

Review of the National Mental Health Statement of Rights and Responsibilities

Mental Health Coordinating Council
Submission

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1. Executive Summary

The Mental Health Coordinating Council (MHCC) is the peak body for non-government community managed mental health organisations (NGOs/CMOs) and services in NSW. Our membership is more than 250 organizations and individuals whose business is related to the promotion or delivery of services for the social inclusion, wellbeing and recovery of people with mental health problems and their families and carers.

In general, the draft Statement is supported by MHCC but could also be further improved within the context of this being a 'limited review'. Some suggestions for this to occur are summarised below and further discussed throughout our submission. In responding, we draw attention to the fact that MHCC represents Community Mental Health Australia (CMHA), a coalition of the eight state and territory community sector mental health peaks which sits on the Safety and Quality Partnership Subcommittee (SQPS) of the Mental Health Standing Committee currently overseeing review of the National Statement of Mental Health Rights and Responsibilities that was first introduced in 1991 (hereafter referred to as "the Statement" and "the draft Statement").

MHCC commends the Department of Health and Ageing (DoHA) and the Centre for the Advancement of Mental Health and Law (CALM) for the work undertaken to date in the limited review of the Statement. We thank the Department for the opportunity to provide this submission in response to the draft Statement.

In particular, we welcome incorporation of the expectations of the UN Convention of the Rights of People with Disabilities (UNCRPD, 2007) including the openness to inclusion of issues related to Australia's position/non-ratification of content related to involuntary treatment. This is described in CALM's consultation 'Introduction' paper as "a declaratory statement to the effect that the UNCRPD is interpreted by the Australian government as permitting involuntary psychiatric treatment, provided that involuntary treatment is a measure of last resort".

It is important that people affected by mental illness, mental health service providers and the broader community are provided with opportunities to have a frank, open, reconciliatory – and hopefully healing - discussion about the health and social impacts of coercive treatment, including traumatisation/re-traumatisation, in comparison to non-discriminatory and human rights based approaches. We propose that there could be additional value in further linking the draft Statement itself to the UNCRPD and to the recommendations of World Network of Users and Survivors of Psychiatry Implementation Guide for the UNCRPD (2008). The inclusion of more contemporary content related to capacity and decision making, including supported decision making and use of advance directives is an important addition which also needs further development.

To consult with MHCC member organisations and other interested people we used an e-survey process (Survey Monkey) utilising the specific consultation questions. The survey approach used could have benefited from the opportunity for respondents to provide additional comments for all questions (i.e., this option was only available for questions six and eight with all others only having the option of a 'yes' or 'no' response).

We received responses from 15 organisations/individuals and these results are incorporated in this submission. We also include additional interpreting comments and value added through our knowledge of sector- based issues as a community mental health peak body in NSW for 27 years.

An interesting finding was lack of knowledge by some survey respondents regarding complimentary legislation, conventions and jurisdictional policy relevant to mental health rights and responsibilities. We therefore suggest that the new Statement could include a summary and further explanation of these, including stronger linkages to the UNCRPD, and provide direction to places

to access this information. An example of a NSW approach is MHCC's Mental Health Rights Manual, an online resource available on our website written in plain English which brings together vital information crucial to anyone having to navigate the mental health system, enabling them to become acquainted with their rights, the legal and service system, and to access support and guidance.

The low number of survey respondents is of concern, nevertheless this may have been because of time constraints or that organisations/individuals preferred to make their own responses. It could also be that there were barriers to participation for consumers, carers and the community – including the community sector – in responding to consultative processes online, and ideally more facilitative approaches are required.

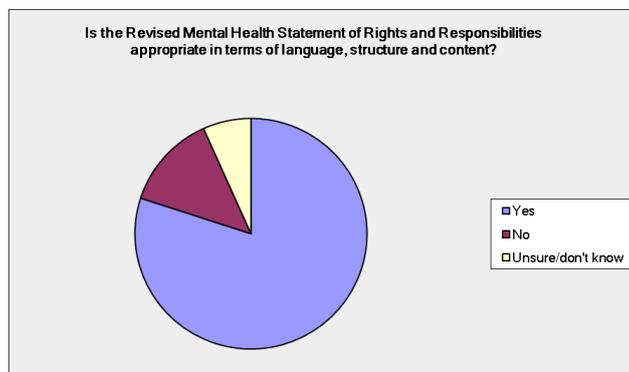
It has been 20 years since the first Statement was endorsed and while much has changed in the mental health policy landscape this has not translated well to achieving community based and recovery oriented services that result in meaningful health and social outcomes for people affected by mental illness. The review of the Statement against the revised National Mental Health Policy 2008 (2009), including new national directions for National Health and Hospital Reform and enhanced roles for primary healthcare providers in mental health service delivery, provide important opportunities for achieving recovery oriented services.

