Mental Health

18

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Learning Objectives
In this chapter, the reader will learn about:

- Burden of mental illnesses.
- Brief history of mental health in Australia.
- Policy context for mental health in Australia.
- Structure of mental health services.
- Pertinent issues within mental health services for the medical administrator.
- Mental health workforce issues.
- Activity-based funding for mental health services.
- Mental health legislation.

18.1 Introduction

The World Health Organisation views health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity [1]. In recent years, there has been increasing recognition of the important role mental health plays in achieving overall happiness [2]. It is now acknowledged that poor mental health contributes to poor health outcomes, premature death, human rights violations, and global and national economic loss [3]. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published in 2021 has defined mental illness as a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or development processes underlying mental functioning [4]. A person, however, does not need to suffer from a mental illness to be adversely impacted by their mental health [5].

A health administrator who is responsible for the decision-making of mental health service provision ought to have an explicit understanding of mental illnesses, mental health services delivery and the issues around providing mental health care, as mental health services are now an integral part of an integrated continuum of health service care. The current chapter aims to discuss current structures and strategies of mental health service delivery in Australia, as well as legislations and common issues, to assist medical administrators in dealing with everyday situations.

18.2 Magnitude of the Issue

The impact of mental illnesses on society is widely known. A study was published in early 2022 [6] which attempted to understand the prevalence and burden of mental disorders across 204 countries and territories between 1990 and 2019. The study noted that the global number of Disability Adjusted Life Years (DALYs) due to

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E. Loh, P. W. Long (eds.), *Textbook of Medical Administration and Leadership*,
https://doi.org/10.1007/978-981-99-5211-3_18

mental disorders increased from 80·8 million to 125·3 million between 1990 and 2019, suggesting that mental disorders remained among the top ten leading causes of burden worldwide, with no evidence of any global reduction in the burden.

The 1997 National Survey of Mental Health and Wellbeing (NSMHWB) was the first nationally representative survey of mental disorders carried out in Australia and represented a landmark study in the epidemiology of mental disorders in Australia [7]. This same survey was repeated in 2007 and recently between 2021 and 2023. These surveys revealed important information about the mental health status of Australians. We know that the proportion of people between 18 and 65, accessing any mental health care service within the previous 12 months increased significantly from 1997 to 2007, from 12.4% to 21.4%. This percentage dropped to 17.5% in 2021, possibly due to lockdowns and restrictions. In 1997 and 2007 surveys, over 90% of participants aged 60 years or over with self-assessed mental health problems reported obtaining no help for their mental health problem [8]. According to the NSMHWB 2007 survey, the prevalence of any lifetime mental disorder was 45.5%. In 2021, this prevalence was relatively unchanged at 43.7%. In other words, over two in five Australians aged 16–85 years (8.6 million people) had experienced a mental disorder at some time in their life. The prevalence of any 12-month mental disorder was 18% in 1997, 20.0% in 2007 and 21.4% in 2021 (Fig. 18.1). There were other 4.4 million people who had a mental illness in their lifetime but not in the last 12 months (Fig. 18.2). In terms of the individual psychiatric disorders among people who experienced a mental disorder within the last 12 months (21.4%), anxiety disorders (16.8%) were the most common class of mental disorder, followed by affective disorders (7.5%), and substance use disorders (3.3%) [9].

Mental illness affects all of us, directly or indirectly. One in five Australians experience mental illness at any given 12 months. Mental

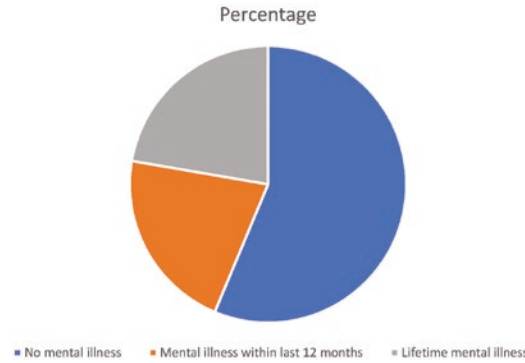

Fig. 18.2 Prevalence of mental illness in Australian population between age 18 and 65 (NSMHWB 2021)

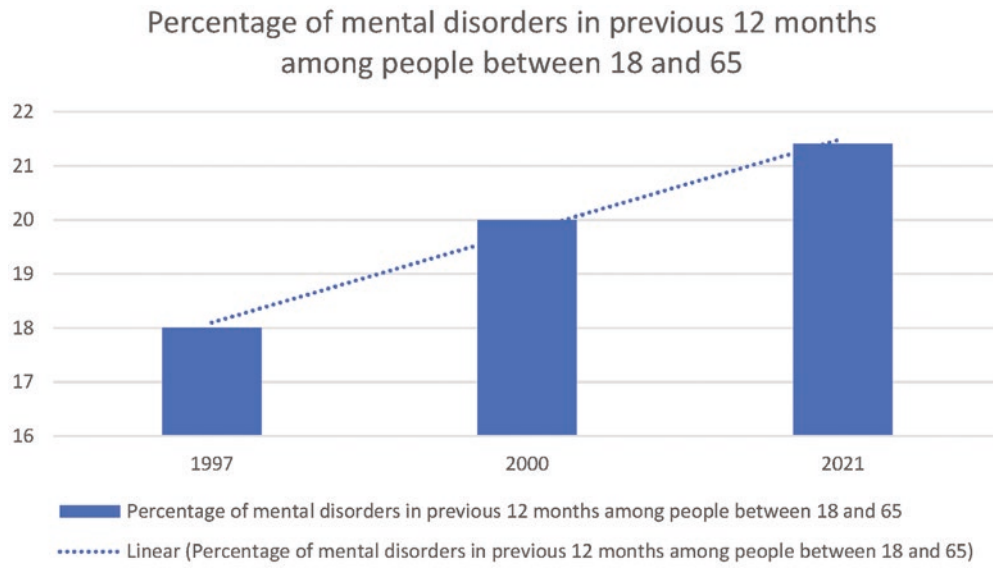

Fig. 18.1 12 Months Prevalence of mental disorders in age 18–65 (NSMHWB 1997, 2000, 2021)

and substance use disorders are important causes of disability and morbidity. The Australian Burden of Disease Study 2015 [10] examined the health loss due to various diseases and injuries that is not improved by current treatment. For Australia, Mental and substance use disorders were estimated to be responsible for 12% of the total burden of disease in 2015, placing it fourth as a broad disease group after cancer (18%), cardiovascular diseases (14%) and musculoskeletal conditions (13%) (Fig. 18.3).

Furthermore, three among six disease groups causing non-fatal burden of disease were mental illnesses [11] (Fig. 18.4). Non-fatal burden of disease is a measure of the number of years of 'healthy' life lost due to living with a disability.

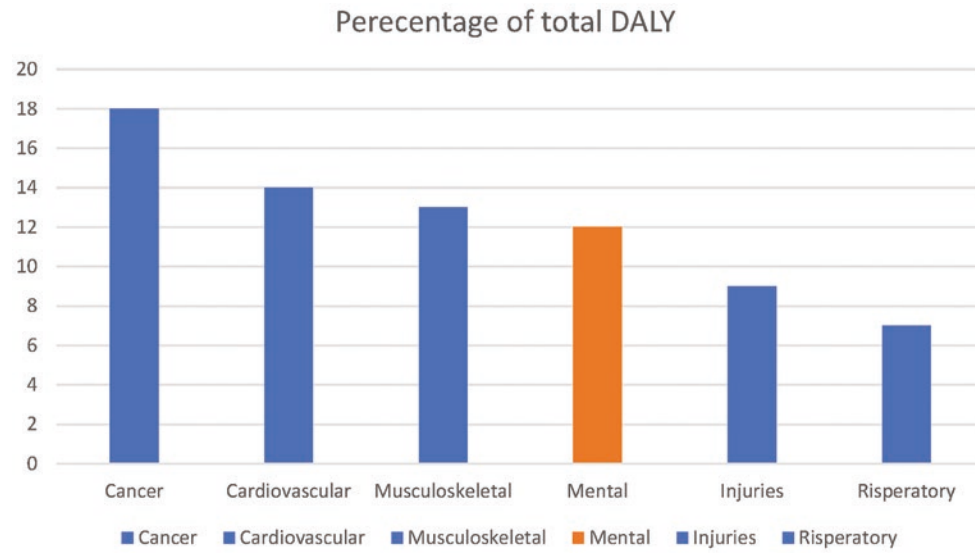

Fig. 18.3 Top 6 by the proportion (%) of total burden (DALY), by disease group in Australia in 2015 (The Australian Burden of Disease Study 2015)

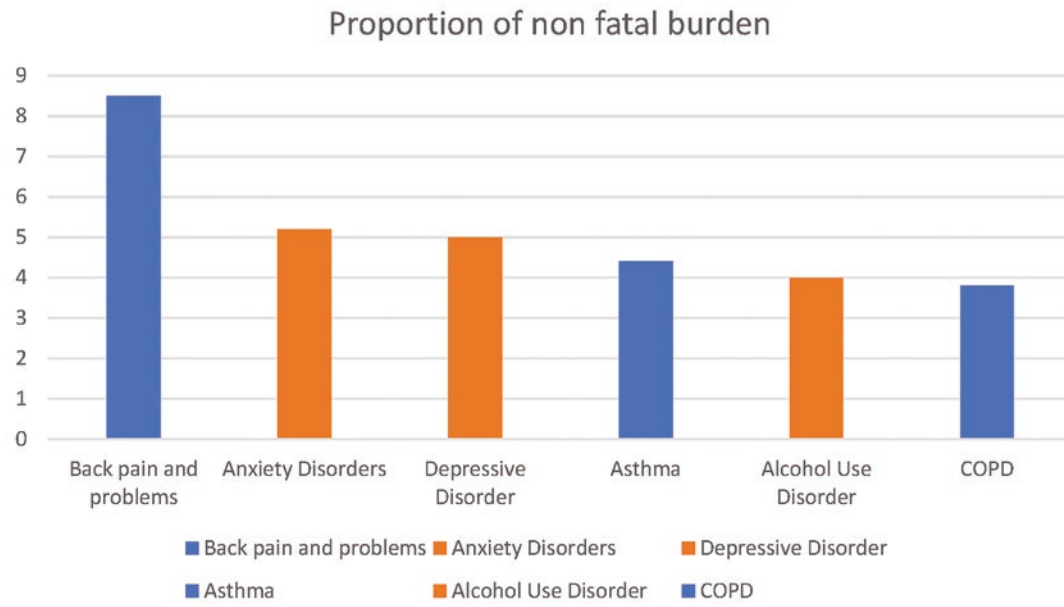

Fig. 18.4 Leading six causes of non-fatal burden in Australia in 2015

18.3 History of Mental Health and Services

Mental disorders have been of concern since ancient times. Interestingly, ancient theories about mental illness across different cultures often included beliefs that supernatural causes, such as demonic possession, curses, sorcery, or a vengeful god, are causing the unexplained symptoms of mental illness [12]. The treatments ranged from trephining (making holes in the skull to let the evil spirit out) to prayers, atonement, exorcisms or incantations [12, 13]. The first psychiatric hospital was established in Valencia, Spain, in 1410 CE [14] (Fig. 18.5), and moral treatments for mental illness were introduced in the late 1700s. It was Pinel who developed a hypothesis that mentally unhealthy patients needed care and kindness in order for their conditions to improve, and this humane approach was regarded as 'moral treatment' [15].

