wards) is used for this purpose. The Psychiatric Registrar on call after hours responds to urgent referrals and is available via the switchboard. Non-urgent messages can be left for the Psychiatric Registrars on extension 4378 and/or the nurse on 2159.

Statewide Services

The Victorian Transcultural Psychiatry Unit

In addition to services to the local community St Vincent's Mental Health Service manages three State - wide services, The Victorian Transcultural Psychiatry Unit (VTPU), the inpatient component of the Victorian Aboriginal Mental Health Network (VAHS), and the Statewide Specialist Dual Disability Service.

The role of the St Vincent's Mental Health Service as a teaching service is important in understanding its overall function. The teaching, training and research activities of the former St Vincent's Hospital Department of Psychiatry and of the associated VTPU have resulted in the SVMHS and VTPU each being designated as collaborating sites in the Australian Multi-site WHO Collaborating Centre in Research and Training in Mental Health. Research programs include mental health promotion in family caregivers, quality of life assessment, the course and outcome of schizophrenia and related disorders, treatment of psychotic disorders in homeless people, psychotherapy in treatment of breast cancer, service development for survivors of childhood sexual abuse, and the programs developed by the VTPU.

Nexus (Dual Diagnosis)

Nexus was established in 2002 as part of the Victorian Dual Diagnosis Initiative (VDDI). The brief of the initiative was one of capacity building and more specifically, to enhance the capacity of Clinical Mental Health Services, Alcohol & Other Drug (AOD) Services and Psychiatric Disability Rehabilitation and Support Services (PDRSS) to work more effectively with clients presenting with comorbid substance use and mental health issues (Dual Diagnosis). The prevalence and complexity of dual diagnosis requires an integrated approach to treatment delivered as 'core business' within specialist mental health and drug and alcohol services.

Nexus Catchment and Service Area

Nexus works with more than 40 agencies within the municipalities of: Yarra, Boroondara, Nillumbik and Banyule. Nexus is also directly linked to the remote and rural regions of: Northern Loddon Mallee, Loddon Southern Mallee and Campaspe.

Victorian Dual Disability Service

Victorian Dual Disability Services (VDDS) has been established to address the needs of a specific group of health service consumers - those who have both an intellectual disability and a mental illness (dual disability). The service provides consultation for professionals dealing with people with a dual disability, assisting a wide range of professionals throughout Victoria to acquire expertise and skill in the assessment, referral and management of consumers who have a dual disability.

Telephone 03 9288 2950, Facsimile 03 9288 2953, Webpage www.vdds.org.au

The Yarra Boroondara Primary Mental Health Service

Primary Mental Health and Early Intervention Service comprises a team of mental health professionals with the aim to support community health services and GP's to provide services to those with high prevalence mental health disorders such as depression and anxiety. The service also has an early intervention worker, to improve detection and treatment of young people with early manifestations of mental illness.

Team members will visit the primary care provider to discuss clients/patients and to conduct joint assessments and assist with the development of management plans. The emphasis is on supporting and developing the skills and knowledge of GP's and primary health workers rather than assuming responsibility for care.

For more information please contact the service on 84150 5022.

Spectrum

Spectrum is a service in Victoria that supports the treatment of people who have severe or borderline personality disorder within Victorian state area mental health services (AMHS). There is a particular emphasis on those who are at risk from serious self-harm or suicide, who have particularly complex needs. Spectrum also supports the treatment of young people with these issues within Victorian child and adolescent mental health services (CAMHS).

Spectrum provides a range of programs to support mental health clinicians and their clients. Some Spectrum programs can be provided at the site of the mental health services in Victoria. Other programs take place at our premises in East Ringwood.

All Spectrum programs are accessed via a referral from a clinician working in a Victorian area mental health service (adult or child and adolescent mental health service).

Spectrum is funded to provide services for people with borderline personality disorder who:

- Have current involvement with a local Area Mental Health Service in Victoria
- Are aged between 16 and 64 years
- Live in the state of Victoria.

Spectrum is not funded to accept referrals for clients who have treatment in the private or non-government sector only.

Spectrum programs are designed primarily to assist mental health clinicians within Victorian area mental health services to better meet the needs of their clients with severe or borderline personality disorder. These clients typically have severe interpersonal difficulties and a long history of self-harm and/or suicide attempts, and particularly complex needs.

If an individual with severe or borderline personality disorder is involved in a Spectrum program, the

area mental health service needs to be able to work with Spectrum during that involvement.

Spectrum provides a range of programs including:

- Secondary Consultation
  A secondary consultation can assist clinicians from area mental health services in their work with clients who have severe or borderline personality disorder. A secondary consultation may involve a treating team within the area mental health service.

- Training
  Spectrum offers a range of training workshops in a central location. The training is designed to assist mental health clinician's better meet the needs of their clients with severe or borderline personality disorder.

- Assessment
  Spectrum provides a specialist clinical assessment service to clients for whom a Spectrum treatment service is being considered, or where a mental health clinician has requested an assessment for a particular purpose.

- Outpatient groups
  Spectrum offers outpatient skills training groups for clients of area mental health services, in a number of locations around Melbourne.

- Residential treatment
  The residential treatment program is a planned therapeutic program for individuals with borderline personality disorder who are working with a local area mental health service.

- Care co-ordination and treatment for high and complex needs clients
  The Chief Psychiatrist in Victoria may sometimes refer clients with particularly complex needs. Sometimes a Spectrum assessment may identify an exceptionally severe and chronic presentation. In these instances, Spectrum can provide clinical leadership and direct work in some instances.

Other programs at Spectrum include:

- Research
- Advocacy Development

Body Image Eating Disorders Treatment and Recovery Service (BETRS)

BETRS is a collaborative partnership between the mental health programs of Austin Health and St Vincent's Melbourne. It is a community based outpatient service for people with eating disorders and their families and carers. The service contributes to a continuum of care between primary, inpatient and community based services and the BETRS Inpatient Specialist Eating Disorder unit located at Austin Health.

The Second Psychiatric Opinion Service

The Second Psychiatric Opinion Service provides independent second psychiatric opinions to people who are 'entitled patients' under the Mental Health Act 2014, where an opinion via other means is not available or feasible.

Contact: 1300 503 426 www.secondopinion.org.au intake@secondopinion.org.au

Secure Extended Care Unit – Austin Hospital

The Secure Extended Care Unit (SECU) is a 25-bed facility providing secure inpatient treatment and care for people who require an extended period of sustained treatment and rehabilitation or treatment and care in a contained environment.

Potential SECU clients are typically difficult to engage in treatment with behaviours that, in the absence of a stable, structured environment, can put themselves and the community at risk.

SECU provides services to St Vincent's, Northern, North West and Austin Health Networks.

Indigenous Beds at St. Vincent's Mental Health Service

The Victorian Aboriginal Health Service (VAHS) purchase five beds on the psychiatric inpatient unit each day of the year. The original reason for this was to enable the VAHS to have quick and ready access to psychiatric beds for people in need who attended the health service in Fitzroy; this might include people whose local service was unable to provide for a bed as well as for those from regional areas or interstate and who have come to the attention of the VAHS.

It was never envisaged that these five beds would provide for all Indigenous psychiatric inpatient needs and the following guidelines outline acceptable usage.

Important points to remember

Aboriginal patients should have the same access to mental health services as any other member of the community, i.e., if they are deemed to need admission the first port of call should be the local inpatient unit.

There are five (5) beds available; the VAHS Family Counselling Service reserves the right to make the final decision on whether or not a patient will be admitted to the Indigenous Unit. During business hours the VAHS must contact the Family Counselling Service to assess a bed. In emergencies where the FCS is not contactable the registrar for the indigenous inpatient service may make a decision without input from the FCS.

This decision would be affected by a number of issues including: history of treatment; if the client is on a CTO to the VAHS consultant psychiatrist; has a history of treatment through the VAHS Mental Health Service; or there are circumstances that make it problematic to access local treatment.

Even when a patient is accepted a bed may not be immediately available and they may be placed on a waiting list.

Possible reasons for admission Indigenous Koori Unit

- Patients already treated by VAHS consultant psychiatrist or the Family Counselling Service.
- A history of treatment at the Indigenous unit.
- Issues within the local service that render it more therapeutic to treat the patient at the Indigenous Unit, e.g., incompatibility between patients or patient's family and local workers or, for instance, when a close family member is already an inpatient at their local area service.
- No beds available at the local area service.

