The Senate

Select Committee on Health

Fourth interim report

Mental health: a consensus for action

October 2015

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Table of Contents

Terms of Reference

That a select committee, to be known as the Select Committee on Health, be established to inquire into and report on health policy, administration and expenditure, with particular reference to:

a. the impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting;
b. the impact of additional costs on access to affordable healthcare and the sustainability of Medicare;
c. the impact of reduced Commonwealth funding for health promotion, prevention and early intervention;
d. the interaction between elements of the health system, including between aged care and health care;
e. improvements in the provision of health services, including Indigenous health and rural health;
f. the better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services;
g. health workforce planning; and
h. any related matters.

Acronyms and abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
ATAPS	Access to Allied Psychological Services
CALD	Culturally and Linguistically Diverse
CEO	Chief Executive Officer
CHC	COAG Health Council
COAG	Council of Australian Governments
Commission	National Mental Health Commission
CP	Carer Payment and Allowance
CRC	Cooperative Research Centre
CRRMH	Centre for Rural and Remote Mental Health
DSP	Disability Support Payment
DSS	Department of Social Services
ED	Emergency Departments
ERG	Expert Reference Group
FAQ	Frequently Asked Questions
FOI	Freedom of Information
Framework	National Mental Health Service Planning Framework
GDP	Gross Domestic Product
GP	General Practice
GPs	General Practitioners
ILC	Information, Linkages and Capacity Building, part of the NDIS implementation (also known as Tier 2)
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
PHCAG	Primary Health Care Advisory Group
PHN	Primary Health Network
MBS	Medicare Benefits Scheme
MHiMA	Mental Health in Multicultural Australia
MHNIP	Mental Health Nurse Incentive Programme
NCOA	National Commission of Audit
NDIA	National Disability Insurance Agency

NDIS	National Disability Insurance Scheme
NGOs	Non-Government Organisations
NMHC	National Mental Health Commission
NMHSPF	National Mental Health Service Planning Framework
OECD	Organisation for Economic Co-operation and Development
PHaMs	Personal Helpers and Mentors programme
PIR	Partners in Recovery programme
PMC	Department of the Prime Minister and Cabinet
RANZP	Royal Australian and New Zealand College of Psychiatrists

Executive Summary

This interim report is the fourth of a series in which the Senate Select Committee on Health proposes to report its findings and conclusions to date.

This report focuses on the Federal Government's approach to mental health. Unfortunately, mental health policy and funding in Australia is in a state of suspended animation while the government re-reviews, re-consults on, and re-considers the findings of the National Mental Health Commission's review of the delivery of mental health services and programmes.

Meanwhile, organisations providing mental health services and programmes are forced to survive on year-to-year funding. The uncertainty caused by the government's constantly delayed decision making has caused workforce instability and increasing uncertainty for mental health consumers and carers. This is an unacceptable situation.

Mental health in Australia – situation: crisis

The National Mental Health Commission (the Commission) begins its report on Mental Health Services and Programme Delivery with a stark set of facts about the prevalence of mental ill-health in Australia:

> Each year, it is estimated that more than 3.6 million people (aged 16 to 85 years) experience mental ill-health problems—representing about 20 per cent of adults. In addition, almost 600,000 children and youth between the ages of four and 17 were affected by a clinically significant mental health problem. Over a lifetime, nearly half of the Australian adult population will experience mental illness at some point—equating to nearly 7.3 million Australians aged 16 to 85. Less than half will access treatment.[1]

Mental ill-health can have devastating consequences for individuals and their families. For instance the Commission's report identified suicide as a major issue in mental health:

> In 2012 more than 2,500 people died by suicide, while in 2007 an estimated 65,000 Australians attempted to end their own life. Suicide is the leading cause of death among people aged between 15 and 44 years old, and is more likely among men, Aboriginal and Torres Strait Islander peoples and people living outside of major cities.[2]

1 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 19.

2 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 19.

Disturbingly, a large number of people, particularly young Australians, do not seek or delay seeking help. Dr Michelle Blanchard, the Head of Projects and Partnerships at the Young and Well Cooperative Research Centre told the committee:

> In the case of young people, 25 per cent of young people experience a mental health difficulty and 70 per cent of those do not seek help and do not receive care. It is a very high figure for a younger population, and that figure is higher again for young men…
>
> We know from international evidence that the time between the onset of symptoms for someone with a mental illness and the time they receive the right care is up to 10 years.[3]

Previous mental health reviews

The Commission's review is the latest in a long line of reviews and inquiries which have considered the most effective and efficient means of delivering mental health services and programmes. Mr Sebastian Rosenberg, a Senior Lecturer at the University of Sydney's Brain and Mind Centre reflected on the growing list of past inquiries:

> Despite four national plans and two national policies, one road map, two report cards and one action plan, genuine mental health reform seems as far away as ever. There is a sense that things have changed and that the asylums have closed in Australia. Well, there are still 1,831 beds in asylums across Australia costing about half a billion dollars per year. Large elements of the old system are still very much in place in our current system… One of the main things that was through all the history of Australian mental health policies and plans has been the desire to establish community-based mental health care, but in fact what we have is an extremely hospital-focused system of care. Even when the National Mental Health Commission suggested a very small change to those arrangements, Minister Ley unfortunately seemed to indicate that that would not be pursued.
>
> We were interested very much in promotion, prevention and early intervention, but in fact we have a system which really is about postvention and crisis management.
>
> We were very much interested in e-mental health technologies, some of which Australia has led in, but in fact what we have is a continued dependence on face-to-face care and fee-for-service type approaches.[4]

Mr Rosenberg told the committee that there have been 32 reviews into mental health between 2006 and 2012. Chief amongst these was the landmark work of the Senate Select Committee on Mental Health in 2006.

The overall findings of the Select Committee on Mental Health are remarkably similar to our current situation:

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3 Dr Michelle Blanchard, Head, Projects and Partnerships, Young and Well Cooperative Research Centre, *Committee Hansard*, 18 September 2015, p. 50.

4 Mr Sebastian Rosenberg, Senior Lecturer, Brain and Mind Centre, University of Sydney, *Committee Hansard*, 26 August 2015, pp 15–16.

> …there is much work to do in the area of mental health. There needs to be more money, more effort and more care given to this neglected part of our health care system. There is not enough emphasis on prevention and early intervention. There are too many people ending up in acute care, and not enough is being done to manage their illness in the community. There are particular groups, and people with particular illnesses, who are receiving inadequate care. Many of these findings have been confirmed by other organisations and reports in recent years.[5]

Findings of the National Mental Health Commission

The Commission found that despite various system-related issues, and a lack of proper evaluation of programmes, at a service level there were:

> …many examples of wonderful innovation and…effective strategies do exist for keeping people and families on track to participate and contribute to the social and economic life of the community. The key feature of these strategies is that they take a person-centred, whole-of-life approach.[6]

Overall the Commission's findings indicated serious problems in the effectiveness and efficiency of the current 'patchwork of services, programmes and systems for supporting mental health'. The Commission stated that as a result, 'many people do not receive the support they need and governments get poor returns on their substantial investment'. According the review the current spending on mental health by Commonwealth, state, and territory governments was about $14 billion per annum.[7]

The case for reform of the mental health system is irrefutable, with the Commission describing the current situation in its report:

> The need for mental health reform has had long-standing bipartisan support. Yet as a country we lack a clear destination in mental health and suicide prevention. Instead of a “mental health system”—which implies a planned, unitary whole—we have a collection of often uncoordinated services that have accumulated spasmodically over time, with no clarity of roles and responsibilities or strategic approach that is reflected in practice.[8]

Duplication

The Commission also found duplication in the current system. This manifested in a lack of flexibility of service delivery which means that services and individuals may

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5 Senate Select Committee on Mental Health, A national approach to mental health – from crisis to community (First Report), 30 March 2006, p. 475.

6 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 13.

7 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 13.

8 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 38.

be mis-matched.[9] The Commission also found that the duplication of services leads to significant gaps in service availability, particularly for Aboriginal and Torres Strait Islanders peoples.[10]

Funding priorities

In terms of resourcing, the Commission found that much of the current funding was focussed on acute care, and very little targeted to early intervention and community-based support:

> Nationwide, resources are concentrated in expensive acute care services, and too little is directed towards supports that help to prevent and intervene early in mental illness. Of total Commonwealth spending of $9.6 billion, 87.5 per cent is in demand-driven programmes, including income support, and funding for acute care. This means that the strongest expenditure growth is in programmes that can be indicators of system failure—those that support people when they are ill or impaired—rather than in areas which prevent illness and will reap the biggest returns economically and 'future proof' people's ability to participate and live productive, contributing lives.[11]

Focus on acute care not early intervention

Related to the funding for acute care, the Commission observed the biggest inefficiencies in the system came from:

> …doing the wrong things—from providing acute and crisis response services when prevention and early intervention services would have reduced the need for those expensive services, maintained people in the community with their families and enabled more people to participate in employment and education.
>
> In fact, there is evidence that far too many people suffer worse mental and physical ill-health because of the treatment they receive, or are condemned to ongoing cycles of avoidable treatment and medications, including avoidable involuntary seclusion and restraint.[12]

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9 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 14.

10 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 14.

11 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 14.

12 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 14.

Financial risk to Commonwealth from current funding structure

The Commission identified significant financial risk for the Commonwealth in the current model of funding for mental ill-health:

> The Commonwealth's role in mental health creates significant exposure to financial risk. As a major downstream funder of benefits and income support, any failure or gaps in upstream services means that as people become more unwell, they consume more of the types of income supports and benefits which are funded by the Commonwealth.[13]

The Commission found that a major contributor to government financial risk, and to increased government spending, was a lack of coordination:

> Ironically, much risk comes from within governments—portfolios working in isolation of each other, aiming to minimise their exposure and their costs without taking into account the downstream costs to their fellow agencies and the overall costs to their government.
>
> For example, many of the services required to keep people well and participating in their homes and the community lie outside the formal health system. This includes areas such as accommodation, education, employment and family and community services. Yet a breakdown in housing or relationships for an individual can pitch them into crisis, resulting in ED [Emergency Department] presentations and extended periods of hospitalisation and acute care. This means that agencies within governments, as well as agencies across governments, need to work together, collaborate and coordinate to manage overall costs and risks.[14]

Need for overall system change

From these findings, the Commission made 25 recommendations aimed at making substantial system-wide changes to the delivery of mental health services and programmes:

> Overall, the findings of this Review present a clear case for reform. The status quo provides a poor return on investment for taxpayers, creates high social and economic costs for the community, and inequitable and unacceptable results for people with lived experience, their families and support people... Managing these costs effectively and sustainably requires a carefully designed programme of practical reforms that rebalance the system to reduce demand for services in the first place and improve the range and appropriateness of support options. This will deliver better

13 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 26.

14 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 26.

> mental health outcomes for individuals and promote economically and socially thriving communities.[15]

Government inaction

The Commission provided its report to the Government on 1 December 2014. However, despite the Government's commitment to 'building a world-class mental health system',[16] the government only released the Commission's report after part of the report had been leaked to the media in April 2015.

Since the release of the report, the government has not formally responded to the Commission's recommendations. Instead, the Minister for Health, the Hon Sussan Ley MP, responded to the commission's report with another review by establishing an Expert Reference Group (ERG). The Minister has recently announced that she intends to respond to the Commission's report by the end of the year.[17]

Mental health sector response

Mental health policy has been on hold since the beginning of the Commission's review in February 2014. In October 2015, ten months after the completion of the Commission's thorough review, the government has still not responded to the Commission's recommendations. As a result, the mental health sector struggles with ongoing funding uncertainty and indecision about the future direction of mental health policy in Australia.

The committee heard the concerns of mental health groups, advocates, service providers, consumers and carers in relation to the uncertain future direction of mental health funding and policy. These groups all gave the committee similar evidence: the government needs to respond positively to the Commission's recommendations and it needs to do so before the end of 2015.

For instance Mr Ivan Frkovic, the Deputy Chief Executive Officer of National Operations at service provider Aftercare, told the committee:

> …we support the directions that were set in the Mental Health Commission report, particularly, again, from a consumers and carer perspective. Let's have a system that focuses and is incentivised for outcomes, not for maintenance, whether it is the public system, the private system or the NGO system.[18]

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15 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 15.

16 The Hon Peter Dutton MP, Minister for Health, media release, 'Mental Health Review', 4 February 2014.

17 The Hon Sussan Ley MP, Minister for Health, media release 'Coming soon: A new approach for our mental health system', 5 October 2015, p. 1.

18 Mr Ivan Frkovic, Deputy Chief Executive Officer, National Operations, Aftercare, *Committee Hansard*, 26 August 2015, p. 20.

Similarly, Professor David Perkins, the Director and Professor of Rural Health Research at the Centre for Rural and Remote Mental Health observed that:

> If we start with community members and people who live in rural and remote areas and ask what they want and need, I think we find the answers have been articulated well by the National Mental Health Commission and by my state's mental health commission. People want a contributing life. They want to live well. They want a secure home, reliable income, education or employment, and to be able to take part in their communities, and they want their symptoms addressed…[19]

Professor Ian Hickie, a Commissioner of the National Mental Health Commission spoke of the consensus which has been built around the Commission's findings:

> I think what has happened here is very unusual. The whole Australian mental health community, through both its lived experience and its technical experts, has combined to say to our respective governments that there is a fundamental need to move away from a programmatic funding approach in response to each crisis and towards locally led and organised services that work in regional Australia.[20]

Committee recommendations

The Senate Select Committee on Health's examination of the issues around mental health services and programmes is relatively brief in comparison with the work done by the Senate Select Committee on Mental Health in 2006. However, the committee notes that the same issues have been raised in both its inquiry, and in the Commission's review of the delivery of mental health services and programmes.

By examining the work of the Commission, the issues raised by witnesses, and the lack of government response to the Commission's review, the committee has demonstrated that once again mental health policy is at a crossroads. Both the issues and the necessary reforms are well documented throughout many inquiries. The committee believes that action now is essential if Australia is to reform its mental health system.

The committee heard from those with lived experience of mental illness, those who care for mental illness suffers, mental health organisations, service providers, and researchers. The evidence from all witnesses was unanimous support for:

- significant change in mental health policy;
- the findings of the National Mental Health Commission; and
- the urgent need for government decision and leadership.

The committee's 13 recommendations reflect what the committee has been told by the mental health sector and those with lived experience of mental illness. The committee

19 Professor David Perkins, Director and Professor, Rural Health Research, Centre for Rural and Remote Mental Health, *Committee Hansard*, 28 August 2015, p. 44.

20 Professor Ian Hickie, Commissioner, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 6.

considers that the government's lack of response to the Commission's findings has caused significant harm. The committee therefore calls on the government to announce its response as a matter of urgency.

As Professor Hickie said when interviewed on 5 October by ABC Radio's *The World Today* program:

> The Abbott government gave a commitment at the 2013 election to conduct a review and implement reforms during this period of government. So it's good to see the [Health] Minister's finally working her way through these issues, but really, really, it's time for action – not more talk.
>
> So we don't need more reviews, we don't need more consultation, we don't need more discussion about discussion – we actually need the Prime Minister, the new Prime Minister, working in combination with the states, so that people get the services that they need no matter where they live.[21]

21 Professor Ian Hickie, Commissioner, National Mental Health Commission, ABC Radio, *The World Today*, 'Mental illness expert unimpressed by Govt lack of reform specifics', 5 October 2015, www.abc.net.au/worldtoday/content/2015/s4325208.htm (accessed 7 October 2015).

Recommendations

Recommendation 1

5.48 The committee recommends that the government:

- **immediately publish the Expert Reference Group report;**
- **urgently respond to the National Mental Health Commission's review; and**
- **guarantee funding for mental health groups and service providers for the 12 months after the announcement of the government response to the National Mental Health Commission's review.**

Recommendation 2

6.13 The committee recommends that the government response to the National Mental Health Commission's report should include a national stigma reduction strategy.

Recommendation 3

6.36 The committee recommends that the government response to the National Mental Health Commission's report should examine the possible role for Primary Health Networks in regionalisation of service and programme delivery.

6.39 The committee therefore recommends that the government response should emphasise the need for mental health, particularly the experience of mental health consumers and carers, to be imbedded in the governance structure of the Primary Health Networks.

Recommendation 4

6.47 The committee recommends that the government response to the National Mental Health Commission's report include evidence-based modes of care that promote early intervention.

Recommendation 5

6.56 The committee recommends that the government's response to the National Mental Health Commission's report recognise the linkages between housing, employment, and mental health. The government's response should include ways for services and programmes to be appropriately connected so that individuals can access holistic care.

Recommendation 6

6.68 The committee recommends that the government's response to the National Mental Health Commission's report recognise need for a clear and comprehensive mental health workforce strategy.

Recommendation 7

6.77 The committee recommends that the government's response to the National Mental Health Commission's report include tangible and measurable actions to achieve the suicide prevention targets recommended by the Commission.

Recommendation 8

6.87 The committee recommends that the government's response to the National Mental Health Commission's report address the challenges of mental health service delivery in rural and remote communities.

Recommendation 9

6.100 The committee recommends that the Government's response to the Mental Health Commission's report sets out a future policy direction to address Indigenous mental health and suicide prevention challenges.

Recommendation 10

6.114 The committee recommends that the government's response to the National Mental Health Commission's report include adequate recognition of the need for data collection to inform services and programmes for LGBTI communities.

6.115 The committee also recommends that the government's response include specific actions and measurable targets in relation to the delivery of services and programmes for the LGBTI community.

Recommendation 11

6.124 The committee recommends that the government response to the National Mental Health Commission's report should include support for the use of the Mental Health in Multicultural Australia *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*.

Recommendation 12

6.135 The committee recommends that the government's response to the National Mental Health Commission's report supports the Commission's findings and recommendations in relation to e-mental health.

Recommendation 13

7.36 The committee recommends that the government immediately clarify how Tier 2 or Information, Linkages and Capacity Building (ILC) will be implemented and how many people it will support.

7.37 The committee recommends that the government share available information on the workings of Tier 2 or ILC in order to quell the disquiet in the community and ensure that individuals do not lose access to much-needed services.

Chapter 1

Introduction

1.1 On 25 June 2014, the Senate established the Senate Select Committee on Health.[1] The final reporting date for the committee is 20 June 2016. The committee's resolution allows the committee to make interim reports such as this one.

Public hearings

1.2 The committee has completed 38 public hearings to date. A list of hearings which focused on mental health is at Appendix 1.[2]

1.3 Through its extensive program of public hearings, the committee has taken evidence from many health experts, practitioners, consumers and communities. The public hearing program has also enabled the committee to engage the wider Australian community, including those in rural and regional areas which may not normally be able to directly engage with the parliamentary process.

1.4 Throughout the committee's inquiry, mental health issues have been raised by witnesses and submitters in connection with evidence about the primary and acute healthcare systems. In order to examine these issues in more detail, the committee held three hearings focussing specifically on mental health:

- 26 August, Canberra;
- 28 August, Hurstville, Sydney; and
- 18 September, Redcliffe, Brisbane.

Submissions

1.5 The committee has received 170 submissions since the beginning of its inquiry. In relation to mental health issues, the committee has received 19 submissions. A list of submissions relating to mental health is at Appendix 2.[3]

1.6 The committee's terms of reference are wide-ranging. It is the committee's intention to explore various issues in depth over the course of its inquiry. While the committee is still accepting general submissions, it is the committee's intention to seek submissions on specific topics as the need arises over the course of the inquiry.

1.7 Additional information, tabled documents, correspondence and answers to questions on notice received by the committee to date and related mental health are listed at Appendix 3.[4]

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1 *Journals of the Senate*, 25 June 2014, pp 996–998.

2 Public hearing details can also be accessed via the committee's website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Public_Hearings.

3 The submissions received by the committee can be accessed via the committee's website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Submissions.

Health Committee's first interim report

1.8 The committee's first interim report was tabled on 2 December 2014.[5] That report detailed the committee's findings and conclusions at that time, focussing on issues raised during the committee's hearings and through submissions. Key areas of focus in the first report were:

- the government's proposed patient co-payments, cuts to hospital funding and the abolition of Australian National Preventative Health Agency;
- the government's plan to close the 61 Medicare Locals and replace them with 30 Primary Health Networks; and
- the merger of the Organ and Tissue Authority and the National Blood Authority.

Second interim report

1.9 The committee's second interim report was tabled on 24 June 2015.[6] That report encompassed the committee's findings regarding the government's primary healthcare and general practice policies. In particular the report was a record of the government's frequent changes of policy since the 2014-15 Budget. The second interim report focused specifically on:

- the vital importance of general practice and primary healthcare and the threat posed by the government's numerous policy changes since the 2014-15 Budget;
- the responses of GPs and the primary healthcare sector to the government's various primary care policies; and
- an examination of the 2015-16 Budget's health measures and commentary from stakeholders.

Third interim report

1.10 The committee's third interim report was tabled on 17 September 2015.[7] That report examined the government's proposed privatisation of Australian Hearing and the National Acoustics Laboratories. The proposal was originally recommended by the National Commission of Audit in February 2014.[8] In the 2014-15 Budget the government allocated funding for a scoping study for the proposed privatisation of

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4 The submissions received by the committee can be accessed via the committee's website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Additional_Documents.

5 *Journals of the Senate*, 2 December 2014, p. 1948. The report can be accessed at: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/First_Interim_Report.

6 *Journals of the Senate*, 24 June 2015, p. 2809. The report can be accessed at: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Second_Interim_Report.

7 *Journals of the Senate*, 17 September 2015, p. 3158. The report can be accessed at: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Third_Interim_Report.

8 National Commission of Audit, *Phase One Report*, paragraph 10.1 and recommendation 57.

Australian Hearing.[9] The 2015-16 Budget included the postponement of a decision on the scoping study, pending further consultation.[10]

1.11 The third interim report outlined the evidence taken at the 10 July 2015 public hearing and the related written submissions made by witnesses. It also examined:

- the impacts privatisation would have on users of the Australian Hearing services; and
- the National Disability Insurance Scheme (NDIS) and Australian Hearing.

Structure of this report

1.12 This fourth interim report examines the mental health issues witnesses and submitters have raised with the committee. The report looks at these issues in the context of the National Mental Health Commission's *National Review of Mental Health Programmes and Services Report* and the pending government response. In addition to this introductory chapter, the report includes six chapters:

- background—setting the broad context of mental health policy in Australia (Chapter 2);
- Chapter 3 examines the high-level findings of the National Mental Health Commission's (the Commission) *National Review of Mental Health Programmes and Services Report*
- the Government reaction to the Commission's review has been minimal and cautious, which has been a disappointment to many in the mental health sector (Chapter 4);
- Chapters 5 and 6 describe the issues witnesses and submitters raised with the committee throughout its inquiry; and
- a key issue of concern for stakeholders is ensuring the smooth transition of Government mental health programmes into the NDIS (Chapter 7).

Notes on references

1.13 References to submissions in this report are to individual submissions received by the committee and published on the committee's website. References to the committee Hansards are to the proof transcripts.[11]

Acknowledgements

1.14 The committee thanks the many organisations and individuals who participated in the mental health hearings on 26 and 28 August, and 18 September as well as those that made written submissions. The committee also acknowledges the

9 Commonwealth of Australia 2014-15 Budget, Budget Paper No. 2, Budget Measure: Smaller Government—scoping studies for four operations of government, May 2014, p. 117.

10 Senator the Hon Mathias Cormann, Minister for Finance, media release, 'Further Consultation on Future Ownership Options for Australian Hearing', 8 May 2015.

11 Committee Hansards can be accessed via the committee's website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Public_Hearings.

contribution of all those who have raised mental health issues in the committee's previous hearings.

1.15 In particular, the committee would like to thank the mental health consumers and carers who told the committee of their personal experiences. Your stories demonstrate strength, hope, and courage. They also show clearly that we need to do better in providing care for those with mental health conditions.

1.16 The personal experiences of carers and consumers who spoke at the roundtables held during the committee's hearings on 28 August (Sydney) and 18 September (Brisbane) are included at Appendix 4.

Chapter 2

Background

...one in two Australian adults will experience mental ill-health at some point – this is 7.3 million Australians[1]

Professor Allan Fels, Chair, National Mental Health Commission

Mental health in Australia

2.1 The National Mental Health Commission (the Commission) begins its Review of Mental Health Services and Programme Delivery report with a stark set of facts about the prevalence of mental ill-health in Australia:

> Each year, it is estimated that more than 3.6 million people (aged 16 to 85 years) experience mental ill-health problems—representing about 20 per cent of adults. In addition, almost 600,000 children and youth between the ages of four and 17 were affected by a clinically significant mental health problem. Over a lifetime, nearly half of the Australian adult population will experience mental illness at some point—equating to nearly 7.3 million Australians aged 16 to 85. Less than half will access treatment.
>
> There are an estimated 9,000 premature deaths each year among people with a severe mental illness. The gap in life expectancy for people with psychosis compared to the general population is estimated to be between 14 and 23 years.[2]

2.2 The Commission found that mental ill-health poses a significant economic and social burden on Australia. This chapter provides information about the Commission's finding in this regard, as well as information about the structure of the mental health system in Australia.