Sigmund Freud, an Austrian neurologist and psychiatrist, has been deemed by some as the father of modern psychiatry. He developed his theory of psychoanalysis, which gave rise to the practice of psychotherapy, which continues to be an important part of modern-day treatment [16]. The importance of Freud's works lies in the recognition of mental illness as similar to other illnesses. Freud's work opened doors for other mental health treatments, such as psychosurgery, electroconvulsive therapy (ECT), and psychopharmacology. These treatments are based on the biological model of mental illness, which considers mental health problems as being caused by biochemical imbalances in the body that can be treated like physical diseases. With its increasing use of medications along with other treatment

Fig. 18.5 A scene from an asylum

approaches such as psychotherapy and social interventions, modern-day psychiatry looks very different from how it was practiced a century ago. The effective use of pharmacotherapy has led to early and substantial improvements in mental illness minimising the need for in-patient care. This has led to the increased integration of the mentally ill population with the general population.

In Australia, criminals, the intellectually impaired and the mentally ill were clustered together in the Town Gaol at Parramatta due to them being seen as a nuisance to the community soon after the settlement. By 1811, a mental asylum was established at Castle Hill, New South Wales and an attempt was made to separate those who were criminal from those who were mentally ill [17]. Later, in 1838, a purpose-built psychiatric facility, Tarban Creek Asylum (later Gladesville Hospital) was established in Sydney. It wasn't until early 1980s, when the deinstitutionalisation process commenced following a landmark report by DT Richmond titled 'The Richmond Report'. This report uncovered the various abuses perpetrated against those individuals being held in institutions and argued for the deinstitutionalisation of people with mental illness [18]. Another seminal work was completed by the Human Rights Commissioner in 1992 titled Burdekin Report, which brought the human rights issues of overt abuse within institutions, and covert neglect in the wider community, to the attention of the general public [19]. For the next decade, Australian government implemented national mental health plans with the aim to improve genuine participation of consumers and carers, develop high-quality community-based mental health services and a broader population-based health promotion and disease prevention approach [20].

Deinstitutionalisation in Australia was certainly not in isolation. Europe had experienced a societal movement of deinstitutionalisation of the mentally ill population since the 1960s. This process commenced in Italy and expanded to other parts of Europe including the United Kingdom [21]. The United States of America also witnessed a significant reduction of admitted patients since the advent of pharmacotherapy, although the significant investment into community mental health did not occur until the end of the twentieth Century [22]. Research [23–26] within Australia and internationally has demonstrated beneficial effects of deinstitutionalisation for the mentally ill population. There have been positive changes in adaptive behaviours, perceived quality of life, improved choice making and reduction of maladaptive coping mechanisms.

18.4 Policy Initiatives and Frameworks

Following the Human Rights and Equal Opportunity Commission (HREOC) inquiry into human rights and mental illness (the Burdekin Report) in the early 1990s finding serious problems in the area of mental health, Federal, State and Territory Governments collaborated to produce the National Mental Health Strategy 1992 [27]. The strategy aimed to

- Promote the mental health of the Australian community;
- Where possible, prevent the development of mental disorder;
- Reduce the impact of mental disorders on individuals, families and the community; and.
- Assure the rights of people with mental disorder.

The1997 report, 'Evaluation of the first National Mental Health Strategy', [28] indicated that the state of mental health services improved from 'being in a poor state' in 1992 to 'raising the awareness of the previously hidden problem areas'. The report emphasised the need for many more improvements. The Australian Government has adopted a series of National Mental Health Plans since, including the last published National Mental Health Plan for 2017 and 2022 (The Fifth National Mental Health Plan). The national direction of mental health reform has been prescribed by this National Mental Health Strategy, which included the National Mental Health Policy, the Mental Health Statement of Rights and

Responsibilities [29] and five National Mental Health Plans. The first National Mental Health Care Plan was introduced in 1992. There have been five national mental health care plans in total. The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) was endorsed by the Coalition of Australian Governments (COAG) Health Council in August 2017.

The National Mental Health Policy 2008 [30] provided a strategic vision for further whole-of-government mental health reform in Australia, with the following four objectives -

- Promote the mental health and well-being of the Australian community and, where possible, prevent the development of mental health problems and mental illness.
- Reduce the impact of mental health problems and mental illness, including the effects of stigma on individuals, families and the community.
- Promote recovery from mental health problems and mental illness.
- Assure the rights of people with mental health problems and mental illness, and enable them to participate meaningfully in society.

18.5 Current and Future Policy Framework

A number of inquiries and strategic documents are likely to shape mental health services of future. The following are some of the key documents.

18.5.1 The Fifth National Mental Health and Suicide Prevention Plan

The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) [31] was endorsed by the Council of Australian Governments (COAG) Health Council in August 2017. The Fifth Plan sets out to achieve outcomes in eight priority areas that align with specific aims and policy directions in the National Mental Health Policy. The eight priority areas of the Fifth Plan are:

1. achieving integrated regional planning and service delivery,
2. effective suicide prevention,
3. coordinating treatment and supports for people with severe and complex mental illness,
4. improving Aboriginal and Torres Strait Islander mental health and suicide prevention,
5. improving the physical health of people living with mental illness and reducing early mortality,
6. reducing stigma and discrimination,
7. making safety and quality central to mental health service delivery,
8. ensuring that the enablers of effective system performance and system improvement are in place.

The National Mental Health Commission (NMHC) is responsible for monitoring and reporting on the implementation of the Fifth National Mental Health and Suicide Prevention Plan. To that effect, the Commission releases annual reports which provide an account of the activities undertaken during the preceding financial year [32]. In 2019, the commission surveyed consumers and carers of mental health services and released a report based on the survey findings [33]. Several key issues were identified by consumers and carers during this survey including the availability and adequacy of services as barriers impacting consumer experiences, as well as issues with access to appropriate support services and the lack of available services during times of need. Issues of availability and cultural appropriateness of services were also reported as barriers by Aboriginal and Torres Strait Islander respondents.

18.5.2 Productivity Commission Inquiry into Mental Health

The Productivity Commission is the Australian Government's independent research and advisory body on a range of economic, social and environ-

mental issues affecting the welfare of Australians. The Commission's role is to help governments make better policies to help the Australian community. Its inquiry into mental health has been described as a 'once in a lifetime' opportunity to reform the mental health system [34]. The scope of the inquiry was broad, covering Australia as a whole, and the roles and responsibilities of different levels of governments. It considered the effect of supporting mental health on economic and social participation, productivity and the Australian economy; how sectors beyond health can contribute to improving mental health; the effectiveness of current programs and initiatives; and whether current investment in mental health is delivering the best outcomes.

The final report was released on 16 November 2020. The package of reforms presented in the Inquiry report cover five broad areas. These are prevention and early intervention, mental healthcare, services beyond the health system, mentally healthy workplaces, and reforms to the overarching system architecture. It reflects many of the recommendations made by the Commission including those for a cross-portfolio and whole-of-government approach to mental health and suicide prevention, priority investment in early intervention and recovery, and clarification of funding arrangements for mental health services.

18.5.3 National Suicide Prevention Adviser Final Advice

In July 2019, then Prime Minister Scott Morrison announced the commitment of the Australian Government to working 'towards zero suicides' and the appointment of the First National Suicide Prevention Adviser, Christine Morgan. Initially an interim advice and more recently a final advice has been released [35]. During the process, consultation included different levels of government and portfolios, organisations working in suicide prevention, researchers, leaders in Aboriginal and Torres Strait Islander suicide prevention, community members and, most importantly, many people who have lived experience of suicide.

Similar to the Productivity Commission's inquiry, the advice calls for a national whole-of-government approach to suicide prevention. Its eight recommendations provide a path for implementing this approach. The advice emphasises that while suicide prevention is generally the responsibility of health departments, the evidence shows that a broader focus is required to ensure that we can address the social and economic drivers of distress, and assist people as early as possible, building social connection and support.

The final advice highlights that suicide prevention would benefit from the involvement of the Prime Minister and premiers to provide this whole-of-government focus. It calls improved data and evidence to inform decision-making. It also emphasises the importance of targeted and coordinated approaches that meet the needs of priority populations.

18.5.4 Vision 2030: Blueprint for Mental Health and Suicide Prevention

Vision 2030 is an aspiration by the National Mental Health Commission of a successful, connected and well-functioning mental health and suicide prevention system that meets the needs of the whole community [36]. It provides a strategic framework through which current recommendations and future strategies and plans can be viewed. It outlines a set of principles including

- Recognition of lived experience knowledge is central to policy, planning and practice and participation.
- Partnership and collaboration across health, other sectors and communities.
- A social and emotional well-being approach.
- A community-based approach.
- Best practice care (education, interventions and supports).
- Equity and equality through a rights-based approach to mental ill-health,
- A recovery-oriented approach.

- Recognition of the importance of intersectionality in the development of mental health policy.
- Flexible solutions.
- Trauma-informed approaches.
- Innovation.

18.5.5 Royal Commission into Victoria's Mental Health System

In February 2019, Premier Daniel Andrews requested the Governor of the State of Victoria to formally establish the Royal Commission into Victoria's Mental Health System as he along with countless people living with mental illness, families, carers and supporters felt that the system was failing to meet their needs and was in fact 'broken'. The Royal Commission has set out an ambitious reform agenda to redesign Victoria's mental health and well-being system [37].

The Royal Commission's report outlines 65 recommendations to transform Victoria's mental health system. Some of the recommendations are foundational and focus on creating new structures to support a sustainable mental health and well-being system. Some concentrate on ensuring that treatment, care and support are available and accessible. Others focus on redesigning services to move from a crisis-driven model to a community-based one that delivers beneficial outcomes for people. Collectively, these reforms go beyond making isolated improvements to the existing system – they represent a complete transformation in the way mental health and well-being treatment, care and support that will be provided in state of Victoria.

18.5.6 Royal Commission into Aged Care Quality and Safety

The Royal Commission into Aged Care Quality and Safety was established on 8 October 2018 to investigate the quality of aged care services currently being delivered to older Australians in the community and in residential aged care facilities [38]. The commission has released its final report titled 'Care, Dignity and Respect'.