Further explanation of the use of Indigenous beds

The mental health workers at VAHS come under the auspices of Family Counselling Services and work between the hours of 9 am to 5 pm Monday to Thursday and 9am to 4pm on Friday. Wherever possible, the VAHS mental health workers should approve and facilitate all admissions; it is desirable that possible admissions be held over to the next working day to allow VAHS involvement. For further information please contact **Carol Potter, Lance James or Gwen Brooks at the Family Counselling Services on 9403 3300.**

For further clarification contact the **Indigenous Co-ordinator, Ann Benson on 9288 4417.**

For the guidance of triage workers, registrars on duty at nights and weekends:

With many Aboriginal and Torres Strait Islander patients communication is problematic. Open ended questions may be met with non-committal or "don't know" answers. Questions about sources of secure income, housing, physical health and past hospital admissions, job, educational background including sporting scholarships, hobbies and recreation, drug and alcohol use and current family and legal circumstances are useful and usually answered.

There are often problems in several of these domains simultaneously before presentation occurs.
The psychiatric presentation may appear to be an adjustment disorder but the content makes clear the lack of social support and personal resources. (A house with no foundation cannot stand.)

Symptoms about `spirits' 'kudaithe men', `bone pointing' being `sung', `cursed', etc. are no longer culturally normative and should be regarded as mental illness.

Dual diagnosis is common. This is not a reason for exclusion; rather it is a reason to manage both diagnoses properly.

STRENGTHS MODEL **for more information please see Strengths Core Training Manual*

STRENGTHS MODEL (Rapp and Chamberlain, 1985)
The Strengths Model – case management with people suffering from severe and persistent mental illness Charles Rapp NY: Oxford University Press 1998

Definition

- Provides an approach to both case management and rehabilitation
- Departure from traditional deficit model of assessment
- Founded on the environmental conception of human behaviour
- Results in more focused and goal oriented behaviour
- Promotes better community linkages and less dependence on hospital

6 principles:

1. Focus on individual strengths rather than pathology
2. Case manager client relationship is primary and essential
3. Interventions are based on principles of client self determination
4. Assertive outreach is the preferred mode of intervention
5. Long term psychiatric patients can continue to learn, grow and change and can be assisted to do so
6. Resource acquisition goes beyond traditional mental health services and actively mobilizes resources of the entire community

4 fundamental concepts:

1. Case manager enters into an active, dynamic relationship based on client needs, goals and aspirations
2. Case managers are trained to see strengths and skills rather than liabilities and deficits
3. All steps, no matter how small, that lead towards a client selected goal are themselves goals that are to be reinforced upon their accomplishment
4. The client selects their own goals and targets. The case manager supports and sustains the client in the process of securing the needed resources in the community, only intervening directly when it is in the long term best interest of the client

Artistic, creative & expressive abilities, interpersonal abilities, constructional and mechanical abilities, intellectual, spiritual & sensual abilities, sporting & physical abilities

Strengths model assessment includes 6 dimensions: (multiaxial)

1. Personal strengths
2. Personal recovery/coping style – activity vs passivity, group vs solitarity, cognitive vs emotional and task vs process orientated
3. Current stage in recovery process – acute illness/crisis, post traumatic, stocktaking, rebuilding, reaching out and consolidation
4. Family and social networks - interactions
5. Community resources – informal links, eg. church, neighbourhood

Desired Outcomes include quality of life, achievement, sense of competency, life satisfaction and empowerment

Niches (life domains) include health, living arrangements, financial situation, leisure, recreation, work, education and social relationships and spiritual supports

Natural enabling niches include work/recreation opportunities, family involvement and affiliation with community

Created enabling niches include supported employment, housing, education and consumer self help

Individual strengths – aspiration, competency and confidence

Environmental strengths – access to opportunities, resources, services, meaningful social relations influence quality of niches

Key propositions of strengths model: people who are successful in living

- have goals and dreams
- use their strengths to attain their aspirations
- have the confidence to take the next step toward their goal
- have access to the resources needed to achieve their goals
- have a meaningful relationship with at least one person
- have access to opportunities relevant to their goals

Functions of strengths model case management

- Engagement and relationship- collaborative helping partnership
- Strengths assessment – current situation -? Consumer wants? Personal and environmental strengths
- Personal planning – negotiate goal setting
- Resource acquisition – environmental resources, community integration
- Collective continuous collaboration and graduated disengagement – ongoing monitoring, modification and adaptation, self-efficacy

Strengths Assessment

This is a tool designed to help the consumer and worker become conscious of the resources the consumer possesses. This enables the consumer to explore not only their strengths at one point in time, but what they have already accumulated in experience and knowledge in the past. Also, what external resources they possess and have access to.

The middles column asks 'what do I want?' This is at the very heart of the work we are doing with our consumers and harnessing these aspirations is critical to recovery.

During the course of multiple conversations, strengths will become apparent, is noted and begin to populate the Strengths Assessment. Deficits or negative comments are not part of this assessment.

Guidelines for completing a Strengths Assessment:

We give pre-eminence to the person's understanding of the facts. The central focus of the assessment is on the person's view of their circumstances, how they feel about it and the meaning they ascribe to their situation/life experiences;
We discover what the person wants. We explore the person's desires and expectations and we ask what they want in relation to their current situation;
We ensure that the strengths assessment is multidimensional. A strengths perspective means believing that the strengths and resources to resolve a difficult situation lie within the person's interpersonal skills, motivation, intellectual and emotional strengths, as well as environmental opportunities. We also include an examination of the person's power and power relationships in transactions between the person and the environment

The Five Critical Components of the
Strengths Assessment is that it be:

1. Thorough, detailed and specific;
2. Developed on an on-going process/updated on regular basis
3. Conducted in a conversational manner
4. Created at the consumer's pace
5. Written in the consumer's own language

The assessment is divided in to 6 domains:

- DAILY LIVING
- FINANCIAL
- WORK/EDUCATION
- SOCIAL/SPIRITUAL
- HEALTH
- LEISURE/RECREATION

The WRAP® is an evidence-based system that is used world-wide by people who are dealing with mental health and other kinds of health challenges, and by people who want to attain the highest possible level of wellness. It was developed by a group of people who have a lived experience of mental health difficulties, people who were searching for ways to resolve issues that had been troubling them for a long time.
Mary Ellen Copeland, 2012
The WRAP® is not a Strengths Model tool, but is used as an inherent part of the model at St. Vincent's, to complement the Strengths Assessment, Goal Plan and the Family Recovery Assistance Plan (FRAP).
The WRAP® is `a plan developed by the consumer and appropriate support people to:

- **identify activities/resources that maintain the person's optimal wellness -** Wellness Maintenance;
- **develop a daily/weekly/regular plan to utilise these activities / resources to support their wellness;**
- **develop and maintain an awareness of early warning signs that they may be becoming unwell;**
- **develop practical** relapse prevention **strategies; and**
- **develop a** crisis and post-crisis plan.

The WRAP® components
Wellness Toolbox
Daily Maintenance Plan
Relapse Prevention Plan

FRAP

This is a means of inviting carers to take an active role in supporting the consumer's recovery and understanding the Strengths Model and ways of working with the family member/person they are caring for. Developed to complement the WRAP by Paul Liddy and others at Timaru, South Canterbury, New Zealand.

It is intuitive and also clear from research evidence, those carers and significant others have a marked impact on our consumer's recoveries and in many cases constitute a person's primary strength. Therefore mental health services have a responsibility to work effectively with these support people to promote the best possible outcomes for our consumers.

Many carers do not know how best to support their family member/friend. They may be exhausted by the time their family member is referred to our services and feel that they have run out of ideas, energy and hope. They may be confused about their supportive role, have had many contacts with health services and received contradictory information, felt excluded from the person's care, experienced multiple confusing referrals and even blamed themselves for the problems their family member/friend is experiencing.

Their care of their family member/friend may have had a significant impact on their own health, the stability of their families and their finances. They may also have experienced the grief of watching someone they love lose their career, relationships, independence and possibilities and experience involuntary admission and uncomfortable medication.

We routinely invite carers/significant others to participate in sessions to discuss their experiences, their needs and identify the ways they can support their family member/friend. Sometimes consumers are not initially willing to have clinicians invite their carers/support persons to such a meeting however clinicians inform the person of the potential benefits, the likely agenda and will re-introduce the idea regularly.

Some clinicians will always include the consumers in these meetings while others have found it is beneficial to have at least one carer session without the consumer present. This will depend on the consumer's wishes, the issues to be discussed and the carer's preferences.

Communication and release of information arrangements need to be clear and abide by all relevant legislation; the Mental Health Act gives clinicians the opportunity to discuss the consumer's treatment and progress with relevant carers who are already engaged in supporting them.