Economic costs of mental ill-health

2.3 In his address to the National Press Club on 5 August 2015, Professor Allan Fels, the Chair of the National Mental Health Commission emphasised the economic costs of mental ill-health to Australia:

> As an economist, I want to emphasise that mental health is a significant problem for our economy – as significant as, often more significant than, tax or microeconomic reform. Many people do not get the support they need, and governments get poor returns on substantial investment. The economic or GDP gains from better mental health would dwarf most of the

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1 Professor Allan Fels, Chair, National Mental Health Commission, transcript of address to the National Press Club, 5 August 2015, p. 3.

2 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 19.

> gains – often modest ones – being talked about in current economic reform debates.[3]

2.4 Professor Fels explained that the economic cost of untreated mental ill-health is also being recognised internationally:

> The world's leading economic commentator, the Financial Times' Martin Wolf, has concluded mental ill health is the developed world's most pressing health problem. He said:
>
> "Given the economic costs to society, including those caused by unemployment, disability, poor performance at work and imprisonment, the costs of treatment would pay for themselves."
>
> Recognition comes also from The Economist magazine which has just published a special report on the growing incidence and costs of mental illness and the Economist Intelligence Unit has done the same.
>
> From Davos, the World Economic Forum has warned finance ministers and economic advisers that they need to react to the 'formidable economic threat' posed by non-communicable diseases, including mental health disorders.
>
> The OECD estimates the average overall cost of mental health to developed countries is about four per cent of GDP. In Australia, this would equate to more than $60 billion or about $4,000 a year for each person who lodges a tax return or over $10,000 per family. The costs include the direct costs of treatment; the indirect costs e.g. disability support pensions, imprisonment, accommodation and so on; the costs of lost output and income and finally costs to carers and families, not to mention that their workforce participation is held back by caring demands.[4]

2.5 In Australia, the Commission's review found that the economic cost of mental ill health is 'enormous':

> Estimates range up to $28.6 billion a year in direct and indirect costs, with lost productivity and job turnover costing a further $12 billion a year – collectively $40 billion a year, or more than two per cent of GDP…[5]

Social costs of mental ill-health

2.6 In addition to these substantial economic costs, mental ill-health imposes a significant social cost burden. The Commission stated that:

> …there are significant and often unquantifiable personal costs associated with mental illness for individuals and their families and other support

3 Professor Allan Fels, Chair, National Mental Health Commission, transcript of address to the National Press Club, 5 August 2015, pp 3–4.

4 Professor Allan Fels, Chair, National Mental Health Commission, transcript of address to the National Press Club, 5 August 2015, pp 3–4.

5 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 6.

people. For Aboriginal and Torres Strait Islander people, there is evidence to suggest that mental ill-health is contributing to the unacceptably high rates of incarceration, unemployment, unsafe communities, school truancy and the continuation of deep and entrenched poverty in some communities. This also applies to other people who are socio-economically disadvantaged.

The significance of these direct and indirect costs means that mental ill-health impacts not only the individual, their families and other support people, but also the standard of living of every Australian and our communities more broadly.[6]

2.7 Put another way, individuals with a mental illness who do not receive adequate support are less likely to be able to participate effectively in community life:

- 37.6 per cent (or 67.3 per cent with severe mental illness) are unemployed or not in the labour force, compared to 22.3 per cent of people without mental health conditions.
- 38.1 per cent are in full-time employment compared to 55.3 per cent of people without mental health difficulties.
- 31.5 per cent of people living with psychosis complete high school, compared to 53.0 per cent in the general community.
- 20.9 per cent are in households in the lowest income bracket, compared to 15.6 per cent of people with no mental illness.
- 26 per cent of people with a mental illness have government pensions and allowances as their main income, increasing to 85 per cent of people living with a psychotic illness, compared to 21.6 per cent for people without mental illness.[7]

2.8 The Commission also noted that there are poorer outcomes for people with a mental illness in terms of the justice system:

- Of the 29,000 people in prisons in Australia in 2012, it is estimated that 38 per cent had a history of mental illness—a rate almost twice that seen in the general population.
- In New South Wales, the annual number of police incidents involving people with a mental health problem increased by 25 per cent, from around 22,000 in 2007–08 to around 30,000 in 2011–12.

6 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 25.

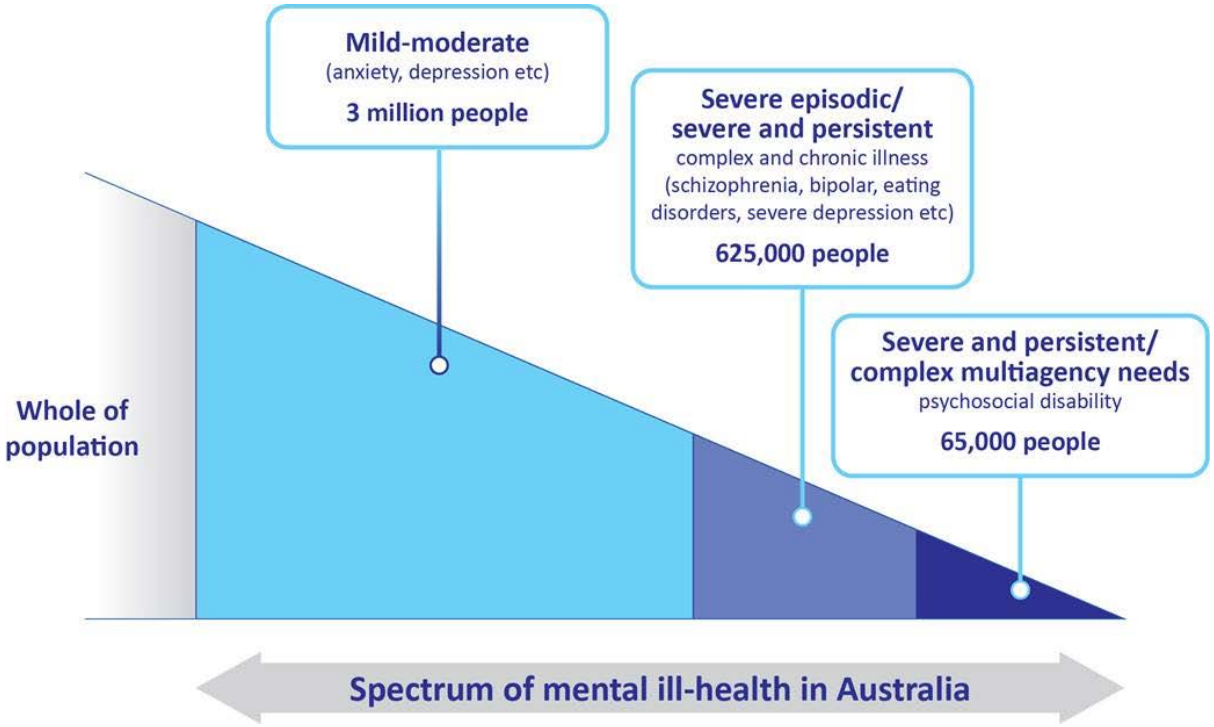
7 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 21.

- Across Australia over the 11 years from 1989–90 to 2010–11, 42 per cent of people shot by police had a mental illness.[8]

Current state of mental ill-health in Australia

2.9 The Commission identified mental ill health ranges from mild-moderate to severe and persistent. The figure below, taken from the review, shows the spectrum of mental ill-health in the Australian population. It is important to appreciate that mental ill-health is on a broad spectrum when examining issues such as access to mental health services, ongoing treatment, and economic impact.[9]

Figure 1—Annual distribution of mental ill-health in Australia[10]



2.10 The Commission's research shows that many of those who experience a mental illness to not seek support:

> …rates of help-seeking and treatment much lower than prevalence in the community. Latest statistics suggest about 46 per cent of people with a mental ill-health problem seek help each year.[11]

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8 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 21.

9 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 20.

10 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 8.

2.11 Dr Michelle Blanchard, the Head of Projects and Partnerships at the Young and Well Cooperative Research Centre told the committee that this is particularly true for young people with a mental illness:

> In the case of young people, 25 per cent of young people experience a mental health difficulty and 70 per cent of those do not seek help and do not receive care. It is a very high figure for a younger population, and that figure is higher again for young men…
>
> We know from international evidence that the time between the onset of symptoms for someone with a mental illness and the time they receive the right care is up to 10 years.[12]

2.12 The review described the current state of mental health in Australia with the following points:

- Stigma persists;
- People with lived experience, families and support people have a poor experience of care;
- A mental health system that doesn't prioritise people's needs;
- A system that responds too late;
- A mental health system that is fragmented;
- A system that does not see the whole person;
- A system that uses resources poorly.[13]

Current government mental health spending

2.13 The Commission's review found that in 2012-13 Commonwealth Government expenditure on mental health, spread across 16 agencies, was almost $10 billion to fund mental health and suicide prevention programmes. The breakdown of this spending is summarised in Figure 2 below.

2.14 The Commission noted that of Commonwealth spending on mental health, 87.5 per cent funds five major programmes:

> Four of these are demand-driven programmes providing benefits to individuals. The fifth major area of expenditure is an estimated $1 billion per year provided to the states and territories under the 2011 National Health Reform Agreement (NHRA) for treatment of patients with a mental

11 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 20.

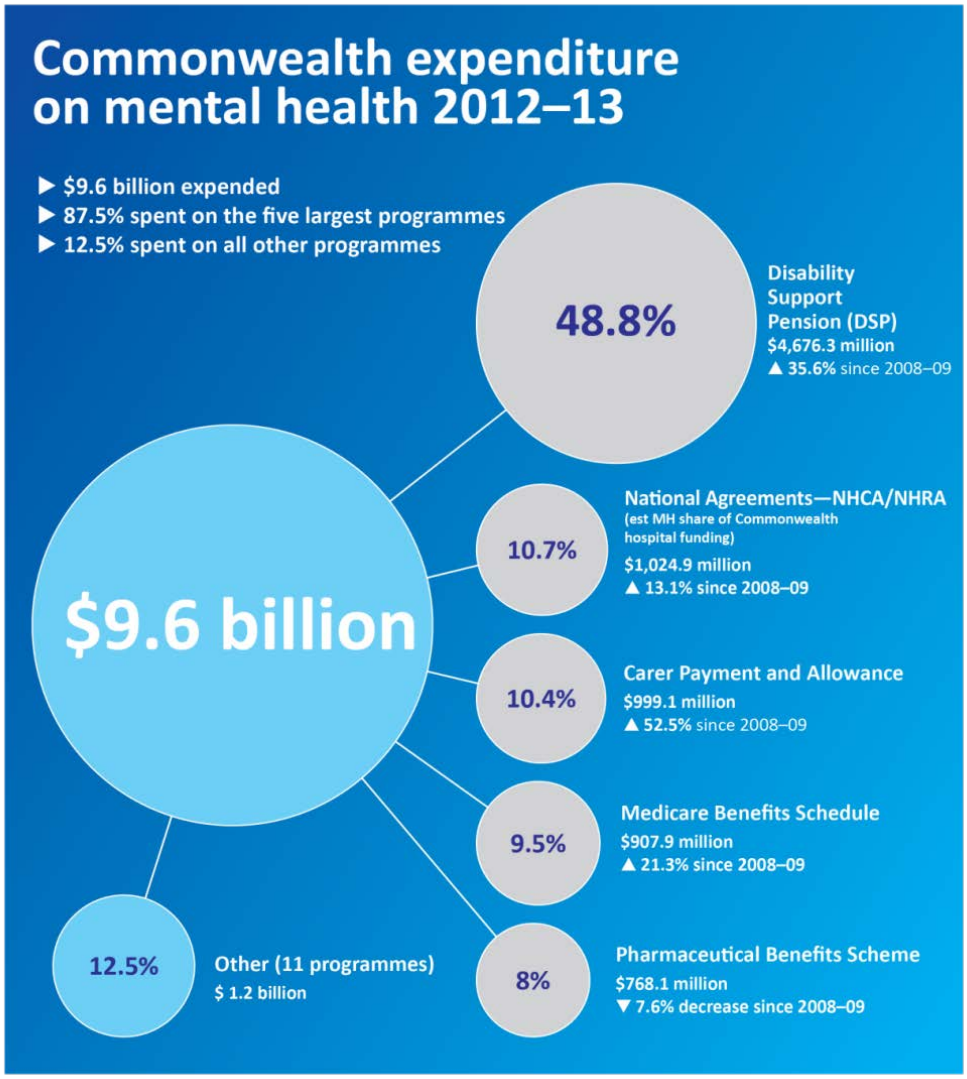
12 Dr Michelle Blanchard, Head, Projects and Partnerships, Young and Well Cooperative Research Centre, *Committee Hansard*, 18 September 2015, p. 50.

13 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 11.

health need in the public hospital system, including an estimated $280 million for patients in standalone psychiatric institutions.[14]

2.15 Figure 2 shows that the largest amount—almost 90 per cent—of Commonwealth expenditure is spent on 'downstream' funding in the form of disability benefits and income support.

Figure 2—Commonwealth expenditure on mental health[15]



2.16 The Commission requested, and received, information from 16 Commonwealth agencies which it used to ascertain the amount and division of

14 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, pp 9–10.

15 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 10.

Commonwealth spending on mental health services and programmes. The breakdown of this spending for 2012-13 is:

> 1. $8.4 billion (87.5 per cent) on **benefits and activity-related payments** in five programme areas:
>
> - Disability Support Pension (DSP) $4,700m
> - National Health Reform Agreement (Activity Based Funding—ABF) $1,000m
> - Carer Payment and Allowance (CP) $1,000m
> - Medicare Benefits Schedule (MBS) $900m
> - Pharmaceutical Benefits Scheme (PBS) $800m
>
> 2. $533.8 million (5.6 per cent) through **programmes and services with Commonwealth agencies and payments to states and territories:**
>
> - DVA and Defence programmes ($192.3m)
> - Private Health Insurance Rebate for mental health-related costs ($105.0m)
> - Payments to states and territories for specific programmes (perinatal depression, suicide prevention, National Partnership Agreement Supporting Mental Health Reform) ($169.0m)
> - National Health and Medical Research Council (NHMRC) research funding ($67.1m).
>
> 3. $606 million allocated by the Department of Health (DoH), the Department of Social Services (DSS) and the Department of the Prime Minister and Cabinet (PM&C) on **programmes delivered by NGOs**.
>
> - DoH spent $362 million on 55 grant programmes, including payments to 213 NGOs, representing 11 per cent of total mental health-related expenditure from this department.
> - DSS spent $180 million on six grant programmes, including payments to 196 NGOs, representing three per cent of total mental health-related expenditure from this department.
> - PM&C spent $64 million on three grant programmes, including payments to 133 NGOs (the proportion of total mental health-related expenditure that this represented was not available).[16]

Financial risks for the Commonwealth

2.17 The Commission argued that the current structure of Commonwealth funding 'creates significant exposure to financial risk':

16 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 22.

> As a major downstream funder of benefits and income support, any failure or gaps in upstream services means that as people become more unwell, they consume more of the types of income supports and benefits which are funded by the Commonwealth.
>
> Those risks also fall back on state and territory crisis teams, emergency departments (EDs) and acute hospital services, so it is in the best interests of the Commonwealth and the states and territories to work together to achieve the best outcomes for individuals and communities and minimise costs to taxpayers.[17]

National Mental Health Commission

2.18 The Commission was established by the Governor General as an Executive Agency under the *Public Service Act 1999* within the Prime Minister's portfolio, on 1 January 2012. The Commission describes its purpose as to provide independent reports and advice to the community and government on mental health services, programmes, and 'on what's working and what's not.'[18]

2.19 The Commission's mission is to:

> …give mental health and suicide prevention national attention, to influence reform and to help people live contributing lives by reporting, advising and collaborating.[19]

2.20 With Machinery of Government changes announced after the September 2013 election, the Commission was transferred to the Health portfolio. It is formally accountable to the Minister for Health. Advice from the Commission to the Government is provided via the Minister for Health under cover of a brief, letter or report from the Chair and/or the CEO of the Commission.[20]

2.21 Professor Fels responded to criticism of the Commission's move into the health portfolio:

> Contrary to some media reports suggesting the Commission will be absorbed into the Department of Health, the Commission understands it will simply now report to the new [now former] Health Minister, The Hon Peter Dutton MP.

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17 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 10.

18 National Mental Health Commission, website, 'About Us', www.mentalhealthcommission.gov.au/about-us.aspx (accessed 7 October 2015).

19 National Mental Health Commission, website, 'About Us', www.mentalhealthcommission.gov.au/about-us/our-vision.aspx (accessed 7 October 2015).

20 National Mental Health Commission, website, PDF document, Prime Minister's Statement of Expectations -2011 www.mentalhealthcommission.gov.au/media/66201/PM%20Statement%20of%20Expectations.pdf (accessed 7 October 2015).

> Chair Professor Allan Fels said, "Our independence is critical to credible reporting and advice and to driving transparency and accountability.
>
> "As I have said previously, we will continue to bring a whole of life, whole of portfolio perspective to our work. In doing so, we will provide clear, independent advice to Government and engage with all relevant portfolios and sectors.[21]

2.22 The Commission undertakes a range of work towards the purpose of promoting mental health and providing advice to Government. Its work includes:

> In 2012 and 2013 we produced two annual National Report Cards on Mental Health and Suicide Prevention. The report cards inform Australians of where we are doing well and where we need to do better in mental health. As well as looking at the facts and figures, the report card tells the real and everyday experiences of Australians. We will be reporting back on all our recommendations at the end of the year.
>
> The Commission is working with the Australian Commission on Safety and Quality in Health Care (ACSQHC) on a scoping study on the implementation of national standards in mental health services.
>
> In 2013, Expert Reference Group chaired by Professor Allan Fels AO provided a report to the COAG Working Group on Mental Health Reform regarding National Targets and Indicators for mental health reform.
>
> We also coordinate Spotlight Reports to shine a light on issues and areas of interest identified by the Commission. These reports are commissioned to inform our work and do not necessarily reflect the views of the Commission.[22]

2.23 The Commission has spent a large part of 2014 conducting its review of mental health programmes and services, which it delivered to the Government on 1 December 2014. The Government subsequently released the Commission's report on 16 April 2015, after parts of the report were leaked to the media.

2.24 The focus of the Commission's review was on 'assessing the efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill-health and their families and other support people to lead a contributing life and to engage productively in the community.'[23] The review delivered a series of findings and 25 recommendations which, if implemented will:

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21 National Mental Health Commission, media release, Commission will remain independent', 19 September 2013, www.mentalhealthcommission.gov.au/media-centre/news/commission-will-remain-independent.aspx (accessed 7 October 2015).

22 National Mental Health Commission, website, 'Our Reports', www.mentalhealthcommission.gov.au/our-reports.aspx (accessed 7 October 2015).

23 National Mental Health Commission, website, 'Contributing lives – thriving communities review of mental health programmes and services', www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx (accessed 7 October 2015).

> …create a system to support the mental health and wellbeing of individuals, families and communities in ways that enables people to live contributing lives and participate as fully as possible as members of thriving communities.[24]

2.25 The Commission's report and the Government's initial reaction are discussed in Chapters 3 and 4 respectively.

Previous mental health inquiries

2.26 The Commission's review is the latest in a long line of reviews and inquiries which have considered the most effective and efficient means of delivering mental health services and programmes. Mr Sebastian Rosenberg, a Senior Lecturer at the University of Sydney's Brain and Mind Centre reflected on these past inquiries:

> Despite four national plans and two national policies, one road map, two report cards and one action plan, genuine mental health reform seems as far away as ever. There is a sense that things have changed and that the asylums have closed in Australia. Well, there are still 1,831 beds in asylums across Australia costing about half a billion dollars per year. Large elements of the old system are still very much in place in our current system… One of the main things that was through all the history of Australian mental health policies and plans has been the desire to establish community-based mental health care, but in fact what we have is an extremely hospital-focused system of care. Even when the National Mental Health Commission suggested a very small change to those arrangements, Minister Ley unfortunately seemed to indicate that that would not be pursued.
>
> We were interested very much in promotion, prevention and early intervention, but in fact we have a system which really is about postvention and crisis management.
>
> We were very much interested in e-mental health technologies, some of which Australia has led in, but in fact what we have is a continued dependence on face-to-face care and fee-for-service type approaches.[25]

2.27 Mr Rosenberg observed that there had been '32 separate inquiries into mental health between 2006 and 2012'.[26] He cited the Senate Select Committee on Mental Health's inquiry as being of particular importance:

> Here is the Senate's recommendations from 2006. They were excellent. The reform of mental health care really depends on filling the gap between the GP and the hospital. There needs to be an establishment of good

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24 National Mental Health Commission, website, 'Contributing lives – thriving communities review of mental health programmes and services', www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx (accessed 7 October 2015).

25 Mr Sebastian Rosenberg, Senior Lecturer, Brain and Mind Centre, University of Sydney, *Committee Hansard*, 26 August 2015, pp 15–16.

26 Mr Sebastian Rosenberg, Senior Lecturer, Brain and Mind Centre, University of Sydney, *Committee Hansard*, 26 August 2015, pp 15–16.

> community mental health services, and this was a key recommendation that the Senate [Select Committee on Mental Health] made in 2006. The issue here is that nobody owns community mental health. It falls between the federal government and the state government in terms of responsibility… despite recent changes to funding arrangements and so on, the mental health share of the health budget is in decline. The mental health system remains in crisis. New funding into existing failed systems is a terrible idea. What we need is a new approach based on genuine community access to mental health care which combines both clinical and non-clinical elements of support.[27]

2.28 The Senate Select Committee on Mental Health was appointed on 8 March 2005 and its terms of reference included, amongst others:

- the adequacy of various modes of care for people with a mental illness;
- the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;
- the special needs of groups such as children…Indigenous Australians, the socially and geographically isolated;
- the role of primary health care in promotion, prevention, early detection and chronic care management;
- the adequacy of education in de-stigmatising mental illness;
- the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;
- the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government; and
- the potential for new modes of delivery of mental health care, including e-technology.[28]

2.29 The Select Committee prepared two reports, the first on 30 March 2006 and the final report on 28 April 2006.[29] The two reports were necessitated by a February 2006 decision by the Council of Australian Governments (COAG) to begin a process of discussion and policy development on mental health. In order to input into the COAG process, the committee decided to make an initial early report of its findings

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27 Mr Sebastian Rosenberg, Senior Lecturer, Brain and Mind Centre, University of Sydney, *Committee Hansard*, 26 August 2015, pp 15–16.

28 Senate Select Committee on Mental Health inquiry website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/tor (accessed 7 October 2015).

29 Senate Select Committee on Mental Health inquiry website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/tor (accessed 7 October 2015).

and those recommendations relating to COAG. A follow up report was then published, with the remaining recommendations.[30]

2.30 Overall, the Select Committee on Mental Health found that:

> …there is much work to do in the area of mental health. There needs to be more money, more effort and more care given to this neglected part of our health care system. There is not enough emphasis on prevention and early intervention. There are too many people ending up in acute care, and not enough is being done to manage their illness in the community. There are particular groups, and people with particular illnesses, who are receiving inadequate care. Many of these findings have been confirmed by other organisations and reports in recent years.[31]

Committee view

2.31 The Senate Select Committee on Health's examination of the issues around mental health services and programmes is relatively brief in comparison with the work done by the Senate Select Committee on Mental Health in 2005-06. However, the committee notes that the same issues have been raised in both its inquiry, and in the Commission's review of the delivery of mental health services and programmes.

2.32 In looking at the work of the Commission, the issues raised by witnesses, and the lack of government response to the Commission's review, the committee hopes to demonstrate that once again mental health policy is at a crossroads. Both the issues and the necessary reforms are well documented throughout many inquiries. The committee believes that action now is essential if Australia is to reform its mental health system. The committee will use the remainder of the report to illustrate this conclusion.

30 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community (First Report)*, 30 March 2006, p. xvii.

31 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community (First Report)*, 30 March 2006, p. 475.

Chapter 3

National Mental Health Commission Review

We have every confidence that the adoption of the recommendations in this report will result in transformational reform of the mental health system, promote significant innovation, particularly at a local level, and enable people, their families and communities to thrive.[1]

National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*

Introduction

3.1 On 4 February 2014 the then Minister for Health, the Hon Peter Dutton MP announced terms of reference for the National Mental Health Commission (the Commission) to review mental health services and programmes.[2] The final report of the Commission was provided to government on 1 December 2014.[3]

3.2 The Commission's review was to 'examine existing mental health services and programmes across the government, private and non-government sectors'. The review was to focus on an assessment of 'efficiency and effectiveness of programmes and services in supporting individuals experiencing mental ill-health and their families and other support people to lead a contributing life and to engage productively in the community'.[4]

3.3 The review's terms of reference were to evaluate:

- the efficacy and cost-effectiveness of programmes, services and treatments;
- duplication in current services and programmes;
- the role of factors relevant to the experience of a contributing life such as employment, accommodation and social connectedness (without evaluating programmes except where they have mental health as their principal focus);

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1 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 5.