The Royal Commissioners has made 148 wide-ranging recommendations and calls for fundamental and systemic aged care reform. One area highlighted was the lack of access to appropriate mental health care for residents in residential aged care facilities. The report recommended the need for strong linkages between aged care service providers and more specialised services to assist older people who need additional services, such as specialist mental health services. The Commission recommends an approach based on the Contributing Life Framework, which provides a whole-of-person, whole-of-system, whole-of-life framework to mental health and well-being.

18.5.7 National Mental Health and Suicide Prevention Plan

In 2021, the Australian Government announced a historic investment of $2.3 billion in the National Mental Health and Suicide Prevention Plan [39]. This was in response to the Productivity Commission's Inquiry into Mental Health and Suicide Prevention Adviser's Final Report. The Budget commitment included creating a landmark national network including up to 57 additional mental health treatment sites as well as more centres for youth and children through the Head to Health and headspace programs. The Plan brings the government's total estimated mental health spend to $6.3 billion in 2021–22. The Plan is based on five key pillars:

1. prevention and early intervention,
2. suicide prevention,
3. treatment,
4. supporting the vulnerable,
5. workforce and governance.

The Plan aspires to transform mental health care in Australia by

- building a digital gateway for Australian dealing with mental health issues;

- ensuring our mental health and suicide prevention system reaches Australians where they work, learn and live;
- enhancing mental health in primary care;
- establishing a network of mental health centres for adults, young people and children through the Head to Health and headspace programs;
- building a system that is efficient, joined up, easy to navigate and people-focused;
- providing appropriate, ongoing follow-up care to every Australian discharged from the hospital after a suicide attempt.

18.6 Structure of Mental Health Service

The Australian Institute of Health and Welfare (AIHW) estimates that spending on mental health-related services in Australia from all sources (government and non-government) was around $9.0 billion, or $373 per person, in 2015–16 and is around 11 billion in 2019–20, which is roughly $431 per person [40]. This equates to 7.6% of government health expenditure. $6.7 billion was spent on state/territory mental health services in 2019–20; $2.9b on public hospital services and $2.6b on community services. $1.4 billion, was spent by the Federal Australian Government on benefits for Medicare-subsidised mental health-specific services and another $566 million was spent on subsidised mental health-related prescriptions under the PBS/RPBS during 2019–20 (Fig. 18.6).

Responsibility for funding and regulating mental health services in Australia is shared between the Australian and state and territory governments [41]. Below is a broad outline of government responsibility for mental health services in Australia.

18.6.1 Federal Australian Government

- Medicare-subsidised mental health services provided by general practitioners (GPs), psychiatrists, and allied health professionals through the Better Access initiative.

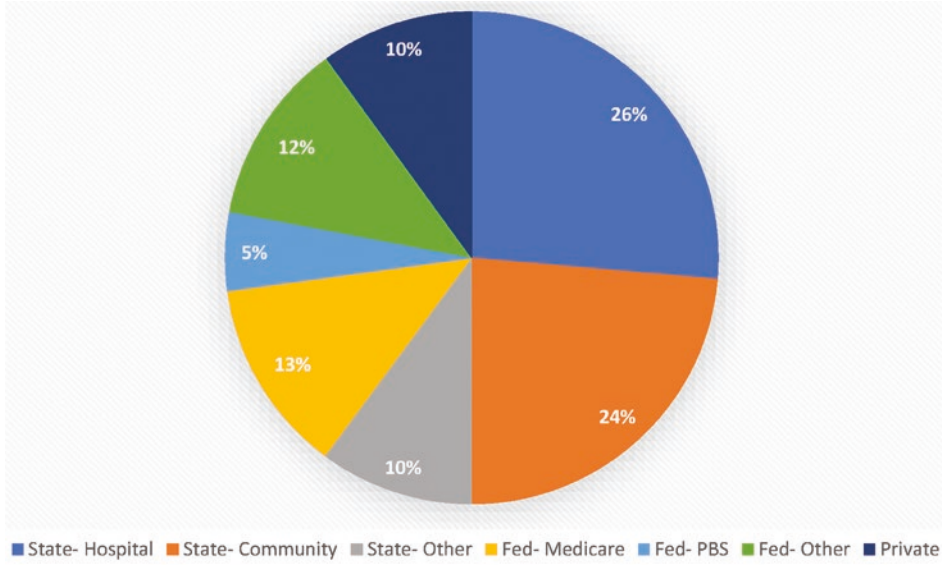

Fig. 18.6 Mental Health Expenditure (AIHW, 2019–20)

- Subsidised mental health prescription medications under the PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS).
- Veterans' mental health services through the Department of Veterans' Affairs.
- Primary care through Primary Health Networks (PHNS).
- Social security payments such as the Disability Support Pension.

18.6.2 State and Territory Governments

- Public hospitals including specialised psychiatric units and Emergency Departments.
- Funding and management of community mental health services including residential units.

18.6.3 Shared Responsibility

- Funding of public hospital services based on an agreed national activity-based funding (ABF) formula as outlined in the National Health Reform Agreement.
- Registration and accreditation of mental health professionals through the Australian Health Practitioner Regulation Agency (AHPRA).
- The National Disability Insurance Scheme.
- Homelessness.
- Suicide prevention.

In addition to these, there are a range of crisis, support and information services. These services are funded by both levels of governments. The following are some of the major crisis services available.

- Head to Health – An online and hotline service to assist individuals struggling with mental health issues.
- At Ease – This organisation helps veterans and families of veterans.
- Beyond Blue – This organisation supports individuals struggling with a wide range of mental health issues.
- Headspace – Headspace targets adolescents and young adults between 12 and 25 years of age with issues surrounding mental health. Headspace focusses on early intervention.
- KidsMatter – This organisation focuses on preventing problems and supporting children's mental health.
- LifeLine Australia – They run a suicide prevention hotline and are a registered charity.
- Health Direct – This is an online portal providing information about Australia's health services and general information about illnesses.
- OzHelp Foundation – It is an organisation that supports industry and workplaces focussing on supporting employees to prevent the development of mental illness.

18.6.4 Private Sector

Private sector services include admitted patient care in a private psychiatric hospital and private services provided by psychiatrists, psychologists and other allied health professionals. In 2019–20, there were 161 public hospitals and 68 private hospitals [40]. Private practice psychiatry is considerably different from public practice psychiatry in many ways. Private psychiatrists rely only on income from seeing patients. In Australia, there is a subsidy from the government through Medicare, but it is usual to charge a co-payment (gap) on top of this. Sometimes patients are seen where a third party assumes responsibility for payment, such as the Department of Veteran Affairs (DVA) or WorkCover.

The types of patients seen in private psychiatry differ considerably in Private Psychiatry. One tends to see high prevalence disorders such as Major Depression, Persistent Depressive Disorder and all the anxiety disorders more than low prevalence, severe disorder such as severe depression, mania, schizophrenia and severe drug dependence [42].

Private health insurers fund treatment costs in private hospitals and sometimes in public hospitals. Despite this, the patients are expected to pick up costs for the initial excess (out-of-pocket)

as well as doctors fees, procedural fees and medication costs, if any. The case mix within private hospitals in different, because of the voluntary nature of the patient population. While a typical public hospital is likely to be full of patients with Schizophrenia, mania, severe depression or severe personality disorders, the main diagnoses within private in-patients are major affective and other mood disorders (49%), and alcohol and other substance abuse disorders (21%) [43].

18.7 Pertinent Issues for Medical Administrators

Mental illnesses are chronic and debilitating. There are a number of issues that impact people with mental illness, which in turn makes their recovery difficult.

18.7.1 Psychological Distress

Psychological distress is unpleasant feelings or emotions that affect a person's level of functioning and interfere with activities of daily living. The presence of psychological distress or impact on socio-occupational functioning is one of the criteria for diagnosing mental illness. The Australian Bureau of Statistics (ABS) measures psychological distress using the Kessler 10 (K10) psychological distress scale measuring non-specific psychological distress based on questions about negative emotional states experienced in the past 30 days. This distress has been increasing over time. In 2017–18, 13% or 2.4 million Australians aged 18 and over experienced high or very high levels of psychological distress, which is higher compared to 2014–15 (12% or 2.1 million Australians). In 2020–21 the Australian Bureau of Statistics conducted the first cohort of the National Study of Mental Health and Wellbeing (NSMHW), a component of the wider Intergenerational Health and Mental Health Study. First insights from the study [44] were published late 2021, which reveals that 15% of Australians are experiencing moderate or severe personal distress (Fig. 18.7).

18.7.2 Co-morbidity

Co-morbidity refers to the occurrence of more than one condition/disorder at the same time [45]. Such co-morbidity is common among those with mental illness and causes more disability.

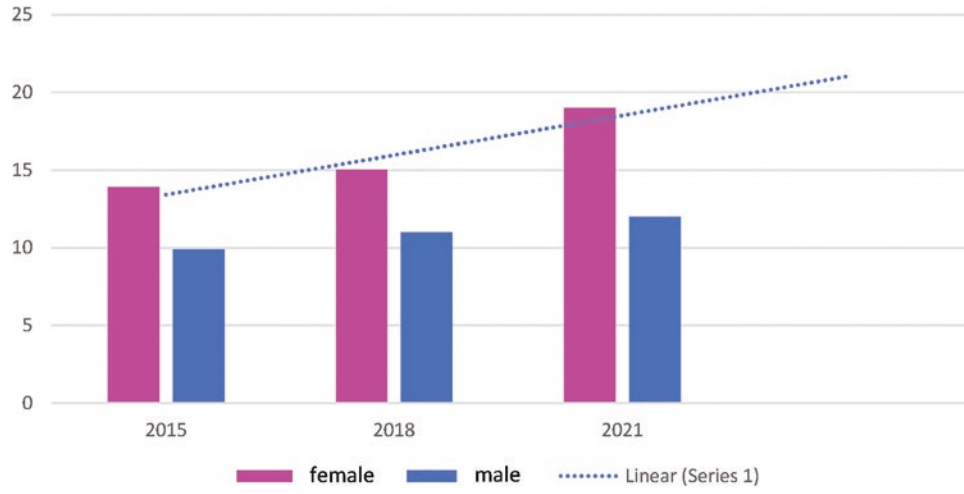

Fig. 18.7 Personal Distress between sex (NSMHW, 2015, 18 and, 2021)

Such individuals are more likely to consume resources than those with one disorder. The co-morbidity can involve the presence of two or more mental disorders or a physical disorder along with a mental disorder.

Psychiatric co-morbidity refers to the presence of two or more psychiatric disorders. Differentiating psychiatric disorders is not always easy. For example, a person with depression who also meets the criteria for alcohol abuse could be seen as self-medicating instead of suffering from two disorders. In the Early Developmental Stages of Psychopathology Study, 48.6% of patients with a diagnosis of major depression also had at least one anxiety disorder. Just over one-third (34.8%) had no other mental disorder [46].