The FRAP has 4 domains

- FAMILY
- INFORMATION/EDUCATION
- SOCIAL/SPRITIUAL/CULTURAL
- WRAP®

Strengths Goal Planning

The worker and consumer review the Strengths Assessment with particular emphasis on the middle column – Desires and Aspirations. They also review the consumer's priorities. They work together to explore these goals and determine which of the long term goals they will work on first.

The Footbridge (Community Care Unit)

The Footbridge CCU is a community residential service part of St Vincent's Mental Health Service, which provides multidisciplinary support to consumers on a 24-hour basis.
It is a group of 10 units consisting of 20 consumers situated in North Fitzroy, staffed 24 hours a day by a multidisciplinary team providing clinical care and a recovery-focused strengths model of case management. The Footbridge has both a rehabilitation review program (4-6weeks) and a residential program.

Telephone 03 9481 5644 Facsimile 03 9481 4193

Access guidelines for Footbridge:

http://intranet/Policies/Mental%20Health%20Adult%20Policies/Footbridge%20Community%20Care%20Units%20Access%20Guideline.pdf

Peer Worker

A Peer Support Worker (PSW) in the context of the Mental health, refers to someone who has a lived experience of Mental illness. This person may have a diagnosis and experience of inpatient, outpatient and community mental health services.

A PSW will use their experience, where appropriate, to foster a connection, create a deeper understanding and empathise with the people they support. Peer Support is not based on psychiatric models or diagnostic tools.

The Peer Support relationship is based on four core principles:

1. Connection – a process of building understanding and trust
2. Worldview – understanding how someone perceives the world
3. Mutuality – learning together, the support isn't one sided it goes both ways (like most other relationships)
4. Moving towards – helping each other move towards what we want rather than dwelling on what we don't.

It has been said that those who have similar life experiences can better relate an therefore offer more genuine empathy, validation and support. Peer support workers may also be able to offer an example of what is possible by role modelling what recovery looks like.

Meeting and Group schedule for Footbridge CCU

Daily	Monday	Tuesday	Wednesday	Thursday	Friday
0700hrs Nursing handover		Reflective Practice Session with Dr Jenny Randles (every 3 weeks)			
0900 hrs Handover to multidisciplinary team			Strengths Brainstorming 1.30-2.30pm		Eric Seal Presentation AIS 12-1.30
1300 hrs handover to pm staff		Clinical Review 2-3.30pm	Community Meeting (Fortnightly) 2.30-3.30pm	Staff Meeting (every 3 weeks) 1.30-2.30pm	
2100 hrs handover to night staff			Relaxation Group (Fortnightly) 2.30pm	In-service Education Sessions 2-3.30pm	

St Vincent's Documentation Policy- Standards for the Footbridge CCU

Medical Records Online

Medical Record Online (MRO) is the St Vincent's scanned medical record. It provides you with an electronic copy of the paper record and is the first step towards a complete Electronic Medical Record (EMR).
MRO is a one stop shop for patient information – diagnostic results such as pathology and imaging reports will be available to view on MRO.
User access will be made available for authorised users to view the MRO from any IT device across the St Vincent's network.

The User Guide can be found here:
http://intranet/Departments/medicalrecordonline/Documents/MRO End User Guide.docx

Instructions for Mental Health Staff using MRO can be found here:
http://intranet/Departments/MentalHealth/Documents/MRO%20Resources/APPENDIX%202%20Instructions%20for%20mental%20health%20staff.pdf

Progress Notes CMHPN Footbridge on MRO

Patient file – Click on "Add" drop down menu and Select document
(CMHPN Footbridge)
Check Date
Complete Time
Complete Participants
Complete:
- Purpose of Contact
- Content of Interview
- Strengths Goals update (as appropriate dependent on contact)
- MSE
- Risk Assessment
- Overall Impression (as appropriate dependent on contact)
- Updated Management Plan (as appropriate dependent on contact)
- Next Anticipated Contact

You can utilize spell check function if needed, once completed click SAVE.

Mental State Assessment:

- Appearance and behaviour – Age, hair, gender, build, hygiene, eye contact, motor activity, cooperativeness
- Speech – Rate, Volume, Pitch, Tone, Fluency, Quality of Articulation and Information.
- Mood and affect - Quality, expression, range, stability, appropriate and congruent
- Form of thought – Amount of thought and rate of production, continuity of ideas, disturbances in language and/or meaning.
- Content of thought – Delusions, thoughts to harm self or others, vulnerabilities, obsessions, compulsions, phobias, pre-occupations, overvalued ideas
- Perception – Hallucinations, illusions, Other perceptual disturbances (derealisation, depersonalisation, heightened or dulled perception)
- Cognition – Level of consciousness, memory (immediate, recent, remote), orientation (time, place, person) concentration, abstract thinking, constructional ability
- Insight – knowledge of illness and treatment, amenable/adherent to treatment, judgement – impaired

Risk Assessment

http://intranet/Policies/Mental%20Health%20Adult%20Policies/Risk%20Assessment%20Policy.pdf

- Risk to Self – thoughts (deliberate self-harm, suicide): frequency, intensity, intent; Plan: specificity, lethality, availability, proximity, self-control; History of attempts, mood
- Risk to Others – thoughts: frequency, intensity, current threats/conflicts; History of violence/intimidation, previous response to anger/frustration, MSE- delusions, persecution, confusion, blunting, command hallucinations, adherence
- Vulnerability – Confusion, delusions, neglect, intellectual/physical impairments, environment, substance use, judgement, history of vulnerable behavior, level of support/social contacts
- Compliance/Adherence- insight, self-harm, history of non-adherence/compliance, use of mental health act (2014), impaired judgement, delusions, persecution, confusion
- Plan to Manage risks/Crisis plans – protective factors, supports, stressors/precipitants, supervised environment, reduce access to means, enhance current coping strategies/develop strategies, continue to review risk, develop agreed management plans

MH eRisk Assessment & Management – MRO form

This form is to be completed at every case review and when there is a change in the person's risk profile and management (including triage / CATS alert). Complete all sections. Where there are no known risks, select "nil known". Contributing factors in past and current risks may include mental state (including behaviours of concern and cognitive fucntioning), attitude to risk, supports and protective factors and psychosocial stressors. For all categories, include context and precipitants, state if risk is present and/or imminent and if assessment is based on your own observation or the report of others.

HANDOVERS & GENERAL COMMUNICATION

During handover:

- Do take notes
- Use the provided handover sheets
- All staff should ensure that they are prepared for handover and that they have the relevant information to hand
- All information related to patients should be presented in an accurate, succinct and factual manner
- The information presented should address the care, treatment and management of patients
- Handover should highlight any reviews or changes that have occurred during the past 24 hours.
- Any incidents involving a patient that have occurred should also be highlighted
- A particular focus on shift requirements should be taken into consideration, e.g.: night shift sleeping patterns etc.

Footbridge – Preceptor/Buddy System

Every individual undergraduate nurse/OT will be 'buddied' with a permanent staff member for each shift that they work. Most often this regular staff will be the undergraduate's preceptor/supervisor. The 'buddy' staff member will assist the learner nurse/OT by:
- sharing knowledge about their specialty,
- guiding the learner nurse/OT through techniques that are unfamiliar,
- acting as a role model
- assisting the undergraduate to achieve his/her educational goals

The 'buddy' will keep each undergraduate's clinical teacher informed about the achievements of the undergraduate they have spent time with and will ensure that all relevant matters are discussed.

Supervision/Reflective Practice/Clinical Support/Debriefing/Feedback

Nursing Students will have weekly sessions with Clinical Nurse Educator- Fridays at 2pm (at Footbridge, AIS, or VDDS).
Students will be provided regular opportunities during their placements to have sessions with their buddy/preceptor to discuss clinical practice and explore any issues/questions that may arise during placement.

During the placement an issue might arise which the undergraduate may wish to discuss in more detail than is possible at the time of the event. Students should seek out support from their Buddy/Preceptors/supervisors who can either provide, or make arrangements for debriefing/reflective practice/supervision session with another clinician (Senior Clinician, or Clinical Educator).

Evaluation

Evaluation forms will be provided to each undergraduate in order to provide SVMH services with information relating to the experience of the undergraduate during their placement.

