Submission to the Senate Standing Committees on Community Affairs Inquiry into Commonwealth Funding and Administration of Mental Health Services

August 2011

Introduction
The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians. The membership of the MHCA includes national organisations of mental health services, consumers, carers, special needs groups, clinical service providers, community and private mental health service providers, national research institutions and state/territory peak bodies.

The MHCA welcomes the mental health initiatives announced in the 2011-12 Budget as an important step towards improving the mental health system and the mental health of all Australians. They reflect a commitment by the Government to improving mental health and increasing the availability of mental health services in Australia.

Extensive consultation and documentation of the issues facing mental health consumers, carers and the broader sector has been undertaken a number of times, including the report of the Senate Community Affairs Committee Inquiry into Mental Health Services in Australia in 2008 and the report of the National Health and Hospitals Reform Commission in 2009. Both noted the high level of urgency for the extensive overhaul and more adequate funding of Australia's mental health system.[1]

More recently the MHCA facilitated 14 national forums across Australia for the Minister for Mental Health, the Hon Mark Butler MP. The Minister heard from mental health consumers and carers directly about their concerns and what needed to be done to improve the lives and outcomes of people living with mental illness, their carers and their families. The Report of these consultations has been attached to this submission.

Amongst the many issues raised, including both what is working now and what is not, there were consistent points of agreement amongst attendees that were raised at session after session, regardless of location. These included (in no particular order):

- Stigma and discrimination against people with mental illness and their carers
- Minority group issues, including indigenous, culturally and linguistically diverse (CaLD) and others
- Dual diagnosis, co morbidity, physical and mental illness
- Integrated services, including housing, employment, disability services, and others
- Mental health workforce needs
- The need for a mental health consumer peak body, and a carer counterpart
- Enhancing community capacity.

In a pre-budget submission, the MHCA noted that announcements in relation to the national health and hospital network reforms had largely ignored the needs of mental health consumers and carers and the Australian mental health system; were primarily bio-medical in focus; and often neglected the social, economic and

[1] Senate Standing Committee on Community Affairs (2008). *Towards recovery: mental health services in Australia*. Commonwealth of Australia, Parliament House, Canberra; National Health and Hospitals Reform Commission (2009). *A Healthier Future for all Australians.* Australian Government, Canberra.

environmental factors the underpin ill health, and mental ill health in our community. In response to these issues, the MHCA proposed a focus on the following key areas for improving mental health in Australia:

- Consumer/carer engagement, participation and representation
- Employment
- Housing
- A national mental health promotion and anti-stigma campaign
- A life-course approach to early intervention
- Mental health workforce. [2]

The 2011-12 *Budget National Mental Health Reform* measures demonstrate that the Government has listened to many of the concerns of the mental health sector – the commitments made to-date have the potential to address many of the issues raised by the sector in recent years.

If effectively implemented the budget measures will be an important contribution to a mental health system that cannot currently respond adequately to community needs. We note, however, that it will only be one important step because, as highlighted by both the Senate Community Affairs Committee Inquiry into Mental Health Services in Australia and the National Health and Hospitals Reform Commission, the mental health sector will require significant long term funding increases to reverse the years of neglect that the system has experienced.[3]

On the other hand, if the reforms are implemented poorly, without direct engagement with consumers and carers and other stakeholders from both within and outside the mental health system, they may only perpetuate current administrative and funding arrangements, making it unlikely that consumers and carers will achieve better mental health outcomes. Without effective consultation and collaboration within and outside the sector, the implementation of any initiative is unlikely to provide effective and efficient services to the groups that need them most.

This submission will outline key principles and goals to inform the implementation of the budget initiatives to ensure their success, and to underpin further developments and future growth in the mental health system.

Consultation and collaboration within and outside the mental health sector
Effective consultation and the facilitation of collaborative approaches will be necessary from the outset. The consultative workshops currently being undertaken by the MHCA around key budget initiatives are one way of informing this process. However, these can only provide a small part of the expertise that the sector has to offer. Ongoing strategic planning in collaboration with the sector will be needed to comprehensively identify sector strengths and weaknesses and to highlight the most appropriate ways forward.

The role of states and territories in this process will be extremely important and ongoing national partnership will play a vital role. The establishment of a national

[2] See MHCA Position Paper - *National Health and Hospital Networks, COAG and Mental Health Reform - Priorities outside the NHHN reforms*, available at: http://www.mhca.org.au/submissions
[3] Senate Standing Committee on Community Affairs (2008) and National Health and Hospitals Reform Commission (2009), op cit.

Mental Health Commission, with engagement from the states and territories, will provide a focal point for ongoing evaluation and monitoring of progress. Linking the various processes around the National Partnership Agreements, COAG working plans and the role of the Mental Health Commission and the current implementation of the Fourth National Mental Health Plan could yield more effective planning across the sector. Ensuring that various plans are linked to clearly defined and reportable targets is one way of ensuring greater scrutiny of progress. Feeding all of these processes into the 10 Year Roadmap will also be important.

Closer engagement with non-government services, both in mental health and in broader social and community services, will also be critical to success. There are currently few opportunities for this engagement between governments and the broader sector and it may be that new structures are required to ensure closer collaboration.