Summary of MHCC's recommended improvements:

1. Include specific content and references in the Statement linking it to the UNCRPD.
2. Develop a plain English version of the Statement (i.e., for people with low literacy and/or other cognitive impairment).
3. Include a summary of rights and responsibilities at the front of the Statement including definitions for the terms 'rights' and 'responsibilities' both here and in the Glossary.
4. Include a summary, further explanation and/or direct people to places to find more information about complimentary legislation, conventions and jurisdictional policy relevant to mental health rights and responsibilities.
5. Revisit and make more explicit (i.e., discuss in the Statement and define in Glossary) the language and service delivery approaches of "support, care, treatment, recovery and rehabilitation" used throughout the document.
6. Revisit and make more explicit (i.e., discuss in the Statement and define in Glossary) the language, functions and philosophical approaches of "supporters and advocates".
7. Part III of the draft Statement is not sufficiently developed with regard to "the general obligation to provide mental health services and community pathways to service access" and expectations regarding the need for integrated and coordinated care should be made more explicit here and throughout the document.
8. Include guidance on the preferred model of mental health service delivery in line with the optimal mix of services recommended by the World Health Organisation (WHO).
9. Review language throughout the document for accuracy in promoting community-based and recovery-oriented versus hospital/medical approaches (e.g., instances where; "services" might replace "treatment"; "entry" might replace "admission"; "exit" might replace "discharge", etc.).
10. Engage in additional and more facilitative consultation processes with consumers and carers as the draft Statement continues to develop.
11. Strengthen accountability mechanisms for ensuring the rights and responsibilities of consumers, carers, service providers and the broader community are upheld.

2. Response to Consultation Questions

2.1 Language, structure and content



Survey respondents largely supported the language, structure and content of the draft. With regard to language, MHCC notes a shift from “care, treatment and rehabilitation” – the phrase used in the 1991 Statement - to “support, care, treatment, recovery and rehabilitation” throughout the revised draft Statement. The inclusion of the words ‘support’ and ‘recovery’ are important additions to the Statement. However, nowhere in the document are any of these words defined or discussed in terms of what they are describing. There is an assumption of knowledge regarding all these functions including how they are similar and/or different from one another with regard to who does what and where. This assumption will continue to present problems for consumers, carers and mental health service providers in asserting their rights and responsibilities, particularly in the absence of an agreed national model for mental health service delivery.

The Appendix to this document provides an overview of key service provision related terms as defined in the glossaries of recent National Mental Health Strategy documents (i.e., the Policy, Plan and Standards). This has been provided to highlight the lack of consensus regarding key service delivery functions, most notably with regard to the concept of (psychosocial) rehabilitation. Rehabilitation approaches require strong links with services outside of the health/mental health sectors such as, for example, employment, education and housing (i.e., social/community services).

Of particular concern is the use of the word ‘recovery’ in a phrase that is otherwise about service types. Recovery is not a service type although services may be, and hopefully are, recovery oriented and supportive of recovery outcomes (i.e., not just reduction of illness/symptoms but housing, employment and social connectedness). Recovery refers to the personal journey of the person living with mental illness and is defined by the National Mental Health Policy (2009, p31):

A personal process of changing one’s attitudes, values, feelings, goals, skills and/or roles. It involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. The process of recovery must be supported by individually-identified essential services and resources.

Language issues are also present in content related to the respective rights and responsibilities of “supporters and advocates” and these are further discussed in Section 2.4.

An additional language concern relates to the accessibility of the language used for people with low literacy and/or cognitive impairment that may or may not accompany mental illness but are

frequently experienced by people with low prevalence disorders (i.e., psychotic illnesses and/or symptoms). A process of facilitated consultation should be used in the development of the Statement which should also be made available as a 'plain English' document to overcome barriers to access.

With regard to structure, the Statement would benefit from a summary of rights and responsibilities at the front of the Statement. This would ideally include definitions for the terms 'rights' and 'responsibilities' both here and in the Glossary.

With regard to content, some discussion about how the first Statement has been helpful in achieving the aspirations of the first National Mental Health Policy and accountabilities of the National Mental Health Plan and how the revised Statement will build on these directions could be included. In addition, Part III of the draft Statement is not sufficiently developed with regard to "the general obligation to provide mental health services and community pathways to service access". Likewise, expectations regarding the need for integrated and coordinated care should be made more explicit here and throughout the document (these considerations are discussed further in responding to the next question).

