Australia Mental Health

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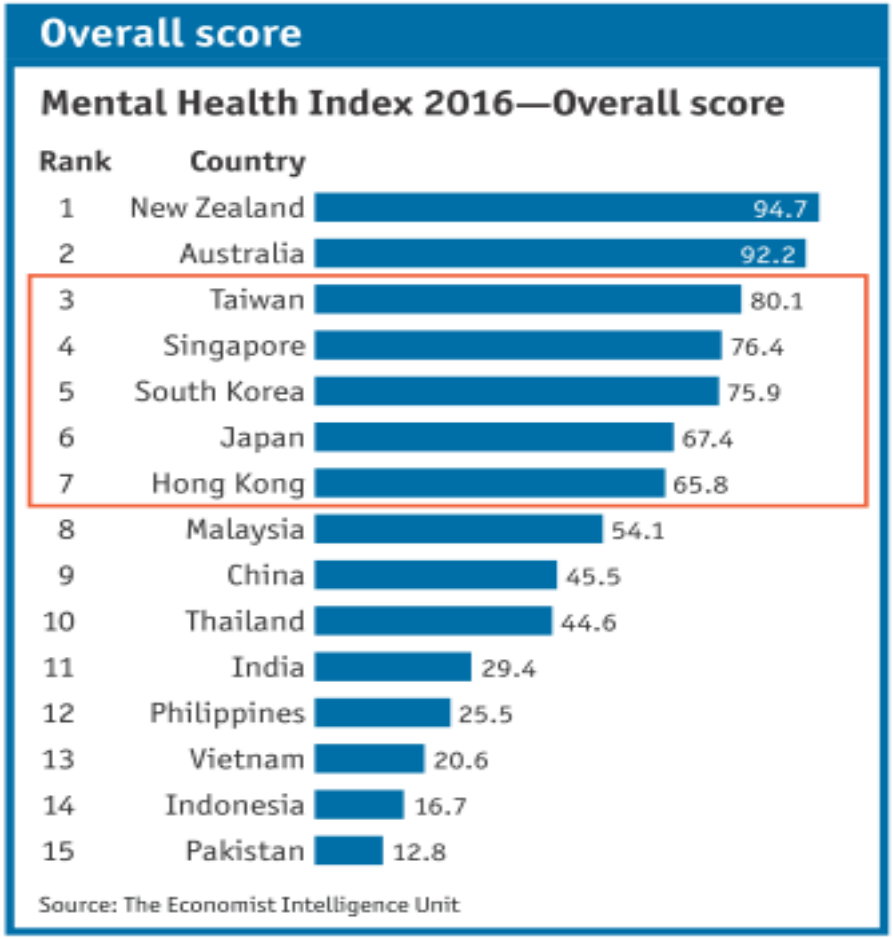
Outline

- Australia Mental Health
- Victoria Mental Health system
- St Vincent Mental Health Services
- Mental Health Act 2014 (Vic)
- Mental Health Tribunal (Vic)
- Australia vs Taiwan

Australia Mental Health

Mental health Index among Asia-Pacific Region, 2016



- Taiwan ranked the No 3 in the Mental Health Index, 2016 among Asia Pacific countries.

Australia vs Taiwan

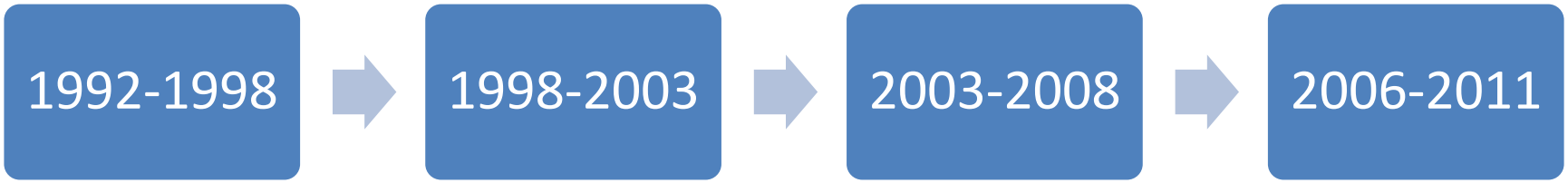
- Australia
  - Population:24,715,868 (2018)
  - Total area: 7,686,850 Km^2
  - GDP: 1204.62 billion USD (2016)
  - NHE 佔GDP : 10.3% (2015-2016)
  - Adj suicide rate: 11.7 (2016)

- Taiwan
  - Population: 23,682,521 (2018)
  - Total area: 35,980 Km^2
  - GDP 529.58 billion USD (2016)
  - NHE佔GDP: 6.3% (2016)
  - Adj suicide rate: 12.3 (2016)

- 澳洲人口與台灣相當
- 澳洲面積是台灣215.6倍

National mental health plans
A Changing Focus

- Focus on public mental health services
  - Shift psychiatric beds to general hospitals
  - Institutional to community care
  - Better integration
- Consumer rights



First Plan

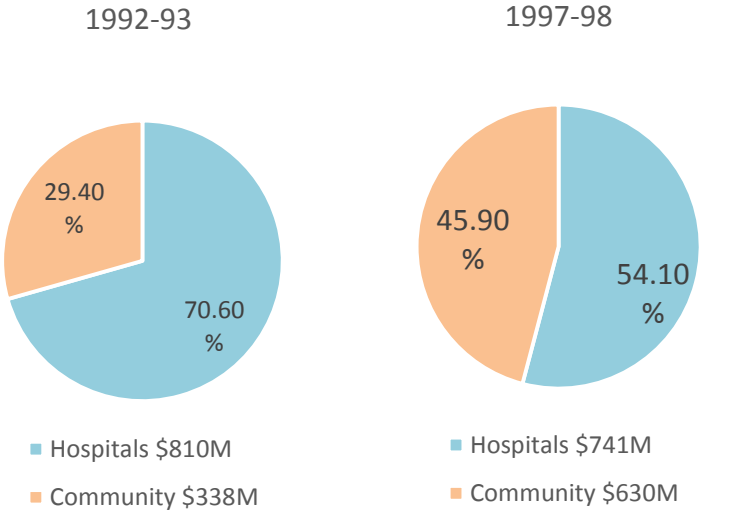
Shift to a community-based system of care

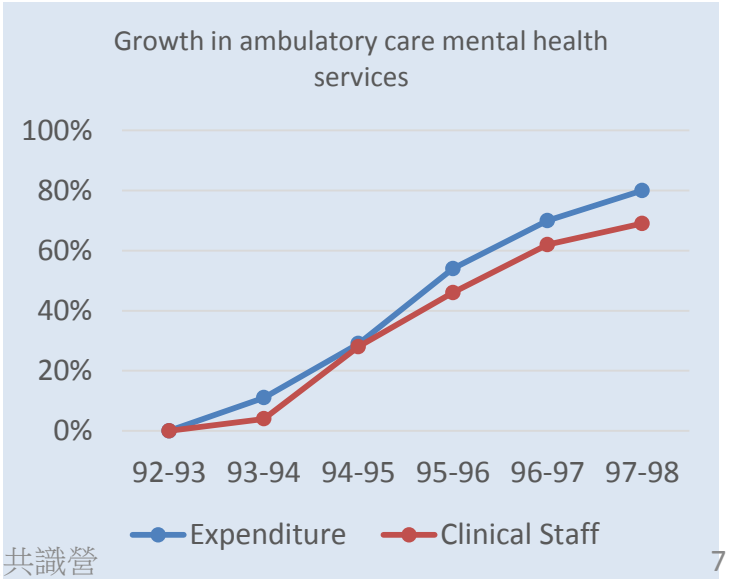
All State and Territory governments strengthened the community treatment and support services available for people affected by mental illness. Spending on community-based services grew by 87% or $292 millions.

At the commencement of the Strategy 29% of mental health spending was dedicated to caring for people in the community. By 1998 , this increased to 46%

The number of clinical staff providing ambulatory mental health care increased by 68% in parallel with increased spending.

2,300 more health professionals were employed in the ambulatory mental health services in 1998 than in 1993.

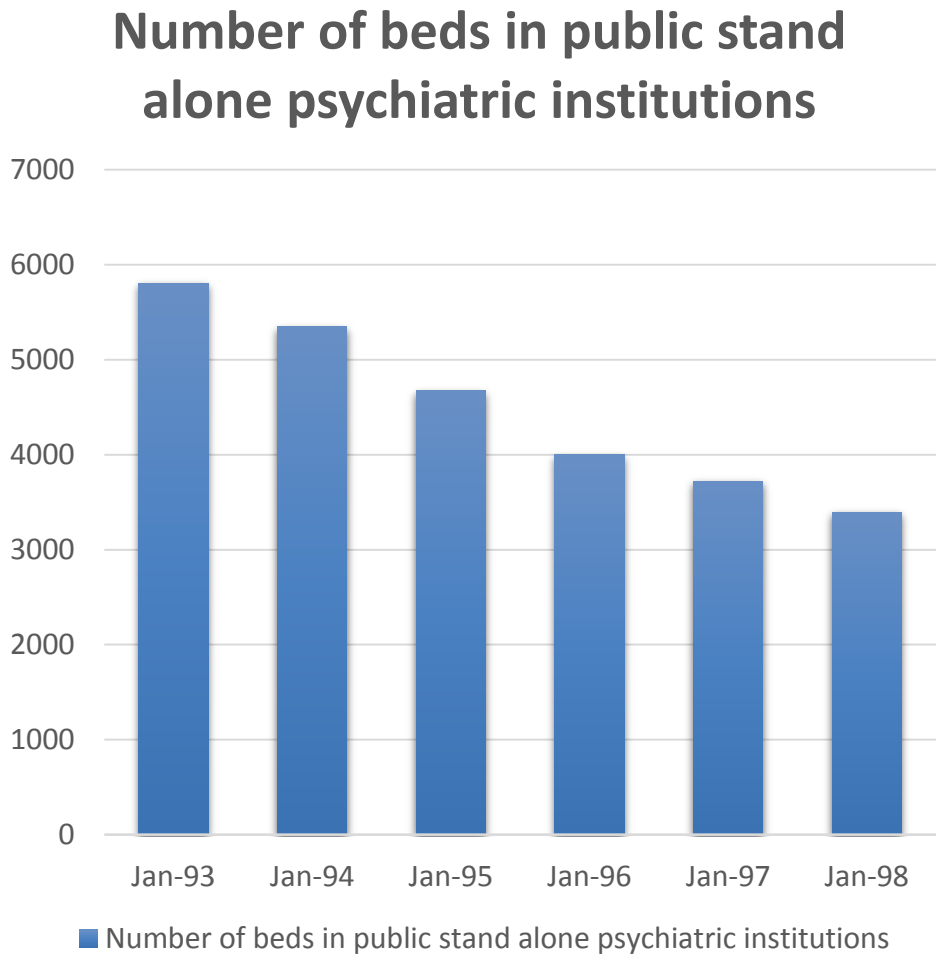




Reduction in size of separate psychiatric institutions

Stand alone psychiatric institutions held a central place in Australia's mental health system at the commencement of the Strategy, accounting for 49% of total mental health resources. By 1998, this reduced to 29%.

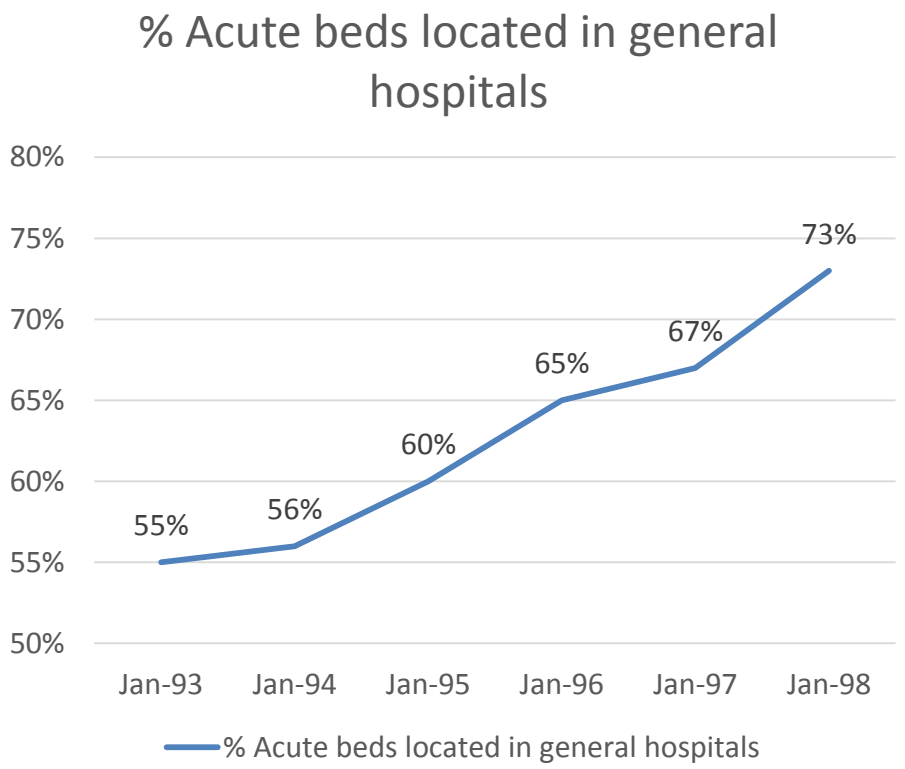
Total beds in institutions reduced by 42%.