Consumer and carer participation

Meaningful engagement and participation of consumers and carers is essential for quality mental health services. This principle is a key element of the Fourth National Mental Health Plan and the National Mental Health Standards.[4]

Effective participation requires the networked support of consumers and carers from a wide variety of backgrounds, including young and aged consumers and carers, consumers and carers from culturally and linguistically diverse (CaLD) and indigenous backgrounds, and rural and remote and urban areas.

Further, mental health consumers and carers may have extremely difficult life journeys, often leading to social exclusion, poverty and homelessness. These consumers and carers need support if their expertise is to be utilised.

Australia continues to have inadequate structures and supports to enable the genuine participation of consumers and carers in their own mental health both at a personal and a systemic level. Without adequate representation their voices are easily ignored. Subsequently, the views of minority and disadvantaged groups will remain marginalised within the mental health service system and inequity in mental health outcomes will persist.

The MHCA welcomes the announcement of a new national mental health consumer representative body. The MHCA strongly supports ongoing formal consultation with consumers on this initiative and involvement of consumers in all aspects of the setting up and management of the organisation.

Carers also require structured and systemic mechanisms for input at the national level. The implementation of the budget measures will also require a consideration of the significant role for consumer and carer input that is required in the development of the *National Mental Health Commission*, the *National Partnership*

[4] Australian Health Ministers (2009). *Fourth National Mental Health Plan – An agenda for collaborative government action in mental health 2009-14.* Commonwealth of Australia, Canberra; Australian Government (2010). *National Standards for Mental Health Services 2010.* Commonwealth of Australia, Canberra.

Agreement and the *10 Year Roadmap* as well as in the management and implementation of ongoing mental health service operations.

Consumers and carers have, and will, participate in the initial consultative workshops being run by the MHCA. The MHCA calls on the Government to ensure that formal ongoing consultation mechanisms with mental health consumers and carers are included in all aspects of the implementation of the budget measures.

Improved accountability and governance

The MHCA has long advocated for investment in better accountability and governance in mental health reform to ensure that implementation, monitoring and evaluation issues are comprehensively addressed.

Challenges with current accountability arrangements – such as how well we are able to identify community need in mental health and how well current programs are able to meet their targets – mean that we do not yet have a solid foundation on which to implement significant changes to the mental health services system.

Short and long term strategies should be developed to deal with this. For current program models, appropriate evaluation measures need to be strengthened. Evaluation measures must include consumer and carer input to ensure that they are meaningful and result in positive health outcomes, not just operational and system requirements. Better methods of systematically determining community need must also be developed and this evidence must inform service planning and development. The Government should be able to identify how well services are achieving their goals and whether funding provides value for money and is well targeted.

Such an overarching strategic approach for mental health accountability and governance is not something that has been achieved by the sector to date. As detailed above, the Mental Health Commission, the development of the National Partnership Agreement between the Commonwealth and the states and territories and the Ten Yean Road Map are all longer term opportunities to ensure that this is addressed in the future.

We are pleased to note that the Minister for Mental Health has already initiated work on the support structures which will underpin the Mental Health Commission through the appointment of its CEO.

<u>Better Access budget initiative</u>

It is clear that many people have benefited from the mental health items in the Better Access program. However, it is also clear that it has not been sufficiently flexible to meet the needs of the whole community and especially those with severe mental illness and those in rural and remote areas and some lower socio-economic groups.

The evaluation of Better Access initiative, released in March 2011, raised many questions that remain unanswered. The report lacked guidance about a way forward and provided little information on the type of care provided or whether increased access has led to an increase in mental health and wellbeing. There is also no information about collaboration between mental health professionals. Importantly,

on its own, the evaluation provides little information about the merits of the Better Access program relative to other program alternatives.

The MHCA is concerned that the evaluation was unable to assess whether Better Access had reached traditionally disadvantaged groups such as those from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander backgrounds.

The Committee will no doubt receive evidence from some groups advocating the benefits of the Better Access program and lamenting the impact that cuts to the program may have. The Committee will also receive evidence from groups advocating the re-direction of funding from Better Access into programs that they will argue are more cost effective measures. The MHCA will look forward to the opportunity to analyse this evidence as it is brought forward. What this debate demonstrates, however, is that current information about the relative merits of various initiatives is poor, and lags well behind other areas of the health system.

It is imperative that a more strategic approach to identifying and addressing the needs of the mental health system is undertaken so that any new initiatives can be measured against targets set according to community need. In the meantime more investment in appropriate processes for data collection and ongoing evaluation needs to support programs across the system.

Service Integration

Service integration on a range of levels will be a key facilitator of effective implementation of the budget initiatives. Better service coordination was a key priority of the COAG National Action Plan on Mental Health 2006-2011[5] and has long been a priority for consumers and carers.[6]

A one-size-fits-all approach to mental health service delivery has not led to accessible services that are equitably distributed or distributed according to need. Mainstream services need to be able to adapt and be flexible to the service needs of all clients no matter what their circumstances or where they attend. This is particularly the case for mental health consumers with co-occurring substance misuse issues or dementia, who are often shunted and moved from service to service or across sectors will little support due to their complex care needs.