AIHW released a report on co-morbidity between mental disorders and physical conditions based on the National Survey of Mental Health and Wellbeing 2007 [47]. The 2007 survey reported that people with anxiety have the highest level of physical co-morbidity. According to the survey, nearly 1.4 million Australians have anxiety and a physical health condition. The survey also found that people with mental illness and physical co-morbidity had a higher rate of hospitalisation, healthcare needs and are more likely from low socio-economic status. The co-morbidity also affected their quality of life. These people rated their personal distress ten times higher than those without the co-morbidities. People with a mental disorder and physical health conditions were also more likely to be out of work.

High mortality among people with mental illness is also related to physical health conditions [48]. Nearly 80% of people with serious mental illness who die before the average life expectancy of 79.5 years for men and 84 years for women do so due to physical health conditions, losing anywhere between 10 and 36 years of expected life. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) and Australian Health Policy Collaboration at Victoria University commissioned a report to determine the cost to the economy due to co-morbidity [49]. This report estimates that the annual cost of premature death from comorbid mental and physical health conditions in people with serious mental illness is $15 billion (AUD) in Australia and $3.1 billion (NZD) in New Zealand. When the burden of substance abuse is included, these costs increase sharply to $45.4 billion and $6.2 billion, respectively.

18.7.3 Mentally Ill in General Hospital

Mental illnesses are much more common in general hospitals than in the general community, with the prevalence of patients with mental health symptoms making up between 60% and 70% of the total hospitalised population [50]. Length of stay is longer, and mortality is worse for patients with mental health problems than those without. Most of such patients would typically receive their mental health care through Consultation-Liaison (CL) Psychiatry services. These services offer ‘consultation’ and ‘liaison’. The consultation component is a process whereby attending physicians, surgeons, other staff, patients themselves or family members may request mental health services, and a clinical team member responds to this request by conducting an initial assessment, arriving at a clinical diagnostic impression, facilitating interventions as needed and making appropriate referrals if warranted. The liaison component refers to collaborative working with non-psychiatric clinicians and requires a certain degree of integration at not only the service level (i.e., multidisciplinary teams) but at the organisational level as well [51].

Mentally ill patients constitute about four percent of general medical and surgical wards but often require more resources in terms of staffing hours and medications. Caring for mentally ill patients with physical ailments can also have an emotional impact on the caring nurses and other staff [52]. A qualitative analysis was completed by Foye, Simpson and Reynolds [53] during a service evaluation of general medical hospitals in the UK, identified a significant care gap between medical and mental health patients, identifying a

number of systemic factors surrounding the institutional culture, ward cultures and collaborative working, and individuals sensemaking of mental health and personal well-being.

Thus, it is important for medical administrators and the rest of the hospital management to provide clear leadership around pathways for mental health needs so staff know the best way to provide care and encourage collaborative working. Furthermore, staff support is also needed to assist them personally manage their own well-being and mental health, including supervision to improve understanding from the patient's perspective and to provide emotional support to manage difficulties.

18.7.4 Emergency Departments and Mentally Ill

Hospital emergency departments (EDs) play an important role often as an initial point of contact or for after-hours care. A report by the Australian Institute of Health and Welfare released in 2020 [54] confirms that 3.8 percent of all presentations are for mental health reasons, with drug-related presentations being the most common (28%). Other three common mental health presentations included stress related (27%), Schizophrenia (12%) and mood disorders (9.7%). Despite low numbers, mentally ill population often have very long ED lengths of stay. For all ED presentations, 90 per cent of people left the ED within seven hours, while for people presenting with acute mental health crises, this figure was 11.5 h [55]. The Australian College of Emergency Medicine (ACEM) had an Australian Summit on Mental Health Care in the Emergency Department in October 2018 which was attended by over 170 delegates. Following the summit, ACEM commissioned the Mitchell Institute for Education and Health Policy to conduct an analysis from an emergency department perspective of why Australia's health system is failing to meet the urgent needs of people presenting to emergency departments for mental health care. The report is titled 'Nowhere Else to Go Report' [56]. The report identifies a lack of alternate and more appropriate mental healthcare options, particularly out-of-hours. It advocates for wider system responses including additional community support to avoid the types of crises that precipitate a visit to the emergency department, as well as more timely treatment options to minimise the time that people seeking mental health care wait in the emergency department.

The issue of long wait times within ED requires a multi-prong approach focussing on different strategies including, but not restricted to [57]

- Telepsychiatry Services – to improve access to psychiatric services.
- Psychiatric Observation Units and Treatment Protocols – Specific psychiatric emergency department, and/or observation units are utilized to pull psychiatric patients out of the general ED once they are stabilized.
- Patient Navigation–Community organisations or paramedics can assist patients in navigating the often-cumbersome health-care environment and take them directly to psychiatric hospitals.
- Mobile Crisis Units – Teams of multidisciplinary mental health professionals that respond to individuals in the community requiring assistance with a psychiatric crisis. The team can provide a range of services that can include assessment, crisis intervention, information, referrals, and supportive counselling.
- Regional Health Registries – A streamlined state or regional dashboard showing bed availability coupled with available transfer mechanisms are helpful in reducing the time and effort it takes to get patients to definitive care.
- Protocols for Safe Discharge – Evidence-based decision tools can be helpful in allowing an emergency physician to safely discharge a patient with a mental health disorder.
- Ambulance and mental health clinician co-responder models – where mental health clini-

cians are co-located with ambulance officers and see people in mental health crisis in their home for assessment to manage the crisis safely if it is safe to do so.
- Safe space hubs – located near emergency departments as an alternative for emergency department presentation either prior or after for people in psychological distress as a peer-led service.

18.7.5 Common Terms Used in Mental Health Services

In contemporary, recovery-oriented mental health services, the term 'patient' is no longer used. Many people prefer the term 'consumer', which implies the centrality of the consumer within the services. Social and emotional well-being is also used to outline mental health [58]. The term reflects the fact that people accessing health care services may experience mental health issues in the absence of a diagnosed mental illness.

'Recovery' is understood to be more than simply reduction in clinical symptoms, and as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues' [59]. Recovery-oriented mental health practice refers to the application of sets of capabilities that support people to recognise and take responsibility for their own recovery and well-being and to define their goals, wishes and aspirations [58]. Such a practice will offer evidence-informed treatment, work in partnership with consumer organisations and ensure the development of new models of peer-run programs and services.

Trauma-informed care is another commonly used term within mental health services. Trauma informed care refers to an organisational and practice approach to delivering health services directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and its prevalence in society. It is a strengths-based framework that emphasises physical, psychological and emotional safety for people who have experienced trauma, their families and carers, and service providers [60].

18.7.6 Mental Health Issues Within Aboriginal Population

Mental health issues within Aboriginal population are often referred to as 'social and emotional wellbeing', which has been defined as 'a multidimensional concept of health that includes mental health, but which also encompasses domains of health and well-being such as connection to land or 'country', culture, spirituality, ancestry, family and community' [61]. A 2020 report into indigenous health [62] found that Aboriginal people experience depression (52%) and anxiety (59%) at much higher levels than non-Aboriginal Australians (32% and 47%). In 2018–19, 31% of Aboriginal people and 23% of Torres Strait Islanders over 18 years reported high or very high levels of psychological distress.

A report titled 'Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice' [58] outlines the historical, social, cultural, and policy contexts that have shaped Aboriginal mental health and well-being. This context includes, but is not restricted to

- Stolen generations – The impact of the past Stolen Generations and ongoing removal of children puts a lot of mental pressure on people.
- Underlying, unresolved trauma – Trauma is a significant factor in aboriginal health and if unresolved can lead to several psychiatric conditions.
- Perceived loss of identity and culture – Separation from their culture and identity gives rise to feelings of incompleteness.
- *Grief and loss* – **A**bout the loss of culture, land, connection, and many more areas, often connected to the history of invasion.
- *Discrimination and racism*. Discrimination based on race or culture, as well as racism, can have a significant impact on any person's mental health.
- *Socio- economic disadvantaged status*.
- *Poor physical health* – Physical health problems contribute to the feeling of inadequacy and exclusion.

- *Incarceration* – Being imprisoned has a profound effect on people's mental health.
- *Culturally inappropriate treatment* – Especially the health area is prone to assess Aboriginal people with non-Aboriginal criteria, or expose them to culturally insensitive environments.
- *Violence* – Domestic violence, as well as violence in prisons, for example, contributes to poor mental health.
- *Substance abuse* – Use of substances to deal with unresolved psychological issues can lead to other mental health issues.

The Australian Government has launched an Aboriginal and Torres Strait Islander mental health program [63], which funds Primary Health Networks to engage culturally appropriate mental health services for Aboriginal and Torres Strait Islander people. Such localised services can include psychological therapies, complex mental health support, case management or clinical care coordination.

Dedicated services specifically to support Aboriginal and Torres Strait Islander people include [64]:

- Eheadspace – which provides free online and telephone support and counselling to young people 12–25 and their families and friends, including fortnightly yarn circles.
- The National Aboriginal Community Controlled Health Organisation – is the national leadership body for Aboriginal and Torres Strait Islander health in Australia.
- WellMob – This organisation brings together online resources made by and for our mob.
- The Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP) – is Australia's leading authority on Indigenous suicide. The Centre promotes evidence-based suicide prevention practice that empowers individuals, families, and communities and respects their culture.
- 13Yarn – is a free support line with free, confidential crisis support 24/7 run by Aboriginal and Torres Strait Islander people.

18.7.7 Homelessness and Mental Health

In Australia, the 2014 General Social Survey (GSS) examined the relationship between mental health and homelessness [65]. The survey showed that 2.5 million Australians (13%) aged 15 years and over reported experiencing homelessness at some point in their lives. People who reported having a mental health condition were more than twice as likely to have experienced homelessness in their lifetime compared with people who did not (25% compared with 10%). People who reported a mental health condition were also more than twice as likely to have experienced homelessness in the last 10 years compared with people who did not (15% compared with 6.1%). People with mental disorders who are homeless also experience wide-ranging and compounded disadvantage issues such as poor education, poor general health, extremely low income and experience high imprisonment rates and social exclusion [66].

Given the fundamental nature of safety, stability and security of home for optimal mental health, National Mental Health Commission has been working towards the issue of housing, homelessness and Mental Health. In 2017, a national consultation on housing issues in relation to mental health was undertaken. This resulted in a comprehensive report by the Australian Housing and Urban Research Institute (AHURI), which was published in 2019 titled Housing, homelessness and mental health: towards systems change [67]. This report identifies housing, homelessness and mental health as being interlinked but receiving fragmented care. It also identified lack of affordable, safe and appropriate housing or discharge planning for people with lived experience of mental ill health. The report produced sixteen options to scale up successful models of consumer and recovery-oriented housing, stabilise existing tenancies, reshape state and federal policies to more effectively address housing insecurity for people with lived experience of mental illness and prevent failed discharge planning.