Reduced isolation of mental health services from the mainstream health system

Acute psychiatric beds in general hospitals have increased by 34% since 1993. By 1998, 3 out of every 4 acute beds were located in general hospitals.

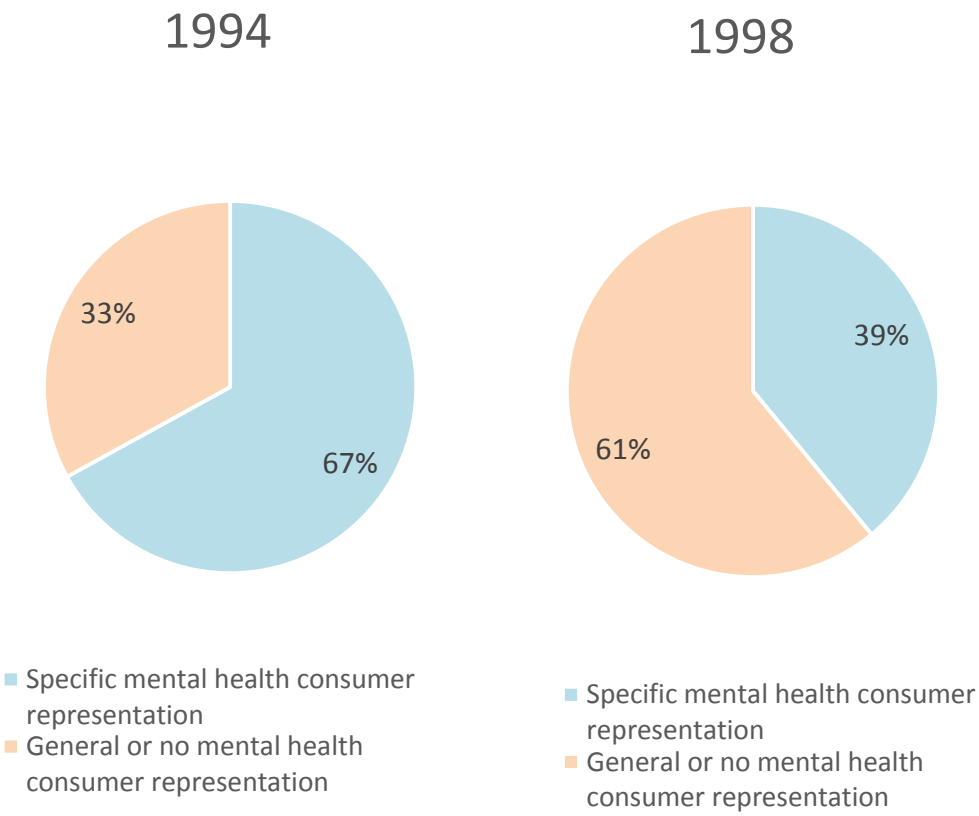
All States and Territories have transferred the management of public mental health services to the mainstream health system.



Increased consumer participation in decision making

Consumers and carers have been included in all national planning groups established since the Strategy began. Mental health leads the health industry in this area.

At the service delivery level, by 1998, 61% of organisations had established a formal mechanism for consumer participation in local service issues.

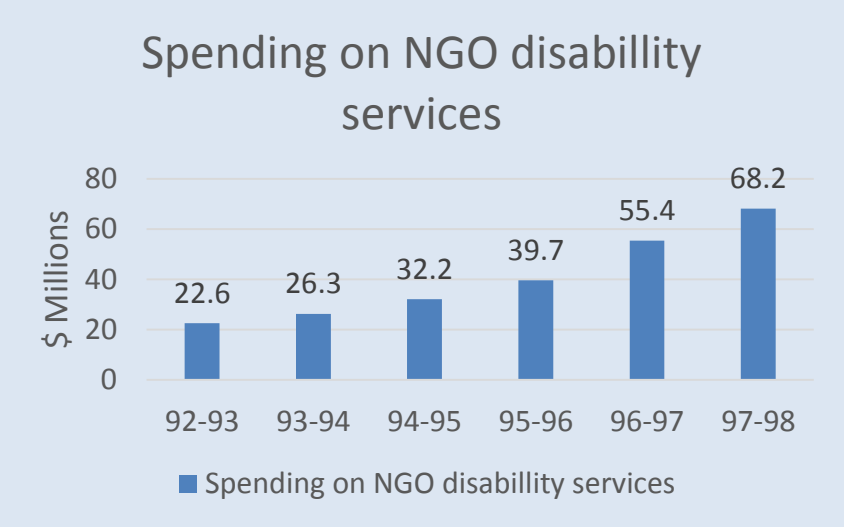


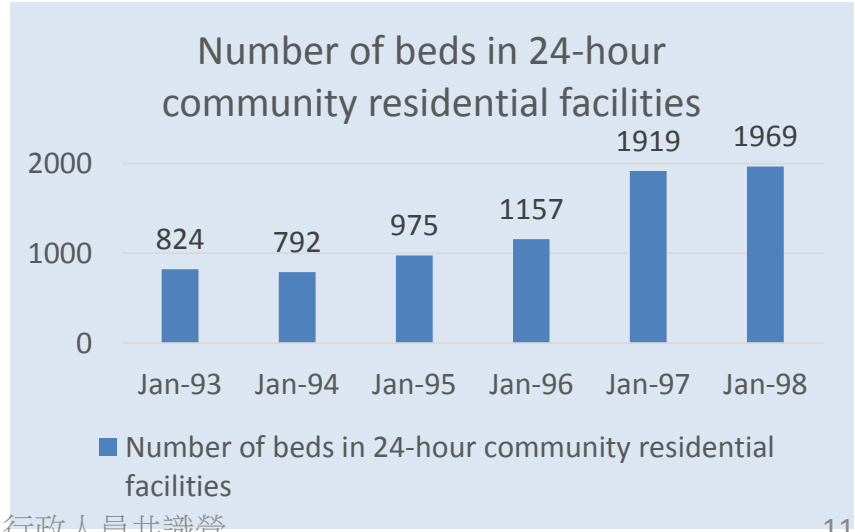
Expansion of psychiatric disability support services

Funds allocated to non-government organisations to provide support to people with psychiatric disability grew by 200%.

The non-government sector increased its overall share of mental health funding from 2% to 5%.

This was accompanied by a 65% increase in the number of beds in 24-staffed hour community residential units, designed to replace the former role of psychiatric institutions.

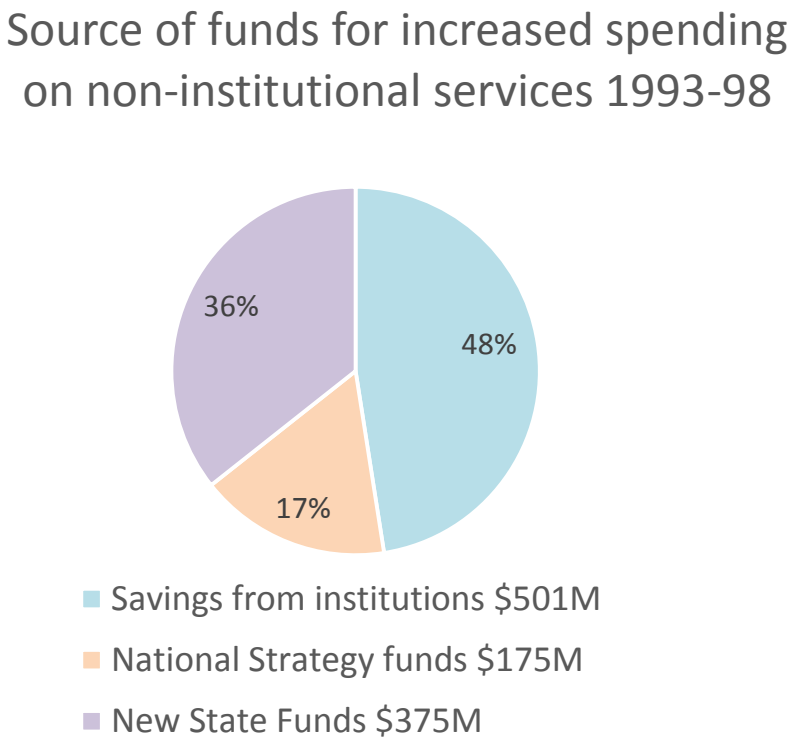




Savings from reduction in institutions redirected to new services

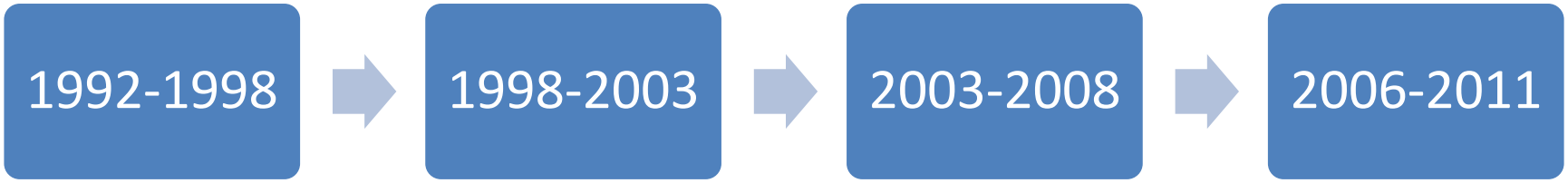
The commitments made to reinvest savings from the downsizing of older style psychiatric institutions back into mental health programs were met by all States.

48% of the growth in community-based and general hospital services was funded by resources related through institutional downsizing.



National mental health plans
A Changing Focus

- Expanded Focus
  - GPs & Private Psychiatrists
  - Depression programs given significance
  - Promotion & Prevention