2 Minister for Health, The Hon Peter Dutton MP, Media Release, 'Mental Health Review', 4 February 2014.

3 National Mental Health Commission, website, 'Review of Mental Health Programmes and Services', www.mentalhealthcommission.gov.au/our-reports/review-of-mental-health-programmes-and-services.aspx (accessed 7 October 2015).

4 National Mental Health Commission, website, 'Review of Mental Health Programmes and Services', www.mentalhealthcommission.gov.au/our-reports/review-of-mental-health-programmes-and-services.aspx (accessed 7 October 2015).

- the appropriateness, effectiveness and efficiency of existing reporting requirements and regulation of programmes and services;

  funding priorities in mental health and gaps in services and programmes, in the context of the current fiscal circumstances facing governments;

- existing and alternative approaches to supporting and funding mental health care;
- mental health research, workforce development and training
- specific challenges for regional, rural and remote Australia;
- specific challenges for Aboriginal and Torres Strait Islander peoples; and
- transparency and accountability for outcomes of investment.[5]

3.4 The review built on the Commission's previous work, including the consultations and research completed for the Commission's two National Report Cards on Mental Health and Suicide Prevention.[6]

3.5 This chapter provides a high-level examination of the Commission's review, and in particular the process it followed, its key findings and recommendations.

Review process

3.6 The Commission described the review as advice to Government on whether:

> …Commonwealth programmes and services are being leveraged to maximise impact and achieve the greatest public value in enabling a contributing life for people experiencing mental ill-health.[7]

3.7 The Commission framed its review within what it described as 'the context of the fiscal constraints faced by all Australian governments'.[8] The result was that the review did not propose any reduction or increase in spending on mental health. Instead the review's recommendations are aimed at 'redirecting existing resources rather than new funding, with resources to be used cost-effectively to leverage better outcomes.'[9]

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5 National Mental Health Commission, website, 'Review of Mental Health Programmes and Services', www.mentalhealthcommission.gov.au/our-reports/review-of-mental-health-programmes-and-services.aspx (accessed 7 October 2015).

6 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 17.

7 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 17.

8 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 17.

9 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 17.

The Commission's website notes that the review 'is framed on the basis of making changes within existing resources, as specified by the Terms of Reference provided to the Commission by the Commonwealth Government.'[10]

3.8 The conduct of the Commission's review included:

- calling for submissions from stakeholders;
- conducting face-to-face meetings with stakeholders;
- gathering and analysing information and data from Commonwealth, state and territory governments;
- building on work already completed for the Commission's National Report Cards; and
- commissioning work from consultants.[11]

3.9 On 24 March 2014, the Commission invited all interested individuals and groups to make submissions to inform its review. The Commission also wrote to over 530 stakeholders and encouraged them to make submissions. As a result, the Commission received over 2000 online and paper-based submissions.[12] The Commission noted:

> The submissions process wasn't the only way we gathered views, ideas and evidence – we asked funders and service providers for data and information; we met face to face with consumer and carer, service provider and professional representatives; and we looked at a range of research, evaluations and reviews.[13]

3.10 The Commission carried out detailed research as part of its review, and considered data and information from Commonwealth agencies, states and territories.

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10 National Mental Health Commission, website, 'Contributing lives – thriving communities review of mental health programmes and services', www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx (accessed 7 October 2015).

11 National Mental Health Commission, website, 'Contributing lives – thriving communities review of mental health programmes and services', www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx (accessed 7 October 2015).

12 National Mental Health Commission, website, 'Contributing lives – thriving communities review of mental health programmes and services', www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx (accessed 7 October 2015). The Commission captured the main themes of the submissions in Volume 3 of its report: National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014.

13 National Mental Health Commission, website, 'Contributing lives – thriving communities review of mental health programmes and services', www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx (accessed 7 October 2015).

A particular concern highlighted by the Commission was that gaps in data seemed to be a result of a lack of proper programme evaluation:

> Overall the Commission was underwhelmed at the level of programme evaluations available, given the significant investment of Commonwealth funds. Hence in critical areas, and for vulnerable populations, it is not possible to say whether resources are being efficiently and effectively targeted. For many Aboriginal and Torres Strait Islander people, for example, the mental health system requires them to rely on general population services and programmes. However, the degree to which they are accessed by Aboriginal and Torres Strait Islander people or are contributing to better mental health outcomes is largely unknown.[14]

3.11 As part of its review, the Commission commissioned a number of supporting reports from consultancies. These included:

- Improving the integration of mental health services in primary health care at the macro level, Primary Health Care Research & Information Service (PHCRIS)
- Advice on Innovative Technologies in e-Mental Health, Young and Well CRC
- Paving the way for mental health: The economics of optimal pathways to care, KPMG
- Advice and recommendations: Specific challenges for regional, rural and remote Australia, University of Newcastle
- Expert advice on specific challenges for Aboriginal and Torres Strait Islander peoples' mental health (Final Report), HMA[15]

Review findings

3.12 The Commission found that despite various system-related issues, and a lack of proper evaluation of programmes, at a service level there were:

> …many examples of wonderful innovation and…effective strategies do exist for keeping people and families on track to participate and contribute to the social and economic life of the community. The key feature of these strategies is that they take a person-centred, whole-of-life approach.[16]

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14 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 18.

15 National Mental Health Commission, website, 'Contributing lives – thriving communities review of mental health programmes and services', www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx (accessed 7 October 2015).

16 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 13.

3.13 However, overall the Commission's findings indicated serious problems in the effectiveness and efficiency of the current 'patchwork of services, programmes and systems for supporting mental health'. The Commission stated that as a result, 'many people do not receive the support they need and governments get poor returns on their substantial investment'. The current spending on mental health by Commonwealth, state, and territory governments was, according the review, about $14 billion per annum.[17]

Duplication

3.14 The Commission also found duplication in the current system. This manifested in a lack of flexibility of service delivery which means that services and individuals may be mis-matched. [18] The Commission also found that the duplication of services leads to significant gaps in service availability, particularly for Aboriginal and Torres Strait Islander peoples: [19]

> For Aboriginal and Torres Strait Islander people, these service and programme gaps can be summarised as:
>
> - a significant gap in community-based social and emotional wellbeing promotion, prevention activity and primary mental health care enabling the prevention, early detection and treatment of mental health problems at an early stage
> - culturally competent general population mental health services
> - ensuring patient transitions from family and community to primary and specialist mental health care, and then back into the community
> - a lack of Aboriginal and Torres Strait Islander specialist care to support transitions and ensure culturally appropriate services that accommodate cultural difference—for example, by supporting access to traditional healers, or working with families.[20]

Resourcing

3.15 In terms of resourcing, the Commission found that much of the current funding was focussed on acute care, and very little targeted to early intervention and community-based support:

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17 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 13.

18 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 14.

19 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 14.

20 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 34.

> Nationwide, resources are concentrated in expensive acute care services, and too little is directed towards supports that help to prevent and intervene early in mental illness. Of total Commonwealth spending of $9.6 billion, 87.5 per cent is in demand-driven programmes, including income support, and funding for acute care. This means that the strongest expenditure growth is in programmes that can be indicators of system failure—those that support people when they are ill or impaired—rather than in areas which prevent illness and will reap the biggest returns economically and 'future proof' people's ability to participate and live productive, contributing lives.[21]

Focus on acute care not early intervention

3.16 Related to the funding for acute care, the Commission observed the biggest inefficiencies in the system came from:

> …doing the wrong things—from providing acute and crisis response services when prevention and early intervention services would have reduced the need for those expensive services, maintained people in the community with their families and enabled more people to participate in employment and education.
>
> In fact, there is evidence that far too many people suffer worse mental and physical ill-health because of the treatment they receive, or are condemned to ongoing cycles of avoidable treatment and medications, including avoidable involuntary seclusion and restraint.[22]

Financial risk to Commonwealth from current funding structure

3.17 The Commission identified significant financial risk for the Commonwealth in the current model of funding for mental ill-health:

> The Commonwealth's role in mental health creates significant exposure to financial risk. As a major downstream funder of benefits and income support, any failure or gaps in upstream services means that as people become more unwell, they consume more of the types of income supports and benefits which are funded by the Commonwealth.[23]

3.18 The Commission pointed out that financial risks also fall in a different way on the state and territory governments. In this instance the financial risk results from

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21 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 14.

22 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 14.

23 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 26.

increased need for acute care, crisis teams, and admissions to emergency departments.[24]

3.19 The Commission found that a major contributor to government financial risk, and to increased government spending, was a lack of coordination:

> Ironically, much risk comes from within governments—portfolios working in isolation of each other, aiming to minimise their exposure and their costs without taking into account the downstream costs to their fellow agencies and the overall costs to their government.
>
> For example, many of the services required to keep people well and participating in their homes and the community lie outside the formal health system. This includes areas such as accommodation, education, employment and family and community services. Yet a breakdown in housing or relationships for an individual can pitch them into crisis, resulting in ED [Emergency Department] presentations and extended periods of hospitalisation and acute care. This means that agencies within governments, as well as agencies across governments, need to work together, collaborate and coordinate to manage overall costs and risks.[25]

Need for overall system change

3.20 From these findings, the Commission made 25 recommendations aimed at making substantial system-wide changes to the delivery of mental health services and programmes. The Commission wrote:

> Overall, the findings of this Review present a clear case for reform. The status quo provides a poor return on investment for taxpayers, creates high social and economic costs for the community, and inequitable and unacceptable results for people with lived experience, their families and support people... Managing these costs effectively and sustainably requires a carefully designed programme of practical reforms that rebalance the system to reduce demand for services in the first place and improve the range and appropriateness of support options. This will deliver better mental health outcomes for individuals and promote economically and socially thriving communities.[26]

Review recommendations

3.21 The Commission described its recommendations as designed to lead to the creation of 'a system to support the mental health and wellbeing of individuals in a

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24 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 26.

25 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 26.

26 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 15.

way that enables them to live contributing lives and participate as fully as possible as members of thriving communities'. The Commission explained that:

> To achieve the required system reform, the Commission recommends changes to improve the longer-term sustainability of the mental health system based on three key components:
>
> 1. Person-centred design principles
> 2. A new system architecture
> 3. Shifting funding to more efficient and effective 'upstream' services and supports.
>
> These principles underpin the Commission's 25 recommendations across nine strategic directions. They guide a more detailed implementation framework of activity over the next decade, which provides a comprehensive plan for action in mental health reform.[27]

3.22 The new system architecture proposed in the Commission's review would '**redesign, redirect, rebalance, repackage** and ultimately **reform** the approach to mental health in Australia'.[28] The Commission explained this as:

> - **redesign** the system to focus on the needs of individuals, and their families and other supporters, rather than on what providers do
> - **redirect** Commonwealth dollars as incentives to purchase value-for-money, measurable results and outcomes, rather than simply funding a myriad of programmes to produce more and more activity
> - **rebalance** expenditure away from those things which indicate system failure and invest in those things which are known to work— prevention and early intervention, recovery-based community support, stable housing, and participation in employment, education and training
> - **repackage** and bundle funds being spent on that small percentage of people with the most severe and persistent mental health problems and who are the highest users of the mental health dollar. Purchase integrated packages of services which support them to lead contributing lives and keep them out of avoidable high cost care
> - **reform** our approach to supporting people and families to lead fulfilling, productive lives so they not only maximise their

27 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 5. The Commission's recommendations are listed in Appendix 5.

28 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 15. Emphasis reproduced from the original text.

> individual potential and reduce the burden on the system but also can lead a contributing life and help grow Australia's wealth.[29]

3.23 In accordance with the instructions from Government, the Commission's recommendations are designed to effect changes to the structure of mental health care and funding within existing resources. For example:

> …the Review identifies measures to help the Commonwealth maximise value for taxpayers' dollars by using its resources as incentives to leverage desirable and measurable results, and funding outcomes rather than activity. It also proposes reallocating funding from downstream to upstream services, including prevention and early intervention.[30]

Person-centred approach to mental health

3.24 The Commission advocated a 'person-centred approach' to mental health. Person-centred approach means that 'services are organised around the needs of people, rather than people having to organise themselves around the system.'[31] In such an approach:

> …as a person's acuity and functional impairment increase, the care team will expand to include different support providers. As acuity diminishes and functional capacity is improved, the team will contract as the person can take on more self-care. People are not transferred from one team to another but remain connected throughout, to a general practice or community mental health service, and with an ongoing core relationship with their family and other support people.[32]

3.25 Under a person-centred approach, individuals experiencing mental ill-health would be involved in decision-making, embodying the ethos "nothing about us without us".[33] The review described an ideal person-centred mental health system as having 'clearly defined pathways between health and mental health'. Such a system

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29 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 39. Emphasis reproduced from the original text.

30 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 5.

31 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 13.

32 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 13.

33 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 42.

would also recognise and build on the non-health supports 'such as housing, justice, employment and education' and focuses on 'cost-effective, community-based care'.[34]

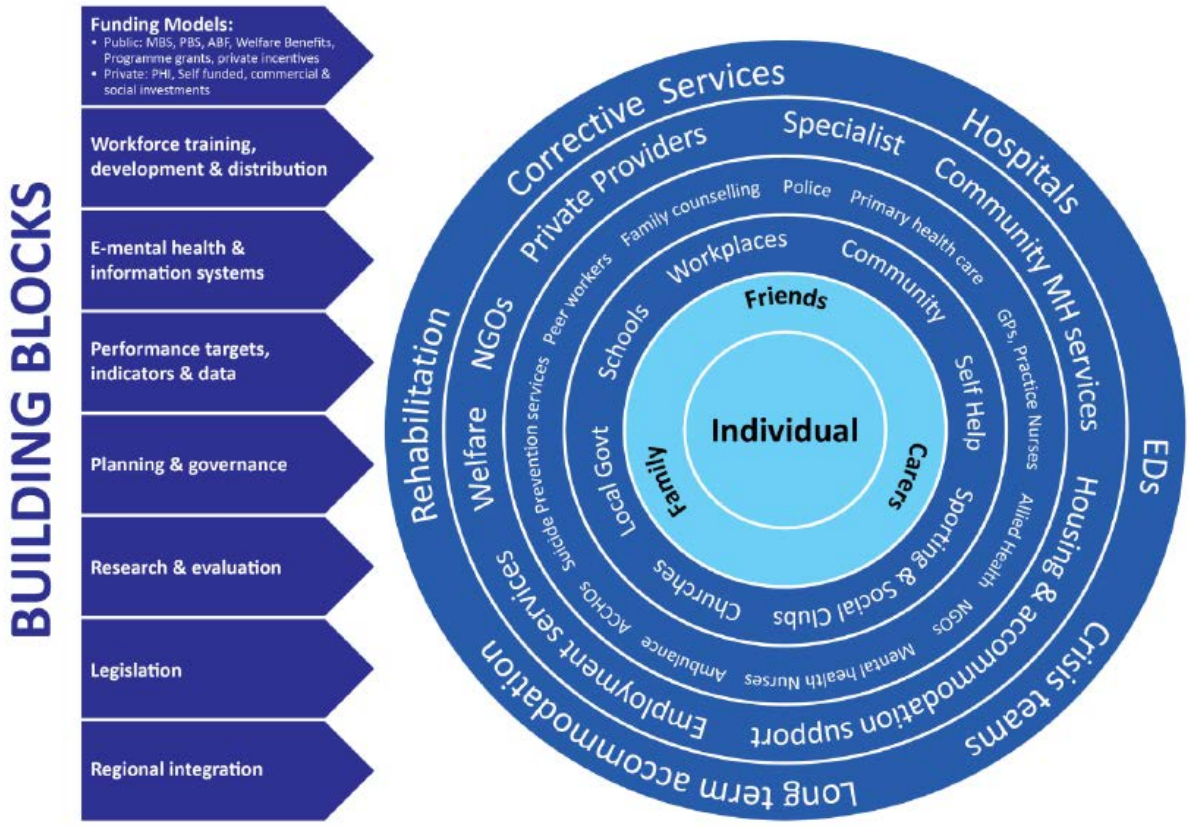
3.26 Figure 3 below, taken from the Commission's review, illustrates the concept of a person-centred approach. The Commission explained that such an approach includes:

- governance models which engage with people with lived experience, their families and support people and enable them to participate at every level in planning, commissioning and monitoring of services
- funding models (which, if properly designed, can drive the right behaviour)
- the right workforce to provide equitable access and to do the job in the most efficient and effective way
- e-mental health and information technology to link people and services and promote self-care and wellbeing
- research and evaluation to translate evidence into practice
- measurement of results to ensure transparency and accountability and to feed into planning
- regulatory frameworks to protect and promote safety and quality for people but which otherwise should be light touch
- regional planning and organising to be responsive to the diverse local needs of the different communities across Australia.[35]

34 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 13.

35 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 44.

Figure 3—A person-centred approach with systems and resources as enablers[36]



3.27 Implementing a person-centred approach is only possible in a system which will appropriately support it. Therefore, the Commission advocated for changes to system architecture to ensure support for a more efficient and effective approach to supporting mental ill-health.

Changes to system architecture

3.28 The current system, as described by the Commission, does not necessarily lend itself to a person-centred approach. The Commission therefore argued that to implement the person-centred approaches embodied in review's findings, it will be necessary to make changes to the system architecture.

3.29 To complement the person-centred approach the Commission outlined three main objectives for a reformed mental health system:

- effective: scarce resources used cost-effectively to achieve identified objectives
- efficient: programmes and services maximise net benefits to the community

36 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 44.

- evidence-based: decisions based on meaningful data[37]

3.30 The review argued that putting the above objectives into effect would mean:

- matching available resources to identified need;
- a focus on prevention, early intervention, and support for recovery; and
- an emphasis on community support and integration.[38]

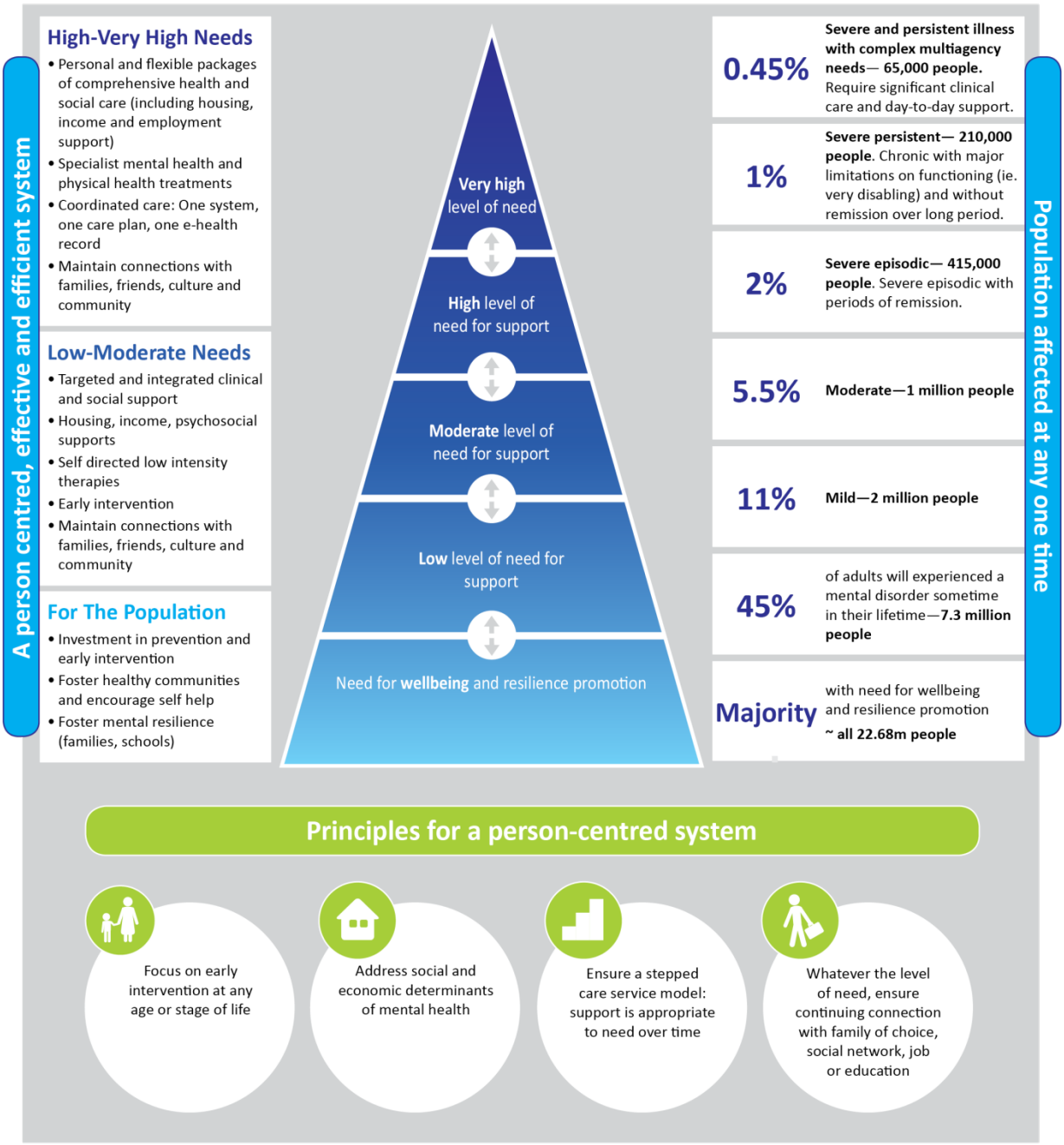
3.31 Figure 4 below, taken from the review, demonstrates the way in which system architecture needs to be shaped to support a person-centred approach. In Figure 4, 'the main features of such an approach are to differently target the population as a whole, the segment of the population with low-moderate needs and the segment of the population with high-very high needs'.[39]

37 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 14.

38 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 14.

39 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 14.

Figure 4—Population-based architecture[40]



3.32 The review argued that a 'stepped care framework' should accompany person-centred care and the complementary changes in system architecture:

> The realignment of system architecture as recommended in this report also involves two other important features:

40 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 14.

- A stepped care framework that provides a range of help options of varying intensity to match people's level of need.
- Integrated Care Pathways (ICPs) for mental health, to provide for a seamless journey through the mental health system.

This approach shifts groups of people towards 'upstream' services (population health, prevention, early intervention, recovery and participation) and thereby reduces 'downstream', costly services (ED presentations, acute admissions, avoidable readmissions and income support payments).[41]

3.33 The review explained that fundamental to a stepped care framework is prioritising the delivery of care through GPs and primary healthcare. The review noted that there is international evidence that:

> …national health care systems with strong primary care infrastructures have healthier populations, fewer health-related disparities and lower overall costs for health care than those countries that focus on specialist and acute care.
>
> Indeed, the World Health Organization (WHO) has endorsed this approach: Integration of mental health into primary health care "not only gives better care; it cuts wastage resulting from unnecessary investigations and inappropriate and non-specific treatments."[42]

3.34 In an Australian context, the review stated that:

> Based on modelling commissioned from KPMG, the outcome of implementing this change [to a stepped care and person-centred approach] would be to slow the rate of increase in Disability Support Pension (DSP) and Carer Payment costs and the costs of acute care and crisis management.[43]

Innovations—refocusing funding

3.35 As a result of the need for restructure of system architecture, the review made the following finding and accompanying recommendations:

> Shift funding priorities from hospitals and income support to community and primary health care services
>
> Recommendations:

41 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p.17.

42 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p.16.

43 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p.16.

- Reallocate a minimum of $1 billion in Commonwealth acute hospital funding in the forward estimates over the five years from 2017–18 into more community-based psychosocial, primary and community mental health services.
- Extend the scope of Primary Health Networks (renamed Primary and Mental Health Networks) as the key regional architecture for equitable planning and purchasing of mental health programmes, services and integrated care pathways.
- Bundle-up programmes and boost the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services and support for people, their families and supporters.
- Improve service equity for rural and remote communities through place-based models of care.[44]

3.36 The Minister for Health, the Hon Sussan Ley MP, has already stated this recommendation of the Commission would not be accepted by the government:

> …the Government does not intend to pursue the proposed $1 billion shift of funding from state acute care to community organisations, as we want to work collaboratively in partnership with other levels of Government.[45]

3.37 An examination of the government's reaction to the Commission's review and recommendations is in Chapter 4.

Sector response to Commission's recommendations

3.38 Since the Commission delivered its review to the government on 1 December 2014, there were calls from mental health groups for the review report to be publicly released. For example, the CEO of Mental Health Australia, Mr Frank Quinlan spoke about the need for the Commission's review to be released as part of a public discussion about mental health sector reform. Speaking on 2 March 2015 about the release of three major reports by non-profit groups, Mr Quinlan said:

> "In the face of these reports, we renew our call on government to release the National Mental Health Commission's Review of Mental Health Services and Programmes to allow consultation and planning, and to commit to ending funding uncertainty for mental health organisations who are delivering essential services across all these areas."
>
> "The mental health sector is committed to reform and renewal, it's time to get started"[46]

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44 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 16.