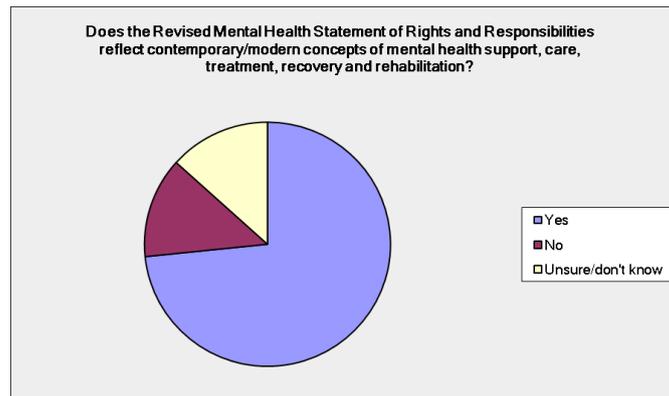
Survey respondent's comments:

The language and set out of the original Statement is much more consumer friendly and accessible. The definitions of recovery are disability focussed rather than mental health recovery orientated.

... the language is still formal and for people with literacy or CALD/Aboriginal language issues it needs a different rewrite.

I suggest that near the beginning is a list of all the rights, so it's easy to photocopy and give to consumers as a one/two page sheet document - rather than have to wade through the whole document in order to find out the most basic of rights - then continue with the explanations.

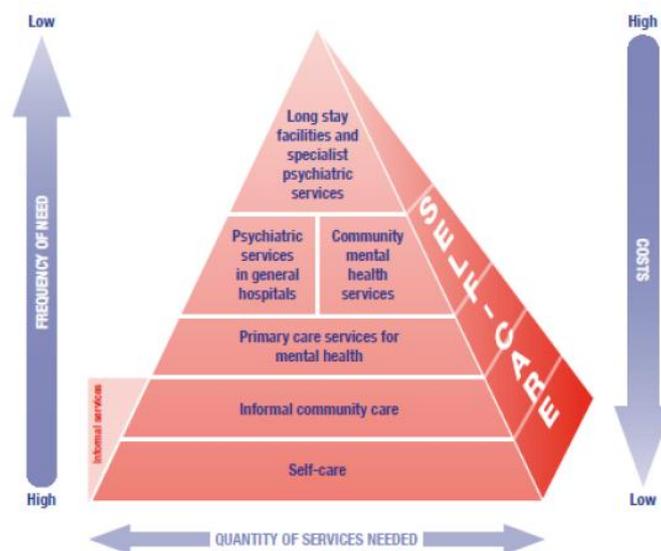
2.2 Currency



Survey respondents largely supported the currency of the draft Statement. Incorporation of the expectations of the UNCRPD and the inclusion of more contemporary content related to capacity, informed consent, supported decision making and use of advance directives is an important aspect of review of the Statement. While noting that this is a 'limited review', MHCC believes that the draft has not sufficiently incorporated the current evidence regarding community-based and recovery oriented service provision (i.e., social as compared to medical/hospital based approaches).

The World Health Organization (WHO, 2008 & 2003) model for mental health service delivery is based on known best practice and promotes the involvement of individuals in their own mental health care, a community-based orientation, with a human rights focus that embraces the following principles: no single service setting can meet all population health needs; essential components of any mental health system include support, supervision, collaboration, information-sharing and education across different levels of support; and, individuals experiencing mental illness need to be involved, to a degree which suits them, in their own recovery.

Figure 1: WHO Service Organisation Pyramid for Optimal Mix of Mental Health Services



WHO note that mental health services should exist in primary health care, community-based and institutional settings. For community based settings there should be both 'formal' (i.e., treatment) and 'informal' (i.e., psychosocial support) mental health services. Figure 1 illustrates the Optimal Mix of Services Pyramid developed by WHO in 2007 and indicates that: psychiatric hospitals should be the least frequently used service type in the mental health system; psychiatric services based in general hospitals and specialist community mental health services should be available; primary healthcare is an essential component supporting mental health; and, informal community mental health services provide broad based, general support. The model is silent as to where 'rehabilitation/habilitation' and other evidence based practices are situated but this likely to be across the entire continuum of services.