In 2020–21, the Australian Federal Government decided to spend $8.4 billion in housing support and homelessness services as part of the National Housing and Homelessness Agreement [68]. This included $5.5 billion in Commonwealth Rent Assistance and $1.6 billion through the National Housing and Homelessness Agreement (NHHA). The Australian Government has also committed up to $118 million over 5 years to 30 June 2023 for the Reconnect program, which assists young people who are homeless, or at risk of homelessness and another $78 million to ensure there are additional safe places for women and children. Specialist Homelessness Services are agencies that receive funding to provide specialist homelessness services under the National Housing and Homelessness Agreement (NHHA) [69]. Australian populations known to be at particular risk of homelessness include those who have experienced family and domestic violence, young people, children on care and protection orders, Indigenous Australians, people leaving health or social care arrangements, and Australians aged 55 or older.

18.7.8 Mental Health and Suicide

During 2020, 3139 people died by suicide and suicide was the 15th leading cause of death [70]. Young and middle-aged people, particularly males, are more likely to die by suicide than those in older age cohorts. In 2020, suicide was the leading cause of death for 15–44-year-olds and was the leading cause of premature mortality due to high likelihood in younger population.

Suicide is often seen as related to mental illnesses, while the causes of suicide are multiple and complex. It includes stressful life events, trauma, mental illness, physical illness, drug or alcohol abuse and poor living circumstances [71]. In some countries, such as Switzerland, assisted suicide is allowed in severe medical illness.

As mentioned above, the Australian Government announced the National Mental Health and Suicide Prevention Plan in 2021, which focusses on reducing suicides across the country. Under this plan, National Suicide Prevention Strategy [72] has been adopted. This strategy focusses on adopting a whole-of-community approach to suicide prevention in order to extend and enhance public understanding of suicide and its causes. It also aims to increasing support and care to people, families and communities affected by suicide or suicidal behaviour by funding and evaluating initiatives that enhance or inform the establishment of better support systems. National Aboriginal and Torres Strait Islander suicide prevention strategy [73] addresses the high rates of suicide among Aboriginal and Torres Strait Islander people. This strategy outlines six action areas including improving resilience within communities and individuals, targeted suicide prevention strategies as well as co-ordinated, evidence-based approach to suicide prevention.

As part of the ongoing efforts to address suicide, Australian Government commissioned a Suicide Prevention Trial, which occurred between 2017 and 2020 and was conducted by the University of Melbourne. During this trial, twelve Primary Health Networks (PHNs) were funded to develop and implement a systems-based approach to suicide prevention at a local level for at-risk populations. A final evaluation report of this trial [74] has been released in 2021, which contains several recommendations. The report advocates for using systems-based suicide prevention frameworks, adopting a broader system-wide approach beyond health and mental health, community involvement and promoting coordination and integration at the service level and system level as critical to the success of some of the projects.

18.7.9 Impact of COVID-19 on Mental Health

During the initial 2 years of the COVID-19 Pandemic, there were significant impacts on mental health in Australia. Widespread restrictions of movement, social distancing measures and physical isolation, or ‘lockdowns’, were implemented from March 2020. This along with the sudden loss of employment and social inter-

action, the added stressors of moving to remote work or schooling, and sudden, localised 'lockdowns' to prevent further outbreaks, impacted the mental health of many Australians [75]. Therefore, during most of 2020 and 2021 we witnessed heightened psychological distress during the pandemic.

Australians used an increased number of mental health services during this period. A wide range of additions to the Medicare Benefits Schedule (MBS) to support the provision of health care via telehealth (telephone and videoconference) were introduced. In August 2020, the Better Access initiative was expanded to provide 10 additional MBS individual psychology sessions for people affected by the pandemic. In the 4 weeks to 19 September 2021, 1,215,475 MBS mental health-related services were processed, 7.1% and 21.8% higher than the same periods in 2020 and 2019, respectively [76]. Crisis services also received historically high number of calls. In the 4 weeks to 19 September 2021, Lifeline saw several historical record high daily call volumes, and 96,273 calls were offered in total, up 14.1% and 33.1% from the same periods in 2020 and 2019, respectively; Kids Helpline received 32,572 answerable contact attempts, up 4.6% and 16.7% from the same periods in 2020 and 2019 respectively and Beyond Blue received 27,099 contacts, down 2.7% and up 20.9% from the same periods in 2020 and 2019 respectively.

In addition to the expansion of Medicare and better access scheme, Head to Health Pop-Up services have been established to provide free mental health support to people of all ages living in New South Wales, Victoria and the Australian Capital Territory who are experiencing mental health issues because of the COVID-19 pandemic [77]. In December 2020, the Melbourne Institute released the report 'Coping with COVID-19: rethinking Australia' [78], which found that rates of mental distress had a similar pattern to financial stress over the course of the pandemic. The rate of mental distress in November 2020 (24%) was slightly higher than in April 2020 (22%), and over double the rate of mental distress in the Australian community prior to the pandemic (10%). It is envisaged that with the life returning to 'normal' the specific impacts of COVID-19 on mental health will also return to its previous levels.

18.8 Mental Health Workforce

The mental health workforce and its challenges are noteworthy. On the ground experience shows significant workforce shortage across all disciplines and sectors within Mental Health Services. When compared with other countries, Australia's mental health workforce superficially seems satisfactory. Data published by the World Health Organisation in 2019 about the number of psychiatrists and mental health nurses per 100,000 population between 2014 and 2016 [79] shows that Australia employs 13.5 psychiatrists and 90.6 nurses. There are countries such as Switzerland, who employs 44 psychiatrists for the same population and Turkey, which employs 150 nurses for the same population.

The mental health workforce consists of psychiatrists, psychiatrists in training (also known as psychiatry registrars) or junior medical officers, nurses, social workers, occupational therapists, psychologists, vocationally trained mental health workers (such as community support workers and recovery support workers) and consumer and carer workers. While working with people from a range of professional backgrounds is a positive aspect of employment in mental health, providing care, support and treatment to people who may sometimes have severe behavioural disturbance and related safety issues can be challenging. The work can be stressful and can test the capabilities, resources or needs of workers [80].

The University of Queensland conducted a literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries commissioned by the Australian Government [81]. The literature review identified six key workforce challenges for mental health services: (1) Defining the mental health workforce; (2) Responding to diverse and changing population needs; (3) Mental health workforce shortages; (4) Rural and remote ser-

vice provision; (5) Developing responsive and flexible mental health workforce and (6) Measuring progress.

The need for a sustainable, skilled and appropriate workforce as being fundamental to the success of the mental health strategy has been long recognised. The Fourth National Mental Health Plan, which was developed in 2009 contained a specific action to support the development of a national mental health workforce strategy. The National Mental Health Workforce Strategy developed in 2011 [82] outlines five priority areas which include –

1. Developing, supporting and securing the current workforce,
2. Building capacity for workforce innovation and reform,
3. Building the supply of the mental health workforce,
4. Building the capacity of the general health and well-being workforce, and.
5. Data and monitoring and evaluation.

Among the recent developments, it is important to note that both The Productivity Commission [34] and National Suicide Prevention Adviser [35] recommended addressing workforce shortages, development and capability to enable the delivery of compassionate care. The National Mental Health and Suicide Prevention Plan 2021 [39] has outlined 'workforce and governance' as an important pillar for mental health and suicide prevention in the country. Accordingly, Australian Government is committed to investing $202 million dollars towards addressing workforce and governance issues. Key workforce areas targeted in this plan include: growing and upskilling the mental health and suicide prevention workforce, supporting the mental health of our critical health workers, putting the needs of people at the centre of design and delivery of mental health services in Australia and stronger governance and accountability.

A National Mental Health Workforce Strategy Taskforce [83] was established in 2020 to oversee the development of a ten-year National Mental Health Workforce Strategy. The taskforce developed a National Mental Health Workforce Strategy – Consultation Draft [84], which was available for public consultation late 2021. This draft aspired to 'develop an appropriately skilled mental health workforce of sufficient size that is suitably deployed to help Australians be mentally well by meeting their support and treatment requirements at the time and in the way that best meets their needs'. This paper outlined six objective area including ensuring that the careers in mental health are, and are recognised as, attractive and that data underpins workforce planning. Other objectives include ensuring that the entire mental health workforce is utilised, that the mental health workforce is appropriately skilled, the mental health workforce is retained in the sector and the mental health workforce is distributed to deliver support and treatment when and where consumers need it.

Consultation was provided by important organisations such as RANZCP [85], Beyond Blue [86] and National Aboriginal Community Controlled Health Organisation [86], which emphasised on a holistic approach centred around social and emotional well-being combining the clinical, non-clinical, and cultural aspects of health to treat the individual, not just the diagnosed health condition. Other feedback included Australian Nursing and Midwifery Federation [87], Mental Health Co-ordinating Council [88] and Volunteering Australia [89].

While the mental health workforce strategy is being developed, A National medical Workforce Strategy 2021–31 [90] was released in late 2021. The strategy aims to address medical workforce issues by exploring actions that fall under the 5 key priorities:

- collaborating on medical workforce planning and design,
- rebalancing the supply and distribution of doctors across specialties and locations,
- reforming medical training pathways,
- building the generalist capability of the medical workforce,
- building a flexible and responsive medical workforce.

18.9 Activity-Based Funding (ABF) for Mental Health Services

The National Health Reform Agreement 2011 [91] led to increased partnership between federal and state governments via the Council of Australian Governments to improve health outcomes for all Australians by establishing an increasing federal proportion of reimbursement to local health districts or local hospital networks by casemix or activity-based funding. The Independent Hospital Pricing Authority's (IHPA) is a body that was established in 2011 to enable activity-based funding for Australian public hospital services [92]. IHPA does this by delivering an annual national efficient price and national efficient cost. These measures determine the level of Commonwealth Government funding for public hospital services and provide a price benchmark for the efficient cost of providing public hospital services. To put it simply, activity-based funding (ABF) is a way of funding hospitals or services whereby they get paid for the number and mix of patients they treat. IHPA updates the pricing framework annually to ensure that the national efficient price and national efficient cost is up to date and current. To achieve this, IHPA classifies patients using classification systems. Classification systems aim to provide the healthcare sector with a nationally consistent method of classifying all types of patients, their treatment and associated costs in order to provide better management, measurement and funding of high-quality and efficient health-care services [93].

For mental health services, IHPA developed a classification system called 'Australian Mental Health Care Classification (AMHCC)' [94]. It covers admitted and community patients and uses six major splitting variables as outlined below.