Establishing and supporting integrated and collaborative service systems across the mental health, aged care, disability, alcohol and other drugs, housing and employment sectors, for example, will advance flexible and holistic mental health service delivery models that address the unique needs of individual mental health consumers.

Current service models tend to mirror available funding pools, creating silos of service administration, management, coordination and expertise. Both professional cultures and services structures do not always lend themselves to multidisciplinary collaboration.

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[5] Council of Australian Governments (2006*). National Action Plan on Mental Health*. COAG, Canberra.
[6] MHCA (2005). *Not for Service – experiences of injustice and despair in mental health care in Australia*. MHCA, Canberra.

The development of integrated funding pools, combining funds from the Department of Health and Ageing (DoHA), Department of Employment, Education and Workplace Relations (DEEWR) and the Department of Families, Housing, Communities, and Indigenous Affairs (FaHCSIA) and relevant state and territory funders will be a key step toward breaking down these silos. Such models will require new governance arrangements within Government in order to manage appropriations across traditional portfolios.

Recent budget initiatives by the Department of Human Services and DEEWR in the employment sector, such as Centrelink *Case Coordination* services and *Local Connections to Work Pilots,* provide a good opportunity for the mental health programs in DoHA and FaHCSIA to work collaboratively to streamline implementation of services for mental health consumers and carers across the health and employment sectors.

The planning for the National Disability Insurance Scheme, recently undertaken by both the Productivity Commission and FaHCSIA, is another opportunity for the mental health sector to access streamlined funding for health and psychosocial disability support.

The MHCA urges the Commonwealth to support the development of these new models of governance and funding within relevant areas of Government.

Coordinated care and flexible funding budget initiatives

The concerns that were previously raised by the MHCA in its submission to the Department of Health and Ageing's *ATAPS Flexible Care Packages for People with Severe Mental illness Discussion Paper February 2011* detail our approach to the proposed implementation of Coordinated Care and flexible funding packages.[7]

These concerns included the need for:

- collaboration of multidisciplinary stakeholders (mental health consumer and carer experts, allied health professionals, community sector specialists) and multisectoral stakeholders (representatives from employment, housing, community justice, mental disability sectors)
- multiple and flexible entry pathways to obtain these packages
- supporting partnerships between the Commonwealth, GP Divisions (Medicare Locals), clinicians and the community or NGO sector
- information dissemination about the program initiatives packages to local NGOs and community networks.

The Coordinated care and flexible funding budget measure will need to be carefully managed to ensure that it facilitates multi-disciplinary and multi-sectoral approaches to support. The measure also needs to ensure that referral pathways to the system are accessible to the most marginalised people with severe mental illness such as those who do not have ready access to GPs or those not engaged with health or other services.

[7] See MHCA submission to *ATAPS Flexible Care Packages for People with Severe Mental illness Discussion Paper February 2011*, available at: http://www.mhca.org.au/submissions

Other issues that will need to be managed to ensure appropriate roll out of this initiative include:

- effective ongoing community consultation at a local and national level to ensure ongoing stakeholder engagement with the program
- identification of appropriate roles and skill sets for coordinated care workers
- identification of appropriate business models for the support of coordinated care workers and to facilitate ongoing community partnerships with particular reference to the development of relationships with clinical and non clinical services
- development of strategies such as training, resources and support for clinical and non-clinical stakeholders to engage in partnerships
- clear guidelines around the role of care coordinators where appropriate services to coordinate.

Just last week the MHCA facilitated a consultative workshop on the Coordinated Care budget measure at the request of the Minister for Mental Health. We will provide a report to Government in the next few weeks highlighting the issues raised at the workshop and will be pleased to make this available to the Committee.

A strong and sustainable workforce
Workforce development initiatives should also be a key component of long term planning for the mental health sector.

Attracting and retaining appropriated skilled and experienced staff in the mental health workforce remains an issue for the sector. There are significant shortages in the number of mental health professionals across the country, most acutely affecting rural and regional Australian.

There is an urgent need for committed investment by all governments to enhance the capacity of the mental health workforce and ensure that the community's mental health needs are adequately met.

In its pre-budget submission, the MHCA highlighted the need for a National Mental Health Workforce Strategy to:

- define roles and address workforce issues for clinical and non-clinical service providers
- enhance opportunities to expand services in areas of need
- outline mechanisms for attracting mental health personnel to rural, remote and other areas of geographic and other need
- develop opportunities for the development of the consumer and carer Peer Workforce.

It is likely that workforce shortages will also mean new and creative service models must be developed. Programs engaging peer support seem to offer particular promise in this context.

Social inclusion and anti-stigma
The new budget initiatives also have the potential to make progress in the key areas of social inclusion and addressing stigma, if these outcomes are highlighted as important targets for Australia's health system.

Australia does not currently have a national mental health promotion and anti-stigma campaign. Mental illnesses, particularly lower-prevalence disorders such as schizophrenia or bipolar disorder, are still the subject of powerful negative community stigma and media portrayal. Discrimination is still a major barrier to community reintegration of people who have experienced a mental illness. Moreover, there is an urgent need to inform people about what they can do to manage risk factors for mental illness, the benefits of seeking early intervention and how to avoid or minimise a relapse.