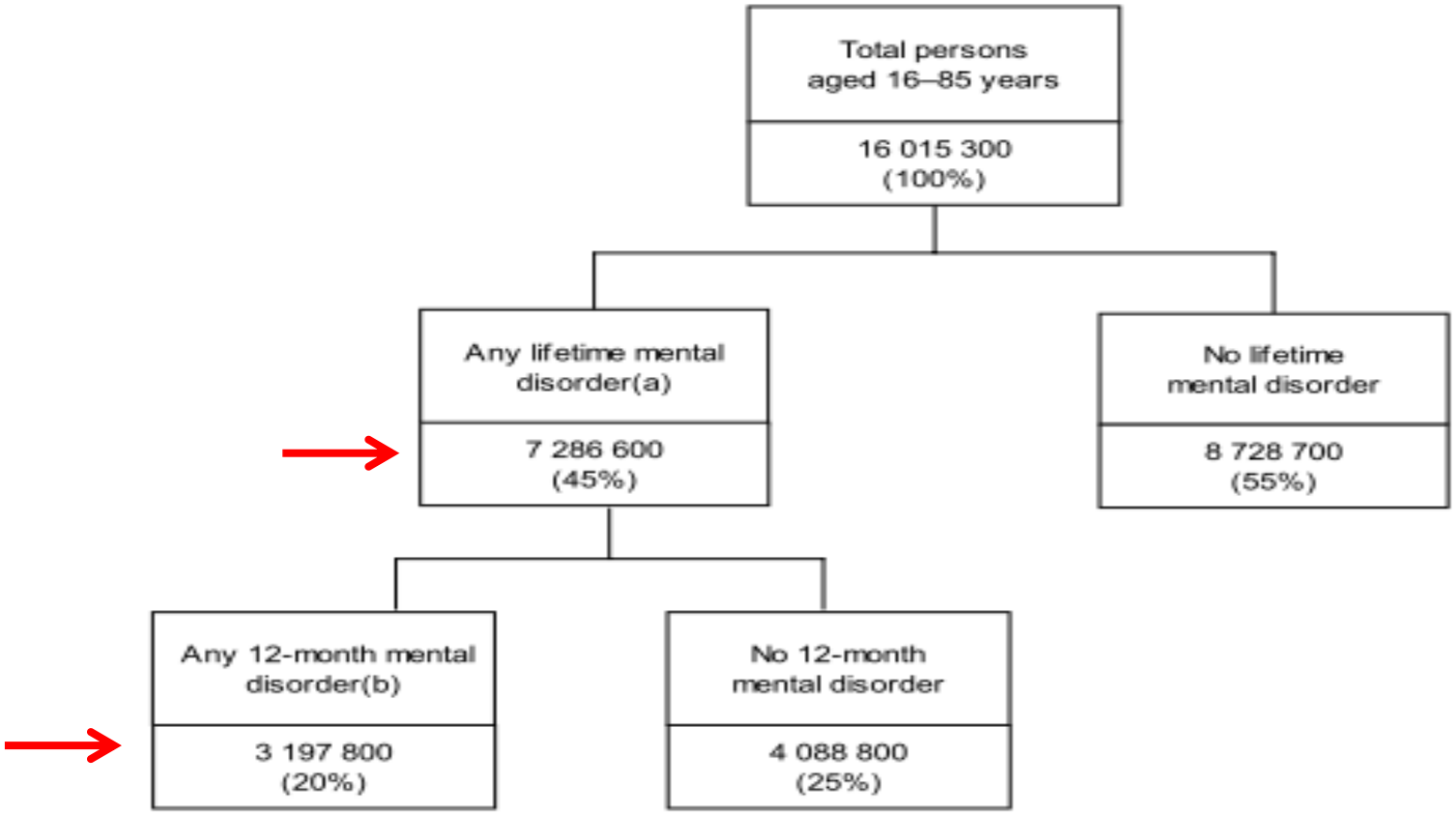
Second Plan

Second National Mental Health Plan, 1998-2003

- 促進及預防(Promotion and Prevention):
  - 心理衛生促進及預防
  - 建立心理健康識能文件
  - 學校心理衛生全國計畫
  - 全國憂鬱行動計畫
  - 自殺防治
- 服務的改革與夥伴關係(Partnerships in service reform)
  - 教育訓練
  - 基層精神醫療
  - 跨部門的連結
- 品質與有效性(Quality and effectiveness)
  - 全國精神疾病調查 (National Survey of Mental health and Wellbeing)
  - 預後研究
  - 立法保護權益

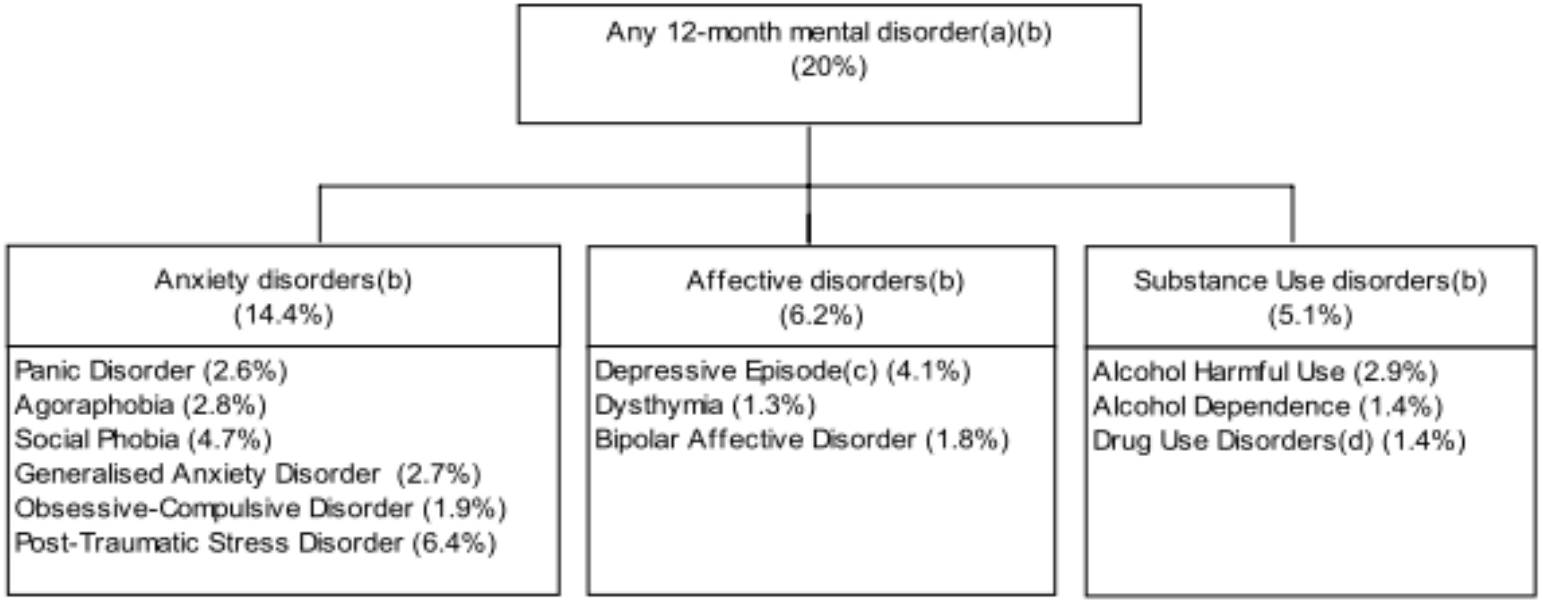
National Action Plan for Promotion, Prevention, and Early Intervention for Mental Health, 1998-2003

National Survey of Mental health and Wellbeing



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy).
(b) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.

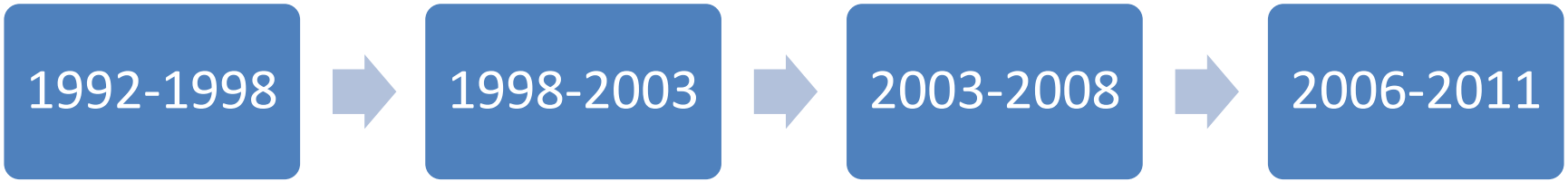
National Survey of Mental Health and Wellbeing



(a) Persons who met criteria for diagnosis of a lifetime mental disorder (with hierarchy) and had symptoms in the 12 months prior to interview.
(b) A person may have had more than one mental disorder. The components when added may therefore not add to the total shown.
(c) Includes Severe Depressive Episode, Moderate Depressive Episode, and Mild Depressive Episode.
(d) Includes Harmful Use and Dependence.

National mental health plans
A Changing Focus

- Mental health for all Australians
  - 34 Outcomes
  - 113 Key Directions
  - No specific Commonwealth funds



Third Plan

Third National Mental Health Plan 2003-2008

- 使用者與照顧者(Consumers and Carers)
- 夥伴關係發展 (Partnership Development)
- 精神醫療人力 (The Mental Health Workforce)
- 特殊精神醫療服務(Specialist Mental Health Services)
- 雙重診斷(Dual Diagnosis)
- 服務不足的族群 (Underserved Populations)
- 品質、有效性與當責性(Quality, Effectiveness, and Accountability)

National Mental Health Action Plan: Ways forward, 2003-2008

Fourth National Mental Health Plan, 2009-2014

- 社會包容與復原 (Social inclusion and recovery)
- 預防與早期接入 (Prevention and early intervention)
- 服務取得、協調與持續照護 (Service access, coordination and continuity of care)
- 品質促進與創新 (Quality improvement and innovation)
- 當責性測量與報告進度 (Accountability-measuring and reporting progress)

National Mental Health Action Plan: An agenda for collaborative government action in mental health, 2009-2014

Fifth National Mental Health and Suicide Prevention Plan, 2017-2022

- 整合區域計畫及服務(Integrated regional planning and service)
- 有效自殺防治(Effective suicide prevention)
- 對嚴重複雜的精神病患協調治療及支持(Coordinated Tx and supports for people with severe and complex mental illness)
- 改善原住民及托雷斯海峽群島住民的心理健康及自殺防治(Improving Aboriginal and Torres Strait Islander mental health and suicide prevention)
- 改善與精神患者同住者的身體降康避免早期死亡 (Improving the physical health of people living with mental illness and reducing early mortality)
- 降低汙名與排斥(Reducing stigma and discrimination)
- 有安全及品質的精神醫療服務 (Making safety and quality central to mental health service delivery)
- 確保有效系統的運作與改善到位(Enablers of effective system performance and system improvement are in place)

Australia's top 5 burden of disease groups

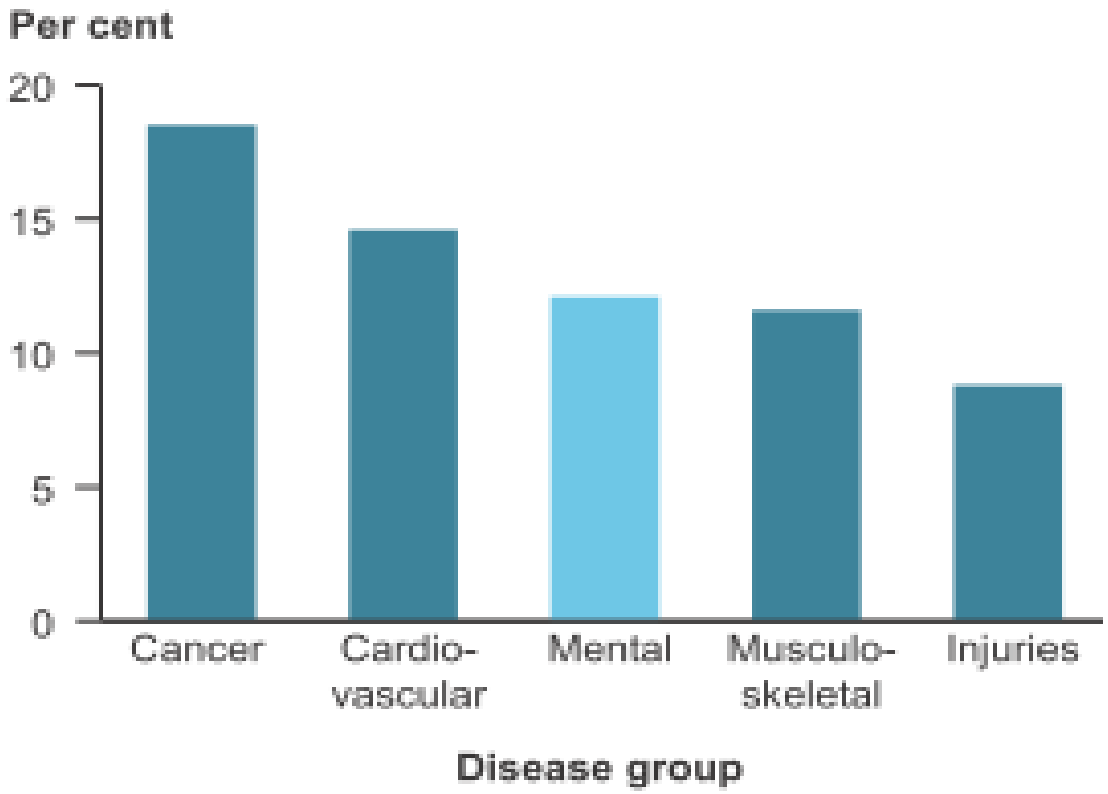


Figure 2: Australia's top 5 burden of disease groups, 2011

Australia Mental Health Services, in brief, 2017

Australia's mental Health Care system

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

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

Australia Mental Health Services, in brief, 2017

Estimates of people with mental illness receiving mental health care

- The 2007 NSMHWB of adults (aged 16–85)

estimated that about one-third of people with a mental disorder in the previous 12 months accessed mental health services (ABS 2008). Of these:

  - 70.8% consulted a general practitioner (GP)
  - 37.7% consulted a psychologist
  - 22.7% consulted a psychiatrist.