45 The Hon Sussan Ley MP, Minister for Health, media release 'Abbott Government plans national approach on Mental Health', 16 April 2015, p. 2.

3.39 However, the Commission's report was not released by the government until 16 April, after parts of the report were leaded to the Australian Broadcasting Corporation on 14 April. Further discussion on the release of the report and the government reaction is in Chapter 4.

3.40 At the committee's public hearing on 26 August 2015, a number of groups were supportive of the work of the Commission and the review's recommendations. For example, Professor Malcolm Hopwood, the President of the Royal Australian and New Zealand College of Psychiatrists told the committee:

> We particularly support the review's and other commentators' focus on bringing things together across the sector. Mental health funding is diverse in its origin, and that is a significant barrier to improving mental health care. By this, I mean not just governmental boundaries but also boundaries across the primary, secondary and tertiary sectors.[47]

3.41 Ms Pamela Rutledge, Chief Executive Officer of RichmondPRA, an organisation which provides Partners in Recovery (PIR) services, also praised the Commission's report:

> Coming from a slightly different angle, and from RichmondPRA's perspective—we work in a way that is very strongly led by people with a lived experience of a mental health issue, and we also support the National Mental Health Commission Review and the direction that it proposes…[48]

3.42 Mr Jack Heath, Chief Executive Officer of SANE Australia voiced the views of many organisations in both supporting the Commission's review and arguing for a government response to the review recommendations:

> In relation to the National Mental Health Commission's review, the sector desperately needs a response this year. We do not want to be in the position where we have funding rolled over for another 12 months. It is just a really terrible way to try and operate services for people with severe needs. When we have seen political leadership in Australia in the past decades—and I would go back to Prime Minister Howard with the work that he did around youth suicide—we have seen significant changes occur. We are not going to see substantial reform in mental health unless we have concerted political leadership around that. I think that at a political level, mental health seems to have dropped off the agenda in the past couple of years. There is an opportunity now for that to be picked up in terms of response to the review. But we need to make sure that those responses are considered and are not done in a simplistic way. At the same time that we have many problems that were identified in the review of the mental health system in Australia, it

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46 Mental Health Australia, media release, 'Three major reports point to need for long term reform', 2 March 2015, http://mhaustralia.org/media-releases/three-major-reports-point-need-long-term-reform (accessed 7 October 2015).

47 Professor Malcolm Hopwood, President, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 26 August 2015, p. 17.

48 Ms Pamela Rutledge, Chief Executive Officer, RichmondPRA, *Committee Hansard*, 26 August 2015, p. 21.

> has been SANE's view for a number of years that we actually believe we have the potential in this country to deliver the best world's best mental health services and programs for a number of reasons but I will not go into that right now.[49]

Committee view

3.43 At the outset the committee wishes to acknowledge the exceptional work of the National Mental Health Commission in undertaking its review. The committee congratulates the Commission on its production of a comprehensive report on the state of delivery of mental health services and programmes in Australia.

3.44 Like the Commission, the committee is underwhelmed by the gaps in data and the lack of detailed evaluation of Commonwealth, state, and territory government services and programmes. Without standardised data collection and thorough programme evaluation, the task of assessing the efficiency and effectiveness of programmes and services becomes high challenging. Poor evaluation not only results in funding being wasted, it also has the far more detrimental consequence of depriving individuals of the help they need.

3.45 The committee notes the findings of the Commission in relation to the need for prevention and early intervention in treating mental ill-health. In particular the committee notes with concern the gap in provision of services to vulnerable groups, including Aboriginal and Torres Strait Islander peoples and those in rural and remote areas. The committee urges the government to have regard to the Commission's findings in relation to prevention and early intervention and the urgent need for support for vulnerable groups.

3.46 Overall the committee considers that the Commission has produced a clear and comprehensive set of recommendations for the future reform of the delivery of mental health programmes and services. The committee urges the government to follow the recommendations made by the Commission, as closely as possible.

3.47 However, the committee is concerned that the Commission was tasked by the government with making recommendations within the boundaries of current government expenditure. The committee believes that this was an unnecessary constraint on the Commission's review.

3.48 Similarly, the committee is concerned that the government has changed the Commission's reporting arrangement, as described in Chapter 2. Placing the Commission within the Department of Health, rather than outside of the department and reporting directly to government, is an unwelcome interference in the independence of the Commission.

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49 Mr Jack Heath, Chief Executive Officer, SANE Australia, *Committee Hansard*, 26 August 2015, p. 39.

Chapter 4

Government reaction

…mental health is probably the hidden epidemic in our community. Something like one in five Australians will have an episode of mental ill-health in any one year; it's something that is happening everywhere, but it's so often unrecognised and it's so often untreated.[1]

Former Prime Minister the Hon Tony Abbott MP

Introduction

4.1 The Government's announcement of a review into the delivery of mental health services and programmes on 4 February 2015 was strongly welcomed by the mental health sector.

4.2 Stakeholders in the mental health sector participated energetically in the Commission's review, with the Commission receiving over 2000 online and written submissions, in addition to its face-to-face meetings with stakeholders.[2]

4.3 The Commission provided its report to the government on 1 December 2014. However, despite the government's commitment to 'building a world-class mental health system',[3] the government only released the Commission's report after part of the report had been leaked to the media in April 2015.

4.4 Since the release of the report, the government has not formally responded to the Commission's recommendations. Instead, the Minister for Health, the Hon Sussan Ley MP, established an Expert Reference Group (ERG) to provide advice to the Department of Health, further to a government response being made at some date in the future.[4]

4.5 This chapter examines the government initial reaction to the Commission's report, including the processes that the Minister for Health has set in place, and the estimated timeline for a formal government response.

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1 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 3.

2 National Mental Health Commission, website, 'Contributing lives – thriving communities review of mental health programmes and services', www.mentalhealthcommission.gov.au/our-reports/contributing-lives,-thriving-communities-review-of-mental-health-programmes-and-services.aspx.(accessed 7 October 2015).

3 The Hon Peter Dutton MP, Minister for Health, 'Mental Health Review', media release, 4 February 2014.

4 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government plans national approach on Mental Health', media release, 16 April 2015, p. 2.

Delay in releasing the report

4.6 From the time the Commission delivered its review to Government in December 2014, there were calls from mental health groups for the review report to be publicly released. For example, the CEO of Mental Health Australia, Mr Frank Quinlan spoke about the need for the Commission's review to be released as part of a public discussion about mental health sector reform. Speaking on 2 March 2015 about the release of three major reports by non-profit groups, Mr Quinlan said:

> In the face of these reports, we renew our call on government to release the National Mental Health Commission's Review of Mental Health Services and Programmes to allow consultation and planning, and to commit to ending funding uncertainty for mental health organisations who are delivering essential services across all these areas.
>
> The mental health sector is committed to reform and renewal, it's time to get started.[5]

4.7 On 14 April 2015, more than four months after the report was provided to the Government, the ABC's *7.30 Report* program obtained part of a leaked report.[6] In response to the resultant pressure from experts and mental health groups,[7] the government released the full report on 16 April 2015.[8]

4.8 In announcing the release of the full review report, the Minister for Health argued that given the complex nature of the findings of the review, 'a consultative and collaborative approach is essential to achieving this and I intend to seek bipartisan agreement to revive a national approach to mental health at tomorrow's COAG [Council of Australian Governments] meeting of Health Ministers.'[9]

4.9 With one exception, the Minister's announcement appears to be the only government response made to date to the review's recommendations:

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5 Mental Health Australia, media release, 'Three major reports point to need for long term reform', 2 March 2015, http://mhaustralia.org/media-releases/three-major-reports-point-need-long-term-reform (accessed 7 October 2015).

6 Ms Sabra Lane and Ms Lucy Barbour, ABC *7.30 Report*, 'Leaked Federal Government mental health report recommends redirecting $1 billion from acute hospital care to community-based services', 14 April 2015, www.abc.net.au/news/2015-04-14/mental-health-services-report-recommends-funds-redirection/6391028 (accessed 7 October 2015).

7 Ms Stephanie Smail, ABC Radio *AM Program*, 'Mental health report delays increase pressure on Federal Government; support groups call for review's immediate release', 15 April 2015, www.abc.net.au/news/2015-04-15/mental-health-report-delays-mount-pressure-on-government/6393078 (accessed 7 October 2015).

8 National Mental Health Commission, website, 'Media coverage of the Review', www.mentalhealthcommission.gov.au/media-centre/news/media-coverage-of-the-review.aspx (accessed 7 October 2015).

9 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government plans national approach on Mental Health', media release, 16 April 2015, p. 1.

> …the Government does not intend to pursue the proposed $1 billion shift of funding from state acute care to community organisations, as we want to work collaboratively in partnership with other levels of Government.[10]

4.10 Decisions regarding the implementation of the Commission's findings are subject to the outcome of two main processes: deliberations by the COAG Health Council and advice from the ERG.

4.11 However, mental health is a policy area which overlaps significantly with that of primary care, including the Medicare Benefits Schedule (MBS) and the Primary Health Networks (PHNs). Other government processes such as the Primary Health Care Advisory Group (PHCAG), the MBS Review, and the establishment of the PHNs, will necessarily have a bearing on any decisions the government may make about the Commission's recommendations.

4.12 Additionally, the transition of government programmes such as Partners in Recovery (PIR) to the National Disability Insurance Scheme (NDIS) is also part of the environment in which the Commission's recommendations must be considered.

4.13 The processes specific and ancillary to the government's consideration of the Commission's review are examined below.

Government response—processes and timeline

4.14 In her comments on the release of the Commission's receive on 16 April 2015, the Minister for Health emphasised that the Commission's review must be placed in context:

> …[it] is a report to government, not of government, and while many recommendations offer positive ideas, others are not conducive to a unified national approach or require further investigation by experts…[11]

4.15 The Minister for Health advocated for having national support for reform, as well as support from the mental health sector, in place before any new policy in response to the Commission's review is announced.[12] To this end, the Minister announced that the government response to the Commission's recommendations would not be released until the COAG Health Council had completed its deliberations and the ERG had made its report.

4.16 Asked at the 16 April press conference why, given the comprehensive report of the Commission, there was the need for a COAG working group and an ERG to advise government the Minister told journalists:

> Because we'll be implementing these recommendations and Government policy together. So this is an important part of the process. Having received

10 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government plans national approach on Mental Health', media release, 16 April 2015, p. 2.

11 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government plans national approach on Mental Health', media release, 16 April 2015, p. 2.

12 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government plans national approach on Mental Health', media release, 16 April 2015, p. 2.

> the report, having worked through the recommendations, having taken careful note, I will now be in close consultation with the mental health sector to reform this fragmented approach and this multisector organisational delivery that we all acknowledge doesn't get the best spend for our mental health dollar – and let's not forget, this is not just about dollars, it's about people. It's about patients, it's about lives and it's about a commitment that I know all Health Ministers want to make to do better. So we're not extending a consultation process, we're implementing an important phase of that consultation process.[13]

4.17 However the timeline on the Minister's consultations at national, state, and stakeholder levels is not fixed. As discussed below, the establishment of a COAG Working Group on Mental Health has not yet proceeded.

4.18 In response to questions about timeframe, and in particular about funding for mental health services while consultation was ongoing, the Minister said:

> …we've extended funding [for mental health services] for another 12 months and we're going to use that 12 months to work through how we implement these recommendations and government policy and practice.[14]

4.19 A breakdown of timeframe for decisions in the 12 months specified by the Minister is not available. Mr Mark Cormack, Deputy Secretary of Strategic Policy and Innovation in the Department of Health told the committee that:

> What we are working to do is to support the Expert Reference Group to complete its advice to government. Government will then release its response to the commission's report and within that response we anticipate that there will be a greater degree of certainty about the timing for contract extensions, renewals and any changes or modifications in the way that services are delivered. Certainly our minister has been making sure that we support the work of the Expert Reference Group to get the advice to her as quickly as possible and then it is really a matter for government decision making. As I said, we believe that the information from the ERG will be made available to government in the time that it is requested and then the deliberations of government will continue on from there, at which time we should be able to identify the impacts on the sector as a result of government decision making… The precise timing of the government response is a matter for government. But all the indications are that they want us to support that being delivered very quickly.[15]

4.20 Stakeholders in the mental health sector are understandably concerned about the prospect of another 12 months without any government response to the

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13 Minister for Health, the Hon Sussan Ley MP, 'Abbott Government plans national approach on Mental Health', transcript 16 April 2015.

14 Minister for Health, the Hon Sussan Ley MP, 'Abbott Government plans national approach on Mental Health', transcript, 16 April 2015.

15 Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation, Department of Health, *Committee Hansard*, 26 August 2015, p. 61.

Commission's review. Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia told the committee that this uncertainty was unprecedented:

> We have really been on hold, largely, in terms of major policy decisions since the government commenced their Review of Mental Health Programs and Services [in February 2014]. Beyond the temporary extension of certain programs just to keep the doors open a couple of times during that period, there have not been substantial reform measures undertaken—this at a time when, I think it is fair to say, there has never been greater unity or clarity from a very broad and diverse sector about the need for reform and, in large measure, about the steps that are required in order to undertake that reform.[16]

4.21 The concerns of stakeholders such as Mental Health Australia, and the issues they raised with the committee are examined in Chapters 5 and 6.

COAG deliberations

4.22 The Minister described the COAG process as 'essential to developing a co-ordinated, binding national approach long-term'. She went on to state that the Government would therefore seek to establish a COAG Working Group on Mental Health Reform to coordinate consultation and decisions with state and territory governments.[17] There is no information publicly available on whether the working group has been established at the time of writing.

4.23 Neither the 17 April 2015 COAG Communique nor the 23 July 2015 Special COAG Communique mention the NMHC Review of Mental Health Services and Programmes and the cooperation of state and Commonwealth governments to implement the review's recommendations.[18]

4.24 The COAG Health Council (CHC) also met on 17 April 2015. The communique issued on 19 April stated that the CHC discussed the release of the NMHC's review and noted Minister Ley's rejection of the review's recommendation to move $1 billion from hospital funding to community-based services. The communique also noted:

> Ministers agreed to work cooperatively with the Commonwealth on a national approach through the COAG Health Council to progress a response to the recommendations of the Review.[19]

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16 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 15.

17 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government plans national approach on Mental Health', media release, 16 April 2015, p. 1.

18 COAG, website, 'COAG Meeting Outcomes', www.coag.gov.au/meeting_outcomes (accessed 7 October 2015).

19 COAG Health Council Communique, 17 April 2015, www.coaghealthcouncil.gov.au/Publications/Communiques/ArtMID/522/ArticleID/53/17-April-2015-COAG-Health-Council-Communique (accessed 7 October 2015).

4.25 However there was no mention made of the establishment of the COAG Working Group on Mental Health in the communique.

Expert Reference Group

4.26 Alongside the consultations that will take place within COAG, the Minister described the Government's approach to including the mental health sector in decisions regarding the implementation of the review's findings. The Minister announced the establishment of an Expert Reference Group (ERG) which would:

> …inform the entire process, including the development of short, medium and long-term strategies in four key areas based on the findings and recommendations presented in the National Mental Health Commission's Review in four overarching mental health areas:
>
> - Suicide Prevention;
> - Promotion, prevention and early intervention of mental health and illness;
> - The role of primary care in treatment of mental health, including better targeting of services;
> - National leadership, including regional service integration.[20]

4.27 The purpose of the ERG is to provide 'expert advice to inform the development and implementation of the Government's response to the Review.'[21] The ERG had its first meeting on 18 June 2015,[22] and presented its report to the government in October 2015.[23] A list of the members of the ERG is provided in Appendix 6.

4.28 The ERG's advice to the Department of Health will centre on the 'policy, programme and service changes' proposed in the review, with specific attention to:

- The evidence base underpinning changes to mental health programmes and services;
- Potential options for and implications of programme redesign;
- Workforce and regional infrastructure issues;
- Process issues in relation to consulting on and developing a response to the Review.[24]

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20 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government plans national approach on Mental Health', media release, 16 April 2015, p. 2.

21 Department of Health, website, 'Terms of Reference - Mental Health Expert Reference Group', www.health.gov.au/internet/main/publishing.nsf/Content/mental-tor (accessed 7 October 2015).

22 Mental Health Australia, 18 June 2015, media release, 'ERG Meeting – countdown to reform begins'.

23 Minister for Health, the Hon Sussan Ley MP, 5 October 2015, media release 'Coming soon: A new approach for our mental health system', p. 1.

24 Department of Health, website, 'Terms of Reference - Mental Health Expert Reference Group', www.health.gov.au/internet/main/publishing.nsf/Content/mental-tor (accessed 7 October 2015).

4.29 Terms of reference for the ERG make it clear that the group's purpose is to provide expert advice and not to be a decision-making body. The ERG's expert advice will be supplemented by 'advice obtained from stakeholders through a broader consultation, and existing ongoing mental health advisory groups over the coming months.'[25]

4.30 The ERG's terms of reference set out the linkage between the work of the ERG and the process of COAG consultation:

> Advice obtained from the Expert Reference Group will also help to inform the Commonwealth's input to discussion with states and territories under the COAG Health Council on the development of a new National Mental Health Plan as well as inform deliberations of the Primary Health Care Advisory Group and the Medicare Benefits Schedule Review taskforce.[26]

4.31 The ERG will be supported by a number of other processes:

- Broad stakeholder workshops to ensure mental services and organisations at the frontline can have direct input into this process;
- An NDIS Mental Health working group;
- An Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group;
- Setting better access to mental health services as a priority for the Government's new Primary Health Networks;
- And an inter-governmental approach to ensure Commonwealth agencies respond to the report's concerns about fragmentation of payments and services and better co-ordinate future systems and policies.[27]

Primary Health Care Advisory Group

4.32 Another current process which may influence the government's mental health priorities is the broader Primary Health Care Advisory Group (PHCAG).

4.33 The Minister announced the establishment of the PHCAG on 22 April 2015, alongside the establishment of the Medicare Benefits Schedule (MBS) Review Taskforce.[28] The PHCAG members were announced on 4 June 2015.[29]

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25 Department of Health, website, 'Terms of Reference - Mental Health Expert Reference Group', www.health.gov.au/internet/main/publishing.nsf/Content/mental-tor (accessed 7 October 2015).

26 Department of Health, website, 'Terms of Reference - Mental Health Expert Reference Group', www.health.gov.au/internet/main/publishing.nsf/Content/mental-tor (accessed 7 October 2015).

27 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government plans national approach on Mental Health', media release, 16 April 2015, p. 2.

28 Minister for Health, the Hon Sussan Ley MP, 22 April 2015, media release 'Abbott Government to deliver a healthier Medicare'.

29 Minister for Health, the Hon Sussan Ley MP, 4 June 2015, media release, 'Establishment of expert groups to shape a healthier Medicare'.

4.34 Announcing the role of the PHCAG, the Minister noted that the PHCAG will 'examine opportunities for reform and to develop them into a series of proposals for consultation, prior to reporting to Government'.[30] Supported by the Department of Health, the PHCAG will 'identify opportunities for health system reform' and focus on:

- Primary / Acute care interface, including the proposed and potential roles of [Primary Health Networks];
- Innovative care models for target groups such as those with complex, chronic disease;
- Funding models that best support proposed service improvements;
- Potential revised roles for existing players in the health system that support proposed service improvements; and
- *Better recognition and treatment of mental illness.*[31]

4.35 The PHCAG released its discussion paper *Better outcomes for people with Chronic and Complex Health Conditions through Primary Health Care* on 4 August 2015. The discussion paper contains limited mention of mental health care in terms of chronic illness. PHCAG consultations have taken place in capital cities and regional centres, and concluded with a national web-linked consultation on 21 August 2015.[32]

4.36 According to the Department of Health website, the PHCAG will report government by the end of 2015.[33] Dr Steve Hambleton, Chairman, Primary Health Care Advisory Group told the committee that they had been asked to report in November 2015.[34]

4.37 Dr Hambleton also noted that the PHCAG had not been provided with a copy of the report or any of the work of the ERG.[35]

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30 Department of Health, website, 'Terms of Reference - Mental Health Expert Reference Group', www.health.gov.au/internet/main/publishing.nsf/Content/primary-phcag-tor (accessed 7 October 2015).

31 Department of Health, website, 'Terms of Reference - Mental Health Expert Reference Group', www.health.gov.au/internet/main/publishing.nsf/Content/primary-phcag-tor, (emphasis added) (accessed 7 October 2015).

32 Department of Health, website, 'Terms of Reference - Primary Health Care Advisory Group', www.health.gov.au/internet/main/publishing.nsf/Content/PrimaryHealthCareAdvisoryGroup-1#consult (accessed 7 October 2015).

33 Department of Health, website, 'Terms of Reference - Primary Health Care Advisory Group', www.health.gov.au/internet/main/publishing.nsf/Content/PrimaryHealthCareAdvisoryGroup-1#consult (accessed 7 October 2015).

34 Dr Steve Hambleton, Chairman, Primary Health Care Advisory Group, *Committee Hansard*, 18 September 2015, p. 11.

35 Dr Steve Hambleton, Chairman, Primary Health Care Advisory Group, *Committee Hansard*, 18 September 2015, pp 11–12.

Primary Health Networks

4.38 In announcing the establishment of the PHCAG, the Minister noted that there would be wide consultation and that the PHCAG (and the accompanying MBS Review) would:

> …draw on a broad range of expertise and experiences to inform the process, including: Clinicians (GPs and Specialists); Consumer and Patient Representatives; Academics; *Primary Health Networks*; Nurses; Allied Health Professionals; Health Economists; and States and Territories.[36]

4.39 The Primary Health Networks (PHNs) are likely to play a significant role in the intersection of primary healthcare and mental health. The NMHC review proposed that the PHNs could play an important role in cementing mental health in the delivery of primary care. This would enable better early intervention and prevention, and assist in de-stigmatisation of mental illness:

> The development of 30 Primary Health Networks (or Primary and Mental Health Networks—PMHNs) across Australia provides the ideal opportunity to harness this infrastructure and better target mental health resources to meet population needs on a regional basis.
>
> These new entities will be the meso-level organisations responsible for planning and purchasing services on a regional basis. They can work in partnership and apply targeted, value-for-money interventions across the whole continuum of mental wellbeing and ill-health to meet the needs of their communities, enabling a stepped care approach with the aims of:
>
> - promoting mental health and wellbeing
> - reducing risk factors
> - preventing mental ill-health
> - reducing or delaying the onset of mental ill-health experiences
> - managing and supporting people in the community as much as possible
> - providing timely access when needed to hospital and other acute services
> - managing the handover from hospital back into the community, step-down care and rehabilitation, aged care and palliative care
> - reducing adverse events, waste and duplication.[37]

4.40 The PHNs therefore have a role alongside both the ERG and the PHCAG to include mental health in primary care as a means to implement the NMHC

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36 Minister for Health, the Hon Sussan Ley MP, 22 April 2015, media release 'Abbott Government to deliver a healthier Medicare', (emphasis added).

37 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 16.

recommendations. Further discussion on the role of the PHNs in mental health care is in Chapter 5.

National Disability Insurance Scheme

4.41 The Commission's review findings included the need to 'set clear roles and accountabilities to shape a person-centred mental health system'. To implement this finding, the review recommended that the Government:

> Urgently clarify the eligibility criteria for access to the National Disability Insurance Scheme (NDIS) for people with disability arising from mental illness and ensure the provision of current funding into the NDIS allows for a significant Tier 2 [now called 'Information, Linkages and Capacity Building'] system of community supports.[38]

4.42 The Minister's announcement of 16 April 2015 states that the ERG will be supported by other processes, including 'an NDIS Mental Health working group'.[39]

4.43 A group called the NDIA Mental Health Sector Reference Group was established in late 2014, 'to develop a strong working partnership between the mental health sector and the NDIA'.[40] The group has held a number of meetings since its establishment and is:

> …is chaired by Strategic Adviser to the NDIA, Mr Eddie Bartnik. Membership consists of consumers, carers, peak associations, NDIS Independent Advisory Council members and key government representatives including Mental Health Commissions.[41]

4.44 The transition of mental health programmes and services to the NDIS and related issues is discussed in Chapter 7.

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38 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 10.