An effective mental health promotion and anti-stigma campaign should not be conceived as a glossy advertising campaign; rather it would be vertically integrated to reach communities, workplaces, the mental health and community sector workforces, schools and universities. The campaign should also have clear target groups and goals for change, and its impact must be evaluated against these goals.

Conclusion

The MHCA welcomes the Government's mental health budget announcements as an important step towards improving outcomes for people living with mental illness and their carers and families. We also welcome the ongoing interest of the Senate, through this Committee, which has demonstrated long term interest in achieving better outcomes for people with a mental illness.

While the budget focus on severe mental illness is welcome, there remains much to be done. A much greater focus is needed on Indigenous social and emotional wellbeing, as well as the needs of those in rural and remote areas and those from culturally and linguistically diverse backgrounds.

The budget initiatives provide an opportunity to develop the first comprehensively strategic approach to addressing the community's mental health needs. However, effective approaches to implementation will need to be underlined by the principles of consultation, consumer and carer participation, accountability and governance and a consideration of strategies to address the role of stigma in mental health.

Attachment

National forums with Minister Butler, 2010

National summary of key themes and critical issues

Introduction

The Mental Health Council of Australia (MHCA) is the peak, national non-government organisation representing and promoting the interests of the Australian mental health sector, committed to achieving better mental health for all Australians.

From 30 November – 17 December 2010, MHCA planned, managed and facilitated 14 sessions across Australia to enable Mark Butler, the Minister for Mental Health & Ageing, to hear first hand from consumers, carers and other stakeholders in the mental health sector.

MHCA had an unprecedented level of responses and had to turn away a number of interested people. In some locations, less than 20% of applicants received a place. Where possible, places were prioritised for consumers and carers, however some had to miss out due to maximum numbers.

While there were a number of issues raised, including both what is working now and what is not, there were items that were consistently raised at session after session, regardless of location. These included (in no particular order):

1. Stigma and discrimination against people with mental illness and their carers
2. Minority group issues, including Indigenous, culturally and linguistically diverse (CALD), and others
3. Dual diagnosis, co morbidity, physical and mental illness
4. Integrated services, including housing, employment, disability services, and others
5. Workforce needs
6. The need for a mental health consumer peak body, and a carer counterpart
7. Enhancing community capacity.

It is not possible to outline every issue raised, but concentrating on these gives a good sense of key themes.

This summary report of the Minister's forums is based on notes taken by MHCA staff at the events, as well as those from state/territory offices of the Australian Government Department of Health & Ageing (DoHA). MHCA will release a jurisdictional and national summary of issues, as agreed by the Minister at the forums. This is important so that consumers and carers know that their voices were heard and concerns collated for consideration and action.

Key issues nationally

None of the key issues raised at these forums was 'new' to MHCA: the concerns are well covered in a range of national reports and recommendations.

1. Stigma and discrimination against people with mental illness and their carers

Stigma and discrimination against people with mental illness, and towards their carers, was mentioned multiple times at every forum.

For some people, this was about 'education' to ensure the community better understands mental illness, although at the crux of this suggestion was current unawareness and stigma towards mental illness. Some identified education through schools and that it start early as the best approach, while others focused on the workplace and how lack of understanding and support means people with mental illness miss out on employment or are treated differently to other employees. For example, at one forum, one table pointed out that "employers want assurances their employee (the consumer) is not 'defective' as they recover". A number of personal examples where consumers and carers had experienced extreme difficulties around employment were presented at most forums.

There were several discussions about enhancing the focus on mental illness prevention, and that this is different to early intervention, which is also vital when needed. Greater awareness of mental illness and reduction in stigma are likely to lead to less self-stigma around mental illness and, with appropriate intervention, lead to better outcomes through community support.

Key message: There was strong support at the national forums for a national anti stigma/ discrimination campaign to educate the community about mental illness and that discrimination on the basis of mental illness is not lawful.

2. Minority group issues, including Indigenous, CALD, and others

Concerns about stigma against, service provision to, and lack of appropriate services for a range of minority groups was raised at every forum. These groups included Indigenous people, CALD communities, children of people with mental illness, the gay, lesbian, bisexual, transgender, intersex (GLBTI) community, people living in rural areas, and others.

Some examples of issues raised across these groups included:

- Respect cultural approaches to mental illness, including how a particular culture may view mental illness, how treatment may need to be tailored
- Deliver appropriate mental health services in the community, by the community – train community members to address mental illness, including in professional roles
- Translators may be required and this can be difficult in communities with a small population – likely people will know each other or at least people in common
- Respite and rehabilitation services must be culturally appropriate
- Support and develop innovative solutions to ensure people in rural areas have access to services they need, when they need them
- Acknowledge models of caring outside current formal definitions, especially for young carers who are very often hidden
- Acknowledge and address the level of trauma many in these communities have faced and are still exposed to, especially the inter-generational trauma of Indigenous communities and people who faced childhood trauma.