Australia Mental Health Services, in brief, 2017

Mental health care provided by general practitioners

- 12.4% of GP care was estimated to be mental health-related in 2015–16
- 18.0 million estimated GP encounters were mental health-related
- 3.2 million mental health MBS-specific GP services were provided to 1.8 million patients
- GPs provided 30.6% (3.2 million) of all Medicare-subsidised mental health-specific services in 2015–16

Australia Mental Health Services, in brief, 2017

The 5 most common problems managed during mental health-related GP encounters, 2015–16

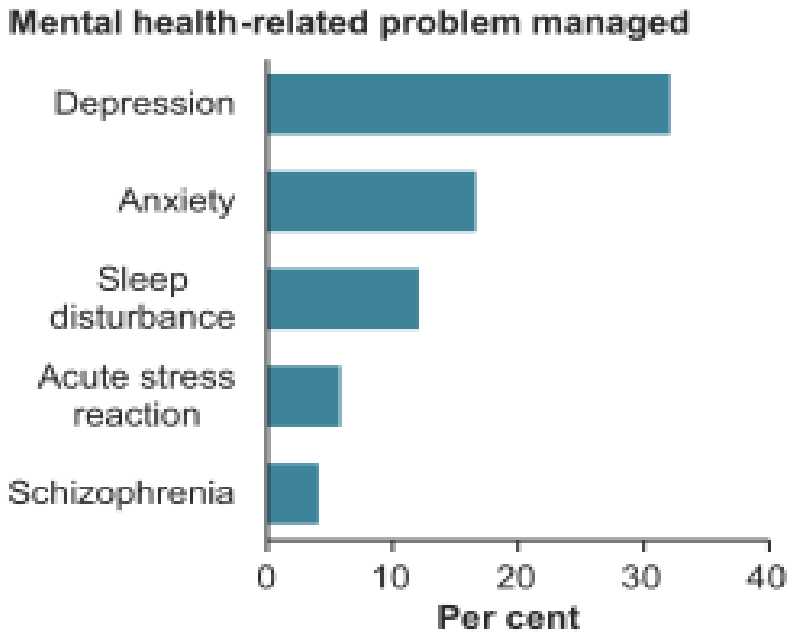


Figure 3: The 5 most common problems managed during mental health-related GP encounters, 2015–16

Australia Mental Health Services, in brief, 2017

State and territory community mental health care services (CMHC)

- 9.4 million community mental health care service contacts were provided to more than 410,000 people in 2015–16
- 40.8% of patients (just under 170,000 people) had a medium to long term treatment length (92 days or more)
- Schizophrenia was the most common principal diagnosis recorded during a service contact
- Nationally, about 1 in 7 (13.5%) service contacts were provided to people with an Involuntary mental health legal status in 2015–16

Australia Mental Health Services, in brief, 2017

Overnight mental health-related hospital care

- 244,934 overnight mental health-related hospitalisations occurred in public and private hospitals in 2015–16
- 16 days was the average length of mental health-related hospitalisations
- 63.7% of overnight mental health-related hospitalisations involved specialised care
- Depressive episode was the most common principal diagnosis for hospitalisations with specialised care

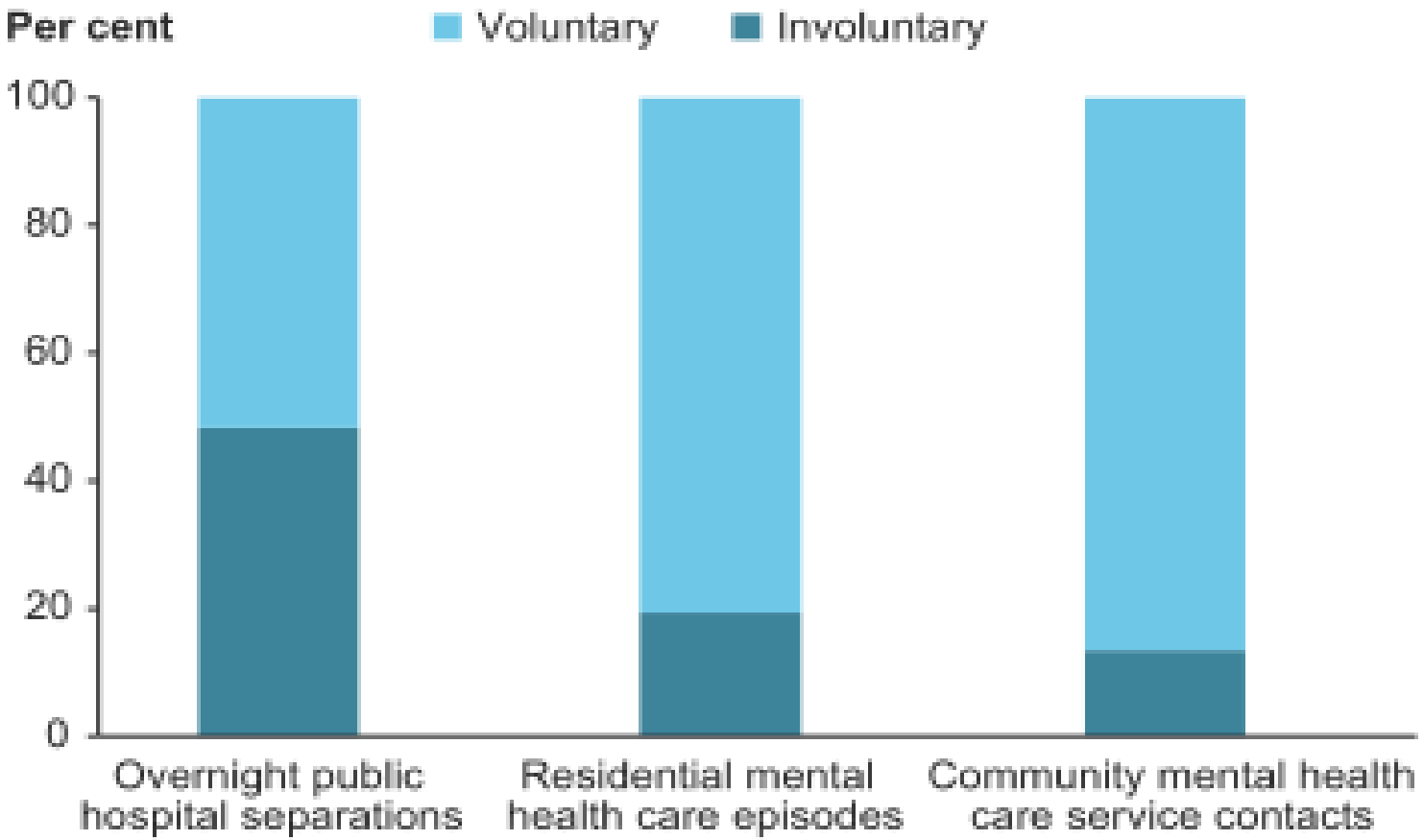
Australia Mental Health Services, in brief, 2017

State and territory residential mental health care (RMHC)

- 5,840 people received residential mental health care during 2015–16
- 7,727 episodes were provided, amounting to more than 307,000 care days
- Schizophrenia was the most common specified principal diagnosis
- 19.4% of episodes were provided to people with an Involuntary mental health legal status
- More than half (54.7%) of all completed residential episodes lasted 2 weeks or less. About 1 in 20 episodes lasted 3 to 12 months (5.4%).

Australia Mental Health Services, in brief, 2017

Mental health care, by setting and mental health legal status, 2015–16



Victoria Mental Health

Victoria in Australia

- Australia
  - six states, two territories.
- Victoria:
  - Population: 6.26 million
  - Total area: 237,629 Km^2
  - 2^{nd} most populated state
- 維多利亞省面積佔澳洲 3%
- 維多利亞省人口佔澳洲1/4

Victorian Mental Health Services

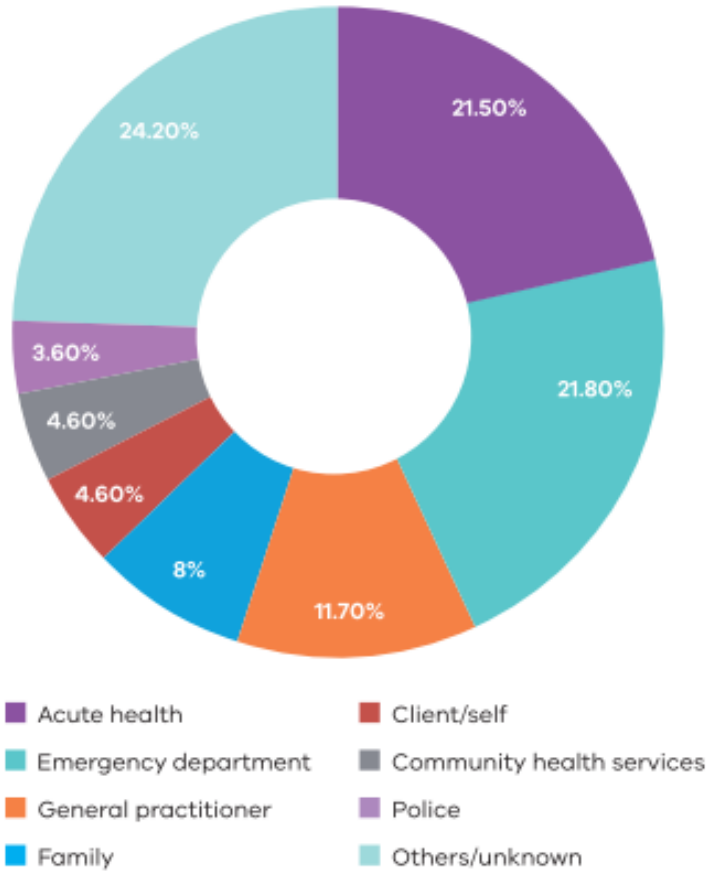
- State-funded specialist mental health services provide community-based and inpatient care for three main population groups in Victoria:
  - Children and adolescents (0-18 years)
  - Adults (16-64 years)
  - Older people (older than 65 years)
- 21 adult mental health services (AMHS), 17 aged persons mental health services, 13 child adolescent mental health services (CAMHS), Orygen Youth Health and a number of youth services statewide.
- People can only access the services in their catchment area. Some people use mental health services from several areas or regions.
- If a person received treatment from an “out of area service”, the AMHS in the person’s area of origin is responsible for ensuring service provision and continuity of care.

How do clients use clinical services in Victoria?

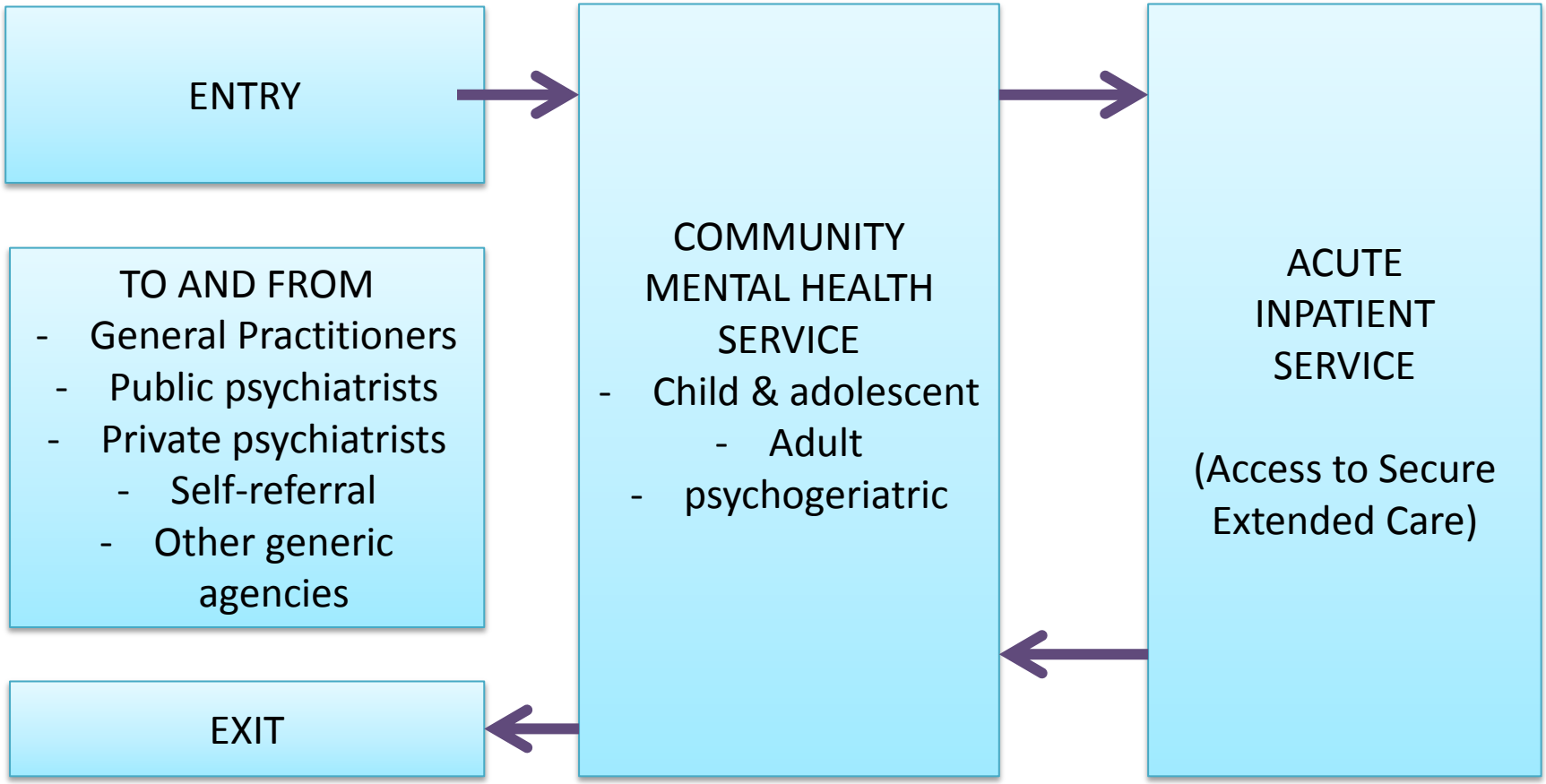
WHO RECEIVES PUBLIC MENTAL HEALTH TREATMENT?