39 The Hon Sussan Ley MP, Minister for Health, 'Abbott Government plans national approach on Mental Health', media release, 16 April 2015, p. 2.

40 National Disability Insurance Scheme, website, 'NDIA Mental Health Sector Reference Group', www.ndis.gov.au/mental-health-sector-reference-group (accessed 7 October 2015).

41 National Disability Insurance Scheme, website, 'NDIA Mental Health Sector Reference Group', www.ndis.gov.au/mental-health-sector-reference-group (accessed 7 October 2015).

Chapter 5

Issues—governance

Instead of a "mental health system"…we have a collection of often uncoordinated services that have accumulated spasmodically over time, with no clarity of roles and responsibilities or strategic approach that is reflected in practice.[1]

National Mental Health Commission
National Review of Mental Health Programmes and Services

Introduction

5.1 The committee has heard much evidence about mental health issues over the course of its 38 hearings. As a result, the committee agreed to hold three hearings on mental health issues, with a key focus on the findings of the National Mental Health Commission and the government's consideration of its response.

5.2 At the committee's public hearings on 26 and 28 August, and 18 September in Canberra, Sydney, and Brisbane respectively, the committee heard from a diverse range of mental health groups, carers, consumers, service providers and others, including the National Mental Health Commission and the Mental Health Commissioners of Queensland and New South Wales.

5.3 This chapter sets out the issues raised with the committee during its hearings, and in the submissions received from groups and individuals, in relation to governance and funding in mental health service and programme delivery. These issues include:

- Fifth National Mental Health Plan;
- Mental Health Service Planning Framework;
- Outcomes focussed funding with reporting; and
- Policy and funding uncertainty.

5.4 The committee has examined each of these issues from three perspectives: the evidence it received from witnesses; the findings of the Commission; and, where it exists, Government reaction to the Commission's findings. The committee summarises its findings and makes its recommendation towards the end of this chapter. Issues relating to delivery of services and programmes, and the committee's recommendations, are in Chapter 6.

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1 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 38.

Fifth National Mental Health Plan

5.5 In the 2015-16 Budget, the Government committed to work in collaboration with States and Territories to develop the fifth national mental health plan.[2]

5.6 The Fourth National Mental Health Plan set:

> …an agenda for collaborative government action in mental health for five years from 2009, offers a framework to develop a system of care that is able to intervene early and provide integrated services across health and social domains, and provides guidance to governments in considering future funding priorities for mental health.[3]

5.7 The Fourth National Mental Health Plan was developed to guide reform and actions as part of the implementation of the National Mental Health Policy, which was endorsed by Australian Health Ministers in 2008.[4] The National Mental Health Policy sits within the National Mental Health Strategy, endorsed in April 1992 by the then Australian Health Ministers' Conference as a framework to guide mental health reform.[5]

5.8 Figure 5 below shows the relationship of the Fourth National Mental Health Plan to the National Mental Health Policy, the National Mental Health Strategy, and the other elements of mental health within the COAG framework.

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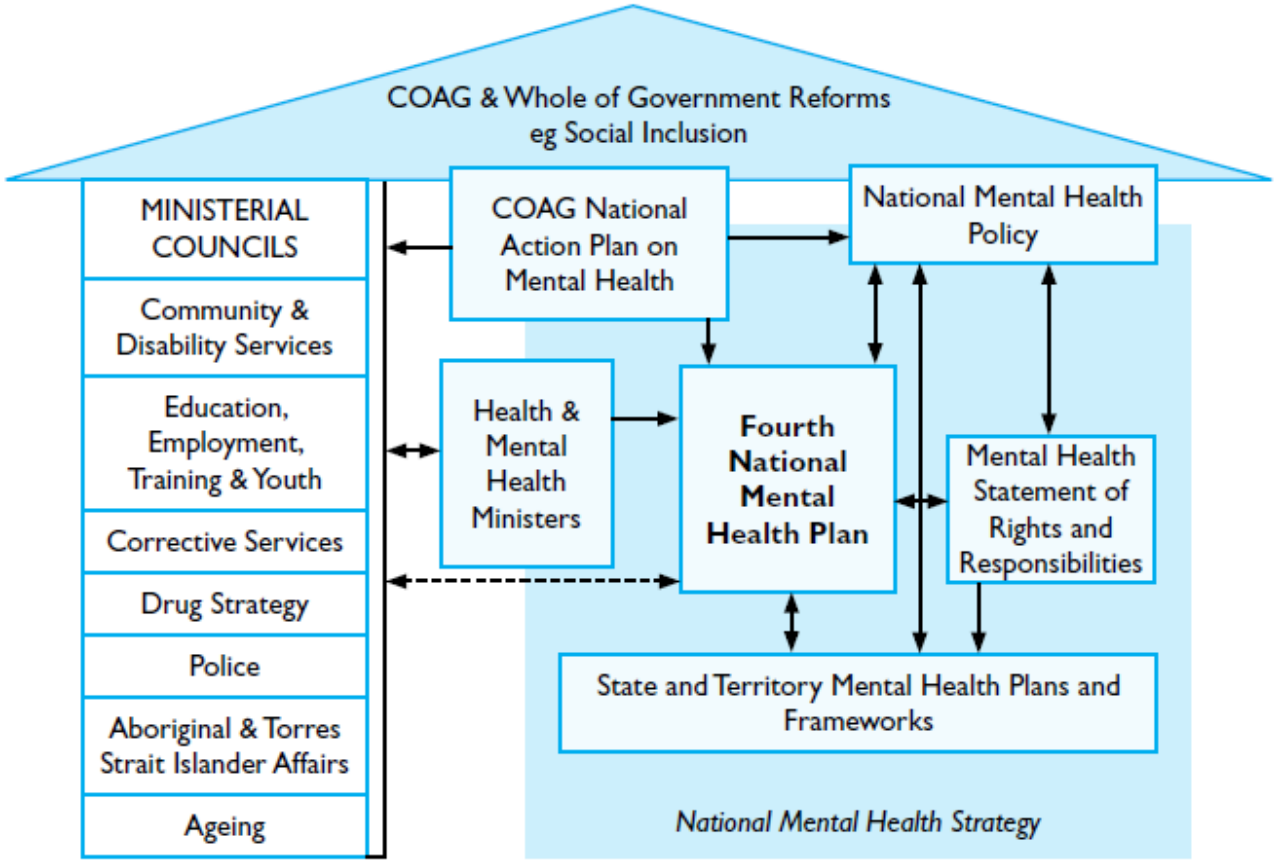
2 Commonwealth of Australia, *Portfolio Budget Statements 2015-16, Budget Related Paper No. 1.10, Health Portfolio*, May 2015, p. 17.

3 Department of Health, website, 'Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014', www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-f-plan09 (accessed 7 October 2015).

4 Fourth National Mental Health Plan -An agenda for collaborative government action in mental health 2009–2014, Australian Health Ministers' Conference, 2009, p. ii.

5 Department of Health, website, 'National mental health strategy', www.health.gov.au/internet/main/publishing.nsf/content/mental-strat (accessed 7 October 2015).

Figure 5—Fourth National Mental Health Plan in context[6]



Fourth National Mental Health Plan and its relationship to the *National Mental Health Strategy* and a whole of government approach

5.9 Mr Cormack told the committee that work on Fifth National Mental Health Plan is in its early stages:

> …the Fifth National Mental Health Plan was a decision taken by the COAG health council to progress that work. It is really just in its early stages. It has been assigned to be led by Tasmania under the Mental Health and Drug and Alcohol Principal Committee of AHMAC [the Australian Health Ministers' Advisory Council] auspices, and a working group has been established to progress that work. Through the course of the development of the Fifth National Mental Health Plan there will be extensive consultation with a wide range of stakeholders within the Commonwealth and also within state and territory governments, the NGO sector and the private sector. At this stage…I think there have been two meetings of the working group. It is hitting its straps, but it is certainly not into the level where they would be ready for wide-scale consultation with the sector. That has always been the process for previous national mental health plans. There is extensive

6 Fourth National Mental Health Plan – An agenda for collaborative government action in mental health 2009–2014, Australian Health Ministers' Conference, 2009, p. 11.

> consultation, and that will be the case with the Fifth National Mental Health Plan.[7]

5.10 Witnesses generally felt that the development of the Fifth National Mental Health Plan should be considered in light of the findings of the Commission's review. For example, Mr David Meldrum, the Executive Director of the Mental Illness Fellowship of Australia argued that to be successful the Fifth National Mental Health plan needed accountability and evaluation mechanisms:

> The First National Mental Health Plan…had a little bit of bite because of its newness and, in fact, it came out of a fair bit of argument between people on which direction we should be heading. In that sense, it was quite influential.
>
> With the last couple [of five year mental health plans], in my view, you have been able to read them and say, 'That's about right,' but that is about the end of the conversation. There has been nobody made accountable to do something about those, particularly in the Commonwealth-state divide. You have mental-health plans in every state and territory being developed, as we speak. They either have just been released or are about to be released or are starting to be formulated. That is the situation at any given time. Most of them are the same. Most of them do not have any sort of a timetable or accountability for implementation. This one needs state ministers and the Commonwealth minister and key departmental heads not only to be saying, 'This looks like the way mental-health services ought to look' but also 'It contains some specific accountabilities for outcomes that will lead to some implementation.'[8]

5.11 Professor Malcolm Hopwood, President of the Royal Australian and New Zealand College of Psychiatrists maintained that the Fifth National Mental Health Plan was an opportunity to organise the government's response to the Commission's findings, in a way which included both a national and regional perspective:

> I would support the idea that, both at a regional level and a national-plan level, a national mental-health plan is an opportunity to say: 'What are the kinds of elements that we really need in a service response that are going to give us the best chance of solving these kinds of difficult problems?' Of course, there are going to be local variables within that. One of our challenges…is that we need a diverse sector to meet the needs of the people we work with. But that can end up being confusing, difficult to approach and, at times, more competitive than is helpful. A national mental-health plan is a great opportunity for us to say a little bit more clearly how we want these elements to fit together, how we are going to govern that niche

7 Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation, Department of Health, *Committee Hansard*, 26 August 2015, p. 58.

8 Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia, *Committee Hansard*, 26 August 2015, pp 25–26.

region and really tell if it is having the impact…We really want to make the best of that opportunity.[9]

Mental Health Service Planning Framework

5.12 The National Mental Health Service Planning Framework (the Framework) was an initiative of the Fourth National Mental Health Plan for:

> …the development of a national service planning framework that establishes targets for the mix and level of the full range of mental health services, backed by innovative funding models.[10]

5.13 The aim of the Framework was to:

> …better estimate service demand across the service spectrum and across different care environments and will allow jurisdictions to identify service areas requiring investment. This project will reform mental health planning in both Australia and internationally and will provide the mental health planning community with a solid tool from which to establish creative resource solutions.[11]

5.14 The Framework was to be guided by the following principles:

- Nationally consistent – The NMHSPF will provide an 'Australian average' estimate of need, demand and resources for the range of agreed mental health services required across the lifespan and across the continuum of care from prevention to tertiary treatment.
- Flexible and portable – The NMHSPF will be flexible to jurisdictional adaptation, and will be presented in a user friendly format. However, some technical aspects cannot be altered or the validity of the product will be compromised.
- Not all, but many – To ensure national viability, the NMHSPF will not account for every circumstance or service possibly required by an individual or group, but will allow for more detailed understanding of need for mental health service across a range of service environments.
- Not who, but what – The NMHSPF will capture the types of care required, but will not define who is best placed to deliver the care. Decisions about service provision will remain the responsibility of each state/ territory and the Australian Government.

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9 Professor Malcolm Hopwood, President, The Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 26 August 2015, p. 23.

10 Department of Health website page 'National Mental Health Service Planning Framework (NMHSPF)' as archived in the National Library of Australia, Australian Government Web Archive. The National Mental Health Service Planning Framework page is no longer available on the department's website.

11 Department of Health website page 'National Mental Health Service Planning Framework (NMHSPF)' as archived in the National Library of Australia, Australian Government Web Archive.

- Evidence and expertise – The NMHSPF will identify what services 'should be' provided in a general mental health service system. Contemporary mental health practice, epidemiological data and working with key stakeholders with diverse expertise will underpin the technical, clinical and social support mechanisms that will form the content of the framework.[12]

5.15 Consultation with a range of mental health sector stakeholders was built into the Framework structure. The project was to be supported by an executive group comprising of mental health representatives from all Australian jurisdictions, and a modelling group with three expert groups:

- Primary Care / Community / Non Hospital Expert Working Group
- Psychiatric Disability Support, Rehabilitation and Recovery Expert Working Group; and
- Inpatient / Hospital Based Service Expert Working Group.[13]

5.16 The modelling group also included a consumer and carers reference group and consumers and carers could participate through the three expert groups.[14]

5.17 Funding for the Framework was provided by the Commonwealth, through the Department of Health and Ageing (now the Department of Health) and the project was led by the NSW Ministry of Health in partnership with Queensland Health and other jurisdictions. The timeframe for the project was two years, with the project to be completed by 2013.[15]

5.18 Mr David Butt, CEO of the National Mental Health Commission told the committee that when the Commission began its review, it requested a copy of the Framework from the Department of Health, but it was not provided:

> No, we were not [provided with a copy of the NMHSPF]. I think we have commented previously that it would have been useful to have it, because what it does is model the staffing and the services to respond to particular assessed needs. So that would have been a very useful tool, and it probably is a very useful tool. My understanding—and you really would need to check this with the department again—is that it has been distributed across all the states and territories and they are all looking at the implications and whether it is in fact a good model...[16]

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12 Department of Health website page 'National Mental Health Service Planning Framework (NMHSPF)' as archived in the National Library of Australia, Australian Government Web Archive.

13 Department of Health website page 'National Mental Health Service Planning Framework (NMHSPF)' as archived in the National Library of Australia, Australian Government Web Archive.

14 Department of Health website page 'National Mental Health Service Planning Framework (NMHSPF)' as archived in the National Library of Australia, Australian Government Web Archive.

15 Department of Health website page 'National Mental Health Service Planning Framework (NMHSPF)' as archived in the National Library of Australia, Australian Government Web Archive.

16 Mr David Butt, CEO, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 10.

5.19 Mr Butt's understanding was that the Framework was still under consideration by the federal and state governments:

> I think some concern has been raised by some states—not all states—that the potential implications of implementing that model would be quite expensive, but the resourcing issue is a separate issue from the planning tool, from our perspective. Governments have to make decisions about how much investment they will put into particular services and obviously there are finite resources available. So we would certainly be eager to see that services planning framework finalised and released.[17]

5.20 Other witnesses told the committee that the Framework was eagerly awaited by the mental health sector. Mr Quinlan, CEO of Mental Health Australia advised that:

> It is fair to say that those across the sector who invested a lot of time—and it is true to say that there were some hundreds of people across the sector—in developing that model [the NMHSPF] have been somewhat frustrated by the fact that it has not yet managed to come out the other end of the process. This is because it is likely to give us some of the answers to the questions that David Meldrum [Executive Director, Mental Illness Fellowship of Australia] alluded to—what are the numbers [of mental health consumers and mental health services]?—and gives us a platform where we can have a sensible debate about who is in what group and where the sorts of services for them should rest.[18]

5.21 According to representatives of the Department of Health, the Framework is still under development. Mr Cormack described the current situation relating to the Framework as 'a collaborative piece of work that is being progressed through the Australian Health Ministers' Advisory Council. It is well advanced.'[19]

5.22 Ms Janet Anderson, First Assistant Secretary of the Health Services Division of the Department of Health expanded on Mr Cormack's answer:

> …the framework exists now, but it is what is known as a beta version. It has had some testing in several jurisdictions, including New South Wales, WA and Queensland. The Mental Health and Drug and Alcohol Principal Committee of AHMAC [the Australian Health Ministers' Advisory Council] has agreed to establish a steering committee to take forward the framework into its further and final stages of development. They are aware of a number of areas where further work is required. It does need some further effort. Apparently there are some technological bugs, which I do not presume to know much about, but they also want to look more closely at some elements of the design model such as the way the care packages are put together. There are further considerations to be given to rural and

17 Mr David Butt, Chief Executive Officer, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 10.

18 Mr Frank Quinlan, CEO, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 26.

19 Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation, Department of Health, *Committee Hansard*, 26 August 2015, p. 56.

> remote residents in terms of mental health and also to Indigenous communities, and at the far end of all of that there is the need to seek state and territory sign-off to the framework in order for it to be a genuinely national product.[20]

5.23 Ms Anderson explained that the 'beta version' was 'a testing model':

> It is something which is recognised as not yet fully developed but has enough of the moving parts to see how it might apply in real life but in a piloted way. It is not currently being used as a planning model, but it is being tested as if it could be used and to identify things that might need further development. Indeed, that list which I partially rendered is still being developed. There is still the need for further identification of the issues to be worked on to move it from its current testing phase into a framework which nine jurisdictions can agree to.[21]

5.24 Ms Anderson's understanding of the timeframe for progressing the Framework to completion was that approximately another year would be required:

> My understanding is that the expectation of the time frame is that it will take at least 11 or 12 months—probably to the middle of the next calendar year—before this work is completed. A steering committee is being established that is chaired by the Commonwealth and has representation from a number of jurisdictions. It has not yet met, and I think its first meeting will be in September. There is work now underway to establish its specific terms of reference and a work plan which will guide its efforts over the coming 12 months.[22]

5.25 The fact that the Framework was in 'beta version' was the Department's reason for the framework not being provided to the Commission during its review. Mr Cormack argued that:

> [The Framework] is a Commonwealth/state piece of work. It obviously has very significant implications for the way services are planned, designed, delivered and resourced. Any endeavour that requires collaboration across the Commonwealth, state and territory governments on matters that would potentially require changes or increases in their levels of resourcing do require a significant degree of scrutiny within the budget processes of nine jurisdictions. Accordingly, there are appropriate safeguards on the release of unfinished, unapproved work. So it is not unusual for something that is in its development stage within this governance context not to be made more broadly available, particularly as it is subject to change. Whatever version they might have been access at that point in time may not even have

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20 Ms Janet Anderson, First Assistant Secretary, Health Services Division, Department of Health, *Committee Hansard*, 26 August 2015, pp 56–57.

21 Ms Janet Anderson, First Assistant Secretary, Health Services Division, Department of Health, *Committee Hansard*, 26 August 2015, p. 57.

22 Ms Janet Anderson, First Assistant Secretary, Health Services Division, Department of Health, *Committee Hansard*, 26 August 2015, p. 57.

> been the beta version; it may have been an earlier version. Clearly, things have moved on.[23]

5.26 Although the Framework is being progressed towards completion, the committee notes that there is limited publicly available information about this fact. The committee gained information about the progress of the Framework through its public hearing on 26 August 2015. The Department of Health's website, which provides information about the Fourth National Mental Health Plan, does not mention the Framework, its history or its current progress. Information about Framework, which does not include its current status, is only available through the National Library of Australia, Australian Government Web Archive.

Outcomes focussed funding with reporting

5.27 It was the Commission's view that 'much of the funding from the Commonwealth is neither particularly effective nor efficient.'[24] Professor Fels told the committee:

> Eighty-seven and a half per cent of the spending is downstream on income support and crisis response, basically—the Disability Support Pension, carer's payments, payments to states for hospitals, Medicare and pharmaceutical benefits. So, much of the Commonwealth spending is for failure to treat the problems early and cost effectively. It is payment for failure. We have made recommendations about how that heavy expenditure could be reduced with a much greater emphasis on and investment in prevention, early detection, recovery for mental ill health and the prevention of suicide.[25]

5.28 Ms Jacqueline Crowe, a National Mental Health Commissioner observed that without the proper identification of outcomes, and monitoring of those outcomes, mental health funding could not properly benefit those with mental ill-health:

> …the key to all change initiatives is to ensure that change means we do better—and we must do better for the people who are caring and our families. To do this, Australia must consistently and rigorously be monitoring and reporting publicly on outcomes. We do not currently do that well—and not just outputs but outcomes for people, which includes human rights issues, the effectiveness and quality of services, service system impacts, immigration, performance and coordination, the reform process and, importantly, what people, families and communities think of those systems.[26]

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23 Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation, Department of Health, *Committee Hansard*, 26 August 2015, p. 58.

24 Professor Allan Fels, Chair, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 2.

25 Professor Allan Fels, Chair, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 2.

26 Ms Jacqueline Crowe, Commissioner, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 5.

5.29 Ms Jaelea Skehan, the Director of the Hunter Institute of Mental Health told the committee that a further impediment on the effectiveness of funding for mental health was the current government funding being provided on a year-by-year basis. Ms Skehan pointed out that this situation meant that early intervention, prevention and health promotion was effectively de-prioritised:

> …around funding, apart from the fact that prevention and promotion is deprioritised compared to the more costly treatment ends of the funding cycle,…I would really like to see some transparency about how funding decisions are made, particularly in certain areas. We have seen a reduction in funding in some areas and an increase in funding in others, and I am not sure that there is a vision statement or a clear plan that makes it really clear to the sector why certain priorities were made.[27]

5.30 Professor Hopwood, the President of the Royal Australian and New Zealand College of Psychiatrists outlined a further funding and outcomes issue. He argued that no future work could be planned without first setting in place mechanisms for targeted research:

> …a really important element of any development in the mental health sphere is research to improve what we do. The risk that we continue to do what we do because we do it will be obviated if we measure the outcome better, but common sense says we would still like to improve on what we can do. So the very best we can do at the minute still could do with a lot of improvement. A significant commitment for research is an important factor—and that includes funding we currently receive from organisations like the NHMRC while a specific allocation from potential new funds like the medical research fund would be something we would like to support.[28]

Policy and funding uncertainty

5.31 As mentioned briefly in Chapter 4, mental health policy and funding has been 'on hold'[29] since February 2014 when the Government tasked the Commission to review of mental health services and programme delivery.

5.32 While the Government has deferred major policy decisions until after the review was completed, and subsequently on completion of the outcome of the ERG and COAG processes (paragraph 4.22 Chapter 4), recent Budgets have made cuts to mental health service funding.

5.33 The 2014-15 Budget included a $53.8 million cut to the Partners in Recovery programme. The Budget also introduced the $7 GP co-payment, much-criticised for

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27 Ms Jaelea Skehan, Director, Hunter Institute of Mental Health, *Committee Hansard*, 28 August 2015, p. 30.

28 Professor Malcolm Hopwood, President, The Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 26 August 2015, p. 27.

29 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 15.

creating a barrier to those seeking to access primary health care, including mental health care.[30]

5.34 The 2015-16 Budget included 'savings' of $962.8 million to be achieved over five years by 'rationalising and streamlining' funding across the Flexible Funds, which include funding for mental health, drug and alcohol dependency and preventative health services and programmes.[31]

5.35 Minister Ley's April 2015 announcement of additional funding of $300 million to mental health services has gone some way to temporarily ameliorating the problem. However, as the funding extension is for a 12 month period, it is at best a stop-gap measure.[32]

5.36 The mental health sector is waiting for the Government response to the Commission's recommendations for sector-wide reform. In the meantime, the uncertainty about future direction and funding means that the sector is facing a crisis.

5.37 In addition to the funding crisis, the mental health sector is waiting to see how the government's response to the Commission's recommendations will link with the transition of mental health programmes to the NDIS. The NDIS transition will be examined in Chapter 7, while this section focuses on the uncertainty caused by the delay in Government decision making.

5.38 Witnesses told the committee of the difficulties of operating services and programmes in the current uncertain environment. Mr Ivan Frkovic, the Deputy Chief Executive Officer, National Operations of Aftercare told the committee that mental health service clients were greatly concerned about the continuation of existing services:

> People are really concerned that existing services, such as Personal Helpers and Mentors and Partners in Recovery, which are helping them to maintain lives in the community to some level and degree, will disappear… This is creating uncertainty at the moment and increasing anxiety and levels of relapse amongst people, because they do not know, as I think has been said. A lot of these programs are due to finish in June next year: 'What happens beyond June? Where do I go?' So, it is creating problems for the participants themselves—the individual consumers—families and carers. They are saying, 'What do we do in this situation?'[33]

5.39 Ms Ka Ki Ng, Senior Policy Officer, Mental Health and Wellbeing Consumer Advisory Group BEING, explained that from the point of view of consumers and

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30 Professorial Fellow Anthony Jorm, *The Conversation*, 'Government shows muddled mental health priorities', 28 May, 2014, theconversation.com/government-shows-muddled-mental-health-priorities-27106 (accessed 7 October 2015).