It is worth noting that there was not a large representation of Indigenous people at the forums, despite several being held in areas with a reasonable Indigenous population size, such as Redfern, Darwin, Cairns and Atherton. This demonstrates the huge disconnect between Indigenous people and current service/consultation styles. If improving Indigenous mental health is something the Minister and DoHA wish to undertake, we recommend specific forums being held in rural and remote areas, aimed particularly at Indigenous consumers and carers, to obtain their views about their mental health needs.

Key message: Ensure models for mental health service delivery address concerns of specific minority groups, many of whom are over-represented as mental health consumers.

3. Dual diagnosis, co morbidity, physical and mental illness

The lack of appropriate management of any other condition combined with mental illness was brought up at every forum. At some sessions this was focused on alcohol and other drug misuse, which is commonly referred to as ‘comorbidity’, although this is not the only meaning. At other forums the focus was more on physical health conditions and mental illness or multiple mental illnesses.

All of these discussions noted that (usually) one of the conditions was managed reasonably, but this was at the peril of the other. For example, a consumer at one forum identified concerns about management of his daughter’s medical conditions and described the medical system to be “medical apartheid”. Many more attendees spoke of “silos of care”, and there were other anecdotes about people having a physical condition managed and treated but not a mental condition. The need for holisitic care was another phrase often repeated at forums.

Key message: Urgently deliver integrated whole-of-person care that addresses the health needs of each individual, regardless of whether it is physical, mental or another issue.

4. Integrated services, including housing, employment, disability services

Some of the discussion about integrated care included the points outlined above under dual diagnosis, but went beyond health-related issues to whole-of-life issues that impact on an individual's mental wellbeing. These included housing, employment, disability services, Centrelink, Personal Helpers and Mentors (PHaMS), justice and forensic mental health, among others.

Attendees regularly spoke about the need for a 'no wrong door' entry point to care to address a person's mental illness, and noted that it is impossible to adequately address mental illness if other areas of someone's life are in chaos. Further, at several forums the need for a 'one stop shop' approach to service delivery was mentioned, where consumers and their carers can access the care that they need, when they need it, in the one place. Service providers noted that this would decrease the disjointed elements of care that many offer now.

These improvements to the system were suggested as a way to stop people falling through the cracks, and would enhance continuity of care /care coordination for those able to enter the system. The need for national consistency across a range of areas was highlighted at many forums, and included areas such as cross border recognition of community treatment orders, a national mental health act, and portability of records so people did not have to repeat their story over and over. The ability to obtain treatment at the most appropriate service was raised, regardless of state of residence and location of a state border.

Several comments were made about specific organisations that demonstrated stigma towards people with mental illness (eg. Centrelink), although examples of other services that were well received were also provided and varied widely depending on local availability. PHaMS continually came up at forums as an example of a program that works well now. A range of other services were listed too, but this was the stand out response to the question about what works now.

Respite services were discussed at many forums as an important component in managing mental illness, and carers in particular highlighted the need for more and better places. Carer fatigue, burn out and the financial, physical and mental drain on carers was a theme often repeated at the forums.

A number of attendees noted that mental wellness depends so heavily on stable and affordable accommodation and that keeping it often relies on stable and supported employment. 'Treatment' for mental illness cannot continue to be seen as only a health issue and in isolation of the other services people with mental illness desperately need.

Key message: Urgently deliver integrated whole-of-person, whole-of-life care that addresses the needs of each individual, regardless of whether it is health, housing, employment, disability, welfare, etc. Increase funding to programs that are well received by consumers and carers and that work for them.

5. Workforce needs

Attendees consistently raised workforce issues as key points, whether this was the need for a stronger and more supported peer consumer/ carer workforce, lack of new professional graduates, or difficulties in accessing mental health clinicians due to waiting lists or lack of local services (particularly in rural areas).

Many participants were concerned that even if services received additional funding to expand, or innovative services commenced, there simply would not be sufficient trained staff to fill positions. Attendees at rural forums regularly raised the difficulties in attracting and retaining trained and experienced health professionals.

Many forums had comments about local design of services to meet local needs. For example, some places might need greater investment in outreach services, while another may need more of a particular health professional. Many queried why funding and resources could not be adapted to best meet local need.

Several comments were made about the need for greater accountability of workers in mental health services, including community sector staff.

While priority was given to consumers and carers to attend these forums, there were health professionals at some forums, particularly the rural ones which were not fully subscribed. Some of these attendees discussed stigma within health services towards staff working in mental health. In addition, understaffing through inability to fill positions, particularly in rural areas, leads to burnout and inability to attract appropriately trained staff.

If fellow health professionals are treating mental health professionals with disdain, it must be incredibly difficult for a mental health consumer to receive sensitive and appropriate care within generic health services, which is where most present at acute onset of illness.

Key message: Expand mental health workforce initiatives, including the consumer and carer peer workforce. Provide incentives to practice in rural areas or with minority groups.

6. The need for a mental health consumer peak body, and a carer counterpart

As the scoping study for the new mental health consumer peak body was finalised earlier this year, it was not surprising that the status of the peak mental health consumer peak was so regularly raised by consumers as an issue of concern.

Carers also queried how a peak mental health carer entity might come about and noted the different issues mental health carers have compared with other carers.