- 66,445 registered clients
- 36.6% new clients
- 1.1% of population
- 50.4% women
- 32.6% rural
- 13.6% CALD
- 2.5% Aboriginal or Torres Strait Islander

Figure 3: Source of mental health referrals, 2016–17



Community-based service delivery



Victoria's public mental health service system

AREA-BASED CLINICAL SERVICES*

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

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

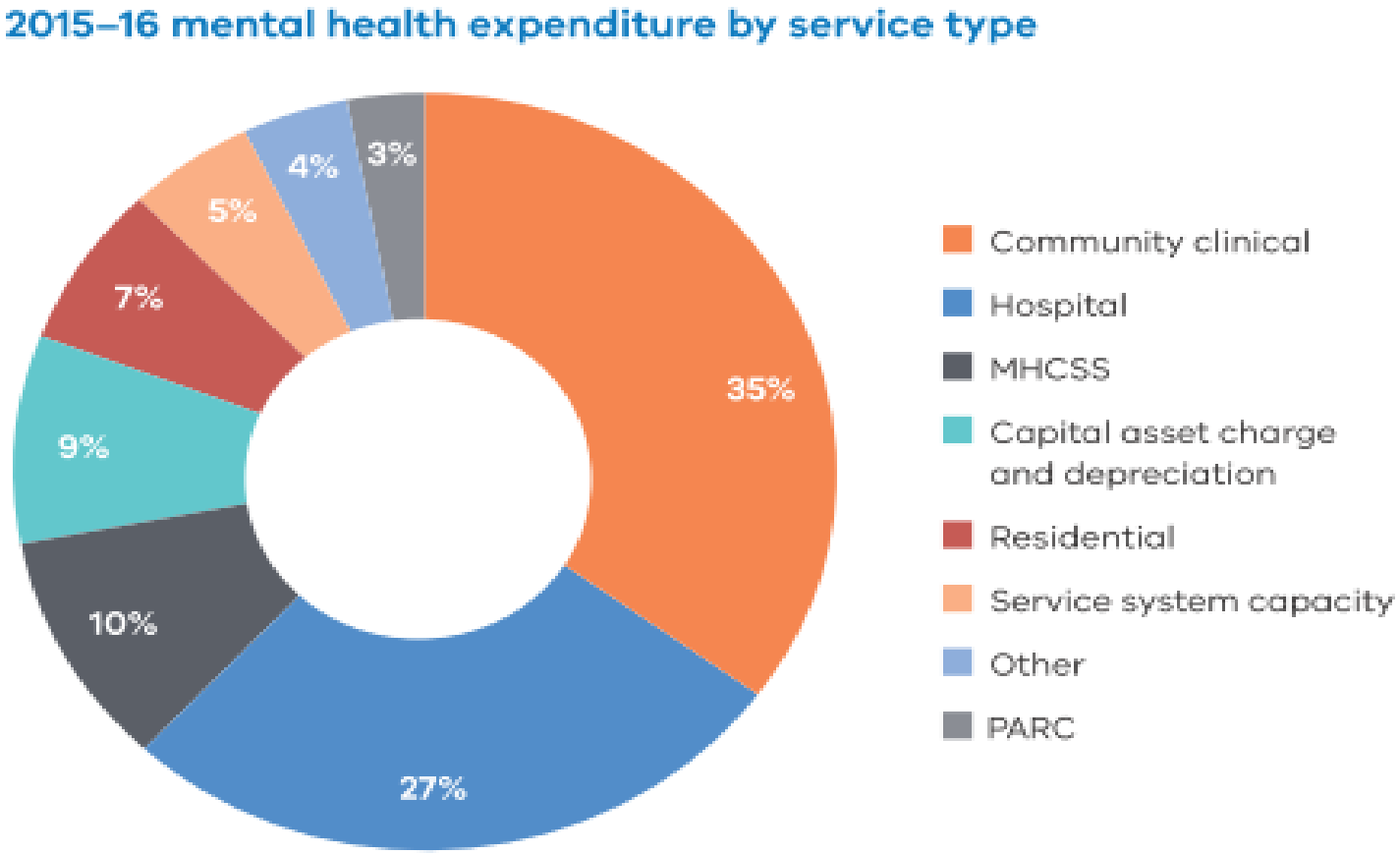
ADULT SERVICES (16–64 YEARS)**

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

AGED PERSONS SERVICES (65+ YEARS)

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

Mental health expenditure by service type



In 2015, the Victorian Government invested $1.14 billion in clinical mental health services and $128 million in MHCSS.

Mental Health Community Support Services (MHCSS)

- Mental Health Community Support Services (MHCSS) are distinct from clinical mental health services, and play a vital role in supporting people with a severe mental illness and psychiatric disability throughout the recovery process.
- MHCSS support people with psychiatric disability to manage their self-care, improve social and relationship skills and achieve broader quality of life via physical health, social connectedness, housing, education and employment.
- The intake assessment service:
  - screens and determines eligibility to receive support
  - prioritises referrals for people most in need
  - refers eligible people to support services
  - provides self-management information and follow-up contact with people on the needs register as required
  - provides general mental health information and facilitates referrals to other services
  - coordinates access to regional bed-based community services and supported residential services
  - ensures that a person's consent is given for the transfer of their information to local service providers.

ST VINCENT'S HOSPITAL
MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

St Vincent Mental Health Services

Psychiatric Triage

- Triage decision-making factors
  - the person's need for specialist mental health services
  - the level of risk to the person and/or others
  - the urgency of the response required from mental health or other services.
- Triage Codes
  - A (emergency services response)
  - B (high urgency mental health response)
  - C (urgent mental health response)
  - D (semi-urgent mental health response)
  - E (non-urgent mental health response)
  - F (referral to alternative provider)
  - G (information only/No further action)

Code/description	Response type/ time to face-to-face contact	Typical presentations	Mental health service action/ response	Additional actions to be considered
A Current actions endangering self or others	**Emergency services response** **IMMEDIATE REFERRAL**	• Overdose • Other medical emergency • Siege • Suicide attempt/serious self-harm in progress • Violence/threats of violence and possession of weapon	**Triage clinician to notify ambulance, police and/or fire brigade**	Keeping caller on line until emergency services arrive CATT notification/attendance Notification of other relevant services (e.g. child protection)
B Very high risk of imminent harm to self or others	**Very urgent mental health response** **WITHIN 2 HOURS**	• Acute suicidal ideation or risk of harm to others with clear plan and means and/or history of self-harm or aggression • Very high risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control • Urgent assessment requested by Police under Section 10 of Mental Health Act	**CATT or equivalent face-to-face assessment** **AND/OR** **Triage clinician advice to attend a hospital emergency department** (where CATT cannot attend in timeframe or where the person requires ED assessment/ treatment)	Providing or arranging support for consumer and/or carer while awaiting face-to-face MHS response (e.g. telephone support/therapy; alternative provider response) Telephone secondary consultation to other service provider while awaiting face-to-face MHS response Advise caller to ring back if the situation changes Arrange parental/carer supervision for a child/adolescent, where appropriate
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	**Urgent mental health response** **WITHIN 8 HOURS**	• Suicidal ideation with no plan and/or history of suicidal ideation • Rapidly increasing symptoms of psychosis and/or severe mood disorder • High risk behaviour associated with perceptual/thought disturbance, delirium, dementia, or impaired impulse control • Unable to care for self or dependants or perform activities of daily living • Known consumer requiring urgent intervention to prevent or contain relapse	**CATT, continuing care or equivalent (e.g. CAMHS urgent response) face-to-face assessment within 8 HOURS** **AND** **CATT, continuing care or equivalent telephone follow-up within ONE HOUR of triage contact**	As above Obtaining corroborating/additional information from relevant others
D Moderate risk of harm and/or significant distress	**Semi-urgent mental health response** **WITHIN 72 HOURS**	• Significant client/carer distress associated with serious mental illness (including mood/anxiety disorder) but not suicidal • Early symptoms of psychosis • Requires priority face-to-face assessment in order to clarify diagnostic status • Known consumer requiring priority treatment or review	**CATT, continuing care or equivalent (e.g. CAMHS case manager) face-to-face assessment**	As above
E Low risk of harm in short term or moderate risk with high support/ stabilising factors	**Non-urgent mental health response**	• Requires specialist mental health assessment but is stable and at low risk of harm in waiting period • Other service providers able to manage the person until MHS appointment (with or without MHS phone support) • Known consumer requiring non-urgent review, treatment or follow-up	**Continuing care or equivalent (e.g. CAMHS case manager) face-to-face assessment**	As above
F Referral: not requiring face-to-face response from MHS in this instance	**Referral or advice to contact alternative service provider**	• Other services (e.g. GPs, private mental health practitioners, ACAS) more appropriate to person's current needs • Symptoms of mild to moderate depressive, anxiety, adjustment, behavioural and/or developmental disorder • Early cognitive changes in an older person	**Triage clinician to provide formal or informal referral to an alternative service provider or advice to attend a particular type of service provider**	Facilitating appointment with alternative provider (subject to consent/privacy requirements), especially if alternative intervention is time-critical
G Advice or information only/ Service provider consultation/ MHS requires more information	**Advice or information only** **OR** **More information needed**	• Consumer/carer requiring advice or opportunity to talk • Service provider requiring telephone consultation/advice • Issue not requiring mental health or other services • Mental health service awaiting possible further contact • More information (incl discussion with an MHS team) is needed to determine whether MHS intervention is required	**Triage clinician to provide consultation, advice and/or brief counselling if required** **AND/OR** **Mental health service to collect further information over telephone**	Making follow-up telephone contact as a courtesy

Acute Inpatient Service (AIS)

- A 44 bed inpatient unit providing short term inpatient treatment to people during the acute phase of mental illness, including a six bed Extra Care Unit (ECU) for people with more intensive care needs.

Dr Matthew Warden

Ms. Holly Francheschi

The Footbridge Community Care Unit (CCU)

- This 20-bed community residential service with 24-hour support, provides medium to long-term accommodation, clinical care and rehabilitation for people with a serious mental illness and psychosocial disability.
- Located in a residential area, it provides the residents with "home-like" accommodation where they can learn or re-learn everyday living skills necessary for their successful living in the community.
- Case manager to
  - Identify your personal recovery goals
  - Identify your personal strengths
  - Explore your support needs
  - Involve you in planning your treatment

Ms. Bronwyn Morrison

Case manager training program

1. Introduction to Case management and Rehabilitation
2. Psychopathology, Clinical Interviews and Mental State Assessment
3. Medication for people with SMI, assessment tools and clinical features of people with Severe mental illness and Substance misuse problems
4. Psychosocial interventions, common assessment tools and outcome measures
5. Crisis intervention, Mental Health legislation and clinical features of people with severe mental illness and personality disorder
6. Recovery Approach to case management, role of case-manager, and individual care plans
7. Individual care plans, Physiotherapy, Community living skills and vocational rehabilitation
8. Communication and counselling skills with individuals and their families
9. Solution-focused therapy, Peer specialist services and utilizing community resources
10. Role of police, Case management consolidation

North Fitzroy Prevention and Recovery Care program (PARC)

- Prevention and Recovery Care program (PARC) Provides short to medium term residential support for people with mental illness. It is a 'step up/step down' service aimed at supporting people in the community to prevent unnecessary hospital admission and provides additional support to people being discharged from hospital before they go home.

Ms. Katherine Davies

Clarendon Community Mental Health Service

- The Community Mental Health Services have multiple functions including psychiatric triage, assessment, secondary consultation and case management services, and rehabilitation. The services have active shared care arrangements with general practitioners and private psychiatrists.