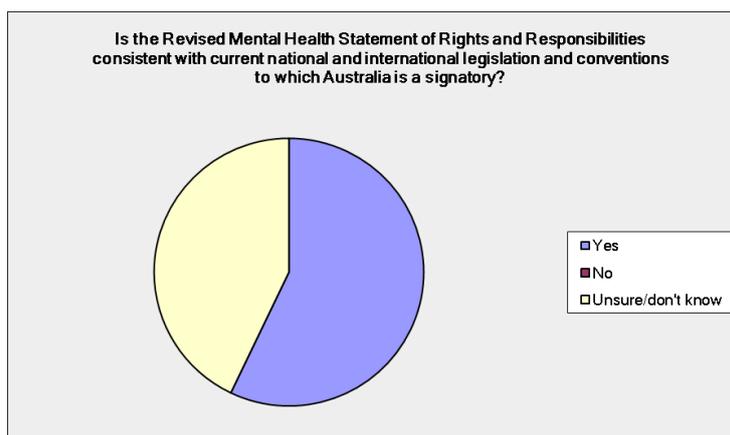
While the limited scope of the Statement review does not lend itself to development of an agreed model for community-based and recovery-oriented service provision, at a minimum, the terms "support, care, treatment, recovery and rehabilitation" should be elaborated upon and defined. This will also be important toward achieving "the general obligation to provide mental health services and community pathways to service access" (i.e. draft Statement Part III). In the first instance, the WHO model could be referenced in Part III (ii) – The Prevention of Mental Health Problems and/or Mental Illness. Part III (iii) – Access to Services and Opportunities - could build on this by noting the availability of service types to be accessed as described by the WHO model. Part IV – Recognition and Referral – could expand on this by making more explicit the important concepts of integrated and coordinated care, including person-centered and self-directed care approaches.

Survey respondent's comments:

The basis of DSMIVR as main diagnostic framework is also questionable – it maintains the power base of psychiatrists (not all psychiatrists). More evidence of trauma and complex underpinning symptomatology - so when do we let people know not to assume the 'correctness' of a diagnosis(es) when different doctors provide different diagnoses for same patient consistently.

Attitudes towards medication and its benefits is biased towards drug companies and doctors when there is as much evidence that placebo in trials has a similar correlation effect as those who 'benefit'.

2.3 Consistency with legislation and conventions



A large number of survey respondents were uncertain as to whether the revised Statement was consistent with current national and international legislation and conventions to which Australia is a signatory. This may be that respondents are unfamiliar with legislations/conventions and/or that the developmental state of the draft Statement does not allow them to form a view. The larger number of respondents stating that the draft Statement is consistent with legislations/conventions suggests that alignment with the UNCRPD is supported and that the current consultation – especially with consumers and carers - is timely to build upon the draft Statement.

This same pattern presented for Question 5 regarding policy alignment and this suggests that there could be value for the Statement to include a summary, further explanation and/or direct people to places to find more information about complimentary legislation, conventions and jurisdictional policy relevant to mental health rights and responsibilities. This discourse currently sits only within CALM's consultation introductory paper and could be made more explicit either as a preamble and/or Appendix to the Statement.

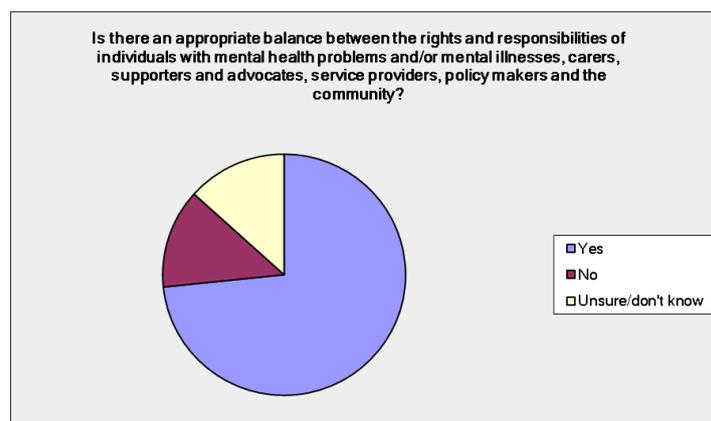
With regard to consumer, care and community consultation – these stakeholder groups don't necessarily speak the technical language of legislations, conventions and policy. It is important for any consultative process to use more facilitative and plain English approaches to ensuring that these important alignments are occurring as the Statement continues to develop.

Survey respondent's comments:

The issue is now, and always has been, that a person's rights can be and often are ignored on the grounds of their putative insanity. Furthermore, the definition of 'ability' and 'capacity' are subjectively determined based on 'professional' judgement. Where it is required that more than one professional makes that judgement, they may well collude together in the interests of their professional relationship to determine a person has no capacity to make decisions about their care.