1. Setting – Inpatient or community.
2. Mental health phase of care – This is the goal of the care and decided clinically. There are five phases of care: assessment only, acute, functional gain, intensive extended and consolidating gain. The classification also provides for 'unknown phase'.
3. Age group – child and adolescents (0–17 years), adults (18–64 years), and older persons (65+ years).
4. Mental health legal status – voluntary or involuntary. Only applies to admitted setting with acute phase for 18–64 years age group.
5. HoNOS complexity – The HoNOS (Health of the Nation Outcome Scales) is a clinical outcome measure that captures the symptoms and functioning of the consumer.
6. LSP-16 complexity – The Life Skills Profile (LSP-16) is a clinical outcome measure that assesses the level of functioning of mental health consumers living in the community.

The Activity-Based Funding Mental Health Care National Best Endeavours Data Set (ABF MHC NBEDS) defines information about consumers receiving mental health care within the activity-based funding scope [95]. The ABF MHC NBEDS 2020–21 contains data elements that are required to be reported for all settings of mental health care and all age groups. These data elements include:

- Organisation/service identifiers.
- Person identifiers.
- Date of birth.
- Sex.
- Marital status.
- Indigenous status.
- Country of birth.
- Area of usual residence.
- Episode start and end date.
- Episode start and end mode.
- Mental health phase of care – start and end date.
- Mental health phase of care.
- Mental health phase of care leave days.
- Service provider setting origin.
- Principal diagnosis.
- Additional diagnoses.

The data elements which describe consumer functioning and symptom severity include:

- Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA).

- Health of the Nation Outcome Scales (HoNOS).
- Health of the Nation Outcome Scales for Older Persons (HoNOS 65+).
- Children's Global Assessment Score (CGAS).
- Factors Influencing Health Status (FIHS).
- Abbreviated Life Skills Profile (LSP-16).
- Resource Utilisation Groups – Activities of Daily Living (RUG-ADL).

The ABF model for Mental Health Care has received varying perception. Mental Health Commission, New South Wales undertook a review of transparency and accountability of mental health funding to health services in 2017 [96]. The commission expressed concerns over challenges with data quality in mental health, especially for non-admitted and other community-based services and paucity of mental health KPIs in the Ministry's Service Agreements with health services. There are ongoing issues around funding of consultation-liaison services and data collection.

18.10 Mental Health Legislation

Mental Health Acts (MHAs) enable the involuntary commitment and treatment of people suffering acute psychiatric illness. There are different Mental Health Legislations in force across all the jurisdictions within Australia and New Zealand (Table 18.1).

Table 18.1 Mental Health Legislations across Australia and New Zealand

Location	Legislation
New South Wales	Mental Health Act 2007 (NSW) [97]
Victoria	Mental Health Act 2014 (Vic) [98]
Queensland	Mental Health Act 2016 (Qld) [99]
Western Australia	Mental Health Act 2014 (WA) [100]
Tasmania	Mental Health Act 2013 (Tas) [101]
South Australia	Mental Health Act 2009 (SA) [102]
ACT	Mental Health Act 2015 (ACT) [103]
Northern Territory	Mental Health and Related Services Act 1998 (NT) [104]
New Zealand	Mental Health (Compulsory Assessment and Treatment) Act 1992 (NZ) [105]

18.10.1 Involuntary Treatment

Each act is slightly different in terms of the criteria that must be apparent before involuntary commitment and treatment can be authorised. The following table is a simplified attempt to compare the acts, while ensuring that the essential criteria are mentioned (Table 18.2).

18.10.2 Capacity to Consent

All mental health acts require that clinicians presume that a person has capacity to give or withhold informed consent to treatment. A clinician must seek the informed consent of the person before administering treatment for a mental illness. A person is presumed to have capacity to consent to be treated they are capable to understand [106]:

- that they have a mental illness which is affecting their mental health and well-being,
- the nature and purpose of the proposed treatment for the illness,
- the benefits and risks of the treatment and alternatives,
- the consequences of not receiving treatment, and,
- the person is capable of making a decision and communicating it in some way.

The clinician should provide support to the individual towards decision-making and should be aware that capacity can fluctuate over time. This means that a cross-sectional assessment of capacity is not always reflective of the person's capacity to consent. The clinician should also be aware that a lack of capacity cannot be concluded based on the person's refusal to consent, despite possessing the capacity to consent.

18.10.3 Less Restrictive Ways

All of the mental health acts do prescribe a requirement to exclude all possible less restrictive forms of treatments prior to administering

Table 18.2 Comparison of Mental Health Legislations across Australia and New Zealand

Criteria	NSW	Vic	QLD	Tas	SA	WA	ACT	NT	NZ
Legislation	MHA 07	MHA 14	MHA 16	MHA 13	MHA 09	MHA 14	MHA 15	MHRSA 98	MHA 92
Mental illness Person is suffering from mental illness	✓	✓	✓	✓	✓	✓	✓	✓	✓
Risk As a result of the illness, there is serious risks to health and/or personal or public safety.	✓	✓	✓	✓	✓	✓	✓	✓	✓
Risk of further deterioration (physical or mental)	×	✓	✓	✓	✓	✓	✓	✓	✓
Treatment The provision of treatment for that illness	×	✓	×	✓	×	✓	✓	✓	✓
No less restrictive option of providing that treatment available	✓	✓	✓	✓	✓	✓	✓	✓	✓
Additional criteria	Continuing mental condition and likely deterioration should be considered.	×	No capacity to consent.	The treatment will alleviate symptoms and person lacks capacity	Consideration be given to voluntary treatment option	Person lacks capacity and the decisions are made according to guidelines by chief psychiatrist	The person should be lacking capacity and refusing treatment	The person lack capacity or has unreasonably refused care	×

involuntary treatment. Such less restrictive ways include [106]:

- Voluntary treatment.
- In case of a minor consent can be obtained from their parents.
- If the person has made an advance health directive – under the advance health directive,
- If a personal guardian or an attorney has been appointed for the person – with the consent of the personal guardian or the attorney.
- The person's statutory health attorney can also provide consent.

18.10.4 Electroconvulsive Treatment (ECT)

ECT can be seen as one of the most invasive procedures in psychiatry and involves application of modified electric current to specific areas of the head to produce a generalised tonic-clonic seizures under general anaesthesia, in conjunction with the administration of a muscle relaxing agent, for the treatment of a mental illness.

It is always desirable to administer ECT with the patient's informed consent. However, if such a consent cannot be obtained, ECT can also be administered under the provisions of a Mental Health Act. The requirements are fairly similar across the states and territories [107]. In order to administer ECT under the Mental Health Act, initial application is ought to be completed by a psychiatrist, preferably with input from another psychiatrist. In some states (e.g. NSW), two psychiatrists are required to make the application. In Western Australia and in New Zealand, the applicant not need to be a psychiatrist. The psychiatrist must be satisfied that the person meets all the essential criteria, which includes

- The person has a mental illness.
- ECT is the most clinically appropriate treatment.
- Other alternative for the treatment been considered.
- Patient/family preferences been considered.
- Given the degree of suffering there is a need for rapid response.

With the exception of Australian Capital Territory (where ACT Civil and Administrative Appeal Tribunal), a Mental Health Review Tribunal makes a decision about the feasibility of ECT.

The tribunal considers the following factors before giving approval [108]:

- the performance of the therapy is in the person's best interests,
- evidence supports the effectiveness of the therapy for the person's particular mental illness,
- if the therapy has previously been performed on the person – the effectiveness of the therapy for the person,
- if the person is a minor, evidence supports the effectiveness of the therapy for persons of the minor's age.

18.10.5 Emergency ECT

A medical administrator is required to be aware of this provision. Under certain circumstances, Emergency ECT can be administered, if there is a need to save the patient's life or prevent the patient from suffering irreparable harm [109]. A psychiatrist makes the application to the Medical Administrator of the hospital. The medical administrator should ensure that a simultaneous application to Mental Health Review Tribunal has also been made and the patient meets criteria outlined in their own jurisdiction (Table 18.3).

18.10.6 Seclusion

The Queensland Mental Health Act (2016) [110] defines seclusion as 'the confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented'. Seclusion significantly affects patient rights and liberty and therefore can only be authorised as a last resort to prevent imminent and serious risk of harm to

Table 18.3 Emergency ECT provisions across Australia and New Zealand

Jurisdiction	Emergency ECT criteria
New South Wales	No specific criteria mentioned
Victoria	ECT is needed to save the life of the patient or prevent serious damage to health or prevent the patient suffering or continuing to suffer significant pain or distress
Queensland	• Need to save the patient's life or prevent the patient from suffering irreparable harm • A second opinion should be sought from another psychiatrist
Western Australia	• ECT needed to save life or because there is an imminent risk of the patient behaving in a way that is likely to result in serious physical injury to the patient or another person • Approved premises (to administer ECT) required
South Australia	ECT urgently needed for the patient's wellbeing, and in the circumstances, it is not practicable to obtain that consent Notify the chief Psychiatrist within one business day afterwards
Tasmania	No specific criteria mentioned
Australian Capital Territory	• The person has a mental illness • ECT is necessary to save the person's life, or to prevent the likely onset of a risk to the person's life within 3 days • ECT is the most appropriate treatment, reasonably available or all other • Treatments reasonably available have failed
Northern Territory	• ECT immediately necessary to save life, prevent serious mental or physical deterioration, or to relieve severe distress • Report ECT to MHRT as soon as practicable afterwards
New Zealand	No specific criteria mentioned

patients and staff, where less restrictive interventions have been unsuccessful or are not feasible. A doctor trained in Mental Health Act (authorised doctor, usually a psychiatry registrar) is required to commence a period of seclusion. However, under emergency circumstances, a health practitioner in charge of a unit (usually the in-charge nurse) can initiate an emergency authorisation of seclusion of a patient for a short period of time, if the authorised doctor is not immediately available and there is no other reasonably practicable way to protect the patient or others from physical harm.

The Australian Institute of Health and Welfare [111] reports 8.1 seclusion events per 1000 bed days for acute specialised mental health hospital services in 2019–20, down from 13.9 in 2009–10. The average duration of seclusion in 2019–20 was 4.9 hours. Seclusion is generally used with the aim of preventing injury and reducing agitation, but evidence shows that their use can also have negative physical and psychological effects on both the individual and staff [112]. It is important to minimise, and where possible eliminate, the use of seclusion, which requires leadership, commitment and motivation, and a change in culture underpinned by the recovery model with a focus on workforce and training, prevention and early intervention, good clinical care, and supporting practice change. RANZCP recommends [113]:

- Appropriate policies, resources and frameworks aimed at minimising seclusion and a culture that uses seclusion and as a last resort.
- Making sure that people with lived experience of mental health conditions are involved in designing policies and frameworks.
- Consistency of definitions and data across jurisdictions to allow for more accurate data collection.
- Long-term research programs into resources, models and strategies.
- Strengthen cultural approaches for Aboriginal, Torres Strait Islander and Maori peoples.
- Appropriate trauma-informed post-incident debriefing for staff and individuals using a lesson learned approach.