31 Commonwealth of Australia, Budget 2015-16, *Budget Paper No 2*, May 2015, p. 110.

32 The Hon Sussan Ley MP, Minister for Health, media release, 'Mental Health funding confirmed', 2 April 2015.

33 Mr Ivan Frkovic, Deputy Chief Executive Officer, National Operations, Aftercare, *Committee Hansard*, 26 August 2015, p. 19.

carers, the uncertainty around policy and funding may have resulted in service disruptions:

> We want to particularly highlight some of the recent proposals and changes that have happened that may have caused some disruptions to mental health service provisions which have had a flow-on impact on mental health consumers as well as family and carers. For example, we are aware that at the moment there are a lot of uncertainties within the community or non-government mental health services sector. We know that things like the national review into mental health programs and services have caused a lot of anxiety in the sector with rumours of our services potentially being defunded or having their budget reduced or possibly being severely restructured.
>
> We have heard that the transition from Medicare Locals to Primary Health Networks has not been a particularly smooth transition in some areas and has led to loss of services or at least disruptions. There are funding uncertainties with regard to ATAPS, Partners in Recovery and also the NDIS rollout—what services may be available to mental health consumers who are not going to be eligible for the scheme. All of these are snowballing into a big mass of uncertainty that is impacting on the wellbeing of the people working in the sector as well the people that are actually trying to access support and services.[34]

5.40 In particular Ms Ng observed that the change from the Medicare Locals to the PHNs had resulted in loss of staff and relationships between consumers and health care professionals:

> For example, people not being referred on by GPs because GPs are not sure where to go to, not knowing whether that particular Medicare Local in their region is going to survive. There is also loss of staff. Often what we have found in the mental health sector, and I would imagine it is the same in many other human services sectors, is that relationships are built between individuals. I may have a really good relationship with a particular staff member in the Medicare Local and I may not know many other people beyond that relationship, or I may not have a lot of trust—it is a particularly profound relationship for consumers and carers. If there is such an uncertain environment at a service, what has been pointed out is that if there is staff turnover, then people will naturally try to find alternatives and those relationships are lost. For a GP it might be a case of, 'Okay, let's find another relationship', but for consumers and carers, it might actually mean that they have to consider whether they want to make the effort to build a relationship again, especially if there have been previous relationships where it was negative. It can be really traumatic. I think people mentioned some of those issues this morning. [35]

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34 Ms Ka Ki Ng, Senior Policy Officer, Mental Health and Wellbeing Consumer Advisory Group BEING, *Committee Hansard*, 28 August 2015, p. 13.

35 Ms Ka Ki Ng, Senior Policy Officer, Mental Health and Wellbeing Consumer Advisory Group BEING, *Committee Hansard*, 28 August 2015, pp 23–24.

5.41 As discussed above, the government's response to the concerns of the mental health sector about the uncertainty around mental health policy is a 12 month funding extension. The government is considering advice from the ERG, and other processes, before it will make its response to the Commission's recommendations.[36]

Committee view

5.42 As noted in Chapter 4, the government received the Commission's completed review in early December 2014. The government then delayed releasing the review until mid-April 2015, when forced to do so when parts of the Commission's report were leaked. In October 2015, ten months after the completion of the Commission's review, the government has still not responded to the Commission's recommendations. As a result, the mental health sector struggles with ongoing funding uncertainty and indecision about the future direction of mental health policy in Australia.

5.43 The committee heard the concerns of mental health groups, advocates, service providers, and consumers and carers in relation to the uncertain future direction of mental health funding and policy. These groups all gave the committee similar evidence: the government needs to respond positively to the Commission's recommendations and it needs to do so before the end of 2015.

5.44 The Commission's review has been delivered at a strategic time for the implementation of change in funding and governance of mental health policy. A number of complementary processes are currently in play:

- the Fourth National Mental Health Plan expired in 2014 and work is beginning on the Fifth National Mental Health Plan;
- according to the Department of Health, the National Mental Health Service Planning Framework has approximately one year of development remaining before it is ready for release; and
- with the PHNs newly established in July 2015, witnesses argued that a further 12 months is needed for PHNs to become fully operational and connected in their regions.

5.45 The committee believes that by making a response to the Commission's review now, the government will set the mental health policy agenda for the foreseeable future and provide much needed certainty for mental health groups, service providers, carers, and consumers.

5.46 The Minister for Health has stated that the $300 million extension of funding for mental health services and programmes provided in April 2015 will provide 12 months for the government to develop its response to the Commission's findings.

5.47 To provide much needed clarity to the mental health sector, the committee urges the government to conclude its deliberations by the end of 2015. Mental health service and programme providers, carers, and consumers, are keenly awaiting the

36 The Hon Sussan Ley MP, Minister for Health, media release 'Coming soon: A new approach for our mental health system', 5 October 2015, p. 1.

government's future policy direction. State and territory governments also await the government's response for their planning of the Fifth National Mental Health Plan. And all stakeholders, including the Commission, are awaiting the release of the National Mental Health Services Planning Framework.

Recommendation 1

5.48 The committee recommends that the government:

- **immediately publish the Expert Reference Group report;**
- **urgently respond to the National Mental Health Commission's review; and**
- **guarantee funding for mental health groups and service providers for the 12 months after the announcement of the government response to the National Mental Health Commission's review.**

Chapter 6

Issues—service delivery

The whole Australian mental health community, through both its lived experience and its technical experts, has combined to say to our respective governments that there is a fundamental need to move away from a programmatic funding approach in response to each crisis and towards locally led and organised services that work in regional Australia.[1]

Professor Ian Hickie
Commissioner, National Mental Health Commission

Introduction

6.1 The previous chapter outlined the issues of governance and funding in mental health service and programme delivery. This chapter draws again on the evidence from witnesses and submitters, but focuses instead on issues relating to service delivery, including services and programmes for specific groups. These issues include:

- stigma;
- Primary Health Networks (PHNs) and mental health;
- access to early intervention;
- linking housing and employment to mental health;
- workforce;
- suicide prevention;
- rural and remote communities;
- Aboriginal and Torres Strait Islander peoples;
- LGBTI (Lesbian, Gay, Bisexual, Transgender, Intersex);
- Culturally and Linguistically Diverse (CALD) communities; and
- e-mental health.

6.2 In considering each issue, the committee examines the findings of the Commission, the evidence received from witnesses, and where it exists, government reaction to the Commission's findings.

Stigma

6.3 A theme that runs throughout the Commission's review is that the aim of any action on increasing the effectiveness and efficiency of mental health services and programmes should be the de-stigmatisation of mental health. In describing the

1 Professor Ian Hickie, Commissioner, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 6.

current state of mental health services and programmes in Australia, the Commission first statement was 'Stigma persists'. [2]

6.4 A relevant Commission recommendation states:

> Promote easy access to self-help options to help people, their families and communities to support themselves and each other, and improve ease of navigation for stepping through the mental health system.[3]

6.5 Stigma was an issue which the Commission identified as needing to be addressed by this recommendation:

> Stigma is associated with poorer physical and emotional health, as well as poorer employment outcomes. It can discourage individuals from disclosing their illness and from seeking help, both of which are important steps to gaining assistance in managing symptoms and preventing the development of a more serious experience of mental illness. In this way, stigma presents barriers to service access, creates additional distress and mental ill-health and ultimately drives up system costs.[4]

6.6 SANE Australia describe the impacts of stigma as:

> People with mental illness put up with a lot more than their illness. Stigma contributes another major stress they can well do without. Many say that stigma and prejudice is as distressing as the symptoms themselves.
>
> Most often stigma against people with a mental illness involves inaccurate and hurtful representations of them as violent, comical or incompetent – dehumanising and making people an object of fear or ridicule.[5]

6.7 Organisations like SANE Australia, ReachOut, RUOK? and Beyondblue try to reduce stigma by raising awareness of mental ill-health and encouraging public discussion of mental health issues. ReachOut for instance works to encourage access to information and assistance for mental ill-health. It has previously run a campaign to normalise the discussion of mental ill-health by making a comparison between the way physical health issues are publicly discussed and the way mental ill-health issues are often hidden or dismissed. ReachOut publishes graphics which ask 'what if we treated all health issues like we treat mental health?' Some example answers to this hypothetical question included:

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2 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 40.

3 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 87.

4 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 89.

5 SANE Australia, website, 'Changing attitudes, changing lives – We can all play a part in combating stigma', www.sane.org/stigmawatch/what-is-stigma (accessed 7 October 2015).

- 'I'm so sick of you and your constant heart disease.'
- 'We all feel like we have diabetes sometimes! Snap out of it.'
- 'I'm getting very tired of this "cancer" of yours.'
- 'Yeah, you just think you need your Asthma puffa because you can't deal with reality.'[6]

6.8 Ms Christine Morgan, the Chief Executive Officer of the Butterfly Foundation supported the need to fight the stigma around mental illness and facilitate better access to services for sufferers. The Butterfly Foundation has a particular focus on the treatment of eating disorders. Ms Morgan told the committee that in the case of eating disorders, the suicide rate is the highest of any psychiatric disorder. Early intervention in eating disorders is vital, but a major barrier to early intervention is the stigma associated with mental ill-health:

> At the moment, we know that less than 23 per cent of people with an eating disorder are seeking treatment. They are highly stigmatised. If you have anorexia nervosa, thankfully it is relatively accepted as a very serious illness. It also physically manifests itself and you must receive treatment. If you suffer from bulimia nervosa, a binge eating disorder or atypical presentations the average nondisclosure time is 10 years. That is 10 years when somebody is too ashamed to go for help. We must reduce stigma. I used to think that if you raised awareness, if you raised an understanding of the genetic vulnerability of somebody with an eating disorder, if you raised the impact of nutritional deprivation triggering something that actually changed their neural pathways, if you helped people understand that, they would not be stigmatised. But they are. Too many people still see it as people who do not know how to eat properly, who eat too much or too little, and they say 'Get on with it and fix it up.'[7]

6.9 Ms Morgan argued that reducing stigma was more complex than awareness raising campaigns. What is needed is a multi-faceted approach which targets all parts of the pathway to accessing mental health services and programmes:

> We must reduce stigma, and that is much more complex than just raising awareness. Sitting behind that, we also need workforce capacity and workforce development. I share the views of my colleague that GPs must not only be recognised as an incredibly important first portal but they have to be resourced. And sitting behind them they need pathways to care that are appropriately funded whether through…better access to Medicare rebates or through private health insurance—which to this day remains discretionary for anybody with an eating disorder, other than for the short time they spend in a private hospital. Anything as [an] outpatient is

6 ReachOut graphics sourced from the ReachOut Facebook page, see http://au.reachout.com/ (accessed 7 October 2015).

7 Ms Christine Morgan, Chief Executive Officer, Butterfly Foundation, *Committee Hansard*, 28 August 2015, p. 15.

> discretionary cover by private health fund. So we must make sure that they have access to those things.[8]

6.10 Mr Jack Heath, the Chief Executive Officer of SANE Australia observed that in terms of fighting the stigma around depression, much work had been done. However, more work was required so that the treatment of mental ill-health was seen as equal to the treatment of physical ill-health:

> In terms of stigma, we have done reasonably well around depression in the past five to 10 years. We have made no progress in the very severe end of the spectrum. SANE Australia earlier this year called for a five-year national stigma reduction campaign. We must have lived experience involved in all aspects of mental health policy formulation, research, system design, promotion, implementation and also evaluation. The life expectancy rates for people with severe mental illness are simply unacceptable, 25 years less than the general public. We need to do much better in terms of combining the work that we do around physical health issues alongside mental health issues. In the past there was an approach which said: let's get your head sorted first and then we will get to your body, and what happened was people never got to the body.[9]

Committee view

6.11 From the evidence the committee has heard, it is clear that one of the major barriers to people with mental ill-health accessing appropriate help is stigma. Many times the committee heard that stigma prevented those with mental illnesses from seeking help, or prevented conversations about the impact of mental ill-health on a person's social, working, and family life.

6.12 Thanks to campaigns like those run by RUOK?, Beyondblue, and ReachOut, mental health literacy is increasing in Australia. But the stigma around mental ill-health persists. The committee considers that there is an urgent need for a national conversation about how to counter it.

Recommendation 2

6.13 The committee recommends that the government response to the National Mental Health Commission's report should include a national stigma reduction strategy.

Primary Health Networks and mental health

6.14 Established in July 2015, the Primary Health Networks (PHNs) replaced the Medicare Locals as a means of organising and facilitating primary health care services

8 Ms Christine Morgan, Chief Executive Officer, Butterfly Foundation, *Committee Hansard*, 28 August 2015, p. 15.

9 Mr Jack Heath, Chief Executive Officer, SANE Australia, *Committee Hansard*, 26 August 2015, p. 39.

at a regional level.[10] There are 31 PHNs located around Australia. According to the information on the Department of Health website, the PHNs have the key objectives of:

> …increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and improving coordination of care to ensure patients receive the right care in the right place at the right time.[11]

6.15 In its review, the Commission recommended that PHNs be used to help shift mental health funding priorities from hospitals and income support to community and primary health care services:

> Recommendation 8: Extend the scope of Primary Health Networks (renamed Primary and Mental Health Networks—PMHNs) as the key regional architecture for equitable planning and purchasing of mental health programmes, services and integrated care pathways.[12]

6.16 Professor Allan Fels, Chair of the National Mental Health Commission expanded on recommendation 8 in his evidence to the committee. Professor Fels argued that PHNs could be a way of 'bringing about greater regional parity in the treatment of mental health' at a primary care level, with PHNs being the facilitators of primary care in regional areas.[13]

6.17 Underpinning much of the Commission's work is the view that a regional approach to service delivery is an essential in order to be responsive to the diverse local needs of the different communities across Australia.[14] The Commission's first recommendation articulated the Commonwealth's role in mental health 'is through national leadership and *regional integration*, including integrated primary and mental health care.'[15]

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10 The committee examined the change from Medicare Locals to Primary Health Networks in Senate Select Committee on Health, First Interim Report, 2 December 2014, www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/First_Interim_Report (accessed 7 October 2015)

11 Department of Health, website, 'Primary Health Networks (PHNs)', www.health.gov.au/internet/main/publishing.nsf/Content/primary_Health_Networks (accessed 7 October 2015)

12 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 10.

13 Professor Allan Fels, Chair, National Mental Health Commission, *Committee Hansard*, 26 August 2015, pp 4–5.

14 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 15.

15 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 10, emphasis added.

6.18 In its report, the Commission argued that PHNs are an ideal mechanism to plan and distribute services on a regional basis, putting mental health care alongside primary care:

> The current development of 30 Primary Health Networks across Australia provides the ideal opportunity to build on that infrastructure and better target mental health resources to meet population needs on a regional basis. These new entities will be the meso-level organisations responsible for planning and purchasing services on a regional basis.[16]

6.19 Further, the Commission saw PHNs as being able to work in partnership with NGOs and others service providers to apply 'targeted, value-for-money interventions across the whole continuum of mental wellbeing and ill-health to meet the needs of their communities'.[17]

6.20 With their focus on primary health care, Professor Fels observed that the PHNs are best placed to promote the role of primary care in treating mental ill-health, and giving mental health a higher priority. Professor Fels explained why the Commission felt that the PHNs should be renamed Primary and Mental Health Networks:

> There are a couple of reasons for that. It would be a really important sign from the government and the parliament that mental health is taken seriously. It remains a rather low priority, I am sorry to say, all over Australia—at a federal and state level and in the community.[18]

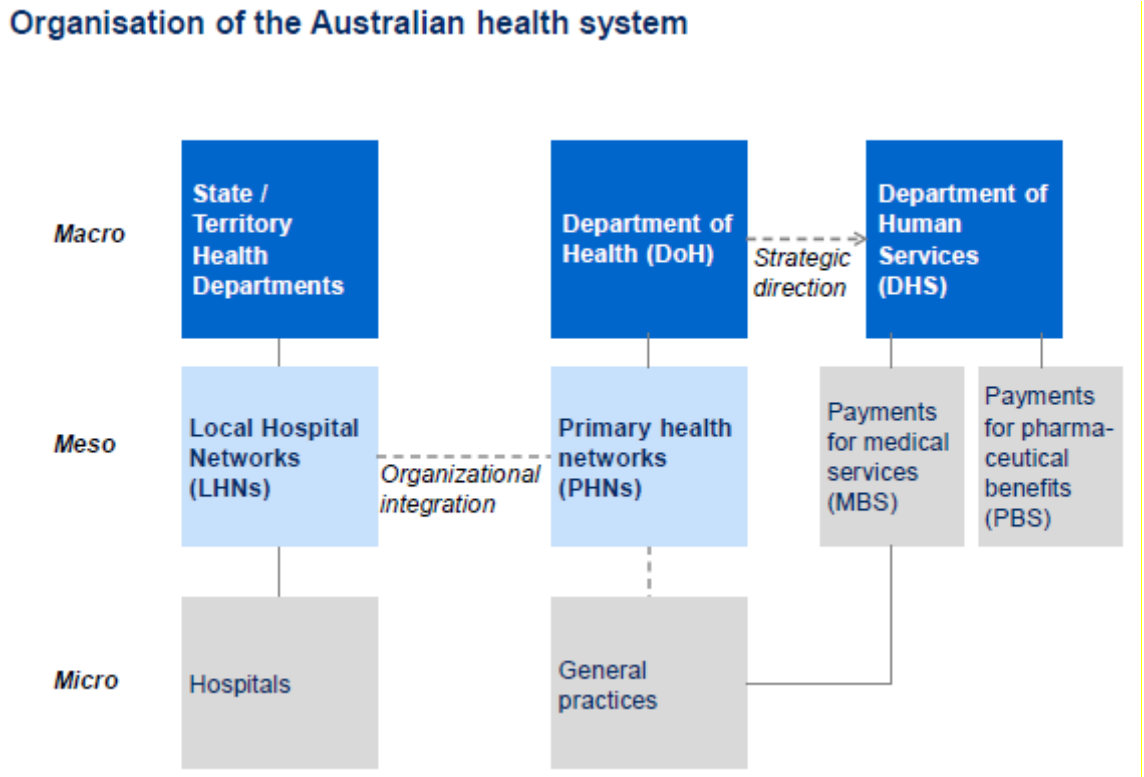
6.21 The grouping of meso-level organisations for regionalisation of planning and purchasing services has been trialled in both Australia and overseas. Figure 6 shows the various levels within the Australian health care system and how meso-level groups could integrate the provision of mental health services.

16 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 48.

17 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 48.

18 Professor Allan Fels, Chair, National Mental Health Commission, *Committee Hansard*, 26 August 2015, pp 4–5.

Figure 6—Australian health care system[19]



6.22 The background paper published by the Primary Health Care Advisory Group (PHCAG), *How can Australia improve its primary health care system to better deal with chronic disease?*, provided examples of where meso-level integration of organisations with combined funding pools have been used. The paper noted that while examples, including the United Kingdom, New Zealand, and Australia (SA Health Plus), 'demonstrate the promise of meso-level integration with combined funding pools, national rollout of the approach could be inefficient if it is not well coordinated.'[20]

6.23 Dr Steven Hambleton, Chair of the PHCAG, told the committee that as part of the PHCAG's public consultation on its discussion paper on chronic conditions 'many of our submissions support a meso-level organisation to assist the GP to deliver an outcome.'[21]

19 McKinsey & Company, written for the Primary Health Care Advisory Group, *How can Australia improve its primary health care system to better deal with chronic disease? Background Paper*, September 2015. p. 33.

20 McKinsey & Company, written for the Primary Health Care Advisory Group, *How can Australia improve its primary health care system to better deal with chronic disease? Background Paper*, September 2015. p. 33.

21 Dr Steven Hambleton, Chair, Primary Health Care Advisory Group, *Committee Hansard*, 18 September 2015, p. 13.

6.24 Professor Ian Hickie, a Commissioner of the National Mental Health Commission explained that regionalisation of care, as advocated in the Commission's report was a significant shift:

> That is the challenge that I think governments face in responding to this particular report. It fundamentally says there is a need to redesign the system architecture, to develop regionalisation of care. So I think both the Australian government and state governments face a challenge: can they actually back local leadership? Can they provide the resources to the 60-plus regions in Australia to bring together the relevant health and social services in a way that is relevant to those particular communities to provide the range of health and social supports that are necessary for people to live a contributing life? That is a fundamental shift in the way we have understood Commonwealth-state relationships and in particular the way that we have organised that set of funding and service priorities.[22]

6.25 Just as Dr Hambleton reported, Professor Hickie explained that despite the challenges associated with regionalisation, there was general consensus amongst organisations and state governments:

> I think it is important to say that it appears that there is consensus not only among providers but also among a number of the states—and, notably, from the Premier of New South Wales. In New South Wales, Queensland and WA in particular, there is a real appetite for implementation of this regionally focused approach that is backed by the resources of both the federal government and the state government. What we want to see is the implementation of locally led programs that are nationally significant, evidence based and accountable at the local level. That runs across the key areas of health and social services and suicide prevention and with a shift to a fundamental focus on resourcing the community, not necessarily the hospitals, the institutions or the traditional providers.[23]

6.26 However, witnesses told the committee that they had some reservations about the Commission's recommendation on PHNs. Mr Quinlan of Mental Health Australia told the committee that during a meeting with the Department of Health regarding the ERG process, PHNs were 'one of the topics of some heated and considered discussion'.[24] Mr Quinlan noted that while there was broad agreement at the meeting about the need for a focus on mental health and a means of delivering that focus at a regional level, the main concern about the PHNs being the vehicle for that delivery

22 Professor Ian Hickie, Commissioner, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 5.

23 Professor Ian Hickie, Commissioner, National Mental Health Commission, *Committee Hansard*, 26 August 2015, pp. 5-6.

24 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 28.

was that as organisations they are very new.[25] Further, Mr Quinlan said the meeting had raised questions about the structure of the PHNs:

> The concern I would summarise as this: if Primary Health Networks are dominated by GP interests and a GP-centric approach in the local community—and this is not to suggest that they are—then that will achieve certain goals but it will not achieve the breadth of engagement that many of our members are keen to see.[26]

6.27 Mr Quinlan argued that if PHNs were to be the delivery mechanisms for regionalisation, the governance of PHNs would be important and it would be essential to have consumers and those with lived experience of mental illness involved:

> If we are going to achieve the breadth of agreement and planning that we need, then we would have to go somewhere to what the commission recommends, which is primary and mental health networks. What would that mean? That would mean that community organisations, consumers and people with a lived experience of mental illness themselves and others were all engaged in those governance structures, on the boards of Primary Health Networks.[27]

6.28 The Royal Australian and New Zealand College of Psychiatrists (RANZP) argued that PHNs have the 'potential to greatly enhance the responsiveness and level of holistic care delivered to consumers', provided the PHN design had an adequate governance structure.[28] RANZP recommended that the PHNs should have:

> …strong mental health representation at all levels of the PHN governance structure, including Board, Clinical Council and Community Advisory Committee.[29]

6.29 In particular, the Community Advisory Committees should:

> …draw on the insight and experiences of mental health consumers and carers. The approach to shared decision making, consumer-focused care and incorporating consumers, carers and family into the treatment team can look very different in the mental health sector compared with other instances where physical health is the focus. For example, the process of developing informed consent, a recovery plan and a meaningful definition of wellbeing may be very different for a consumer with a severe mental illness, compared with a physical health issue. It is therefore essential that

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25 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 28.

26 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 28.

27 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 28.

28 Royal Australian and New Zealand College of Psychiatrists, Answer to Question on Notice, p. 4.

29 Royal Australian and New Zealand College of Psychiatrists, Answer to Question on Notice, p. 4.

> the insight, priorities and experiences of mental health consumers and carers is adequately and consistently incorporated onto the Community Advisory Committees.[30]

6.30 Mr Quinlan also raised concerns about the 'localness' of PHNs and consequently their ability to deliver mental health services to a local and regional level:

> …Primary Health Networks would also look at their localisation and many of them, I suspect, would say: 'Actually, we're not that local. If there's only one Primary Health Network in this vast area, perhaps we need to have some structures by which we can have sublocalisation, if you like.' So I think there is a lot of anxiety about us investing too much too early in structures that are just emerging, notwithstanding, I think, the broad agreement that we need local structures to steer and govern investment.[31]

6.31 Conversely, Mr Meldrum of Mental Illness Fellowship of Australia reasoned that ultimately the PHNs are 'the only game in town for a regional structure and…we are going to have to work out a way…' to use the PHNs for mental health service delivery.[32] However, Mr Meldrum thought that some time would be needed for the PHNs to find their 'mission' and become established.[33] Without this, Mr Meldrum argued, little could be achieved:

> I also feel they need a personality transplant in a lot of cases before they can do it, because they are focused specifically on the role of the GP, who has an important role but not all the roles. The key issue is that they do not have a mission… Why suddenly chuck a whole amount of money at an organisation yet again without specifying what we want it to achieve? And while we have a national mental health plan that has not been finished, while any implementation strategy is yet to be dreamt up, while the NDIS arrangement is so unclear et cetera and while we do not have any of those key outcome objectives, there is no mission to give them. I would suggest that we are at least a year away from being able to describe to a Primary Health Network, 'The mission we need to achieve in mental health with this money is this.' That would be the very first step before they get given the job [of equitable planning and purchasing of mental health programmes, services and integrated care pathways], from my perspective.[34]

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30 Royal Australian and New Zealand College of Psychiatrists, Answer to Question on Notice, p. 5.