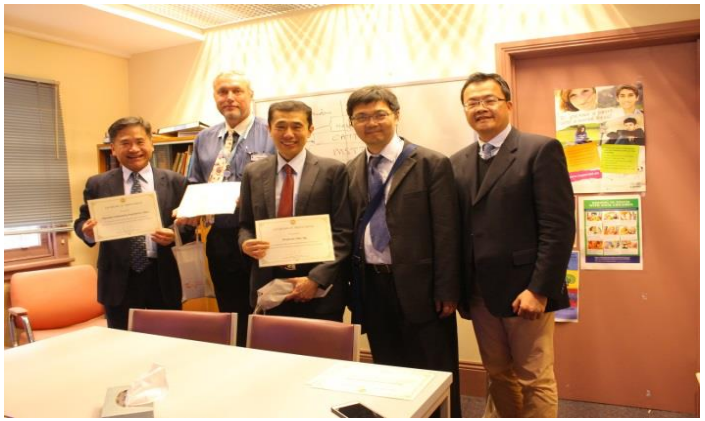
Mr. Graeme Doidge &Prof Chee Ng

Crisis Assessment and Treatment Service (CATS)

- CATS provides urgent assessment and short-term intensive treatment in the community to people in psychiatric crisis. This includes assessing the most effective and least restrictive service options for clients and may include facilitation of acute inpatient care.
- CATS provide treatment and support for people whose acute mental illness can be managed in the community with intensive outreach support as an alternative to hospitalisation. CATS operate 24 hours per day, 7 days a week.

Continue Care Teams (CCT)

- The CCT provides assessment, treatment and consultancy services and case management to people with a mental illness needing treatment and rehabilitation in the community.
- It also provides an initial assessment for people requesting assistance where a CAT service is not required.



Mr. Graeme Doidge &Prof Chee Ng

Mobile Support and Treatment Service (MSTS)

- Intensive ongoing support and treatment for people in their home.
- The MSTS provides intensive long-term outreach support to people in the community with substantial and prolonged severe mental illness and associated disability. These services operate extended hours over 7 days a week.

Primary Mental Health Primary Intervention Team (PMH PICT)

- PMH provides education and support to GPs and primary health care providers within St Vincent's catchment in regard to the treatment of people with high prevalence disorders (eg. anxiety and depression). This may involve direct (one-off) assessment, treatment recommendations and assistance navigating the mental health and other support systems; or indirect support through secondary consultation.

Ms. Fran Timmins

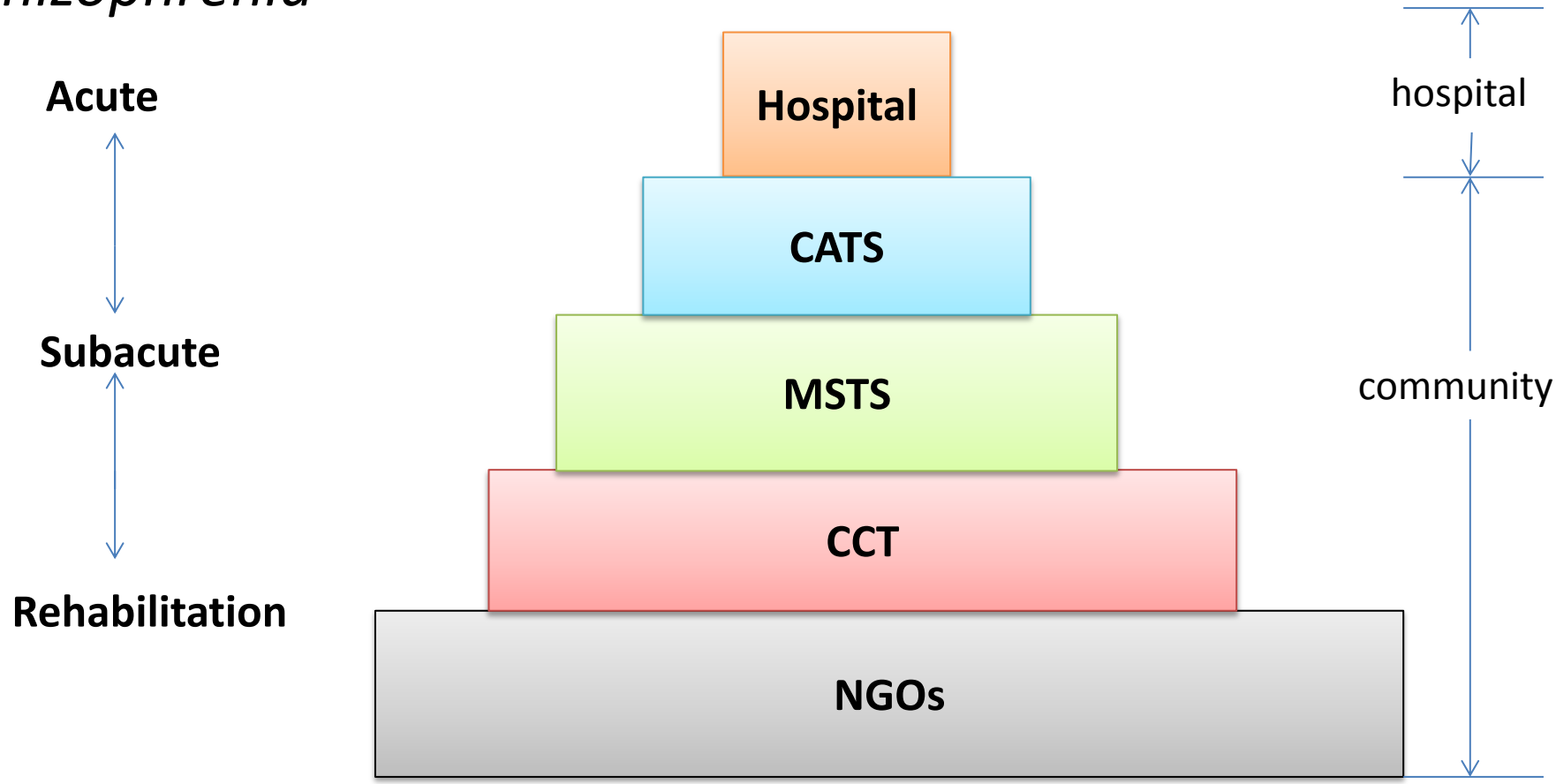
Primary Mental Health Primary Intervention Suicide Prevention (PMH HOPE)

- HOPE (Suicide Prevention): Aim to reduce suicide attempts and associated psychological distress for clients, their carers and families through coordinated care and assertive outreach support for people who have presented to the hospital following suicide attempt and/or associated behaviours.

  Referrals are from within the MH service.

Continuous Tx of schizophrenia: From hospital to community

Schizophrenia



Mental Health Act 2014 (Vic)

Mental Health Act 1986 vs 2014

Old term (1986)	New Term (2014)
Mental Health Review Board (MHRB)	Mental Health Tribunal (MHT)
Involuntary treatment	Compulsory treatment
Involuntary patient	**Compulsory patient** – a person who is subject to: (a) an assessment order (b) a court assessment order (c) a temporary treatment order (d) a treatment order.
Request and recommendation	**Assessment order** 24 hrs or 24 hrs after admission (and possibly up to 96 hours) for inpatients made by doctor or mental health practitioner if person meets assessment order criteria, allows for compulsory examination and detention (if inpatient) Note: Criteria only requires a person to 'appear to have mental illness'.
Involuntary treatment order	**Treatment order (community or inpatient)** temporary treatment order (authorised psychiatrist, 28 days max – or potentially 42 if the tribunal extends it in light of exceptional circumstances) treatment order (Mental Health Tribunal, if <16yo, max 3 months, if 16 and over, duration max 12 months community, 6 months inpatient)

Compulsory assessment and treatment pathway

The Mental Health Act 2014:

- promotes voluntary treatment in preference to compulsory treatment
- seeks to minimize the use and duration of compulsory treatment to ensure that the treatment is provided in the least restrictive and least intrusive manner possible
- establishes compulsory treatment orders comprising:
  - Assessment Orders
  - Temporary Treatment Orders
  - Treatment Orders

Compulsory assessment and treatment pathway - definitions

- Authorised person - ambulance paramedic, police officer, medical practitioner employed by a designated mental health service or mental health practitioner
- Authorised psychiatrist may delegate:
  - any power, duty or function of the authorised psychiatrist to a consultant psychiatrist except power to delegate
  - the powers, duties and functions of an authorised psychiatrist relating to Assessment Orders to a registered medical practitioner including:-
    - power to examine a person and extend the duration of an Assessment Order
    - power to assess a person subject to an Assessment Order and to
    - make a Temporary Treatment Order
    - power to revoke an Assessment Order.

Compulsory assessment and treatment pathway - definitions

- Designated mental health service – new term for approved mental health service

- Mental health practitioner is a registered nurse, registered psychologist, registered occupational therapist or social worker employed by a designated mental health service

Assessment Order criteria

Criteria for Assessment Orders:

- person appears to have mental illness
- the person appears to need immediate treatment to prevent serious deterioration in the person's mental or physical health or serious harm to the person or another person
- if the person is made subject to an Assessment Order the person can be assessed
- there is no less restrictive means reasonably available to have the person assessed.

Assessment order

Assessment Order may be made by a registered medical practitioner or mental health practitioner employed or engaged by a designated mental health service

- Community – maximum 24 hours
- Inpatient:
  - Maximum 72 hours for purpose of transport
  - max 24 hours when person received at hospital (authorised psychiatrist or delegated psychiatrist can extend up to two times for a total of 72 hours)

Treatment criteria

Criteria for Temporary Treatment Order and Treatment Orders (treatment criteria):

- person has mental illness
- the person needs immediate treatment to prevent serious deterioration in the person's mental or physical health or serious harm to the person or another person
- the immediate treatment will be provided if the person is made subject to an Order
- there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.

Temporary Treatment Orders and Treatment Orders

- Temporary Treatment Orders: made by authorised psychiatrist

Community or Inpatient (maximum duration of 28 days)

- Treatment Orders: made by Mental Health Tribunal
  - Community (maximum duration 12 months – adult; maximum duration 3 months person <18 years)
  - Inpatient (maximum duration 6 months – adult; maximum duration 3 months person <18 years)
- Setting (inpatient or community) may be varied by authorised psychiatrist as clinically appropriate
- Authorised psychiatrist must immediately revoke an order when the criteria no longer apply to the patient.

Authorised persons – powers under the MHA 2014

- Authorised person is an ambulance paramedic, police officer, medical practitioner employed by a designated mental health service and mental health practitioner
- Authorised persons under the Mental Health Act 2014 may:
  - enter premises
  - apprehend
  - search
  - use force and bodily restraint
  - transport people to a designated mental health service in prescribed circumstances.

Mental Health Tribunal (Vic)

President Matthew Carroll

Mental Health Tribunal

- The Mental Health Tribunal (the Tribunal) is an independent statutory tribunal established under the Victorian Mental Health Act 2014 (the Act).
- The Tribunal is an essential safeguard under the Act to protect the rights and dignity of people with mental illness.
- The primary function of the Tribunal is to determine whether the criteria for compulsory mental health treatment as set out in the Act apply to a person. The Tribunal makes a Treatment Order for a person if all the criteria in the legislation apply to that person.
- A Treatment Order enables an authorised psychiatrist to provide compulsory treatment to the person, who will be treated in the community or as an inpatient in a designated mental health service for a specified period. The Tribunal also reviews variations in Treatment Orders and hears applications for the revocation of an Order.

Mental Health Tribunal 2O16–2O17 Annual Report

Tribunal: Temporary Treatment Order to Treatment Order

- An authorised psychiatrist may make a Temporary Treatment Order for up to 28 days duration. The Tribunal is notified that a person has been placed on a Temporary Treatment Order and the Tribunal is required to list a hearing before the expiry of the 28 day period. This hearing is to determine whether or not the criteria are met to make a Treatment Order.
- The Tribunal must be satisfied that all of the treatment criteria apply to a person before making a Treatment Order. These criteria are:
  - the person has mental illness;
  - because the person has mental illness, the person needs immediate treatment to prevent:
    - serious deterioration in the person's mental or physical health; or
    - serious harm to the person or another person;
- the immediate treatment will be provided to the person if
- the person is subject to a Treatment Order;
- there is no less restrictive means reasonably available to enable the person to be immediately treated.