18.10.7 Restraint

Restraint is the restriction of individual's freedom of movements [114]. Restraint can be of different types: Physical restraint refers to physically

stopping the person from moving; mechanical restraint involves the use of mechanical devices; restraint by threat involves the threat of using restraint; while chemical restraint is a pharmacological method used solely to restrict movement of an individual. As this is the most restrictive form of intervention, most of the Mental Health Acts do prescribe its use only when there is no other less restrictive way to protect the patient or others from physical harm, absconding or persistent destruction of the property. Clinicians are required to use it for the least amount of time possible and use interventions to minimise its need in future.

Similarly, mechanical restraint is to be used as a last resort to prevent imminent and serious risk of harm to patients and staff, where less restrictive interventions have been unsuccessful or are not feasible. Chief Psychiatrist's Policy in Queensland [115] prescribes the following principles:

- maintaining the safety, well-being and dignity of the patient,
- protecting the safety and well-being of staff,
- mechanical restraint should only be used for the minimum period of time necessary,
- all staff actions should be justifiable and in proportion to the patient's behaviour and broader clinical context.

Mental Health Services are attempting to reduce seclusion and restraint and consequently, there have been increasing restrictions towards use of these restrictive interventions. Australian Health Ministers' Advisory Council have outlined national principles to support the goal of eliminating mechanical and physical restraint in mental health services [116]. Routinely collecting data around seclusion and restraint will allow services to analyse information around restrictive practices. Secondly, for restrictive restraints to decrease, training for all staff needs to be built on personal relationships around values and a person-centred approach, consistent and replicable.

18.11 Reflections

In this chapter, you have learned:

- Complexities of Mental Illnesses, burden and impact of mental illnesses on patients, families and the communities.
- Policy context of Mental Health services.
- Relevant issues that a medical administrator should be aware of, within Mental Health Services.
- Relevant and specific workforce issues for Mental Health Services.
- Activity-Based Funding for Mental Health Services.
- Mental Health Legislation within different jurisdictions, their similarities and differences.

References

1. World Health Organisation. Basic documents: forty-ninth edition (including amendments adopted up to 31 May 2019). Geneva: World Health Organization; 2020. p. 6.
2. AhmadiGatab T, Shayan N, Taheri M. The relationship between psychological health, happiness and life quality in the students. Procedia Soc Behav Sci. 2011;30:1983–5.
3. World Health Organization. The WHO special initiative for mental health (2019–2023): universal health coverage for mental health. World Health Organization; 2019.
4. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington, VA: American Psychiatric Association; 2013.
5. Slade T, Johnston A, Oakley Browne MA, Andrews G, Whiteford H. National Survey of Mental Health and wellbeing: methods and key findings. Aust N Z J Psychiatry. 2007;2009(43):594–605.
6. Global Burden of Diseases Study 2019 mental Disorders Collaborators. Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990–2019: a systematic analysis for the global burden of disease study 2019. Lancet Psychiatry. 2022;9:137–50.
7. Henderson S, Andrews G, Hall W. Australia's mental health: an overview of the general population survey. Aust N Z J Psychiatry. 2000;34:197–205.

8. Parslow RA, Lewis V, Marsh G. The general practitioner's role in providing mental health services to Australians, 1997 and 2007: findings from the national surveys of mental health and wellbeing. Med J Aust. 2011;195(4):205–9.
9. Australian Bureau of Statistics. National Survey of Mental Health and Wellbeing: user's guide, 2007, Cat. No. 4327.0. Canberra: Australian Bureau of Statistics, 2009. https://www.abs.gov.au/ausstats/abs@.nsf/mf/4327.0. Accessed 5 Apr 2022.
10. Australian Institute of Health and Welfare. Australia's health 2020 in brief: burden of disease. Canberra: Australian Institute of Health and Welfare; 2020.
11. Australian Institute of Health and Welfare. Australian burden of disease study: impact and causes of illness and death in Australia 2015. Australian burden of disease series no. 19. Cat. no. BOD 22. Canberra: AIHW; 2019.
12. Foerschner AM. The history of Mental illness: from skull drills to happy pills. Inquiries. 2010;2(9):1–4.
13. Hardy J. A beautiful mind: the history of the treatment of mental illness. History cooperative, 2015. https://historycooperative.org/a-beautiful-mind-the-history-of-the-treatment-of-mental-illness/. Accessed 5 Apr 2022.
14. López-Ibor JJ. The founding of the first psychiatric hospital in the world in Valencia. Actas Esp Psiquiatr. 2008;36(1):1–9.
15. Sushma C, Meghamala S, Tavaragi. Moral treatment: Philippe Pinel. Int J Indian Psychol. 2016;3(2):165–70.
16. Feeley AM. The relevance of Freud to modern psychiatry. Elsevier Psychiatry. 2008;7(5):203–5.
17. Parkinson J. The Castle Hill lunatic asylum (1811-1826) and the origins of eclectic pragmatism in Australian psychiatry. Australas Psychiatry. 1981;15(4):319–22.
18. Richmond DT. Richmond report: inquiry into health services for the psychiatrically ill and developmentally disabled 1983. NSW Ministry of Health, NSW.
19. Human Rights and Equal Opportunity Commission. Human rights and mental illness. Report of the National Inquiry into the human rights of people with mental illness: Burdekin Report. 1993. Canberra.
20. Groom G, Hickie I, Davenport T. 'OUT OF HOSPITAL, OUT OF MIND!' A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003–2008. Canberra: Mental Health Council of Australia; 2003.
21. Laine K, Kuusterä K. De-Institutionalisation in Europe: literature review and meta-analysis on de-institutionalisation - reports of Finnish Association on intellectual and developmental disabilities. Kehitysvammaliton Selvityksia, Helsinki; 2008.
22. Koyanagi C. Learning from history: deinstitutionalization of people with mental illness as precursor to long-term care reform. Washington, USA: Kaiser commission on Medicaid and the uninsured; 2007.
23. Cummins RA, Polzin U, Theobold T. The Deinstitutionalisation of St Nicholas Hospital: a four year follow up of resident lifestyle. Aust NZ J Dev Disabilities. 1997;16:305–21.
24. Fine MA, Tangeman PJ, Woodard J. Changes in Adaptative Behaviours of older adults with intellectual disability following deinstitutionalisation. Am J Ment Retard. 1990;94:661–8.
25. Lemay R. Deinstitutionalization of people with developmental disabilities: a review of the literature. Can J Comm Mental Health. 2009;28(1):181–94.
26. Young L, Ashman AF. Deinstitutionalisation in Australia part I: historical perspective. Br J Dev Disabilities. 2004 Jan;50(1):21–8.
27. Whiteford H, Buckingham B, Manterchied R. Australian's National Mental Health Strategy. Br J Psychiatry. 2002;180:210–5.
28. Rosen A. Australia's national mental health strategy in historical perspective: beyond the frontier. Int Psychiatry. 2006;3(4):19–21.
29. Safety and Quality Partnership Subcommittee of the Mental Health Standing Committee of the Standing Council on Health. Mental health statement of rights and responsibilities. Canberra: Commonwealth of Australia; 2012.
30. Commonwealth of Australia. National Mental Health Strategy: National Mental Health Policy 2008. Canberra: Commonwealth of Australia; 2009.
31. Council of Australian Government (COAG). The Fifth National Mental Health and Suicide Prevention Plan. Canberra: Department of Health Commonwealth of Australia; 2017.
32. National Mental Health Commission. Annual report 2020–2021. Canberra: National Mental Health Commission, Commonwealth of Australia; 2021.
33. National Mental Health Commission. Monitoring mental health and suicide prevention reform, fifth National Mental Health and suicide prevention plan, 2019: the consumer and carer perspective. Sydney: NMHC; 2019.
34. Productivity Commission. Mental health: productivity commission inquiry report. Canberra: The Commonwealth of Australia; 2020.
35. National Suicide Prevention Office. National suicide prevention adviser final advice. Canberra: Australian Government; 2021.
36. National Mental Health Commission. Vision 2030 blueprint for mental health and suicide prevention: roadmap key concepts consultation. Sydney: NMHC; 2020.
37. State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations, Parl Paper No. 202, Session 2018–21 (document 1 of 6). 2021. State of Victoria.