Nothing about us without us?

2.4 Balance of rights and responsibilities



The majority of survey respondents stated that there is an appropriate balance of rights and responsibilities for consumers, carers, supporters and advocates, service providers, policy makers and the community. However, as previously noted the phrase “supporters and advocates” is confusing and requires clarification. These concepts are further complicated through being joined up with content related to carer rights and responsibilities.

We note that the term ‘supporters’ is introduced in CALM’s consultation Introductory document towards the UNCRPD aspiration of all stakeholders working together in a coordinated way to facilitate client self-directed care, and to achieve supported decision making approaches that are more meaningfully inclusive of capacity and participation considerations, but that this has not translated well across to the draft Statement. Furthermore, the use of the term ‘supporters’ for achieving this purpose is questionable against an Australian background and context of non-government community mental health services (i.e., NGOs) being perceived as the key providers of support services as demonstrated by the definitions provided in Appendix 1. Further clarification of the terms and functions of: “supporters and advocates” must occur while also clarifying the phrase “support, care, treatment, recovery and rehabilitation”.

Appendix 2 provides a summary of advocacy related terms in glossaries of national mental health strategy documents. None of the current National Mental Health Strategy documents include definitions for the term ‘supporters’ or phrase “supporters and advocates”. However, all National Mental Health Strategy documents, including the National Mental Health Policy (2009, p. 28), defines advocacy as:

Representing the concerns and interests of consumers and carers, speaking on their behalf, and providing training and support so they can represent themselves.

The National Mental Health Strategy definition of advocacy differs conceptually from the content of the draft Statement and these differences, along with the Glossary definition provided for “Advocates”, need to be reconciled. That fact that advocacy can be undertaken by anyone is implicit in the Strategy definition (i.e., it is not just a defined job role for consumer advocates), and this applies conceptually to the concept of support service provision as well. However, both functions are ideally undertaken with a view toward protecting the rights of, and promoting self-advocacy and self-directed care by, the person living with mental illness. It may be that the term ‘supporters’ needs to be replaced by the conceptually similar term ‘advocacy/ advocates’ as understood by the National Mental Health Strategy in the Statement, and this needs to be further consideration by stakeholders including specific discussion with consumers and carers.

Several survey respondent comments received related to confusion and tensions that the current content regarding “supporters and advocates” elicits with regard to both consumer advocate/peer worker vocational roles and the balance of respective rights and responsibilities between peer workers – especially those in consumer advocate roles – as well as carers and families. Further delineation of the respective rights, responsibilities and roles of paid (i.e., service provider whether in identified peer work roles or not) and unpaid (i.e., family and friends) supporters/advocates is needed.

The Statement would be strengthened through clarification of language and conceptual issues related to “supporters, carers and advocates” including discussion of these issues in the body of the document and revisiting definitions of these and related terms in the Glossary.

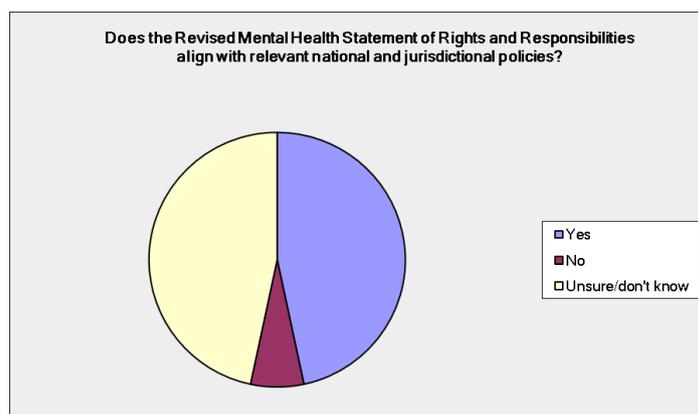
Survey respondent’s comments:

I have answered the initial questions in the negative to ensure that the section on consumer advocates is picked up and totally reworded to ensure that no consumer advocate exceeds the inherent boundaries of the consumer advocates role.

Sections 48 and 49 - re consumer advocates have consumer advocates lumped in together with family members etc. and given 'rights' which clearly go way beyond the advocacy role, even though it is with the consent of the consumer.