31 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 28.

32 Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia, *Committee Hansard*, 26 August 2015, p. 29.

33 Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia, *Committee Hansard*, 26 August 2015, p. 29.

34 Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia, *Committee Hansard*, 26 August 2015, p. 29.

Committee view

6.32 The committee supports the Commission's findings in regards to regionalisation of service and programme delivery, and commends the Commission for identifying this area as a means of mitigating inequity of access.

6.33 The committee thanks the witnesses at its public hearings for their insightful comments regarding the suitability of PHNs for regionalisation, and their support of the need for regionalisation of service delivery.

6.34 In its First Interim Report, the committee examined the change from Medicare Locals to PHNs, and in its Second Interim Report the committee looked at the progress towards the commencement of the PHNs. The committee agrees with witnesses who argued that the PHNs need time to become established. For some PHNs, the process has been easier as they have changed from being Medicare Locals to being PHNs. For others the process requires more time as they are new organisations, or Medicare Locals with new regions to establish.

6.35 The committee considers that while the PHNs will have an important role in the regionalisation of service and programme delivery, including them in this process needs to recognise the challenges the PHNs face being relatively new organisations.

Recommendation 3

6.36 The committee recommends that the government response to the National Mental Health Commission's report should examine the possible role for Primary Health Networks in regionalisation of service and programme delivery.

6.37 However, the government should have regard to the evidence given to the committee in relation to the time needed for the PHNs to adequately establish themselves in their regions.

6.38 PHNs also need time to ensure that they have a governance structure in place which includes mental health at each level. The committee considers the suggestions provided by the RANZP about Community Advisory Councils and the inclusion of those with lived experience of mental illness to be particularly important.

6.39 The committee therefore recommends that the government response should emphasise the need for mental health, particularly the experience of mental health consumers and carers, to be imbedded in the governance structure of the Primary Health Networks.

Access to early intervention

6.40 Another central tenet of the Commission's findings was that access to early intervention not only resulted in a significant benefit to the individual sufferer, but also produced a major economic benefit as it reduced the need for acute and crisis

care.[35] However, the Commission found that the current system did not promote access to early intervention:

> For example, sometimes people need to inflict serious physical harm to gain access to support; even then, sometimes that care and support is not made available.
>
> The idea of late intervention in physical health conditions (such as cancer, heart disease, COPD [Chronic Obstructive Pulmonary Disease]) is plainly unacceptable, with obvious costs and unnecessary harm to individuals. However, in mental illness, late intervention is too often the norm. This is due to two factors:
>
> - low rates of help-seeking and treatment for mental illness, including delaying or avoiding treatment due to stigma, stress and other related factors, as well as anosognosia or lack of awareness of illness
> - low prioritisation of mental illness within the system as compared to physical illness.
>
> These are symptoms of a crisis-driven system. Critically, this system is trapped in a vicious cycle of underinvestment in effective services, leading to higher demands on more expensive and reactive modes of care and demand-driven safety net programmes.[36]

6.41 Witnesses agreed with the Commission's findings. For example Mr Ivan Frkovic, the Deputy Chief Executive Officer of Aftercare compared the situation in Australia with that in New Zealand, where a redirection of funding to community-based interventions meant a significant saving in spending on acute care, and a major benefit to individuals with a mental illness:

> What we do not have right in this country, and the Mental Health Commission report picked this up, is that we do not have the right balance of investment.
>
> I might not have the latest data, but New Zealand got to the stage where they had an investment in the community sector…at such a level that they started to feel the pressure come off their ED departments and their inpatient beds. That was with about 35 per cent of the mental health budget going into the community sector; that was the point where they started to feel it. That could be different for Australia and other jurisdictions, but you get to a point where, if you have supports for people in the community, you will see that translate into [reduced] pressure on inpatient beds and ED

35 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 28.

36 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 28.

> departments. I cannot tell you what that percentage is, but I think it is a bit like New Zealand: we need to keep investing until we see the benefits.[37]

6.42 Mr Quinlan, the CEO of Mental Health Australia argued that what was needed to embed early intervention into mental health pathways was certainty about what resources exist and the outcomes that need to be achieved:

> What we continue to fail to do is to set any overarching targets. So we ask those organisations that you listed—we ask Centacare to look at some family services, we ask Anglicare to do some youth counselling and we ask the Salvos to help out with financial support. Nobody ever sets a goal for your area and says, 'Okay, in the area of Inverell, here is what we want to achieve with our families: greater stability, higher employment rates and so forth.' We do not go to that local community of Inverell and say, 'Okay, what are the local assets and resources in terms of the abattoir and the agencies that are working there? Overall, how do we actually target this problem? We will put all of the money into one pool.' At the moment, I can guarantee you that all of those agencies working in your electorate are drawing a pittance of funding from 20 different funding sources each to try to put together a comprehensive program. What I think the commission has done is say, 'We don't want to support a system anymore, we want to look at some outcomes.' They have listed some very solid outcomes that could be agreed in the mental health space, which is to say that we want people to be in more secure and stable housing, we want people to be in employment, we want people to be less engaged with the criminal justice system…[38]

6.43 Ms Morgan of the Butterfly Foundation agreed that access to early intervention in mental health could make a significant difference to an individual's recovery. She advised the committee that the Butterfly Foundation had commissioned research which demonstrated that early intervention could reduce the impact of mental illness and increase benefits to the individual and to society as a whole:

> One thing that I would emphasise from an eating disorder perspective…is the importance of early intervention. The Butterfly Foundation has commissioned two socioeconomic reports from Deloitte Access Economics to try and put some figures on it and to take that business approach that we have heard around it. We know that the illness is very prevalent. It has a very high socioeconomic cost because the delay in the effect of treatment means that the productivity costs and the burden of disease cost are highly inflated, much higher than they need to be. The second report the Butterfly Foundation commissioned, *Investing in Need*, put a figure around the benefit of early intervention and fully integrated care for anybody with an eating disorder as akin to the sort of care you would get if you suffered from cancer in this country. Although the cost of rolling out that care was $2.8 billion the net savings or the benefit to cost was 5.38 to one—because

37 Mr Ivan Frkovic, Deputy Chief Executive Officer, National Operations, Aftercare, *Committee Hansard*, 26 August 2015, p. 21.

38 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 22.

> if you intervene early you reduce the impact of the illness, you increase the survival rate and you increase productivity.[39]

6.44 Mr Jonathan Harms, the CEO of Mental Health Carers, ARAFMI NSW, compared the mental health funding and treatment model with that for physical health, and observed that in mental health, there was little funding dedicated to early intervention. Mr Harms told the committee that the result was that mental health treatment was so often focused on crisis. He argued that this would be unacceptable in the treatment of physical ill-health:

> There was an article in the *Medical Journal of Australia*, 'Where to mental health reform in Australia: is anyone listening to our independent auditors?' where one of the authors who was a former commissioner of mental health made the point that because we are spending so little on mental health compared to the need it is almost always focused on crisis and when people have become as sick as possible. It is something we would not accept in any other area of medicine. We would not say to someone with a broken leg, 'Come back when it's gangrenous.' We would actually start treating it straight away. What passes for early intervention in mental health is what would pass for simply ordinary treatment in any other area of health care. So we are squandering almost all of the money we are spending in many respects when you look at the results we could achieve compared to the results we do achieve because we are sticking a bandaid on. We are putting the ambulance at the bottom of the cliff. We are not comprehensively addressing the needs across sectors and across life span et cetera.[40]

Committee view

6.45 The committee strongly supports the findings of the Commission in relation to access to early intervention. The evidence the committee received clearly demonstrates that early intervention and prevention allows for better treatment of mental ill-health and facilitates the individual being active socially, economically, and in their community.

6.46 The benefit for Australia as a whole is also clear, as a reduction in individuals requiring acute care will result in a saving in the health system. Similarly the committee notes that one of the greatest economic costs of mental ill-health is through lost productivity. If a person can be treated effectively at an early stage, they can continue to be productive in both their work and family life.

Recommendation 4

6.47 The committee recommends that the government response to the National Mental Health Commission's report include evidence-based modes of care that promote early intervention.

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39 Ms Christine Morgan, Chief Executive Officer, Butterfly Foundation, *Committee Hansard*, 28 August 2015, p. 15.

40 Mr Jonathan Harms, Chief Executive Officer, Mental Health Carers ARAFMI NSW, *Committee Hansard*, 28 August 2015, p. 36.

Linking housing and employment to mental health

6.48 Closely related to the Commission's findings on access to early intervention is the connection between the treatment of mental ill-health, access to housing, and workforce participation.

6.49 A major part of the economic cost of mental ill-health (as discussed in Chapter 2) is the loss of productivity. In its report, the Commission noted that estimates of the cost of mental ill-health to the Australian economy from lost productivity and job turnover cost some $12 billion per annum.[41] The OECD figures, quoted in the Commission's report note:

> The costs of mental ill-health for the individuals concerned, employers and society at large are enormous… Most of these costs do not occur within the health sector. Mental illness is responsible for a very significant loss of potential labour supply, high rates of unemployment, and a high incidence of sickness absence and reduced productivity at work. In particular, mental illness causes too many young people to leave the labour market, or never really enter it, through early moves onto disability benefit. Today, between one-third and one-half of all new disability benefit claims are for reasons of mental ill-health, and among young adults that proportion goes up to over 70 per cent. [42]

6.50 As part of its findings the Commission argued that treatments for mental health conditions should centre on the whole person, and that this approach needed to include the person's community and economic participation. Professor Fels, the Chair of the National Mental Health Commission explained:

> If you can get labour force participation up, that is almost the best way of improving productivity and I am sure at this reform summit today [event on 16 August 2015 sponsored by *The Australian Financial Review* and *The Australian*] we will hear a lot about measures, tinkering here and there, that will get participation up. People with mental health problems have a 38 per cent non-participation rate versus 22 per cent in the general population. Our participation rate is low by the standards of good OECD countries. We are at the bottom of the top good 10, 12, 13 OECD countries. Most people with mental illness are at the mild to moderate end. The scope for their better participation in the workforce is very large. The World Economic Forum estimates the cost of lost output and income at about 1.75 per cent of GDP. Most people with mental illness want to work but find it difficult to get a job and then to hold it.[43]

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41 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 24.

42 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 24.

43 Professor Allan Fels, Chair, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 2.

6.51 Professor Ian Hickie, a National Mental Health Commissioner told the committee that Australia already had a vast amount of evidence that the approach advocated by the Commission could be beneficial:

> There is a lot of evidence from specific trials. We love to trial things here in Australia. We have done trials of all of these things. We never move from the trials to the systematic implementation. So you not only have a reduction in cost; if you have somewhere to live, you do not come back into hospital. In Sydney a hospital bed is $800 to $1,000 a day. You could be at a very nice hotel for $800 to $1,000 a day. Currently we are using hospital beds for that. Not only will you offset the cost, you will be well. You will stay well if you have a home, and you will be less likely to have a relapse in your clinical problems. If you have a job, you do better. We use this expression all the time: 'You don't get well to go to work; you go to work to get well'. We all thrive in environments where we have a home and we have a job and we have social connections. Those things are not simply cost offsets; they deliver better outcomes.[44]

6.52 Professor Fels advised the committee that the connection between mental ill-health, housing and workforce participation was also recognised internationally:

> If I could just add to that: there is a movement in the US called Housing First. It really subscribes to the view that, if you fix housing for people with mental illness as the top priority, a lot of improvements will flow simply from that. It does not mean that they do not need other help. There is now a fair bit of data about the effectiveness of Housing First. Also in Canada the government gave $100 million to Housing First experiments, if you like—although that is a fairly big experiment—and there is now reporting and data showing there has been quite a significant improvement in mental health. I mentioned a project like that I am part of in Melbourne. It was independently evaluated by Monash University. Using a number of measures it concluded what everyone who goes there knows, which is that there has been an enormous improvement in the lives of people who are at the severe end.[45]

Committee view

6.53 The committee supports the Commission's finding in relation to the linkages between housing, employment, and mental health.

6.54 The committee notes Professor Hickie's comments regarding the need for action in this area.[46] The committee agrees that numerous past trials have proven beyond doubt the benefits to a coordinated approach to supporting those with mental illness. And the committee therefore reiterates its disappointment that the government,

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44 Professor Ian Hickie, Commissioner, National Mental Health Commission, *Committee Hansard*, 26 August 2015, pp 8–9.

45 Professor Allan Fels, Chair, National Mental Health Commission, *Committee Hansard*, 26 August 2015, p. 9.

46 Professor Ian Hickie, Commissioner, National Mental Health Commission, *Committee Hansard*, 26 August 2015, pp 8–9.

rather than responding quickly to the Commission's findings, chose to review the Commission's review resulting in a delay of at least ten months.

6.55 Further, the committee considers that this linkage demonstrates that mental health is not solely the preserve of the health portfolio. The effective treatment of mental health crosses into the portfolios of housing, employment, and others. The segregation of policy into separate portfolios has produced a situation in which programmes and services are not connected, or are duplicated, and people do not receive the help they need. It is clear that a mechanism which links programmes and services across portfolios is required.

Recommendation 5

6.56 The committee recommends that the government's response to the National Mental Health Commission's report recognise the linkages between housing, employment, and mental health. The government's response should include ways for services and programmes to be appropriately connected so that individuals can access holistic care.

Workforce

6.57 The Commission wrote in its report that the inefficiencies it had identified in the delivery of mental health services and programmes were exacerbated by issues related to the mental health workforce:

> These challenges [inefficiency, incorrect distribution of funding, the system not being cost-effective] are compounded by a mental health workforce under pressure, with services experiencing shortages, high rates of turnover and challenges in recruiting appropriately skilled and experienced staff. Too frequently, the voices of people with lived experience, their families and support people are ignored, misheard and undervalued.[47]

6.58 Further, the Commission noted that the efficiency of service delivery to rural and remote areas was greatly affected by the poor distribution of workforce, amongst other issues.[48]

6.59 Workforce issues appear in many of the Commission's recommendations, but particularly in recommendations 21 and 22 which related to the Commission's finding around the need to build workforce and research capacity to support systems change. Recommendations 21 and 22 are:

> Recommendation 21. Improve supply, productivity and access for mental health nurses and the mental health peer workforce.

47 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 13.

48 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 29.

> Recommendation 22. Improve education and training of the mental health and associated workforce to deploy evidence-based treatment.[49]

6.60 A particular example of the types of workforce issues the Commission identified is the Mental Health Nurse Incentive Programme (MHNIP). The Commission commented that the effectiveness of the MHNIP is limited by regulatory barriers, and programme requirements are 'often rigid and inflexible, potentially stymying innovation and integrated multi-disciplinary support by limiting fundholding arrangements.'[50] For example:

> …headspace cannot access the MHNIP to employ mental health nurses. Similarly, Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services) cannot hold Access to Allied Psychological Services (ATAPS) funding even though one of the target populations under the programme is Aboriginal and Torres Strait Islander people. These types of access barriers decrease timely and appropriate support, including through community-based services.[51]

6.61 Witnesses at the committee's public hearings agreed with the Commission's findings in relation to the MHNIP and the mental health workforce generally. For instance Mr Sebastian Rosenberg, a Senior Lecturer at the Brain and Mind Centre of the University of Sydney told the committee:

> With respect to mental health community outreach nurses, the Mental Health Nurse Incentive Program is a proven program that adds so much to the armaments of GP practices so that they can follow people into the community and provide care. The cost is only $40 million, which would be less than three weeks' worth of the Better Access program [government program which aims to provide better access to mental health practitioners through Medicare]. It is a tiny program with massive effectiveness. So, again, Australia has a program which it could scale but has not... and, again, the amount of money that is set aside for workforce development is tiny. Some of our colleagues in the College of Mental Health Nurses have been struggling to build that workforce.[52]

6.62 Mr Quinlan of Mental Health Australia told the committee that the MHNIP is one of the programmes which has been subject to short-term funding extensions and that this issue is further negatively impacting on the effectiveness of the programme:

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49 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 11.

50 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 31.

51 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 31.

52 Mr Sebastian Rosenberg, Senior Lecturer, Brain and Mind Centre, University of Sydney, *Committee Hansard*, 26 August 2015, p. 29.

> **Mr Quinlan:** The Mental Health Nurse Incentive Program is one of those programs on the list that has been extended on a 12-month-by-12-month basis for quite a number of years. It is not unique to this area, but it is one of those areas where clearly if you are a nurse in the community who is thinking, 'Where will I build my career in nursing?' this notion of 12-month-by-12-month funding does not create…a platform for people to say, 'That's where I'm going to invest my future', because you never know—
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> **Mr Peters:** The uncertainty of mental health funding is probably causing as much stress as anything else...[53]

6.63 Mr Quinlan also explained that the uncertainty of funding was having an impact on the wider mental health workforce. He gave the committee an example from one of the members of Mental Health Australia in relation to the Partners in Recovery programme:

> As at today, if one of our agencies loses a staff member in, say, the Partners in Recovery Program, it can only offer a replacement staff member an eight-month contract with an uncertain future beyond that. That means that, as at today, the sorts of programs and services that we are delivering to people on the ground are starting to deteriorate again, because of the uncertainty of the arrangements beyond June next year. That is something that I think we need to be doing much more work on, and we stand ready to assist government and other interested parties to develop that work. I am happy to take further questions as we go on.[54]

6.64 Mr Frkovic of Aftercare agreed that uncertainty of funding was causing significant impacts on the mental health workforce. Mr Frkovic also acknowledged the consequent flow on effect on the provision of support to those with a mental illness and their families:

> …we have staff who are really struggling in terms of what happens to them. When you think about it, we have 450 staff, and a lot of people are wondering what happens beyond June next year. That whole system that is currently working is being unravelled from a whole range of perspectives, which I think is causing us some major challenges in terms of ongoing support for people with mental illness, and their families.[55]

6.65 Ms Jaelea Skehan, the Director of the Hunter Institute of Mental Health told the committee that a further impediment on the effectiveness of funding for mental health was the current government funding being provided on a year-by-year basis, creating a stressful situation for staff and putting pressure on organisations:

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53 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, and Mr Andrew Peters, Chief Executive Officer, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard*, 26 August 2015, p. 29.

54 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 15.

55 Mr Ivan Frkovic, Deputy Chief Executive Officer, National Operations, Aftercare, *Committee Hansard*, 26 August 2015 p. 19.

> Single year funding is inefficient for any service, and it is completely inefficient when you are trying to work in a prevention framework, where you are really looking at five-year planning. Like many organisations, for the past two years we have been given notification of funding extensions in June for funding starting on 1 July. That is stressful for staff; it is very hard for staff turnover. My organisation, as well as many others at this table and in our sector, has staff on contracts. You can imagine that is a very challenging environment to work in. It is also not very good for those sectors that we are working with, particularly for front-line services that are providing services to individuals and families, to have that lack of certainty around continued funding.[56]

Committee view

6.66 The committee strongly supports the Commission's finding that a robust workforce is a key to the successful delivery of mental health services and programmes. The committee was disappointed that the government abolished the Health Workforce Australia agency in the name of efficiency. The committee considers that the government's action was a false economy, particularly in light of the Commission's findings that workforce development and distribution are critical in effective mental health service delivery.

6.67 The committee hopes that a government response to the Commission's findings will recognise the need for an overall health workforce strategy.

Recommendation 6

6.68 The committee recommends that the government's response to the National Mental Health Commission's report recognise need for a clear and comprehensive mental health workforce strategy.

Suicide prevention

6.69 The Commission's report identified suicide as a major issue in mental health:

> In 2012 more than 2,500 people died by suicide, while in 2007 an estimated 65,000 Australians attempted to end their own life. Suicide is the leading cause of death among people aged between 15 and 44 years old, and is more likely among men, Aboriginal and Torres Strait Islander people and people living outside of major cities.[57]

6.70 Reflecting the importance of including suicide prevention in any national mental health approach, the Commission made three recommendations and one finding relating specifically to suicide prevention:

> Recommendation 2. Develop, agree and implement a *National Mental Health and Suicide Prevention Plan* with states and territories, in

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56 Ms Jaelea Skehan, Director, Hunter Institute of Mental Health, *Committee Hansard*, 28 August 2015, p. 30.

57 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 19.

> collaboration with people with lived experience, their families and support people.[58]
>
> Recommendation 4. Adopt a small number of important, ambitious and achievable national targets to guide policy decisions and directions in mental health and suicide prevention.[59]
>
> Finding 7. Reduce suicides and suicide attempts by 50 per cent over the next decade.[60]
>
> Recommendation 19. Establish 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.[61]

6.71 Witnesses supported the Commission's emphasis on suicide prevention with many telling the committee that there is a clear and urgent need for action in this area in Australia. For example Associate Professor Judith Proudfoot, the Head of eHealth at the Black Dog Institute observed that:

> Suicide prevention is cost-effective and Australia was one of the first countries to develop a national suicide prevention strategy, in 1995. Suicide rates have not declined significantly, in Australia, in the last decade. In fact, in the last 12 months the numbers have increased, particularly in young girls and Aboriginal and Torres Strait Islander men. Progress in this area has been hampered by the lack of integration and poor coordination of suicide-prevention activities and strategies. There has been activity there and a lot of good activity but it has not been integrated or coordinated… The economic cost, apart from the very traumatic personal cost, is $17.5 billion, annually, to the Australian community. So it is really timely that we do something about suicide and suicide prevention.[62]

6.72 Associate Professor Proudfoot explained that there was substantial evidence supporting a multi-faceted, cross-government approach to suicide prevention of the kind advocated by the Commission's report:

> Evidence from overseas shows, very clearly, that successful suicide prevention requires a simultaneous systems based approach that involves

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58 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 10.

59 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 10.

60 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 11.

61 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 11.

62 Associate Professor Judith Proudfoot, Head of eHealth, Black Dog Institute, *Committee Hansard*, 26 August 2015, p.40.

> multisectoral involvement by all government, non-government, health, business, people with lived experience, and education, research and community agencies and organisations. That is, it needs multiple points of intervention. Within a localised area, having done an audit of what services are available in the localised area, it means implementing evidence based strategies, at the same time, that are effective and demonstrating sustainability and long-term commitment… The research shows there are nine strategies that are evidence based and effective. The most promising of those is restricting means to suicide, GP education and gatekeeper training but, of course, they need to be fine tuned and tailored to the particular local area.[63]

6.73 One point of disagreement with the Commission's finding and recommendations on suicide prevention related to funding. The Commission had, in accordance with the government's direction, made its recommendations with the assumption of no additional funding to what was already being spent by government. Mr Matthew Tukaki, a Board Member of Suicide Prevention Australia; and Chairman of the National Coalition for Suicide Prevention argued that additional funding was essential if the recommendations the Commission had made were to be achieved:

> The stark reality is that many of our front-line service providers are already facing funding challenges and living from short-term contract to short-term contract. Imagine as we go deeper into the rabbit hole that the number of Australians seeking help will increase, thereby overwhelming services already under pressure. This comes back to the perennial question of whether or not the quantum of funding required is enough and how it is distributed is adequate. This means we need to look past just providing short and medium-term contract certainty, if indeed the current model of tendering or contracting out services is to continue, and focus more on the long-term certainty required by the many front-line service providers.[64]

6.74 Mr Tukaki told the committee that to make an impact on the economic costs of mental ill-health and suicide, additional funding was vital:

> Just as we have outlined our desire to see suicide reduced by half over the decade, we cannot get to that point unless we have an honest discussion about the investment required to reach that goal and the return on investment to the taxpayer. Saving lives saves money. But, as I know in business, to make money, you need to spend it. You need to make the long-term investments to make the return, the return obviously being the increased economic productivity of those who have been taken from us too early who otherwise would have made a substantive contribution to the national productivity question.[65]

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63 Associate Professor Judith Proudfoot, Head of eHealth, Black Dog Institute, *Committee Hansard*, 26 August 2015, p.40.

64 Mr Matthew Tukaki, Board Member, Suicide Prevention Australia; Chairman, National Coalition for Suicide Prevention, *Committee Hansard*, 28 August 2015, p. 14.

65 Mr Matthew Tukaki, Board Member, Suicide Prevention Australia; Chairman, National Coalition for Suicide Prevention, *Committee Hansard*, 28 August 2015, p. 14.

Committee view

6.75 The committee supports the priority the Commission has given to suicide prevention in its review, and commends the Commission's findings to the government.

6.76 The committee notes the comments from witnesses, particular Suicide Prevention Australia, that additional funding is needed if the suicide prevention targets recommended by the Commission are to be achieved.

Recommendation 7

6.77 The committee recommends that the government's response to the National Mental Health Commission's report include tangible and measurable actions to achieve the suicide prevention targets recommended by the Commission.