Both of these entities were seen as vital to provide a strong mental health consumer/ carer voice to ensure a better mental health system that truly meets the needs of its key stakeholders.

Key message: Release findings of scoping study for mental health consumer peak body, investigate options for a counterpart mental health carer body, and resource appropriately both

entities to ensure a stronger voice for, and greater participation by, mental health consumers and carers.

7. Enhancing community capacity

More and better local services in the community were often stated as a key need at the forums. More hospital beds was ***not*** a key message that came through the forums; rather attendees very much focused on what services were already provided locally, what needed expanding, and what was missing to support people with mental illness to live in the community. Attendees at one forum described this particularly well, and commented that funding was “spread so thin it becomes ineffectual for both the service delivery organisations and the recipients of the services”.

Some of the concerns can be described as workforce issues, but most were about the capacity of community or non-government organisations (NGOs) to deliver a range of services when they do not receive adequate or ongoing funding. Many NGOs do not have the resources to put into business infrastructure and all funds are directed towards service provision. For example, one forum noted that fixed term funding for NGOs meant disruptions to service provision and impacted on continuity of care.

While “more funds/ dollars/ investment in mental health” came up *very* regularly at the forums, community capacity funding was an area in which attendees were more explicit. Many noted the relatively small amount of funding community NGOs receive to deliver programs and the cyclical nature of non-recurrent funding that meant precious staff time being spent on re-applying for funds and onerous reporting requirements rather than on service delivery.

Key message: Provide an ongoing and regular commitment to invest in infrastructure for mental health community organisations/ NGOs to support better service delivery.

Conclusion

There were numerous important issues brought up at the national forums, however there would be strong community and sector support, as well as improved outcomes for consumers and carers, if all of the above key themes were acted upon. Most of these concerns are well covered in recent national reports, many of which have recommendations relating directly to these areas for action and improvement. Following now is a list of the key themes including a summary of the critical issues discussed at each of the jurisdictional forums. These lists formed the basis for the national summary document presented above.

Attachment

Jurisdictional summary of key themes and critical issues

Adelaide, South Australia

Key themes	Summary of critical issues discussed
Need for collaboration and coordination of services	Need for a new consumer representative organisation.
Access to services	Need for improved coordination and collaboration between services, including self-referral options.
Next steps from this round of consultations	Lack of consistency in use of procedures eg. mental health management plans.

Mandurah, West Australia

Key themes	Summary of critical issues discussed
Care co-ordination and utilising existing services efficiently	Discussion held on the need for better case co-ordination and a more efficient way of accessing services and support for both consumers and carers. It was noted consumers may have to deal with a number of Commonwealth/State departments, and community services as part of their treatment. It was noted the Personal Helpers and Mentors (PHaMS) program has provided excellent support in terms of practical assistance that focuses on accommodation, employment and other matters, but does not include clinical support.
Increased community awareness of what mental health services are available	Mental health training for police/ambulance workers was discussed, and the meeting was advised the WA Police no longer mandate this training. It was noted police in both NSW and Queensland do receive mental health training. Some carers are reluctant to call police support due to mandatory sentencing laws in WA as they are concerned the consumer could be charged rather than assisted to receive treatment.
Community awareness and education concerning mental illness – reducing stigma, including within Indigenous communities	The Carer's Bill should include rights and responsibilities for carers and consumers nationally; with follow up review of the Carer's Act and its implementation.
Increased funding to ensure that outcomes focussed mental health services can be delivered to meet community needs	
Greater support/respite for carers	Support and respite for mental health carers was raised, and queries were made regarding the recently announced National Respite for Carers program providing funding for carers to access respite services of their choice. Minister

Attachment

	Butler advised this was a small pilot covering a wide spectrum of carers, with 200 packages of $4,800 being released as part of this pilot. The aim of the pilot is to provide carers the flexibility to access appropriate respite for their needs. This announcement included the newly released pilot budgets for consumers of aged care to buy their own care services. Minister Butler noted whilst Access Economics have public definitions regarding informal and primary carers, there are no stereotypical carers. For example, there are thousands of children caring for a parent with mental illness and a number of aged people caring for adult children with mental illness.
Services across all age ranges – from perinatal to aged care	

Perth, West Australia

Key themes	Summary of critical issues discussed
Coordination of services - including the need for better coordination of and between existing services; increased promotion of services available to carers and consumers; and increased support and coordination for consumers navigating the system	There is a lack of communication between stakeholders.
Improved and more services for Aboriginal people and communities	
Improved services and access for other groups	Access to services can be difficult and overly encumbered by bureaucracy.
Improved services and access for other groups - including CALD, rural and remote, youth, young carers and the homeless	CALD and Indigenous Australians require appropriate mental health care.
Appropriateness of services and accommodation issues for people with Acquired Brain Injury (ABE); aged people; homeless; and people with chronic mental illness.	
More community based services – moving away from medical model	There is still a strong stigma about mental health issues.