Contacts

Anna Peake | Clinical Nurse Educator | St Vincent's Mental Health
Acute Inpatient Services Building| 2nd Floor Office 10 | 46 Nichoslon Street, Fitzroy VIC 3065
t: +61 3 9231 2194 | Mon-Fri 8.30am-5.00pm | www.svha.org.au

Jennie Fairclough | Manager | Footbridge CCU & North Fitzroy PARC
540, Napier Street, North Fitzroy, 3068.
t: +61 3 9481 5644 | f: +61 3 9481 4193 | m: 0407 680 408 | www.svha.org.au

Corinne Owens | Senior Occupational Therapist
Footbridge CCU 540 Napier Street, Fitzroy North , 3068
9481 5644 | f: +61 3 9489 4193| www.svhm.org.au

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Medication Administration – Undergraduate Nursing Students

Factors to Consider:

- You are not yet registered nurses, so you are not required nor expected to perform the duties of the permanent staff with reference to medication related matters. However as nurses in training, you can observe and participate in various medication-related activities.
- For example, you can assist permanent nursing staff to make up medication from the treatment room for consumers, as long as the registered nurse observes and approves of everything that you do. You cannot give medication to a consumer unless you are continuously directly observed either by the registered nurse who made up the medication, or by the registered nurse who assisted and therefore also witnessed the medication being dispensed.
- You can give an injection, as long as you are continuously supervised by the registered nurse. Remember to "z" track our depot preparations. Ensure that you have covered the procedure during lab time at your respective university. If you have not been taught you cannot do it.
- Take time to learn about the various medications in common use in mental health services. Learn the intended effects, and the side-effects. Be alert and vigilant for signs that the patient may be experiencing side-effects. If you feel confident enough, assist the registered nurse to educate the patient regarding these side-effects.
- Always monitor compliance when administering medication in this setting; consumers have many ingenious methods to dispose of medication.
- Try to relate the prescribing practice to the consumer's presenting features. Why did the psychiatrist prescribe certain medication? What is the intended outcome for the consumer?
- Communicate any concerns to the registered nurse.

Policies & Procedures:

Medication Policy Acute Inpatient Service
Administration of Medication: Depot Anti Psychotic Injection Guidelines
Guidelines for safe administration of medication in the acute inpatient service
St Vincent's Policy & Procedures for Mental Health Services:
http://intranet/Policies/Mental%20Health%20Adult%20Policies/Forms/Current%20Policies.aspx
Or via http://intranet/Policies/Pages/MentalHealthAdultManual.aspx

Relevant Legislation:

Accreditation of a university course by the Victorian Nurses Board to prepare learners to become registered nurses.
Contractual agreement between the university and the hospital Nurses Act (1993)
Drugs, Poisons & Controlled Substances Act (1981)
Mental Health Act (2014)
National Standards for Mental Health Services – Safety
Australian Council of Healthcare Standards – Continuum of Care, Safe Practice & Environment
Confidentiality agreement (St Vincent's Hospital)
Code of Conduct (St Vincent's Hospital)

COMMONLY UTILISED DRUGS IN PSYCHIATRIC NURSING

Anxiolytics
BENZODIAZEPINES

DRUG	*USUAL DAILY DOSE (MG)*	*APPROX. EQUIV. TO DIAZ. 5MG*
Alprazolam	1-4	0.5-1
clonazepam	4-8	0.5
diazepam	5-20	5
flunitrazepam	0.5-2	1-2
lorazepam	2-4	1
nitrazepam	5-20	5-10
oxazepam	45-90	15-30
temazepam	10-30	10-20
triazolam	0.125-0.25	0.25

OTHERS

Buspirone 15-30
Zopiclone 3.75-7.5

Antidepressants

DRUG	DAILY ORAL DOSE (MG)	GROUP
Amitriptyline	75-150	Tricyclic
Clomipramine	75-150	Tricyclic
Desipramine	75-150	Tricyclic
Dothiepin	75-150	Tricyclic
Doxepin	75-150	Tricyclic
Imipramine	75-150	Tricyclic
Nortriptyline	75-150	Tricyclic
Trimipramine	75-150	Tricyclic
Mianserin	30-90	Tricyclic
Citalopram	20-40	SSRI's
Fluoxetine	20-40	SSRI's
Fluvoxamine	100-200	SSRI's
Paroxetine	20-40	SSRI's
Sertraline	50-100	SSRI's
Moclobemide	300-600	RIMA
Nefazodone	300-600	SARI
Venlafaxine	75-100	SNRI
Phenelzine	45-60	MAOI
Tranylcpromine	30-40	MAOI

Antipsychotics

DRUG	DAILY ORAL DOSE RANGE (mg)	GROUP
Chlorpromazine	50-1000	Typical
Droperidol(out of use)	5-10 (IM)	Typical
fluphenazine	5-20	Typical
haloperidol	0.5-20	Typical
pericyazine	25-75	Typical
pimozide	2-12	Typical
Thioridazine(out of use)	50-600	Typical
thiothixene	10-40	Typical
trifluoperazine	10-50	Typical
Zuclopenthixol acetate	50-150 (IM)	Typical
Zuclopenthixol dihydrochloride	10-75	Typical
Clozapine	100-600	Atypical
Olanzapine	5-20 (oral-IM)	Atypical
Quetiapine	300-700	Atypical
Risperidone	0.5-6	Atypical
Risperidone Consta	IM preparation 25-75mgs 2/52	Atypical
Amisulpride	400-800	Atypical
Ziprasidone	40-80mgs	Atypical

Antiparkinsonian Medication (for side effects to antipsychotics)
Benzhexol
Benztropine
Biperiden

Mood Stabilizers
Carbamazepine
Lithium Carbonate
Sodium Valproate

References
Kaplan H and Saddock B, 1998, Synopsis of psychiatry: behavioral sciences, clinical psychiatry – 8th edition. Lippincott Williams & Wilkins, Baltimore.
Mims

Mental Health Act 2014
www.health.vic.gov.au/mentalhealth/mhactreform

Mental illness is a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.

A person is not to be considered to have mental illness merely because the person:

- expresses or refuses or fails to express a particular political opinion or belief, religious opinion or belief, philosophy, sexual preference or sexual orientation, political activity, or religious activity
- engages in sexual promiscuity, immoral or illegal conduct or antisocial behaviour
- is intellectually disabled
- uses drugs or consumes alcohol
- has a particular economic or social status or is a member of a particular cultural or racial group
- is or has previously been involved in family conflict
- has previously been treated for mental illness.

Assessment Order

A registered medical practitioner or a mental health practitioner will be able to make an Assessment Order for a person if they believe the person 'appears to have a mental illness' and needs compulsory treatment.

The criteria for an Assessment Order will require that the practitioner examining the person will need to determine that the person appears to have a mental illness and needs treatment to prevent serious harm to the person, serious deterioration in their mental or physical health or serious harm to another person. The practitioner must be satisfied that there is no less restrictive means reasonably available to assess the person, including whether the person can be assessed on a voluntary basis.

The purpose of an Assessment Order is to enable an authorised psychiatrist to assess the person to determine whether they 'have a mental illness' and require compulsory mental health treatment. Assessment may be conducted in an inpatient setting or in the community.

An Inpatient Assessment Order enables the transport of a person to a designated mental health service within 72 hours. Once the person is received at the designated mental health service, an Assessment Order will last for a maximum of 24 hours but may be extended up to a maximum of 72 hours in exceptional circumstances.

A Community Assessment Order will last for a maximum of 24 hours but may be extended up to a maximum of 72 hours in exceptional circumstances.

Temporary Treatment Order

At the assessment, if the authorised psychiatrist determines the criteria for compulsory treatment apply to the person, the authorised psychiatrist may make a Temporary Treatment Order. **A Temporary Treatment Order has a maximum duration of 28 days.**

The criteria for a Temporary Treatment Order require that the authorised psychiatrist determine that the person has mental illness and needs immediate treatment to prevent serious deterioration in their mental or physical health or serious harm to the person or to another person.

The authorised psychiatrist must be satisfied that there is no less restrictive means reasonably available to ensure the person receives the treatment, including whether the person can receive treatment on a voluntary basis. The criteria set a high threshold because compulsory treatment imposes a serious limitation on personal liberty and autonomy. The criteria make it clear that a person is not to be placed on a compulsory treatment order simply because they have a history of mental illness.

Where the authorised psychiatrist has determined that the treatment criteria apply to the person and makes a Temporary Treatment Order, the authorised psychiatrist must also specify the setting where compulsory treatment is to be provided. **The setting** must be 'inpatient' if the authorised psychiatrist considers that the only way to provide the treatment is by detaining the person in an inpatient unit. The setting must be 'community' if the authorised psychiatrist considers the treatment can be provided while the person lives in the community. The authorised psychiatrist must regularly review the patient and immediately revoke the Temporary Treatment Order if the criteria no longer apply to the patient.

Treatment Orders

If a patient remains on a Temporary Treatment Order at the end of the period of the order, the Mental Health Tribunal must conduct a hearing to determine whether the criteria for a Treatment Order apply to the person. If the matter is not heard by the Tribunal within the 28 day period of the Temporary Treatment Order, the Order will expire.