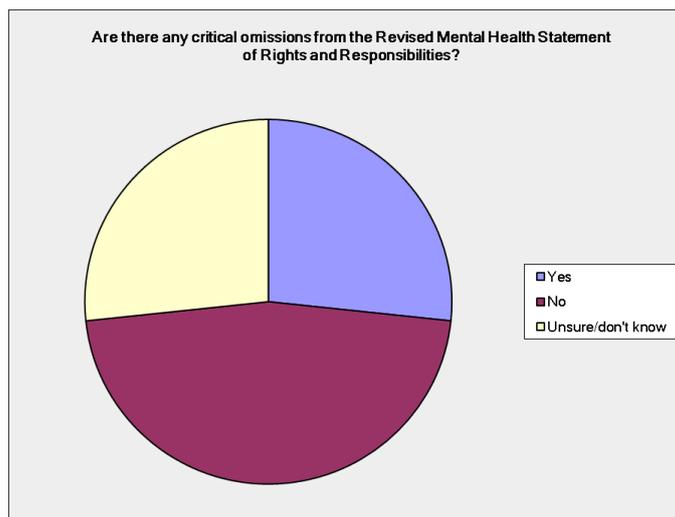
I suggest you separate these population groups and clearly articulate the actual rights that differ for carers and family members to that of consumer advocates. This is a very critical mix up. Omission of the consumer advocacy role and can be totally misinterpreted down the track by people inexperienced in the advocacy role and also by service providers.

2.5 Policy alignment



A large number of survey respondents were uncertain as to whether the revised Statement aligned with relevant national and jurisdictional policies and MHCC’s thoughts about this were outlined in responding to consultation Question 4.

2.6 Omissions

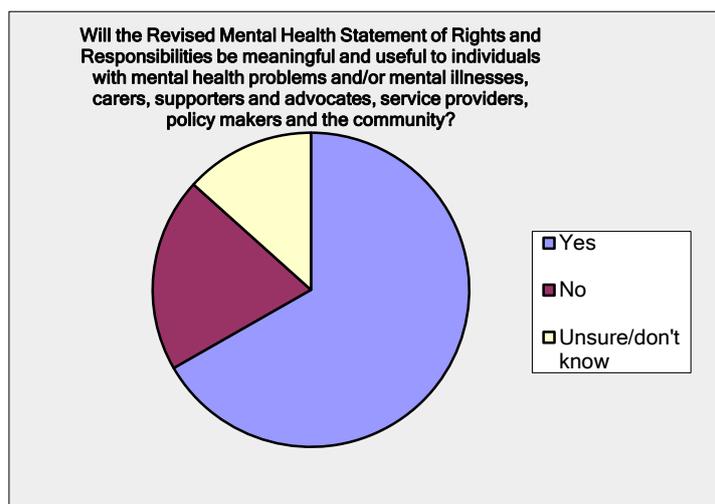


Comments from those that said 'yes' (i.e., that there were critical omissions in the draft Statement) have been used throughout this submission to further illustrate the feedback provided. In summary, survey respondents noted omissions as related to:

- Accessibility of language used in the draft Statement including recovery orientation
- Continuing dominance of medical model approaches
- Confusion and tension around the respective rights of people living with mental illness, consumer advocates/peer workers and carers/families
- Insufficient/confusing information regarding rights in determination of capacity

MHCC asserts that more specific content and references in the Statement directly linking it to the UNCRPD is also an important omission along with the need for information and references to places where people can find more information about complimentary legislation, conventions and jurisdictional policy relevant to mental health rights and responsibilities.

2.7 Utility



Most survey respondents stated that the revised Statement would be meaningful and useful to a variety of stakeholder groups. However, a substantial number also disagreed with this statement or did not know. MHCC propose that the draft Statement needs a strengthened balance of consumer, carer, service provider and community rights and responsibilities (and we note the intentional omission here of the phrase “supporters and advocates” for reasons elaborated upon previously). Addressing the feedback provided by MHCC regarding the concepts, language and meaning of “support, care, treatment, recovery and rehabilitation” and “supporters and advocates” will be important towards ensuring this balance.

Some survey respondents were critical that the revised Statement had not gone close enough in ensuring that the rights of people living with mental illness were understood, articulated and/or asserted. These concerns are illustrated by the comments below and are provided elsewhere in this submission. The issue here appears to be one of accountability. That is, how might we best ensure that the respective rights and responsibilities of consumers, carers, service providers and the broader community are upheld? Necessary also are strategies that identify where rights and responsibilities are at their weakest in terms of implementation, and target these areas for related quality improvement activity.