38. Royal Commission in Aged Care Quality and Safety. Care, dignity and respect: final report- executive summary. Canberra: Commonwealth of Australia. 2021.
39. Australian Government. Prevention, compassion, care: national mental health and suicide prevention plan. Canberra: Commonwealth of Australia; 2021.
40. Australian Institute of Health and Welfare. Expenditure on mental health-related services. 2021.
41. Cook L. Research Paper Series: Mental health in Australia: a quick guide. 2019, Feb. Parliament Library.
42. Atkinson M. Caring for patients outside the public system. 2021. Royal Australian and New Zealand College of Psychiatrists. https://www.ranzcp.org/pre-fellowship/become-a-psychiatrist/a-day-in-the-life-of-a-psychiatrist/caring-for-patients-outside-of-the-public-system. Accessed 31 July 2022.
43. Looi JC, Bastiampillai T, Pring W, Kisely SR, Allison S. Private psychiatric hospital care in Australia: a descriptive analysis of casemix and outcomes. Australian Psychiatry. 2022;30(2):174–8.
44. Australian Institute of Health and Welfare. First insights from the National Study of Mental Health and Wellbeing, 2020–21. Canberra: AIHW; 2021.
45. Feinstein AR. The pre-therapeutic classification of co-morbidity in chronic disease. J Chr Dis. 1970;23(7):455–68.
46. Maj M. 'Psychiatric comorbidity': an artefact of current diagnostic systems. Br J Psychiatry. 2005;186:182–4.
47. Australian Institute of Health and Welfare. Comorbidity of mental disorders and physical conditions 2007.
48. Momen NC, Plana-Ripoll O, Agerbo E, Christensen MK, et al. Mortality associated with mental disorders and comorbid general medical conditions. JAMA Psychiatry. 2022;79:444–53.
49. Royal Australian and New Zealand College of Psychiatrist. The economic cost of serious mental illness and comorbidities in Australia and New Zealand: a report prepared for Royal Australian and New Zealand College of Psychiatrist and the Australian Health Policy Collaboration by Victorian Institute of Strategic Economic Studies. Melbourne, VIC: Royal Australian and New Zealand College of Psychiatrist.
50. Witte G. Should Mental Health services be integrated into general hospitals? Health management. org 2007; 9(3).
51. Scott G, Beauchamp-Lebrón AM, Rosa-Jiménez AA, Hernández-Justiniano JG, et al. Commonly diagnosed mental disorders in a general hospital system. Int J Mental Health Syst. 2021;15:61.
52. Kabbabiran M, Deshpande S, Walling A, Alagarsamy J, et al. Cross-sectional survey of disturbed behaviour in patients in general hospitals in Leeds. Postgrad Med J. 2018;84:428–31.
53. Foye U, Simpson A, Reynolds LM. "Somebody else's business": the challenge of caring for patients with mental health problems on medical and surgical wards. J Psychiatr Ment Health Nurs. 2020;27(4):406–16.
54. Australian Institute of Health and Welfare. Mental health services in Australia: Mental health services provided in emergency departments. Australian Institute of Health and Welfare; 2020.
55. Australasian College for Emergency Medicine Department of Policy, Research and Advocacy. The Long wait: an analysis of mental health presentations to Australian Emergency Departments. 2018.
56. Duggan M, Harris B, Chislett WK, Calder R. Nowhere else to go: why Australia's health system results in people with mental illness getting 'stuck' in emergency departments. Mitchell Institute Commissioned report. Victoria University, 2020.
57. Australasian College for Emergency Medicine. Practical solutions to boarding of psychiatric patients in the emergency department does your emergency department have a psychiatric boarding problem? 2015. Australasian College for Emergency Medicine.
58. Dudgeon P, Milroy H, Walker R. Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. Canberra: Commonwealth of Australia; 2014.
59. Commonwealth of Australia. A national framework for recovery-oriented mental health services: guide for practitioners and providers. Canberra: Commonwealth of Australia; 2013.
60. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health service standards user guide for health services providing care for people with mental health issues. Sydney: ACSQHC; 2018.
61. Gee G, Dudgeon P, Schultz C, Hart A, Kelly K. Aboriginal and Torres Strait Islander social and emotional wellbeing. In: Dudgeon P, Milroy H, Walker R, editors. Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice. second ed. Canberra: Department of The Prime Minister and Cabinet; 2014. p. 55–68.
62. Australian Indigenous Health. Overview of Aboriginal and Torres Strait Islander health status, 2019. InfoNet 2020.
63. The Commonwealth of Australia. Aboriginal and Torres Strait Islander Mental Health Services: PHN Primary Mental Health Care Programme Guidance 2019.
64. Blackdog Institute. Support services for Aboriginal and Torres Strait Islander peoples. Blackdog Institute 2022. https://www.blackdoginstitute.org.au/emergency-help/support-services-for-aboriginal-and-torres-strait-islander-peoples/. Accessed 25 Apr 2022.
65. Australian Bureau of Statistics. General social survey: summary results, Australia 2014, 2015. Australian Bureau of Statistics. https://www.abs.

gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/2014#summary-of-findings. Accessed on 26 Apr 2022.
66. Robinson C. Understanding iterative homelessness: the case of people with mental disorders. Australian Housing and Urban Research Institute UNSW-UWS Research Centre. 2003, July. Australian Housing and Urban Research Institute.
67. Australian Housing and Urban Research Institute. Housing, homelessness and mental health: towards systems change. Australian Housing and Urban Research Institute; 2019.
68. Commonwealth of Australia, Department of Social Services. National Housing and homelessness agreement (NHHA) with Queensland. Commonwealth of Australia; 2021.
69. Australian Institute of Health and Welfare. Mental health services: specialist homelessness services collection. Australian Institute of Health and Welfare; 2021.
70. Australian Bureau of Statistics. Causes of death, Australia. 2021. https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#data-download. Accessed 1 May 2022.
71. Brådvik L. Editorial: suicide risk and mental disorders. Int J Environ Res Public Health. 2018;15(2028):1–4.
72. Commonwealth of Australia, Department of Health. National suicide prevention strategy. 2014. https://www1.health.gov.au/internet/publications/publishing.nsf/Content/suicide-prevention-activities-evaluation~background~national-suicide-prevention-strategy. Accessed 1 May 2022.
73. Australian Government, Department of Health and Ageing. National Aboriginal and Torres Strait Islander suicide prevention strategy. 2013, May. Commonwealth of Australia.
74. Currier D. King K. Oostermeijer S. Hall T. National Suicide Prevention Trial Final Evaluation Report. 2020, Dec. University of Melbourne.
75. Aknin L, De Neve JE, Dunn EW, Fancourt D, et al. Mental health during the first year of the COVID-19 pandemic: a review and recommendations for moving forward. Perspect Psychol Sci. 2022; 1–22.
76. Australian Institute of Health and Welfare. COVID-19 impact on mental health. 2021, Oct. Commonwealth of Australia.
77. Commonwealth of Australia. Head to Health website. 2022. https://www.headtohealth.gov.au/popup. Accessed 1 May 2022.
78. Broadway B. Payne AA. Salamanca N. Coping with COVID-19: rethinking Australia. 2020. Melbourne Institute: Applied Economic & Social Research, the University of Melbourne.
79. World Health Organisation. Global Health Observatory data repository: mental health workers Data by country. 2019. https://apps.who.int/gho/data/view.main.HWF11v. Accessed 1 May 2022.
80. Moore KA, Cooper CL. Stress in Mental Health professionals: a theoretical overview. Int J Soc Psychiatry. 1996;42(2):82–9.
81. Cleary A, Thomas N, Boyle F. Final Report. National Mental Health Workforce Strategy – A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries. Brisbane: Institute for Social Science Research, University of Queensland; 2020.
82. Mental Health Workforce Advisory Committee. The National Mental Health workforce strategy and plan. Melbourne, VIC: Victorian Government Department of Health; 2011.
83. Department of Health, Australian Government. National Mental Health workforce strategy taskforce –terms of reference. Commonwealth of Australia; 2020.
84. Mental Health Workforce Advisory Committee. Acil Allen: National Mental Health workforce strategy consultation draft. Commonwealth of Australia; 2021.
85. Royal Australian and New Zealand College of Psychiatrists. Improve the mental health of communities: Australian Government Development of the National Mental Health Workforce Strategy 2021–2031. Melbourne: Royal Australian and New Zealand College of Psychiatrists; 2021.
86. National Aboriginal Community Controlled Health Organisation. National Mental Health workforce strategy: submission to the National Mental Health workforce strategy taskforce. National Aboriginal Community Controlled Health Organisation; 2021.
87. Australian Nursing and Midwifery Federation. Submission to the development of the National Mental Health workforce strategy 2021–2031. Australian Nursing and Midwifery Federation; 2021.
88. Mental Health Co-ordinating Council. Submission to the National Mental Health Workforce Strategy 2021-2031.
89. McDermott J. Volunteering Australia. Submission on the National Mental Health Workforce Strategy 2021-2031. 2021. Volunteering Australia.
90. Department of Health, Australian Government. National Medical Workforce Strategy 2021–2031. Commonwealth of Australia; 2021.
91. Commonwealth of Australia. Council of Australian Governments: National Health Reform Agreement. Canberra: Commonwealth of Australia; 2011.
92. Independent Hospital Pricing Authority's (IHPA). What we do. 2019. IPPA. https://www.ihpa.gov.au/what-we-do. Accessed 2 May 2022.
93. Independent Housing Pricing Authority. Development of the Australian Mental Health Care classification – public consultation paper 1. Commonwealth of Australia; 2015.
94. Independent Hospital Pricing Authority's (IHPA). Mental health care. 2019. IPPA. https://www.ihpa.gov.au/what-we-do/mental-health-care. Accessed 2 May 2022.

95. Independent Hospital Pricing Authority's (IHPA). Activity based funding mental health care national best endeavours data set 2020–21. IHPA; 2020.
96. Mental Health Commission, New South Wales. Review of transparency and accountability of mental health funding to health services. Mental Health Commission, NSW; 2017.
97. New South Wales Government. Mental Health Act 2007 no. 8. NSW Government; 2007.
98. Victorian Government. Authorised Version No. 022. Mental Health Act 2014 No. 26 of 2014. Victorian Government; 2020.
99. Queensland Government. Mental Health Act 2016: Act No. 5 of 2016. Queensland Government; 2016.
100. Western Australia Government. Mental Health Act 2014. Western Australia Government; 2014.
101. Tasmania Government. Mental Health Act 2013: No. 2 of 2013. Tasmania Government; 2013.
102. South Australian Government. Mental Health Act 2009. South Australian Government; 2021.
103. Australian Capital Territory Government. Mental Health Act 2015 A2015–38: republication no 17. Australian Capital Territory Government; 2021.
104. Northern Territory of Australia Government. Mental Health and related services Act 1998. Northern Territory of Australia; 2020.
105. New Zealand Government. Mental Health (Compulsory Assessment and Treatment) Act 1992. New Zealand Government; 2021.
106. Queensland Health. Chief Psychiatrist Policy on Mental Health Act 2016: treatment criteria, assessment of capacity, less restrictive way and advance health directives. Brisbane: Queensland Government; 2020.
107. Royal Australian and New Zealand College of Psychiatrist (RANZCP). Regulation of electroconvulsive treatment (ECT) in Australian and New Zealand Mental Health Acts. Melbourne: RANZCP; 2017.
108. Queensland Government, Mental Health Review Tribunal. Information about Electroconvulsive Therapy (ECT). 2017. https://www.mhrt.qld.gov.au/information-about/electroconvulsive-therapy. Accessed 5 May 2022.
109. Weiss A, Hussain S, Ng N, Sarma S, et al. Royal Australian and New Zealand College of Psychiatrists professional practice guidelines for the administration of electroconvulsive therapy. Aust N Z J Psychiatry. 2019;53:609–23.
110. Queensland Health. Chief Psychiatrist Policy: Mental Health Act 2016 – seclusion. Brisbane: Queensland Health; 2021.
111. Australian Institute of Health and Welfare. Mental Health services: restrictive practices. Australian Institute of Health and Welfare; 2021.
112. Cusack P, Cusack F, McAndrew S, McKeown M, Duxbury J. An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings. Int J Ment Health Nurs. 2018;27:1162–76.
113. Royal Australian and New Zealand College of Psychiatrists. Position Statement 61: minimising and, where possible, eliminating the use of seclusion and restraint in people with mental illness. Melbourne: Royal Australian and New Zealand College of Psychiatrists; 2021.
114. Queensland Health. Chief Psychiatrist Policy-Mental Health Act 2016: Physical Restraint. 2020. Queensland Health.
115. Queensland Health. Chief Psychiatrist Policy-Mental Health Act 2016: mechanical restraint. Queensland Health; 2020.
116. Australian Health Ministers' Advisory Council: Mental Health, Drug and Alcohol Principal Committee: Safety and Quality Partnership Standing Committee. National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services: Developed by the Restrictive Practice Working Group: Endorsed by the Mental Health Drug and Alcohol Principal Committee. Australian Health Ministers' Advisory Council; 2016.