The Mental Health Tribunal can make a Treatment Order if it determines that all the criteria for compulsory treatment apply to the person. The Tribunal must also determine the setting where compulsory treatment is to be provided (either inpatient or community) and the duration of the order: up to six months for an Inpatient Treatment Order or up to 12 months for a Community Treatment Order.

A young person may only be placed on a Treatment Order for a maximum of three months regardless of whether the young person is receiving treatment in an inpatient unit or in the community. This shorter timeframe will ensure that there is greater oversight of the compulsory treatment provided to young people.

The authorised psychiatrist will be responsible for providing treatment during the period of the Treatment Order and will be able to vary the setting where treatment is to be provided if required.

At the end of the period of the Treatment Order, the authorised psychiatrist may make an application to the Mental Health Tribunal for a further Treatment Order if the criteria for compulsory treatment still apply to the patient. The Tribunal will hear and determine the matter in the same way as described above. If the matter is not heard by the Tribunal within the period of the order, the Treatment Order will expire.

The authorised psychiatrist must regularly review the patient and immediately revoke the treatment Order if the criteria no longer apply to the patient.

A patient can make an application to the Mental Health Tribunal to have the Temporary Treatment

Order or Treatment Order revoked at any time.
A patient may apply to the Victorian Civil and Administrative Tribunal for review of any decision made by the Mental Health Tribunal at any time.

Nominated person

A patient will be able to nominate a person to receive information and to support the patient for the duration of the compulsory treatment order.
The nominated person will assist a patient to exercise their rights and represent the patient's views and preferences. They will be consulted at critical points in the patient's treatment such as intake and discharge planning and will be able to express their views. The nominated person is not able to make treatment decisions on behalf of the patient.
The appointment of a nominated person will make information disclosure clear for patients, family members, carers and the authorised psychiatrist.

Advance statements

The Bill enables a person to make an advance statement to record their treatment preferences in the event that they become unwell and require compulsory treatment.
Advance statements facilitate a collaborative treatment approach at times where a patient is so unwell that they are unable to communicate their treatment preferences. They will assist the authorised psychiatrist to understand the patient's treatment preferences and enable the authorised psychiatrist to make treatment decisions that better align with the patient's treatment and recovery goals.
Advance statements will improve communication, give patients greater control over their treatment when they are subject to a compulsory treatment order and promote an improved patient experience.

Presumption of capacity

A presumption of capacity is the foundation of the supported decision-making model. The Bill provides that all people are presumed to be able to make treatment decisions.
People with serious mental illness may have fluctuating capacity to make decisions about treatment. A person with mental illness may not be able to make a treatment decision at a particular point in time, but may regain capacity to make that decision at another point in time.
Under the Bill, patients and young people will be provided with information and support to make decisions about their treatment. This support may include the support of a carer, a nominated person or a parent of a young person. The Bill contains a capacity test and principles to assist clinicians to determine whether a person can or cannot give informed consent to treatment at the time the decision needs to be made. Where a patient or young person is unable to consent, they will be supported to be involved in the decision-making process to the greatest extent possible

Mental Health Tribunal

The Bill establishes a Mental Health Tribunal as an independent body to replace the Mental Health Review Board and the Psychosurgery Review Board.
The Tribunal will make Treatment Orders for patients. The Tribunal must be satisfied that all the treatment criteria apply to the patient before making a Treatment Order. In coming to this decision it is expected that the Tribunal will take a holistic approach that considers a range of factors including the patient's recovery goals and treatment preferences and the views of the nominated

person, carer, guardian or parent of a young person and take into account any second psychiatric opinion report.
By assigning responsibility to the Tribunal for making Treatment Orders, the Bill leaves the authorised psychiatrist and other members of the treating team free to engage with the patient in a collaborative treatment relationship consistent with recovery-oriented practice.
Each division of the Tribunal will consist of three members: a lawyer, a registered medical practitioner and a member of the community. Registered medical practitioner members will be qualified psychiatrists wherever practicable. Where the Tribunal is considering an application for electroconvulsive treatment or neurosurgery for mental illness, the registered medical practitioner must be a psychiatrist.

Electroconvulsive treatment

Electroconvulsive treatment (ECT) is considered an effective treatment for some mental illnesses. However the public consultations identified that the community expects greater oversight of the performance of ECT on compulsory patients and young persons. In response, the Bill includes the following new safeguards.
The Bill provides that ECT may only be performed with the approval of the Mental Health Tribunal on a patient who does not have capacity to give informed consent to ECT or a young person under 18 years of age.
The Bill seeks to maximise the patient's autonomy wherever possible. Consistent with this intention, an adult patient (18 years of age or over) with capacity may consent to or refuse ECT without requiring Tribunal approval. The authorised psychiatrist will not be able to compulsorily perform ECT on a patient with capacity who is refusing ECT.
Where the Tribunal determines that any young person under the age of 18 has capacity to consent to ECT, the Tribunal may only approve ECT if the patient or young person gives informed consent.
Where a patient or any young person under the age of 18 does not have capacity to consent to ECT, the Tribunal must decide whether the ECT is the least restrictive treatment. For this purpose, the Tribunal will consider the person's views and preferences about the ECT, whether the ECT is likely to remedy the mental illness or lessen the ill effects, and a range of other factors described in the Bill.
In addition, where a young person under 18 years of age does not have capacity to consent to ECT, a parent will be required to consent to an application being made to the Tribunal. The Tribunal must take the views of the parent into account when determining whether to approve ECT for a young person.
The Bill will require services to report to the Chief Psychiatrist about the performance of ECT in the public system. The Chief Psychiatrist, whose role is outlined on page 8 of this paper, has an important role in improving safety and quality of ECT performed in public mental health services

Restrictive interventions

The use of restrictive interventions (bodily restraint and seclusion) will be subject to improved safety and accountability requirements. Restraint and seclusion are highly intrusive practices that tragically have been linked to patient deaths. Accordingly in 2005 the Mental Health Working Group of the Australian Health Ministers' Advisory Council committed to reduce and wherever possible eliminate the use of restraint and seclusion.
The Bill regulates physical restraint in addition to the existing regulation of mechanical restraint and seclusion. This will improve the safety of bodily restraint and seclusion by increased oversight of and accountability for these restrictive practices.

In addition the Bill specifies that restrictive interventions must only be used after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable.

Statement of rights

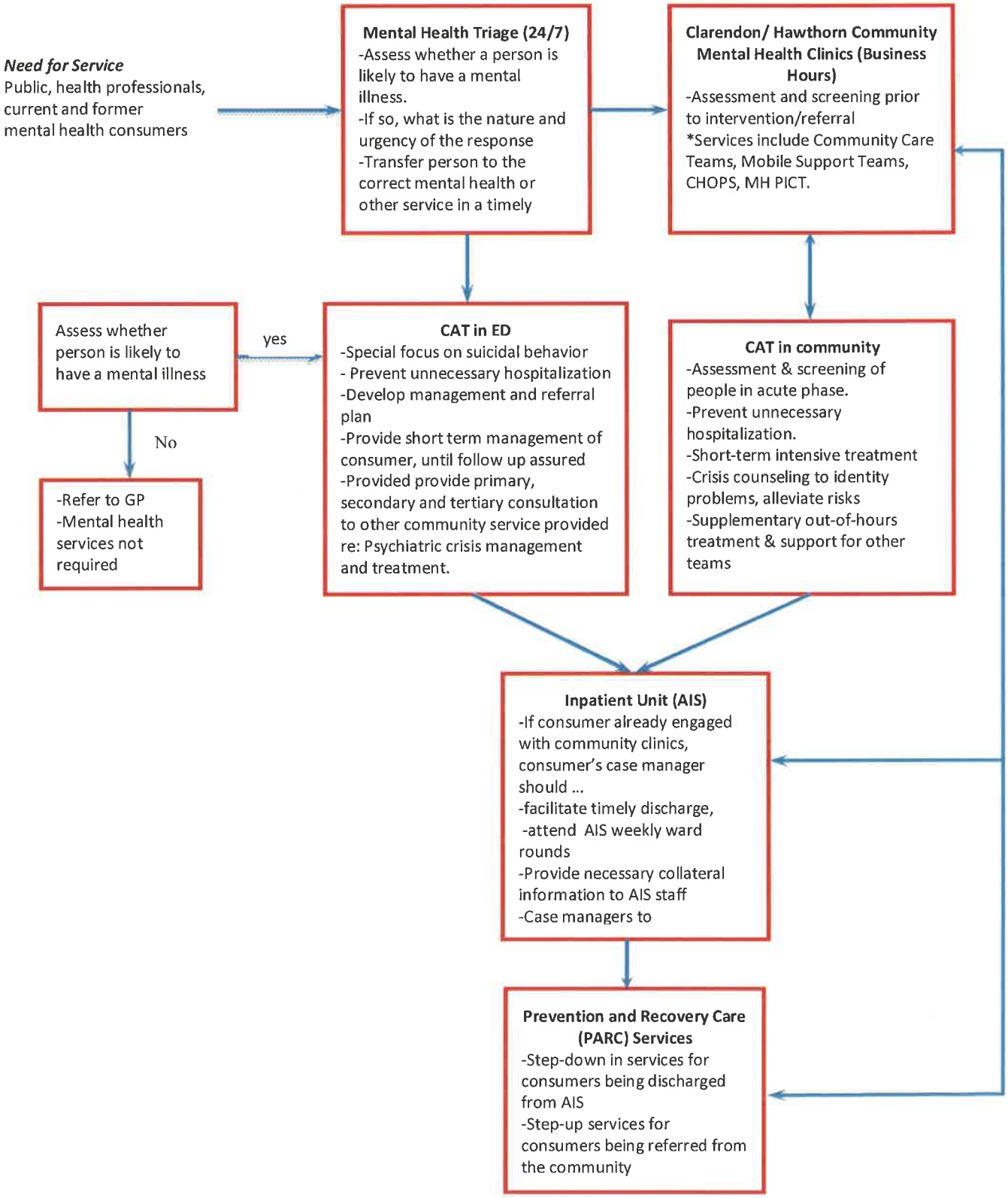
The Bill sets out the requirements for informing patients about their rights. Central to the reforms introduced by the Bill is the right of patients to make or participate in decisions about their treatment and care. This remains the case even where a patient does not have the capacity to provide informed consent to treatment.