Without an evaluation strategy it is difficult to objectively say whether the balance is right. Part V of the draft Statement - Standards and Accountability – is not sufficiently developed with regard to accountabilities. It is also important that the Statement includes a section on complaints mechanisms and avenues to assist people if they believe their rights are not being upheld?

Survey respondent’s comments:

I answered no to Q7 because the major source of stigma and discrimination towards people with mental illness comes from mental health professionals. You can pass all the legislation you like but until it is enforced nothing will change. It is a deeply ingrained and culturally reinforced attitude. They are socialised into these attitudes by the service culture. Until such time as concerted efforts are made to effect culture change, the human rights of people who are distressed will continue to be ignored in practice.

I notice that the word ‘should’ is used throughout the document. When will Australia come to a place that mental health services ‘will’ implement rather than ‘should’ implement?

2.8 Other

As previously noted, all comments provided by survey respondents have been used throughout this submission to further illustrate the feedback provided.

The following additional feedback is provided in regard to issues related to the rights of people receiving involuntary care and the principle of least restriction:

- Clause 24 (j) should add more emphasis on the principle that reviews of involuntary treatment and detention should be not only regular but also timely. An additional sentence should be added to provide a right to an independent and timely review of a person's detention as soon as practicable after a person is assessed by medical practitioners needing to be compulsorily detained and treated for a mental illness. Only in exceptional circumstances should patients be detained for over a week without an independent review.
- The Statement should clearly restate the principle of least restriction in relation to those with mental illness interacting with the criminal justice system including when considering diversionary options in the criminal justice system. This principle should apply to: all courts and tribunals making orders in relation to people who are found unfit to stand trial or not guilty because of mental illness, in deciding whether they are to be detained or released; and, all courts when dealing with applications for bail and in sentencing people with cognitive and mental health impairments, including Magistrates Courts (called Local Courts in NSW).
- Inclusion of the right of forensic patients who have not been convicted of an offense to not be held in a correctional rather than a therapeutic setting (as is currently the case in NSW).

MHCC thank the organisations and individuals who took the time to complete the e-survey that helped inform this submission and provided us with rich material with which to support the recommendations we propose.

3. References

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World Health Organisation (2007), *The Optimal Mix of Services for Mental Health*. Mental health policy, planning and service development information sheet (accessed July 2009). Geneva.

World Health Organisation (2003), *Organisation of services for mental health*. (Mental Health Policy and Service Guidance Package). Geneva.

World Network of Users and Survivors of Psychiatry (2008), *Implementation Guide for the United Nations Convention on the Rights of People with Disabilities*.

Appendix 4.1

Service Provision Related Terms in Glossaries of National Mental Health Strategy Documents

Term	National MH Policy 2008 (2009)	Fourth National MH Plan (2009)	National MH Standards (2010)	Draft Statement (2011)
Care	n/a	n/a	All services and interventions provided to a person with a mental health problem and / or mental illness by health and other sectors, community organisations, family and carers.	n/a
Rehabilitation	n/a	n/a	n/a	Rehabilitation refers to the restoration of capacity and ability. It generally applies to individually tailored processes that an individual may require to re-adapt to society after acquiring a disability.
Services	n/a	n/a	Products of the organisation delivered to consumers or units of the organisation that deliver products to consumers.	Mental health services provide support, care, treatment, recovery and rehabilitation or community support targeted towards people with mental health problems and/or mental illnesses. Mental health services may be provided by organisations operating in the public, private and non-government sectors.
Service Provider	n/a	n/a	A person, usually with professional qualifications, who receives remuneration for providing services to people who have a mental health problem and /or mental illness.	A service provider is someone (usually with professional qualifications) who receives remuneration for providing services to people with mental health problems and/or mental illnesses.
Staff	n/a	n/a	Term which includes employed, visiting, sessional, contracted or volunteer personnel.	n/a
Supporter	n/a	n/a	n/a	A supporter is someone who assists individuals with mental health problems and/or mental illnesses to make decisions about their support, care, treatment, recovery and rehabilitation.