Attachment

Sydney, New South Wales

Key themes	Summary of critical issues discussed
Need for more Funding	Need for more services that are holistic and recovery oriented with a strong role for consumers and carers.
Need to address stigma/discrimination	Support for a national campaign to decrease stigma around mental health issues and disorders.
Need for greater consumer involvement	Support for funding a national consumer peak body.
Impact of health reform process	Strong support for work across sectors including health, housing and employment.
	Uncertainty around what health reform will mean for the mental health sector.
	Need for a greater focus on prevention within schools and workplaces.
	Need to do more to address specific needs of GLBTI communities.

Newcastle, New South Wales

Key themes	Summary of critical issues discussed
Increased resources required and distributed fairly	Funding - More resources needed – primary/tertiary/acute/community, in particular, more supported accommodation.
Care coordination, continuity of care and navigation of the system	Care coordination and continuity of care - Access including pathways of care, decisions for funding made inclusively, right support/service at right time.
De-stigmatisation and awareness of mental illness	Issues around privacy.
National approach to workforce training and development, including emotional intelligence	Mental health literacy - A national approach to education required. Mental health literacy for all professions involved (eg general health services, police, schools) and the general community about how to best respond, intervene and where to go.
Focus on prevention	Prevention -Focus on preventing mental illness (including onset plus decreasing severity and duration for people) by linking services (health, MH, community) so people can get the right service before they are really unwell.

Focus on community mental health recovery model	Models - Agreed models for community mental health – treatment and support, for access and availability to be achieved (eg NGOs, talking therapies, residential and non-residential sub acute in the community, focus on recovery).
Linkages between early childhood abuse, trauma and mental health	

Brisbane, Queensland

Key themes	Summary of critical issues discussed
Importance of early intervention and recovery process, including step-up and step-down support centres	More funding for community based service providers. Hospitals not suitable for MH sufferers outside the acute diagnosis range. A lot of support for community based care instead of hospital based care.
Coordination and integration of services	National Advisory Council for Mental Health (NACMH) plays a valuable role in bringing issues and a national voice to the Government.
Timely and accessible support and information for carers	Make information more accessible.
Public education to address the stigma associated with mental health conditions	Early intervention, primary schools, to address stigmatisation.
Consumer and carer specific issues	Carers must be involved in acute care and recovery plans. Make consumer and carer support more accessible.

Attachment

Canberra, Australian Capital Territory

Key themes	Summary of critical issues discussed
Importance of workforce retention, education and 'churn rate'	Education for consumers, carers, employers and all involved with people with a mental illness. Should be a national role for this.
Equity and access – power and bullying – power is with big guy not consumer	
Increasing focus on alternative treatments, wellness programs, and community service programs	Extra resources in mental health system and community sector. Avoiding Commonwealth/State duplication.
System is misoriented to acute care. Need to focus on intervention and prevention	Dual diagnosis centres needed nationally. More and responsive emergency care.
Consumer and carer participation in service design, delivery, and monitoring. Increased focus on consumer and carer decision making. Carers and consumers should be the primary decision makers.	National peak consumer and carer body. Existing Centrelink guidelines need to be adjusted to reflect the needs of carers and consumers. Currently 25 hours of work including travel time. Mental health can be a cyclic process. Patients and carers are bound by state issues. Having a 'National Mental Health Act'.
Service integration with mental health care. Needs to be underpinned by a robust service delivery accountability framework.	
Investment in evidence and research to discover what works. Evidence based practices.	Educating society about mental illness to reduce the stigma. Starting in schools. Requires funding injection.
Ensure that adequate housing is provided to people with mental illness. Funded places need to be provided	Supported accommodation. Only 1/10th the amount of support currently available to meet demand.
Significant investment of funds to increase the mental health workforce to ensure everyone with mental illness is provided with treatment (all aspects of treatment). Effect of reducing suicides hopefully to 0 in future	Having a holistic approach to mental health. Need a comprehensive package that supports the family as a unit, not just the primary carer. Service providers need to work together to create holistic approach. Service providers need to properly train workers, not just raise awareness of mental health. Improving funding. Especially to educate professional staff to work in new units currently being built.

Care in line with human rights - accommodation options, employment options	Addressing gaps in services – supported accommodation, respite care.
Care that goes across the lifespan of a person	Early intervention regardless of age.

Tamworth, New South Wales

Key themes	Summary of critical issues discussed
Incentives to attract and retain workforce	Workforce and training. Trained staff in Rural and remote – incentives, mechanism to support R&R staff. Workforce availability, funding cycles, training, networking and coordination between services. Incentives for staff/maintaining/retaining staff in rural areas. GP training in mental health.
Importance of collaboration between agencies delivering services	Greater collaboration between agencies.
Increased access to a range of successful service models including PHaMS, Clubhouse, Headspace	Facilities/Infrastructure – need step down beds, need AOD rehab unit in Tamworth. Funding for services, projects, and infrastructure. Expand Clubhouse model.
Barriers to accessing services including cost and transport	Mental Health First Aid training in Indigenous communities. Transport to acute mental health unit often by ambulance and police refuse to transport patients. Community awareness/promotion.