Tribunal: Temporary Treatment Order to Treatment Order

- When the Tribunal makes an Order, the Tribunal must determine the category of the Order, being a Community Treatment Order or an Inpatient Treatment Order, based on the circumstances in existence at the time of the hearing.
- The patient's treating team is required to regularly reconsider both the need for an Order and the treatment setting.
- The Tribunal also determines the duration of a Treatment Order. The maximum duration of a Community Treatment Order is 12 months, while an Inpatient Treatment Order can be for up to six months. Where the patient is under 18 years of age, the maximum duration of any Treatment Order is three months.

Mental Health Tribunal 2O16–2O17 Annual Report

Conduct hearing of MHT

- The Act requires the Tribunal to sit as a division of three members.
- A general division of the Tribunal can hear and determine all matters within the jurisdiction of the Tribunal except those relating to the performance of electroconvulsive treatment or neurosurgery for mental illness. Each division of three is made up of a legal member, a psychiatrist member or registered medical practitioner member, and a community member. The legal member is the presiding member.
- A special division of the Tribunal must hear and determine applications for the performance of electroconvulsive treatment or neurosurgery for mental illness. Each division of three is made up of a legal member, a psychiatrist member and a community member. The legal member is the presiding member.

Mental Health Tribunal 2O16–2O17 Annual Report

Determinations at Tribunal hearings

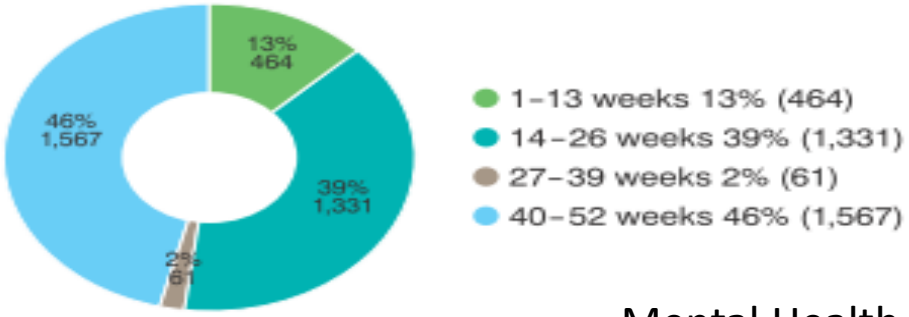
Type of hearing	2016–17	2015–16	2014–15
Hearings regarding a treatment order			
Community Treatment Orders made	3,423	3,121	2,588
Inpatient Treatment Orders made	2,502	2,482	2,324
Temporary Treatment Orders / Treatment Orders revoked	371	358	417
Hearings struck out	67	65	62
No jurisdiction	5	11	21
Total	6,368	*6,037*	*5,412*
Urgent applications for electroconvulsive treatment			
ECT Orders made	351	353	280
ECT applications refused	54	44	23
No jurisdiction	0	0	3
Total	405	*397*	*306*
Standard applications for electroconvulsive treatment			
ECT Orders made	237	267	270
ECT applications refused	46	42	45
No jurisdiction	0	0	0
Total	283	*309*	*315*

Mental Health Tribunal 2O16–2O17 Annual Report

Duration of Community Treatment Orders made

	2016-17		2015-16		2014-15	
	No.	%	No.	%	No.	%
1-13 weeks	464	13%	478	15%	403	16%
14-26 weeks	1,331	39%	1,193	38%	923	36%
27-39 weeks	61	2%	51	2%	62	2%
40-52 weeks	1,567	46%	1,399	45%	1,200	46%
Total	3,423	100%	3,121	100%	2,588	100%

Figure 4: *Duration of Community Treatment Orders made in 2016-17*

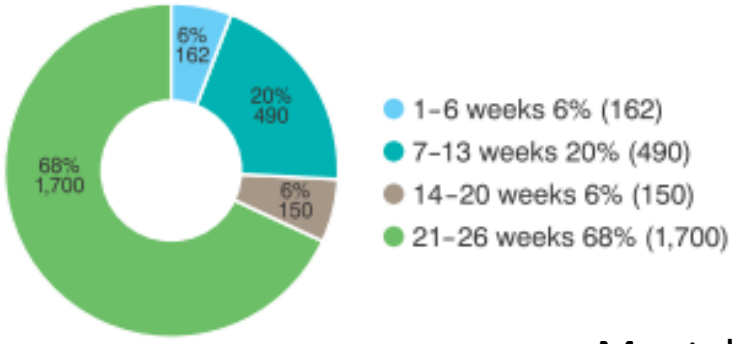


Mental Health Tribunal 2O16–2O17 Annual Report

Duration of Inpatient Treatment Orders

	2016-17		2015-16		2014-15	
	No.	%	No.	%	No.	%
1–6 weeks	162	6%	164	7%	233	10%
7–13 weeks	490	20%	546	22%	565	24%
14–20 weeks	150	6%	168	7%	157	7%
21–26 weeks	1,700	68%	1,604	65%	1,369	59%
Total	2,502	100%	2,482	100%	2,324	100%

Figure 5: *Duration of Inpatient Treatment Orders made in 2016-17*

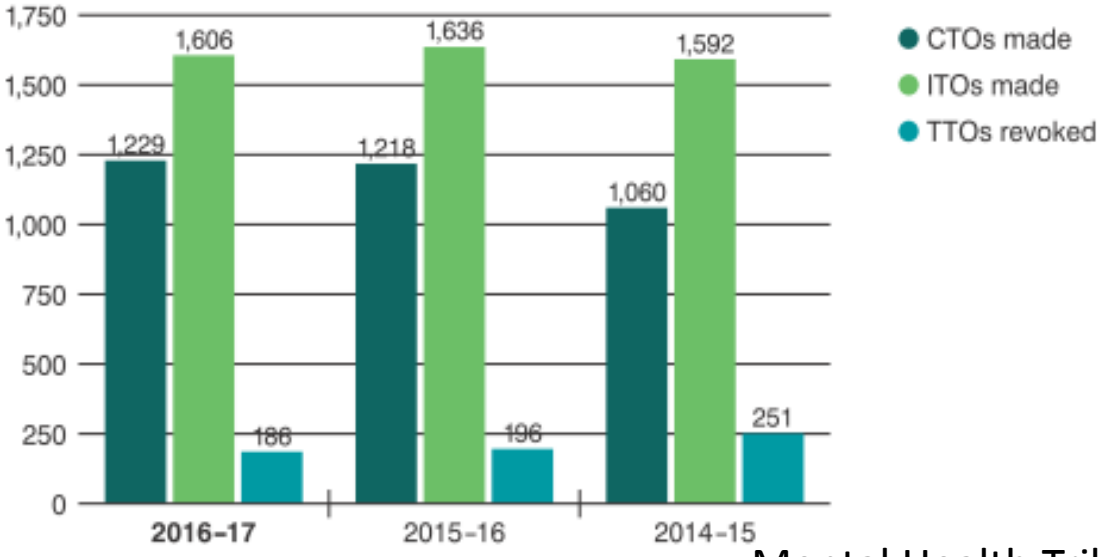


Mental Health Tribunal 2O16–2O17 Annual Report

Outcome of 28 days Hearings

	2016–17		2015–16		2014–15	
	No.	%	No.	%	No.	%
Community Treatment Orders made	1,229	41%	1,218	40%	1,060	36%
Inpatient Treatment Orders made	1,606	53%	1,636	54%	1,592	55%
Temporary Treatment Orders revoked	186	6%	196	6%	251	9%
Total Treatment Orders made or revoked	3,021	100%	3,050	100%	2,903	100%

Figure 6: *Outcomes of 28 day hearings*



Mental Health Tribunal 2O16–2O17 Annual Report

Hearings conducted by mode

	2016-17		2015-16		2014-15	
	No.	%	No.	%	No.	%
In-person	5,966	76%	5,502	74%	4,707	71%
Video conference	1,835	24%	1,956	26%	1,908	29%
Teleconference	25*	<1%	13	<1%	–**	–**
Totals hearings conducted#	7,826	100%	7,471	100%	6,615	100%

Mental Health Tribunal 2O16–2O17 Annual Report

Australia vs Taiwan

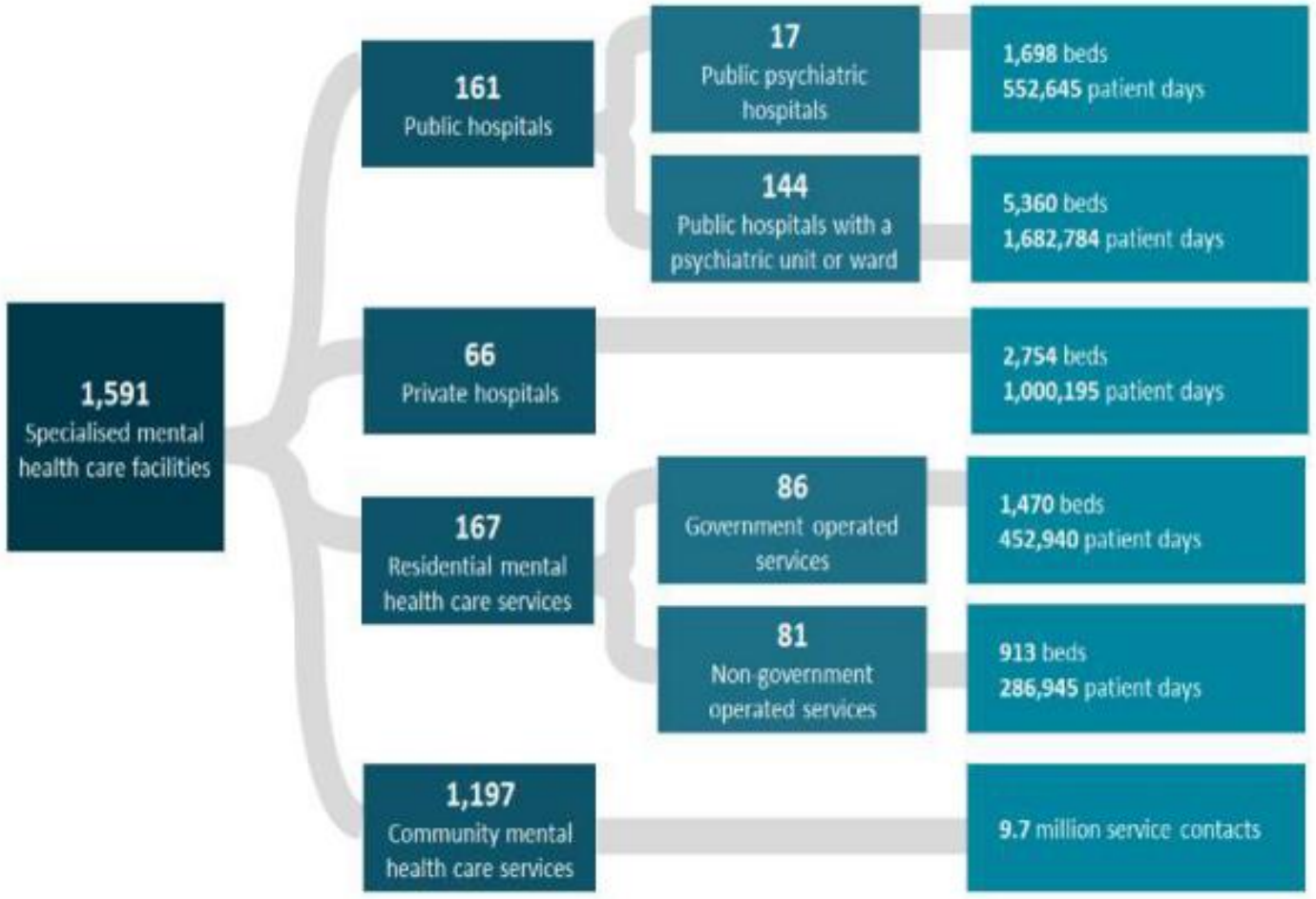
Australia vs Taiwan

- Australia
  - Population:24,715,868 (2018)
  - Total area: 7,686,850 Km^2
  - GDP: 1204.62 billion USD (2016)
  - NHE 佔GDP : 10.3% (2015-2016)
  - Adj suicide rate: 11.7 (2016)