Term	National MH Policy 2008 (2009)	Fourth National MH Plan (2009)	National MH Standards (2010)	Draft Statement (2011)
Support (services)	n/a (below of relevance) Psychiatric Disability Support Services Services provided by the non-government sector including: physical healthcare; assertive outreach; advocacy services; peer support services; consumer-operated services; and programs addressing areas such as living skills, vocational training, accommodation support and respite care.	n/a (below of relevance) Non-government mental health sector: Private, not-for-profit, community managed organisations that provide community support services for people affected by mental illness and their families and carers. Non-government organisations may promote self -help and provide support and advocacy services for people who have a mental health problem or a mental illness, and their carers, or have a psychosocial rehabilitation role. Psychosocial rehabilitation and support services provided by non-government community agencies include housing support, day programs, pre-vocational training, residential services and respite care.	Direct services and interventions provided for a person with a mental health problem and / or mental illness and associated disability aimed at reducing handicap and promoting community tenure, for example assistance with cooking and cleaning. Support services do not necessarily have a treatment or rehabilitation focus.	n/a
Treatment	n/a	n/a	Specific physical, psychological and social interventions provided by health professionals aimed at the reduction of impairment and disability and / or the maintenance of current level of functioning.	n/a

Appendix 4.2

Advocacy Related Terms in Glossaries of National Mental Health Strategy Documents

Term	National MH Policy 2008 (2009)	Fourth National MH Plan (2009)	National MH Standards (2010)	Draft Statement (2011)
Advocacy	Representing the concerns and interests of consumers and carers, speaking on their behalf, and providing training and support so they can represent themselves.	Representing the concerns and interests of consumers and carers, speaking on their behalf, and providing training and support to enable them to represent themselves.	Representing the concerns and interests of consumers and carers, speaking on their behalf, and providing training and support so they can represent themselves.	n/a
Advocates	n/a	n/a	n/a	Advocates are people who have been appointed, or have been chosen by individuals with mental health problems and/or mental illness to seek the outcomes the later desire. Advocates are directly accountable to individuals with mental health problems and/or mental illness.
Carer	n/a	A person who has a caring role for a person with a mental health problem or mental illness. They could be family, friends or staff and be paid or unpaid. The role of the carer is not necessarily static or permanent, and may vary over time according to the needs of the consumer and carer.	A person whose life is affected by virtue of close relationship with a consumer, or who has a chosen caring role with a consumer. Carer, in this document, may also refer to the consumer's identified family, including children and parents, as well as other legal guardians and people significant to the consumer.	A carer is someone who by virtue of his or her close relationship with an individual has become involved, or has chosen or contracted to be involved, in the care of that individual.

Term	National MH Policy 2008 (2009)	Fourth National MH Plan (2009)	National MH Standards (2010)	Draft Statement (2011)
Carer Consultants	People who have experience of caring for a person with a mental illness. They are employed by public mental health services, and have a good knowledge of the mental health system and the issues that are faced by families and other carers. Carer consultants provide emotional support, information and referral advice for families and carers. They also work with mental health staff in developing service responsiveness to the needs of carers and families.	People who have experience of caring for a person with a mental illness. They are employed by mental health services, and have knowledge of the mental health system and the issues that are faced by families and other carers. They work with mental health staff in developing service responsiveness to the needs of carers and families.	n/a	n/a
Consumer	n/a	A person who uses or has used a mental health service.	A person who is currently using, or has previously used a mental health service.	n/a
Consumer Advocate	n/a	n/a	People who have been given the power by consumers to speak on their behalf, who represent the concerns and interest of the consumer as directed by the consumer, and seek the outcomes desired by the consumer. Although government and others may give power to advocates, such advocacy is token unless it is directly accountable to the consumer.	Consumer advocates are advocates (as defined above) who also advocate for systemic change.
Consumer Consultant	Consumers who are employed to advise on and facilitate service responsiveness to people with a mental health problem or mental illness and the inclusion of their perspectives in all aspects of planning, delivery and evaluation of mental health and other relevant services.	Consumers who are employed to advise on and facilitate service responsiveness to people with a mental health problem or mental illness and the inclusion of their perspectives in all aspects of planning, delivery and evaluation of mental health and other relevant services.	n/a	n/a

Term	National MH Policy 2008 (2009)	Fourth National MH Plan (2009)	National MH Standards (2010)	Draft Statement (2011)
Consumer Representative	n/a	n/a	A member of a government, professional body, industry or non-government organisation committee who voices consumer perspectives and takes part in the decision-making process on behalf of consumers. This person is nominated by, and is accountable to, an organisation of consumers. The role of a consumer representative is to provide a consumer perspective.	n/a
Peer Support	Social and emotional support, frequently coupled with practical support, provided by people who have experienced mental health problems to others sharing a similar mental health condition. Peer support aims to bring about a desired social or personal change and may be provided on a financial or unpaid basis.	Social and emotional support, frequently coupled with practical support, provided by people who have experienced mental health problems to others sharing a similar mental health condition. Peer support aims to bring about a desired social or personal change and may be provided on a financial or unpaid basis.	n/a	n/a