Attachment

Launceston, Tasmania

Key themes	Summary of critical issues discussed
Holistic services work well	Full participation and citizenship for people with a mental health issue. This isn't happening with clients as there is no holistic government approach. Want Government to make a commitment to this issue.
Improve the number of professionals in Tasmania by increasing salary/career structure/Position description and supervision support	Ageing workforce – a significant amount of workforce will retire. Tasmania has its own issues about attractiveness and retention. What is the government going to do about attracting and retaining permanent workforce in Tasmania such as psychiatrists, psychologists, social workers, and nurses?
Mental health helpline not working	
No clear referral pathway	
Volunteer services are working under pressure, under funded	
Barriers to communication – No knowledge of available services, no interface between public and private services	
Lack of acute care/services (no CAT team)	

Hobart, Tasmania

Key themes	Summary of critical issues discussed
'A One Stop Shop' for service deliver and information provision, too many service providers offering various disjointed elements of care.	The need to consolidate funding and services for the sector particularly in the areas of Dementia and Alzheimer's disease. Too many service providers were offering various disjointed elements of care. One stop shop model is required with an individual "case manager" to guide affected family members through the maze of services and bureaucracy.

Attachment

Single entry point with a 'No wrong door' policy	A focus on what was easier for the consumers of the services and not the NGOs, Medical Professionals and government organisations was identified as a priority and discussed.
Early intervention strategies for Mental Health and Dementia diagnosis, training for health professionals required	Adequately trained health professionals, commencing with GP, in recognising (in particular) the early onset of Dementia and Alzheimer's disease. It was noted that the Mental Health area through work pressures, use of volunteers, lower levels of salary and training did not always deliver compassionate, quality, patient focussed care to the level desired by the industry and consumers of services.
Cultural awareness and local responsiveness issues to clinical treatment and service provision	Still a social stigma associated with mental health although there was some recognition for efforts by the government to diminish this effect.
Consumer and carer issues	Respite and support services must flexible. Carers also discussed the longer term negative fiscal, mental & physical health consequences of looking after a loved one, the increasing social isolation as their partner's illnesses became progressively worse and the reduced capacity for workforce participation adversely affecting their financial & social situations.
Cross boundary patient data sharing for provision of appropriate service provision	

Melbourne, Victoria

Key themes	Summary of critical issues discussed
Victoria has long standing investment in NGO sector, particularly home based outreach based on the need to shift from hospital to community as soon as possible.	Need for collaboration and streamlining of services.
Have a greater proportion of staff in the community and step up step down in almost every region and strong primary mental health teams.	Need for education for mental health practitioners for evidence based treatment.
Victoria is moving towards prevention framework and new community based services, trying to reduce entrenched disadvantage and build intensive mental health care etc for older people.	Need for Mental Health Education across the board – Centrelink, GPs, nursing, Need to implement Senate enquiry recommendations from 2006.

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	Need greater employment options for affected by mental health conditions Need for appropriate accommodation with certified standards and affordable accommodation. Funding needs to be more appropriately provided and more into direct services.
Consumer and carer issues	Need for improved carer and consumer participation. Need to implement recommendations on national consumer peak and undertake scoping activity around national carer peak.

Darwin, Northern Territory

Key themes	Summary of critical issues discussed
Need for appropriate accommodation with certified standards and affordable accommodation	Housing for local workers in remote areas.
Funding needs to be more appropriately provided and more into direct services.	Funding - need to develop broad-based funding for mental health based on International Principles of Primary Care, eg. Ottowa Declaration and similar to that developed by Ken Henry (COAG National Indigenous Framework 2008). Workforce - urgent action to address deficient and anticipated future severe shortage of mental health nurses. Increased recruitment and professional support.
Need for education for mental health practitioners for evidence based treatment	Need recognition of Mental Health qualifications on National Registration AHPRA. Formal National recognition of specialty of Indigenous workforce.
Need for mental health education across the board – Centrelink, GPs, nursing,	
Need for improved carer and consumer participation	
Need to implement Senate enquiry recommendations from 2006.	

Need greater employment options for those affected by mental health conditions	
Need to implement recommendations on national consumer peak and undertake scoping activity around national carer peak	
Need for collaboration and streamlining of services	

Cairns, Queensland

Key themes	Summary of critical issues discussed
Delivery of Culturally appropriate services	Increased funding for community based service providers.
Importance of early intervention	Early intervention, including education at primary schools.
Role of family, friends and carers in recovery and support services *they* require to continue to provide care	Ensure consumer and carer support more accessible. Carers must be involved in acute care and recovery plans.
Coordination and integration of services	Greater focus of support for community based care instead of hospital based care. Enhanced communication between services to support integration and continuity of care and with careers.
Timely and accessible support and information for carers	Ensure information more accessible.
Public education to address the stigma associated with mental health conditions	
Policy and plans are good. Need resources to implement.	

Attachment

Atherton, Queensland

Key themes	Summary of critical issues discussed
Rural and remote servicing: access and equity	Resources to expand and increase services in rural and remote communities. Lack of afterhours services. Distance to specialists and transport issues. Need for respite options. Aged Care beds and options critical on Atherton Tablelands.
Technology is an issue due to isolation	Immediate implementation of eHealth and 'Networking the Nation'.
Indigenous service issues around access, responsiveness and appropriateness	More social, emotional wellbeing and family based programs.
Mental Health and Justice System	