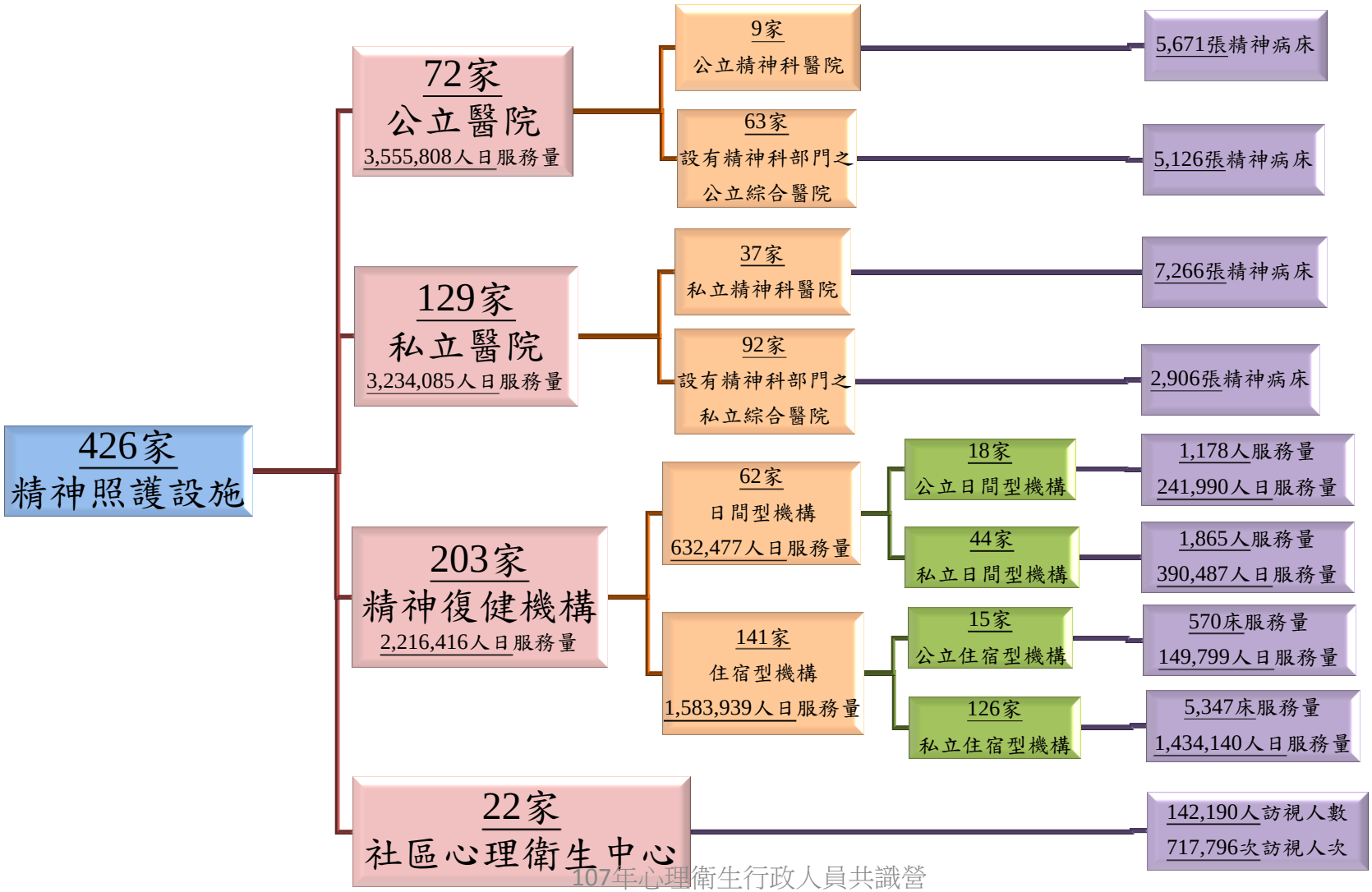
- Taiwan
  - Population: 23,682,521 (2018)
  - Total area: 35,980 Km^2
  - GDP 529.58 billion USD (2016)
  - NHE佔GDP: 6.3% (2016)
  - Adj suicide rate: 12.3 (2016)

- 澳洲人口與台灣相當
- 澳洲面積是台灣215.6倍

澳洲精神醫療系統與醫療利用, 2016



台灣精神醫療系統與醫療利用, 2016



澳洲與台灣精神機構家數與床數

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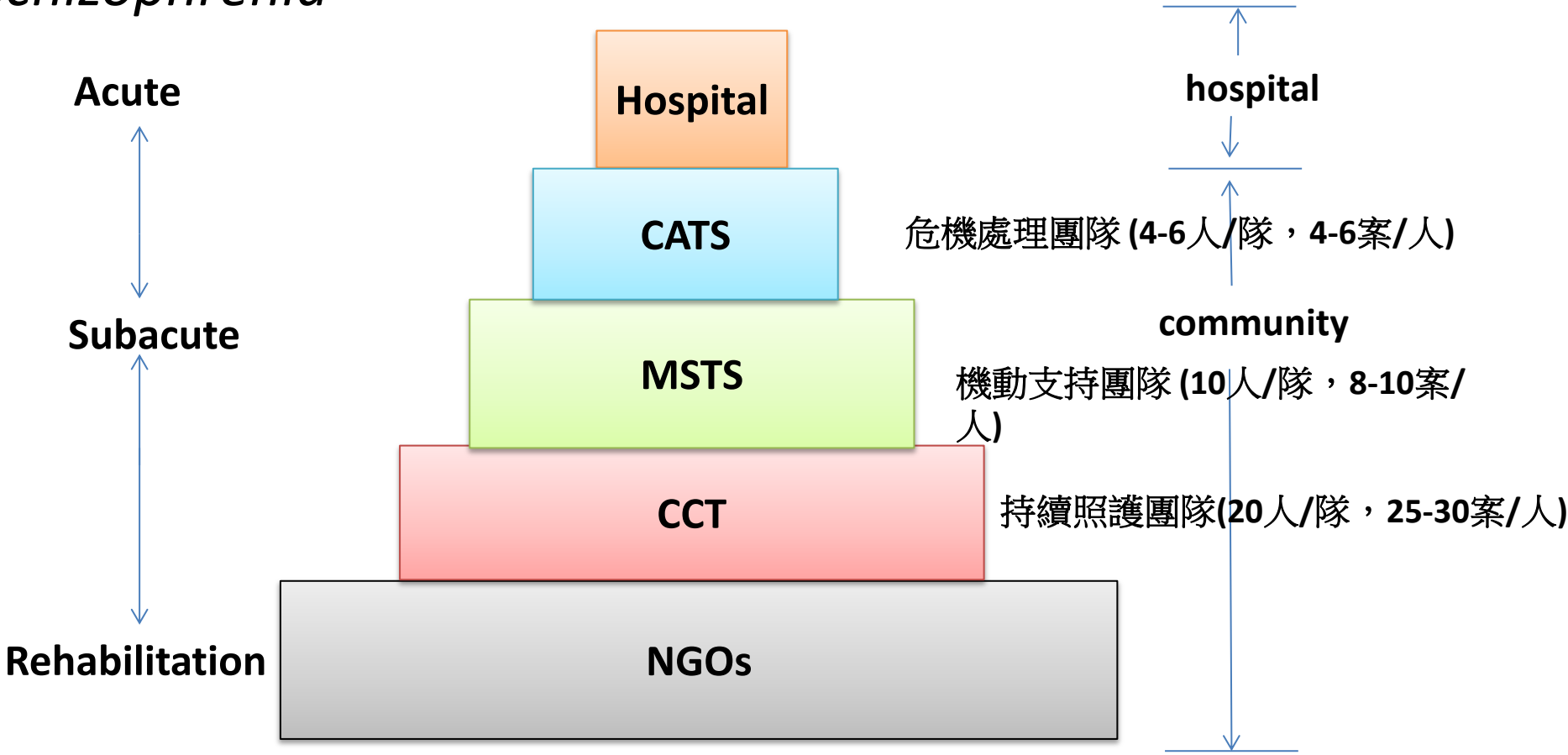
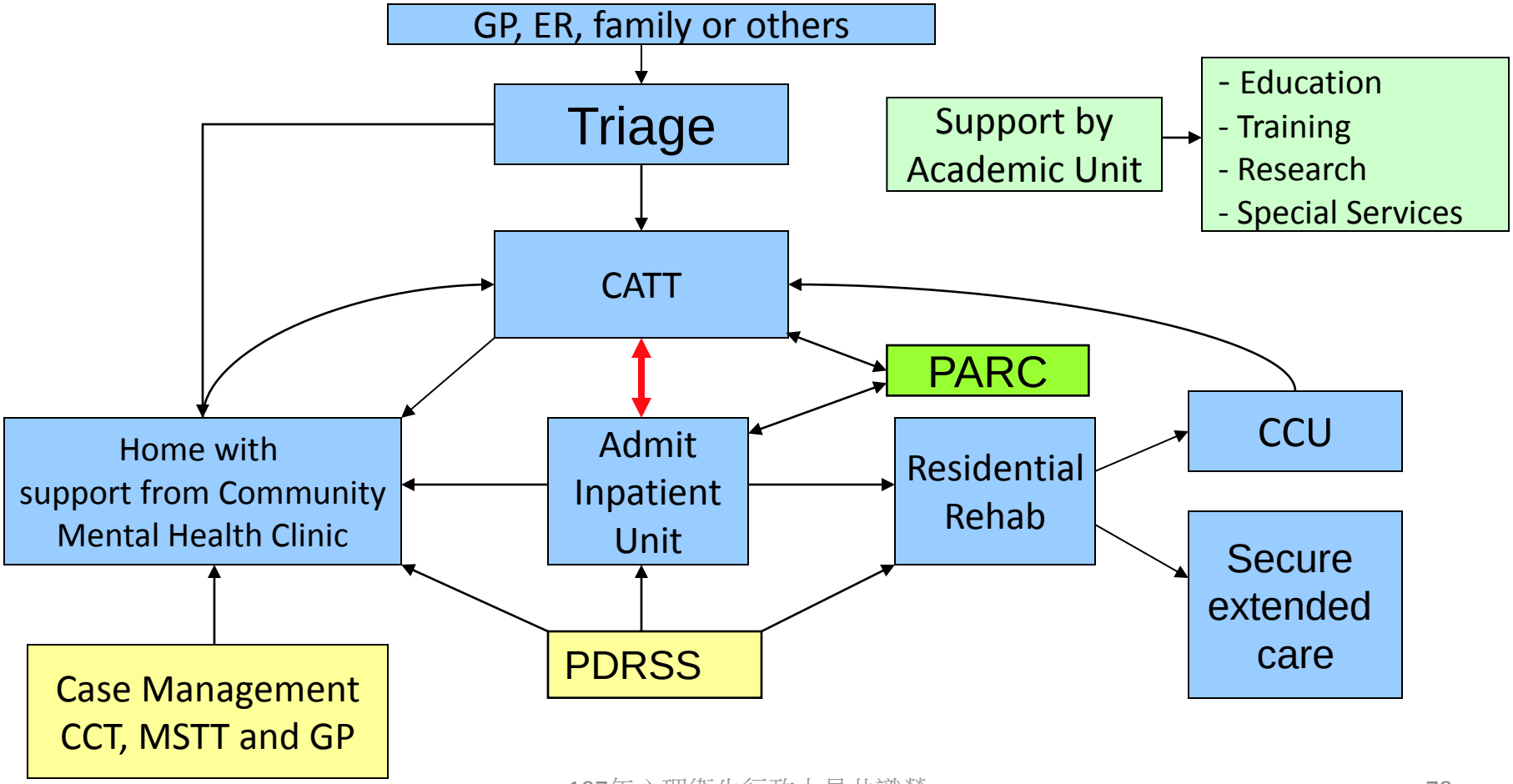
澳洲強調社區為基礎的精神醫療照護

Schizophrenia



Operational Flow Chart
Community Mental Health Service



澳洲與台灣的強制治療

		澳洲 (維多利亞省)	台灣
審查單位		精神衛生法庭	審查會
審查單位組成		3人 (精神科醫師、司法人員、社區人員)	7人 (專科醫師、護理師、職能治療師、心理師、社會 工作師、病人權益促進團體代表、法律專家及其他相關專業)
強制種類		(a) 強制評估 (社區、住院) (b) 強制暫時治療 (社區、住院) (c) 強制治療(社區、住院)	(a) 強制鑑定 (b) 強制治療 (住院、社區)
強制鑑定	條件	個案顯然有精神疾病; 需要立即治療去預防: 嚴重身心健康惡化; 或嚴重傷害自己或他人;	嚴重病人(現實脫節之怪異思想及奇特行為，致不能 處理自己事務，經專科醫師診斷認定者) 傷害他人或自己或有傷害之虞，
	決定者	註冊的醫療人員或精神醫療人員或精神醫療服務機構來決定	兩位專科醫師
	時間	社區 – 最長24 小時 住院 – 最長72 小時含交通	兩日內

澳洲與台灣的強制治療

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(社區)</td><td rowspan="2">條件</td><td rowspan="2">暫時強制住院者
個案有精神疾病;
需要立即治療去預防: 嚴重身心健康惡化; 或嚴重傷害自己或他人;</td><td>強制社區</td><td>強制住院</td></tr>
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他山之石

Thank you for your attention