A patient has a right to be legally represented and be supported by a carer, family member or friend at a hearing of the Mental Health Tribunal. The Bill establishes a right to communicate lawfully and specifies that right may only be restricted in limited circumstances.

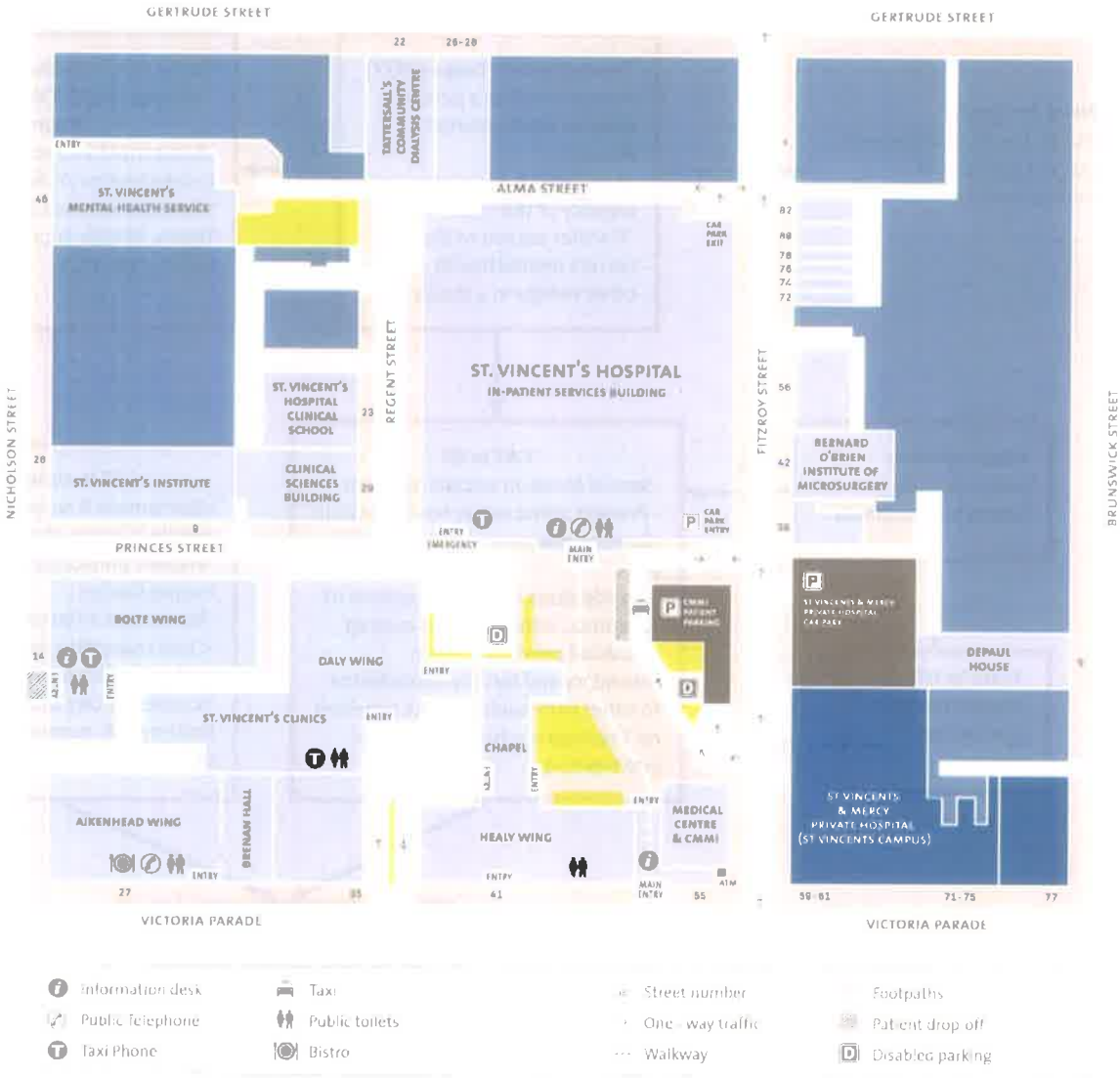
Patients subject to compulsory treatment orders will have the right to apply to an independent body, the Mental Health Tribunal, at any time if they consider the criteria for compulsory treatment no longer apply to them.

The Bill continues the right of patients to discuss their treatment and care with community visitors, who will routinely visit designated mental health services.

Frameworks for Mental Health Service Delivery



St. Vincent's Hospital Campus Map



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Depression. Anxiety.

Things to remember

- Anxiety and depression are common and treatable.
- Help is available and it's important to seek help early – the sooner the better.
- Anxiety and depression are illnesses, not weaknesses, and people shouldn't feel ashamed to seek help.
- By talking about anxiety and depression, we can help raise awareness and reduce stigma.

Where to find more information

beyondblue
www.beyondblue.org.au
Learn more about anxiety and depression, or talk it through with our support service.
1300 22 4636
Email or chat to us online at
www.beyondblue.org.au/getsupport

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Depression. Anxiety.

Understanding anxiety and depression

Anxiety

Over two million people in Australia experience anxiety each year. On average, one in three women and one in five men will have anxiety in their lifetime.

What is anxiety?

Anxiety is more than just feeling stressed or worried. Anxious feelings are a normal reaction to a situation where a person feels under pressure – for example, meeting work deadlines, sitting exams or speaking in front of a group of people.

However, for some people these anxious feelings happen for no apparent reason or continue after the stressful event has passed.

For a person experiencing anxiety, anxious feelings cannot be brought under control easily. Anxiety can be a serious condition that makes it hard for a person to cope with daily life.

There are many types of anxiety, please see page 4 for a list of the most common. It is important to note that many people with anxiety experience symptoms of more than one type of anxiety.

Anxiety is common, but the sooner you get help, the sooner you can learn to control the condition – so it doesn't control you.

If you are concerned you (or someone you know) is experiencing anxiety, please consult a GP or other health professional.

For more information on anxiety visit **www.beyondblue.org.au/anxiety** or call the *beyondblue* support service on **1300 22 4636**.

How do you know if someone has anxiety?

The symptoms of anxiety are sometimes not all that obvious as they often develop gradually and, given that we all experience some anxiety, it can be hard to know how much is too much.

Some common symptoms of anxiety include:

- hot and cold flushes
- racing heart
- tightening of the chest
- snowballing worries
- obsessive thinking and compulsive behaviour.

These are just some of a number of symptoms that may be experienced.

If you are familiar with any of these symptoms, check the more extensive list of symptoms common to anxiety on the next page. They are not designed to provide a diagnosis – for that you need to see a doctor – but they can be used as a guide.

Common symptoms of anxiety

Behaviour

- withdrawing from, avoiding, or enduring with fear objects or situations which cause anxiety
- urges to perform certain rituals in a bid to relieve anxiety
- not being assertive (i.e. avoiding eye contact)
- difficulty making decisions
- being startled easily

Feelings

- overwhelmed
- fear (particularly when having to face certain objects, situations or events)
- worried about physical symptoms (e.g. fearing there is an undiagnosed medical problem)
- dread (e.g. that something bad is going to happen)
- constantly tense, nervous or on edge
- uncontrollable or overwhelming panic

Thoughts

- "I'm going crazy."
- "I can't control myself."
- "I'm about to die."
- "People are judging me."
- having upsetting dreams or flashbacks of a traumatic event
- finding it hard to stop worrying
- unwanted or intrusive thoughts

Physical

- increased heart rate/racing heart
- shortness of breath
- vomiting, nausea or pain in the stomach
- muscle tension and pain (e.g. sore back or jaw)
- feeling detached from your physical self or surroundings
- having trouble sleeping (e.g. difficulty falling or staying asleep or restless sleep)
- sweating, shaking
- dizzy, lightheaded or faint
- numbness or tingling
- hot or cold flushes
- difficulty concentrating

Types of anxiety

There are different types of anxiety. The six most common are:

Generalised anxiety disorder (GAD)

A person feels anxious on most days, worrying about lots of different things, for a period of six months or more.

Social phobia

A person has an intense fear of being criticised, embarrassed or humiliated, even in everyday situations, such as speaking publicly, eating in public, being assertive at work or making small talk.

Specific phobias

A person feels very fearful about a particular object or situation and may go to great lengths to avoid it, for example, having an injection or travelling on a plane. There are many different types of phobias.

Obsessive compulsive disorder (OCD)

A person has ongoing unwanted/intrusive thoughts and fears that cause anxiety. Although the person may acknowledge these thoughts as silly, they often try to relieve their anxiety by carrying out certain behaviours or rituals. For example, a fear of germs and contamination can lead to constant washing of hands and clothes.

Post-traumatic stress disorder (PTSD)

This can happen any time from one month after a person experiences a traumatic event (e.g. war, assault, accident, disaster). Symptoms can include difficulty relaxing, upsetting dreams or flashbacks of the event, and avoidance of anything related to the event.

Panic disorder

A person has panic attacks, which are intense, overwhelming and often uncontrollable feelings of anxiety combined with a range of physical symptoms. A person having a panic attack may experience shortness of breath, increased heart rate, dizziness and excessive perspiration. Sometimes, people experiencing a panic attack think they are having a heart attack or are about to die.

Depression

Over one million people in Australia live with depression each year. On average, one in five women and one in eight men will experience depression in their lifetime.

What is depression?

While we all feel sad, moody or low from time to time, some people experience these feelings intensely, for long periods of time (weeks, months or even years) and sometimes without any apparent reason.

Depression is more than just a low mood – it's a serious condition that has an impact on both physical and mental health.

Depression affects how you feel about yourself. You may lose interest in work, hobbies and doing things you normally enjoy. You may lack energy, have difficulty sleeping or sleep more than usual. Some people feel anxious or irritable and find it hard to concentrate.

The good news is, just like a physical illness, depression is treatable and effective treatments are available.

How do you know if someone has depression?

A person may be depressed if he or she has felt sad, down or miserable most of the time **for more than two weeks** and/or has lost interest or pleasure in usual activities, and has also experienced several of the signs and symptoms across at least three of the categories on the next page.

It's important to note that everyone experiences some of these symptoms from time to time and it may not necessarily mean a person is depressed. Equally, not every person who is experiencing depression will have all of these symptoms.

The symptoms will not provide a diagnosis – for that you need to see a health professional – but they can be used as a guide.

If you are concerned you (or someone you know) is experiencing depression, please consult a GP or other health professional.

For more information on depression visit **www.beyondblue.org.au/depression** or call the *beyondblue* support service on **1300 22 4636**.

Common symptoms of depression

Behaviour

- not going out anymore
- not getting things done at work/school
- withdrawing from close family and friends
- relying on alcohol and sedatives
- not doing usual enjoyable activities
- unable to concentrate

Feelings

- overwhelmed
- guilty
- irritable
- frustrated
- lacking in confidence
- unhappy
- indecisive
- disappointed
- miserable
- sad

Thoughts

- "I'm a failure."
- "It's my fault."
- "Nothing good ever happens to me."
- "I'm worthless."
- "Life's not worth living."
- "People would be better off without me."

Physical

- tired all the time
- sick and run down
- headaches and muscle pains
- churning gut
- sleep problems
- loss or change of appetite
- significant weight loss or gain

Get support

People with anxiety and/or depression can find it difficult to take the first step in seeking help. They may need the support of family, friends and a health professional.

There is no one proven way that people recover from anxiety or depression. However, there is a range of effective treatments and health professionals who can help people on the road to recovery.

There are also many things that people with anxiety and depression can do to help themselves to recover and stay well.

What treatments are available?

Different types of anxiety and depression require different types of treatment. This may include physical exercise for preventing and treating mild anxiety or depression, through to psychological and medical treatment for more severe episodes.

There is a range of treatments to help, but it's different for everybody. **The important thing is finding the right treatment and the right health professional that works for you.**

Who can assist

Anxiety and depression can go on for months, sometimes years, if left untreated, and can have many negative effects on a person's life. It's important to seek help early – the sooner a person gets treatment, the sooner they can recover.

Different health professionals (such as General Practitioners (GPs), psychologists and psychiatrists) offer different types of services and treatments for anxiety and depression.

If you think that you or someone you know has anxiety or depression, talking to a GP is a good place to start. A GP can make a diagnosis, check for any physical health problem or medication that may be contributing to the anxiety and depression, and discuss treatment options.

For a list of GPs, clinical psychologists, psychologists, mental health nurses, social workers and occupational therapists with expertise in treating mental health problems, visit **www.beyondblue.org.au/find-a-professional** or call the *beyondblue* support service on **1300 22 4636**.

Recovery and staying well

Recovery can take time. As well as getting treatment underway, the person has to find new ways to manage, and live with, the changes and challenges of having anxiety and/or depression.

While psychological and/or medical treatment can help with a person's recovery, there are many other ways people can help themselves to get better and stay well, such as:

- learning new ways to reduce and manage stress
- maintaining a healthy lifestyle, such as eating a healthy and balanced diet, exercising regularly, getting a good night's sleep, and reducing alcohol and other drugs
- recognising triggers and warning signs
- getting over setbacks.

How can I help someone with anxiety or depression?

It is helpful to:

- let them know if you've noticed a change in their behaviour
- spend time talking about their experiences and let them know that you're there to listen without being judgmental
- help them to get information from a website, library or community health centre
- suggest they go to a doctor or health professional, and help them to make an appointment
- offer to go with them to their appointment and/or follow them up afterwards
- encourage them to get enough sleep, exercise and to eat well
- encourage family and friends to invite them out and keep in touch, but don't pressure them to participate in activities
- encourage the person to face their fears with support from their doctor/psychologist
- discourage them from using alcohol or other drugs to try to feel better
- contact a doctor or hospital if they become a threat to themselves or others.

It is unhelpful to:

- put pressure on them by telling them to "snap out of it" or "get their act together"
- stay away or avoid them
- tell them they just need to stay busy or get out more
- pressure them to party more or wipe out how they're feeling with drugs and alcohol
- assume the problem will just go away.

If you (or someone you know) needs help, talk to your GP or other health professional about getting appropriate treatment.

Know the options and develop an action plan

Anxiety and depression are like any other medical condition – you need ways to manage them and stop them happening again later.

Some people think that it's weak to admit that they're going through a tough time, but if you have anxiety or depression, you can't just 'snap out of it' or 'pull yourself together'. There's more to it than that.

If you think you may have depression or anxiety, and want to take action, start by talking to someone you trust – keeping it to yourself only makes things worse. Discuss your situation with a mate, partner, family member or a colleague.

Take action and find out more. Visit **www.beyondblue.org.au/taking-action**

Stress

Stress is not the same as anxiety or depression – but for some people, being stressed for a long time can lead to anxiety and/or depression, plus it can affect a person's physical health, particularly cardiovascular health.

When we talk about being stressed, it usually means we're upset or tense about something that's happening in our lives.

Stress is a normal part of daily life. It's a natural physical and mental response that is designed to help people cope effectively with emergencies.

Some stress can be a good thing. It can help us get motivated to get things done, but health problems from stress happen when it is regular and doesn't let up.

References

[1] Australian Bureau of Statistics, *National Survey of Mental Health and Wellbeing*, 2007, Catalogue Number 4326.0, 2008

[2] Australian Bureau of Statistics, *Causes of Death Australia 2011, preliminary data*, Catalogue Number 3303.0, 2013

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Where to find more information

beyondblue
www.beyondblue.org.au
Learn more about anxiety and depression, or talk it through with our support service.
1300 22 4636
Email or chat to us online at
www.beyondblue.org.au/getsupport

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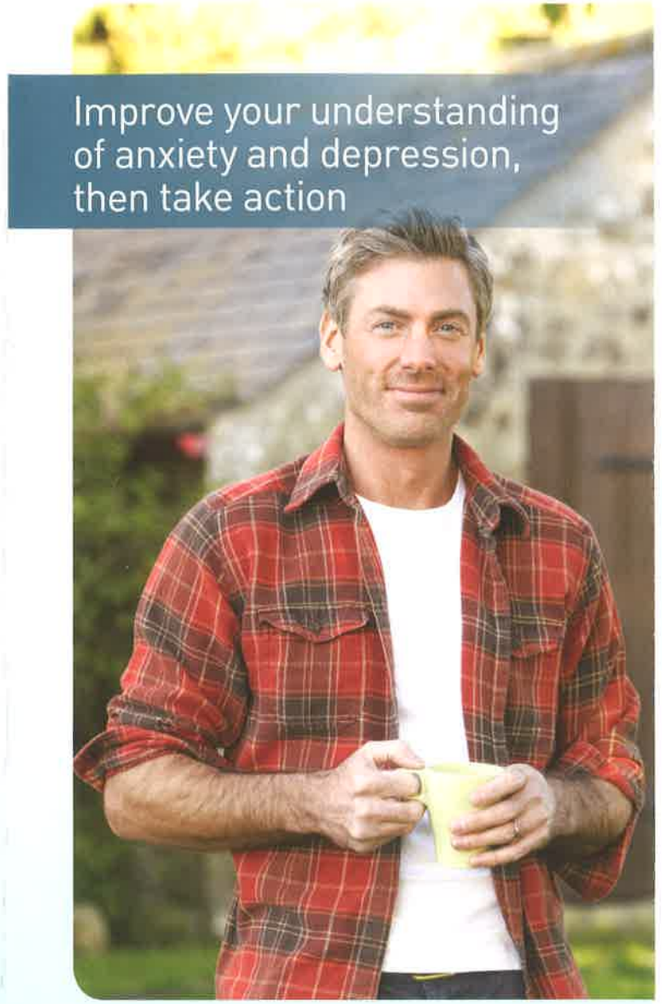

In general, men tend to put off getting any kind of assistance because they think they are supposed to be tough, self-reliant, and able to manage pain and take charge of situations. This can make it hard for men to acknowledge they have any health problems, let alone one which affects their social and emotional wellbeing.

Depression is a serious and common condition which won't get better by itself. If you had a broken arm or a deep cut on your foot, you wouldn't expect that to heal without medical help. It's the same with depression.

On average, one in eight men will have depression and one in five men will experience anxiety at some stage of their lives.[1]

While women are more likely to experience anxiety and depression, men are less likely to talk about it. This increases the risk of their anxiety or depression going unrecognised and untreated.

Untreated depression is a high risk factor for suicide and in Australia, there are approximately 2,200 suicides each year. Eighty per cent of people who take their lives are men – with an average of five men dying by suicide every day. Suicide is the leading cause of death for men under the age of 44, significantly exceeding the national road toll.[2]

It's important to remember that anxiety and depression are illnesses, not weaknesses, and effective treatments are available.

Signs and symptoms

You need to know the signs – not only for you, but also for your mates and family.

Anxiety

Anxiety is more than having sweaty palms and butterflies in your stomach. Symptoms of anxiety can include feelings of worry, stress, fear and impending doom so severe they interfere with your ability to work, maintain relationships and get a decent night's sleep.

What to watch for:

Physical

- pounding heart
- excessive sweating
- choking sensations
- dizziness and vertigo
- shortness of breath
- hot flushes or chills
- insomnia and exhaustion
- panic attacks

Emotional

- feelings of dread
- concentration problems
- inner tension and nervousness
- catastrophic thinking
- irritability or edginess
- hyper vigilance toward danger
- absentmindedness
- fear of losing control

To find out more about anxiety and depression in men visit **www.beyondblue.org.au/men**

Depression

While depression is often associated with sadness and hopelessness, it often manifests itself in fits of rage, unnecessary risk taking, and alcohol or drug abuse in men.

What to watch for:

Physical

- persistent pain
- loss of energy
- loss of sex drive
- changes in appetite
- lethargy and/or exhaustion
- exhaustion
- change in sleep patterns and restlessness
- alcohol or drug abuse

Emotional

- feeling guilty
- feeling angry or violent
- losing interest in hobbies
- feeling apathetic
- feeling sad or nervous
- feeling alone
- taking unnecessary risks
- thinking about death or suicide

Seek support from your GP

Your doctor is a good source of information and can assess if what you are feeling is anxiety or depression. If you are diagnosed with either of these conditions, together you can work out an action plan.

Your action plan can cover a wide range of options. The plan can include exercise, stress management and how to improve your sleep. You may be referred to a psychologist who can help you to address things like negative thinking and how to deal with hassles in your relationships.

For some people, medication might also be necessary. Most people using medication report a significant improvement in their condition, and greater capacity to get back to the things they used to enjoy. Antidepressants take at least two weeks before they start to help, and it may also take some time for the doctor to find the medication and dose that is most effective for you.

There is a range of different health professionals who are able to provide advice or services if you're experiencing anxiety or depression.

Supporting yourself

You are in control of your health and wellbeing - there are lots of different things you can do so find an approach that best suits you. For example, try to stay active and make plans for the day – they don't have to be grand plans, just small things like going for a run, talking to a mate or doing some gardening. Try to include activities or hobbies that you specifically enjoy. At first, you may not enjoy them as much as you did before, but if you keep active and persist, the enjoyment should eventually return.

It's important to look after your body by staying physically active, eating healthily and getting plenty of sleep. Try not to drink or take drugs to block out how you're feeling and what is happening – this is not a positive long-term solution and only makes the anxiety or depression worse.

So, there is a range of options available, but it's different for everybody. The important thing is finding the right options and the right health professional that works for you.

Supporting others

How can I help someone with anxiety or depression?

It is helpful to:

- let them know if you've noticed a change in their behaviour
- spend time talking about their experiences and let them know that you're there to listen without being judgmental
- help them to get information from a website, library or community health centre
- suggest they go to a doctor or health professional, and help them to make an appointment
- offer to go with them to their appointment and/or follow them up afterwards
- encourage them to get enough sleep, exercise and to eat well
- encourage family and friends to invite them out and keep in touch, but don't pressure them to participate in activities
- encourage the person to face their fears with support from their doctor/psychologist
- discourage them from using alcohol or other drugs to try to feel better
- contact a doctor or hospital if they become a threat to themselves or others.

It is unhelpful to:

- put pressure on them by telling them to "snap out of it" or "get their act together"
- stay away or avoid them
- tell them they just need to stay busy or get out more
- pressure them to party more or wipe out how they're feeling with drugs and alcohol
- assume the problem will just go away.

If you or someone you know needs help, talk to a GP or other health professional about getting appropriate treatment.

EVERY $1 BUSINESS INVESTS IN MENTAL HEALTH RETURNS $2.30.

From absences to lost productivity and compensation claims, the hidden cost of poor mental health in Australia's workplaces has been valued at $10.9 billion a year. But a small investment could change all that. For every dollar spent in this area, your business could see an ROI of $2.30. Completing a tailored step-by-step Heads Up Action Plan makes it easy to boost your productivity – and your bottom line.

Whichever way you look at it, investing in workplace mental health is good business.

Start your action plan at headsup.org.au

PwC 2014, 'A mentally healthy workplace: Return on Investment Analysis'

Heads up

MENTALLY HEALTHY WORK PLACE ALLIANCE

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1 IN 5 WORKERS IS LIKELY TO BE AFFECTED BY A MENTAL HEALTH CONDITION.

A mental health condition like anxiety or depression can be hard to talk about. In fact, half of Australian workers say they'd feel uncomfortable discussing mental health with their managers. So we want to kick start the conversation and make Australian businesses happier, healthier places to work. You can help initiate the change in your workplace. Register with Heads Up today to create a tailored step-by-step action plan.

Whichever way you look at it, investing in workplace mental health is good business.

Start your action plan at headsup.org.au

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Mental Health Act 2014

No. 26 of 2014

TABLE OF PROVISIONS