Rural and remote communities

6.78 The Commission gave particular emphasis to the mental health challenges facing those in rural and remote areas:

> On almost any indicator, people living outside of metropolitan areas experience inequity both in terms of their health and in getting access to the right services: lower life expectancy, lower access to Medicare-funded services which diminishes with increasing remoteness, reduced health workforce distribution, and lower rates of mental health service access, with access to psychological services significantly less than in major cities. The impact of these inequities is particularly significant for Aboriginal and Torres Strait Islander people living in these areas.[66]

6.79 Added to the factors facing those in rural and remote areas, the Commission also identified access to services, particularly the limited availability of non-medical services, as a significant barrier to those in rural and remote areas accessing assistance:

> In rural and remote areas, issues in mental health are compounded by reduced access to infrastructure, communications and costs to access services. The Commission has learned from submissions to the Review that discrimination due to mental illness is a factor which affects whether a person seeks services in their town. For some, anonymity is important and they will travel to the next town or regional centre to get the support they need. This presents another barrier to them getting timely access to the type of supports they need. The impacts of drought, bushfires and hard economic times also add to the distress of families and communities in these areas.[67]

66 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 36.

67 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 36.

6.80 The Commission found in relation to mental health in rural and remote areas that:

- Mental health services are often transient, impacted by workforce shortages, and are decreasing despite increased demand;
- Programmes are inadequately funded for the increased cost of delivering services across the distances in rural and remote areas; and
- Access to services could be improved by wider use of technology and by increasing community capacity.[68]

6.81 As a result of its findings, the Commission recommended that service equity for rural and remote communities should be improved through place-based models of care.[69]

6.82 Professor David Perkins, who is a Director and Professor for Rural Health Research at the Centre for Rural and Remote Mental Health (CRRMH) agreed with the Commission's findings in relation to rural and remote communities. He noted that needs and expectations of those in rural and remote communities is exactly the same as those in metropolitan areas:

> If we start with community members and people who live in rural and remote areas and ask what they want and need, I think we find the answers have been articulated well by the National Mental Health Commission and by my state's [NSW] mental health commission. People want a contributing life. They want to live well. They want a secure home, reliable income, education or employment, and to be able to take part in their communities, and they want their symptoms addressed—it might even be in that order. Sometimes we do not see it that way. Obviously, Aboriginal colleagues and friends refer to this as social and emotional wellbeing. I think the professions are beginning to talk about recovery.[70]

6.83 Professor Perkins told the committee that the term 'rural and remote' does not accurately reflect the great variety of communities that exist in regional areas. This variety is, as was identified in the Commission's findings, a key part of the difficulty in service delivery in regional Australia:

> The first [issue] is just how variable rural and remote communities are. A lot of our data says 'metropolitan and rural'. It does not distinguish adequately between the needs and the character of such communities, whether it is farming, mining, tourism or gastronomic rural, such as where I

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68 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 37.

69 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, Recommendation 10, p. 10.

70 Professor David Perkins, Director and Professor, Rural Health Research, Centre for Rural and Remote Mental Health, *Committee Hansard*, 28 August 2015, p. 44.

> live in Orange. There are also the needs of the local population—Indigenous and non-Indigenous. There are socioeconomic differences. There is also location and distance from service centres... I find myself defining 'rural' by saying the usual challenge is that there is a shortage of experts and specialists in every area. Those experts and specialists include medical experts and specialists, but across the board you begin to lose people with that level of expertise living locally.[71]

6.84 Despite the challenges of ensuring equity of access to services in rural and remote areas, Professor Perkins argued that community-based services were the best means of programme delivery. Further, Professor Perkins advocated for the need for health promotion and preventative health to be part of any community-based service delivery:

> Often, the poor health outcomes in rural and remote areas are attributed just to poor access. It is a bit like saying at an interview, 'It is the chemistry.' People have a simple explanation, which often does not seem to go far enough. We think that a broader, patient- and community-centred approach is needed that includes the traditional health services—the GPs and the mental health services—but also employers, community organisations, local government and other interested parties. We need rural and remote communities with health systems that will promote mental health and wellbeing, respond to mental illness and work collaboratively on those suicide rates. We need to develop mental health promotion, mental illness care and suicide prevention that are different for different sorts of communities, and they need to be fairly and equitably funded. But they will need to be designed to meet local needs—perhaps backed up by e-health and telehealth solutions where appropriate. In terms of that mental health promotion, one of the things we are trying to do is to set off 'mentally healthy Orange'. We are using the phrase 'mentally healthy' to be different to 'mental illness', and to say what are the things that an individual can do—at the personal, family, practical and non-institutional level—and then building in employers and others to improve one's mental health.[72]

Committee view

6.85 The committee commends the Commission for including in its review the difficulties of mental health service delivery in rural and remote communities, and the particular challenges facing those communities.

6.86 The committee agrees with the Commission's recommendations in relation to mental health service and programme delivery in rural and remote communities.

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71 Professor David Perkins, Director and Professor, Rural Health Research, Centre for Rural and Remote Mental Health, *Committee Hansard*, 28 August 2015, p. 44.

72 Professor David Perkins, Director and Professor, Rural Health Research, Centre for Rural and Remote Mental Health, *Committee Hansard*, 28 August 2015, p. 45.

Recommendation 8

6.87 The committee recommends that the government's response to the National Mental Health Commission's report address the challenges of mental health service delivery in rural and remote communities.

Aboriginal and Torres Strait Islander peoples and mental health

6.88 The *Close the Gap Progress and Priorities Report 2015* (Close the Gap Report), which was published in February 2015, shows the stark reality of the number of Indigenous Australians who suffer from mental health issues:

> There is an entrenched mental health crisis among Aboriginal and Torres Strait Islander peoples that must be addressed. Mental health problems, including self-harm and suicide, have been reported at double the rate of that of non-Indigenous people for at least a decade. Recent data suggests the situation is getting worse…
>
> The Aboriginal and Torres Strait Islander mental health gap:
>
> **Psychological Distress:** In 2012-13, 30 percent of respondents to the AATSIHS [Australian Aboriginal and Torres Strait Islander Health Survey] over 18 years of age reported high or very high psychological distress levels in the four weeks before the survey interview. That is nearly three times the non-Indigenous rate. In 2004-05, high and very high psychological distress levels were reported by 27 percent of respondents suggesting an increase in Aboriginal and Torres Strait Islander psychological distress rates over the past decade.
>
> **Mental Health Conditions:** Over the period July 2008 to June 2010, Aboriginal and Torres Strait Islander males were hospitalised for mental health-related conditions at 2.2 times the rate of non-Indigenous males; and Aboriginal and Torres Strait Islander females at 1.5 times the rate of non-Indigenous females. Rates of psychiatric disability (including conditions like schizophrenia) are double that of non-Indigenous people.
>
> **Suicide:** The overall Aboriginal and Torres Strait Islander suicide rate was twice the non-Indigenous rate over 2001-10. Around 100 Aboriginal and Torres Strait Islander deaths by suicide per year took place over that decade. In 2012, 117 suicides were reported. The OID [Overcoming Indigenous Disadvantage report] 2014 Report shows that hospitalisations for intentional self-harm increased by 48 percent since 2004-2005.[73]

6.89 The Closing the Gap Campaign Steering Committee therefore recommended that:

> The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* provides the basis for a dedicated Aboriginal and Torres Strait Islander mental health and social and emotional wellbeing plan. This is developed and implemented with the Health Plan, the *National Aboriginal and Torres*

73 Closing the Gap Campaign Steering Committee, *Close the Gap Progress and Priorities Report 2015*, p. 38.

> *Strait Islander Suicide Prevention Strategy 2013* and the *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy* implementation processes in order to avoid duplication, be more efficient, and maximise opportunities in this critical field.[74]

6.90 The Commission's findings agreed with the findings of the Close the Gap Report:

> Of critical concern is the dire status of the mental health and wellbeing of Aboriginal and Torres Strait Islander people. Indigenous people have significantly higher rates of mental distress, trauma, suicide and intentional self-harm, as well as exposure to risk factors such as stressful life events, family breakdown, discrimination, imprisonment, crime victimisation and alcohol and substance misuse. Service and system responses to these poor outcomes are inadequate, and have generally not been designed with the particular needs of Aboriginal and Torres Strait Islander people in mind.[75]

6.91 Similarly to the Close the Gap Report, the Commission found that rates of mental illness amongst Indigenous Australians are significantly higher than the non-Indigenous population:

> The mental health needs of Aboriginal and Torres Strait Islander people are significantly higher than those of other Australians. In 2011-12 nearly one-third (30 per cent) of Aboriginal and Torres Strait Islander adults (aged 18 years and older) had *high* or *very high* levels of psychological distress, almost three times (2.7) the rate for other Australians. Nationally, there were 22.4 suicides per 100,000 Aboriginal and Torres Strait Islander people during 2012, more than double the rate of 11.0 for other Australians. Aboriginal and Torres Strait Islander people aged 15 years and older report stressful events at 1.4 times the rate of non-Indigenous people.[76]

6.92 Further, the Commission noted that the concept of 'mental health' for Aboriginal and Torres Strait Islander peoples is 'tied inextricably to the concept of social and emotional wellbeing', thus placing wellbeing within the context of a person's experience of family, community, culture, and history:

> The concept of mental health comes more from an illness or clinical perspective and its focus is more on the individual and their level of functioning in their environment. The social and emotional wellbeing concept is broader than this and recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how these affect the individual. Social and emotional wellbeing problems cover a

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74 Closing the Gap Campaign Steering Committee, *Close the Gap Progress and Priorities Report 2015*, Recommendation 7, p. 40.

75 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 14.

76 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 19.

> broad range of problems that can result from unresolved grief and loss, trauma and abuse, domestic violence, removal from family, substance misuse, family breakdown, cultural dislocation, racism and discrimination and social disadvantage.[77]

6.93 The Commission's finding in relation to Aboriginal and Torres Strait Islander mental health was that there is an urgent need to 'expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people'.[78] As a result, the Commission recommended:

> Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services), linked to Aboriginal and Torres Strait Islander specialist mental health services.[79]

6.94 Witnesses at the committee's public hearings echoed the findings of the Commission and the Closing the Gap Report. Mr Quinlan of Mental Health Australia told the committee that a key part of delivering services in Indigenous communities was community ownership. He used the example of the Aboriginal Community Controlled Health Organisations to illustrate his point:

> I think supporting the sort of community controlled organisations that are genuinely taking control of their own destiny and delivering programs is important. As part of my trip north I visited the Miwatj health service, where there is a genuine ownership of the local strategies and services that are being delivered in that community. I think those sorts of programs provide an excellent model for what we could be doing in other places too.[80]

6.95 Mr Rosenberg of the Brain and Mind Centre agreed with Mr Quinlan, and gave the committee an example of the effectiveness of the Partners in Recovery (PIR) programme when coupled with community ownership and Indigenous workforce:

> I used to do some work in the Cairns area with their local Aboriginal mental health service, and that was one of the first times where I came across PIR in a very effective way. There was an Aboriginal workforce that was working within that program, and I was blown away. But one of the things that they found very difficult was that the rules preclude PIR from working with kids under 16. It is a classic example of a well-intentioned program

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77 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 19.

78 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 11.

79 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, Recommendation 18, p. 11.

80 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 33.

> that is applied to mainstream health services with rules and so on, but its application to the Aboriginal community was so completely wrong and counter to their whole view about family and about the social and emotional wellbeing of the whole family. I think it was an example of the fact that we have got some things in place, but they need to be tailored appropriately to make the most of those opportunities.[81]

Committee view

6.96 The committee strongly supports the findings of the Commission in relation Indigenous mental health. From the evidence the committee has heard, it is clear that the Commission's findings are widely accepted, and that they align closely with those of the Closing the Gap Report.

6.97 The committee notes that the Closing the Gap Report identified health as a major area of need for Indigenous Australians and argued that without first addressing health, including mental health, little could be done to close the gap in other policy areas.

6.98 The committee agrees with this argument and strongly urges the government to have regard to the alignment between the Closing the Gap Report and the Commission's review findings and make Indigenous mental health a priority in the government response.

6.99 In this regard the committee notes that the ERG process was informed by an Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group. Ultimately, the government response in this area will be judged by the level of input, support, and ownership it has from Indigenous communities.

Recommendation 9

6.100 The committee recommends that the Government's response to the Mental Health Commission's report sets out a future policy direction to address Indigenous mental health and suicide prevention challenges.

LGBTI

6.101 The Commission identified LGBTI individuals as a vulnerable group, at risk in terms of mental ill-health and its attendant economic and social costs.[82] The Commission noted that there are gaps in the provision of specialised supports and programmes for LGBTI individuals, and that their situation is made more difficult as a result of discrimination and stigmatisation.[83]

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81 Mr Sebastian Rosenberg, Senior Lecturer, Brain and Mind Centre, University of Sydney, *Committee Hansard*, 26 August 2015, p. 33.

82 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 107.

83 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 34.

6.102 Ms Rebecca Reynolds, the Executive Director of the National LGBTI Health Alliance told the committee that her organisation agreed with the findings of the Commission regarding the risk of mental ill-health for LGBTI individuals:

> The prevalence of mental health problems in LGBTI Australians is disproportionately high and carries significant human, social and economic consequences… LGBTI people are part of all population groups, including Australians living in rural and remote areas, in Indigenous communities and in culturally and linguistically diverse populations. LGBTI people have demonstrated considerable resilience in looking after themselves in their communities despite adversity, and they lead healthy and fulfilling lives, contributing to their families, local communities, workplaces and society as a whole in most cases. Nevertheless, the experience of dealing with marginalisation and stigma often impacts on LGBTI people's mental health. These social determinants of mental health are reflected in higher rates of suicide, self harm and depression in LGBTI communities.[84]

6.103 Ms Reynolds told the committee that in comparison to the general population, LGBTI communities risk of suffering mental ill-health was in some instances double:

> …suicide rates for lesbian, gay and bisexual people are 14 times higher than for the general population. The rates for gender diverse Australians are alarmingly high at 35 per cent. Suicide Prevention Australia estimates that 28 per cent of lesbians have self harmed, compared with 8.3 per cent of heterosexual women. Self harm is also higher among gay men at 20.8 per cent, compared to 5.4 per cent for heterosexual men. Of young bisexual men and young bisexual women, 29.4 per cent and 34.9 per cent, respectively, commit self harm. The rate of depression in LGBTI communities is much higher than for the general population, sitting at three times higher for LGB Australians and 6.5 times higher for gender diverse Australians. *Private Lives 2*, a report on the health and wellbeing of LGBTI Australians, reported that 49 per cent of men and 45 per cent of women had experienced a major depressive episode and that 16 per cent of all respondents to that online survey had had suicidal ideation in the two weeks prior to the survey—this was conducted late last year.[85]

6.104 Recommendation 20 of the Commission's review stated the need to:

> Improve research capacity and impact by doubling the share of existing and future allocations of research funding for mental health over the next five years, with a priority on supporting strategic research that responds to policy directions and community needs.[86]

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84 Ms Rebecca Reynolds, Executive Director, National LGBTI Health Alliance, *Committee Hansard*, 28 August 2015, p. 31.

85 Ms Rebecca Reynolds, Executive Director, National LGBTI Health Alliance, *Committee Hansard*, 28 August 2015, p. 31.

86 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 116.

6.105 In outlining how this recommendation could be achieved, the Commission argued that there is a need to:

> Develop evidence about what works in areas which have the potential to realise greatest public value; for example:
>
> - infant trauma
> - child and adolescent health
> - mental health and aged care
> - stigma and discrimination
> - medications use, including metabolic syndrome
> - mental health for vulnerable groups e.g. people from culturally and linguistically diverse backgrounds, Lesbian Gay Bisexual Transsexual and Intersex (LGBTI) people
> - suicide and suicide prevention.[87]

6.106 Further, the Commission emphasised the need to direct research on successful programmes and services into interventions:

> Include consideration of interventions across the domains of:
>
> - promotion
> - prevention and early intervention
> - crisis intervention and suicide prevention
> - treatment
> - recovery and support[88]

6.107 Ms Reynolds explained that the lack of adequate data on LGBTI populations was one major reason for the services targeted at LGBTI communities not receiving attention and funding:

> Data collection is, however, one of the major issues I wanted to raise with you today—gaps in identifying key strategies for addressing negative mental health and suicidal behaviours in LGBTI populations and communities. Those statistics that we do have largely come from service attached consumers, not general population surveys. The 2007 national survey was one of the first national Australian surveys to include a question on sexual orientation. While this was a major step forward in gathering data on the lives of the same-sex attracted and bisexual people, the survey did not include questions on gender identity and intersex status. The continued

87 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 116.

88 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 117.

> absence of these questions on sexuality or sexual orientation, gender identity or intersex status means that our populations remain invisible in the programming of strategies and data. In the absence of any questions on gender identity and intersex status, there is no representative national data on the mental health of trans and intersex Australians and no way of comparing the rates of mental ill health and suicidal behaviours of trans and intersex Australians to the mainstream population and general community.[89]

6.108 Ms Reynolds also pointed out that in comparison to other vulnerable groups, LGBTI communities are often left out of national strategies and plans on mental health, and thus miss out on much-needed research and resourcing:

> The National Mental Health Strategy is made up of three documents: the National Mental Health Policy, released in 2008; the Fourth National Mental Health Plan, from 2009 to 2014; and the Mental Health Statement of Rights and Responsibilities, released in 2012. The first two documents have no mention of LGBTI people in them at all. The Mental Health Statement of Rights and Responsibilities states that in many cases people deserve to have their sexual orientation, gender and gender identity taken into consideration across multiple areas. However, there is no inclusion of intersex people in that at all—an invisible group. Finally, there are many other examples, but the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy has no inclusion of LGBTI, sistergirl or brotherboy people at all.[90]

6.109 Ms Reynolds argued that LGBTI mental health issues and support programmes and services must be included in any response to the Commission's review, or other national mental health plan:

> Given such a glaring lack of consistency across the national level, we strongly advocate for the adoption of an LGBTI mental health promotion and suicide prevention strategy, as is being successfully implemented in the ageing and aged-care sector by other government departments. A mental health and suicide prevention strategy must address these social determinants of reduced mental health amongst LGBTI people, including deeply embedded heterosexist beliefs and practices. It must also build on the capacity of LGBTI people and organisations to develop social relationships and networks with LGBTI populations and between LGBTI populations and the mainstream. Such individual and collective relationships are a source of resilience and social capital that act as protective factors against the increased risk of mental ill health and suicidal behaviours for LGBTI people.[91]

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89 Ms Rebecca Reynolds, Executive Director, National LGBTI Health Alliance, *Committee Hansard*, 28 August 2015, p. 31.

90 Ms Rebecca Reynolds, Executive Director, National LGBTI Health Alliance, *Committee Hansard*, 28 August 2015, p. 31.

91 Ms Rebecca Reynolds, Executive Director, National LGBTI Health Alliance, *Committee Hansard*, 28 August 2015, p. 31.

Committee view

6.110 The committee commends the Commission on its coverage of LGBTI issues in its review. The committee supports the Commissions assessment of the LGBTI community as an extremely at-risk segment of Australian society.

6.111 The committee acknowledges the work of the National LGBTI Health Alliance and similar groups in advocating for those vulnerable members of the LGBTI community.

6.112 The committee notes that the issue of data collection on 'what works' in mental health services and programmes is not restricted only to the LGBTI community. In fact the Commission identified that research across the entire range of Australian communities and mental health issues is badly needed. Targeted research funding must form part of the government's response to the Commission's review, as noted in Chapter 5.

6.113 The committee considers that the government response to the Commission's review must include specific actions in relation to services and programmes for the LGBTI community.

Recommendation 10

6.114 The committee recommends that the government's response to the National Mental Health Commission's report include adequate recognition of the need for data collection to inform services and programmes for LGBTI communities.

6.115 The committee also recommends that the government's response include specific actions and measurable targets in relation to the delivery of services and programmes for the LGBTI community.

Culturally and Linguistically Diverse communities

6.116 One of the Commission's findings was the need to 'promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life'.[92] As part of this finding the Commission recommended:

> Use evidence, evaluation and incentives to reduce stigma, build capacity and respond to the diversity of needs of different population groups.[93]

6.117 This recommendation specifically included the need for cultural responsiveness and culturally appropriate programmes for Culturally and Linguistically Diverse (CALD) communities. In explaining how this recommendation could be achieved, the Commission listed requirements such as:

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92 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 11.

93 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 11.

> 3. Improve cultural responsiveness by supporting the widespread adoption of the *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery* as a tool to help organisations identify what they can do to enhance their cultural responsiveness…
>
> 5. Adopt clear and explicit equity-oriented targets for people from Culturally and Linguistically Diverse (CALD) backgrounds from multicultural communities to include in government funding agreements.[94]

6.118 Mr Hamza Vayani, the National Project Manager of the Mental Health in Multicultural Australia (MHiMA) told the committee that in fact the first and most urgent task in providing targeted services to CALD communities was research and measurement of mental ill-health in CALD populations:

> If you then try to disaggregate [overall Australian mental-ill health population data] by population groups, it is simply not possible. If we were then to talk about investing prevention money and getting people in earlier, absolutely we would support that. But if we have not actually got an understanding or fix on the cultural and linguistic population groups, whilst you may be wanting to go down that trajectory, if you have not got any measurement around how that population group is going, the risk is that innovation in new practice can occur but you do not have quantified information vis-a-vis this population group and they are left further and further behind as the system progresses. That is the first kind of key challenge that I would really encourage us to think about.[95]

6.119 Ms Sharon Orapeleng, a Senior Project Officer at MHiMA told the committee that often language was a barrier to CALD individuals accessing mental health care. Ms Orapeleng argued the need for workforce training and cultural communication skills:

> Every single service in this country needs to be thinking, 'If I have somebody coming through my door who does not speak English, has a very different understanding of what mental health is because of their cultural background, and has a family who do not even have a word for it—because there are cultures who do not even have a word for mental health—what am I going to be doing to provide the support?' Either it is in the early intervention or prevention space or it is in acute. The whole spectrum of mental health care is where we really need to start thinking about what we are doing for whoever comes through that door. I would really like to see this conversation happening as a mainstream conversation rather than a conversation on the side. Almost 50 per cent of the population is born overseas or has one parent born overseas. It is our reality.[96]

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94 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, pp 105–6.

95 Mr Hamza Vayani, National Project Manager, Mental Health in Multicultural Australia (MHiMA), *Committee Hansard*, 18 September 2015, p. 42.

96 Ms Sharon Orapeleng, Senior Project Officer, MHiMA, *Committee Hansard*, 18 September 2015, p. 44.

6.120 Ms Orapeleng also noted that language was a barrier in collecting data about mental ill-health in CALD populations:

> If somebody comes to me and says, 'You work with multicultural communities; what is the prevalence of depression in the multicultural communities?' I would not be able to say what it is, because we know that, even in the national mental health and wellbeing survey, people who did not speak English were excluded. If you were able to speak English then you were able to answer the questions that were provided, but if you were not able to speak English then you were excluded… Unfortunately, we can say anecdotally that these things happen, but the data that is out there is not supporting what is going on.[97]

6.121 Mr Vayani told the committee that MHiMA's *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery* online tool would be a great benefit for organisations to assess their multicultural work:

> …the Framework for Mental Health in Multicultural Australia, which is I believe world-leading work in that it is online and allows services to really assess what they are doing in terms of being culturally responsive and sets for the first time some metrics around services being able to plot what they are doing and also to measure that impact against national standards for quality and safety in health care as well as the national standards for mental health services.[98]

6.122 In fact, Mr Vayani advised that the Sydney Local Health District had been using the framework with good results, because it demonstrated a gap in service provision and allowed action to be taken:

> For instance, we know that in the Sydney Local Health District, when they started using this framework and mapping what they were doing, they realised that interpreters were not being called in, potentially two or three days into somebody's length of stay. That person does not have language and may not define mental health as we know it. Imagine: they are really unwell, and three days of very little or no communication or understanding of what is happening to them is difficult.[99]

Committee view

6.123 The committee supports the Commission's findings and recommendations in relation to targeting services and programme delivery to CALD communities. In particular, the committee commends the Commission for its support of the MHiMA *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*.

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97 Ms Sharon Orapeleng, Senior Project Officer, MHiMA, *Committee Hansard*, 18 September 2015, pp 43–44.

98 Mr Hamza Vayani, National Project Manager, MHiMA, *Committee Hansard*, 18 September 2015, p. 37.

99 Mr Hamza Vayani, National Project Manager, MHiMA, *Committee Hansard*, 18 September 2015, p. 44.

Recommendation 11

6.124 The committee recommends that the government response to the National Mental Health Commission's report should include support for the use of the Mental Health in Multicultural Australia *Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery*.

e-mental health

6.125 The Commission included e-mental health and information technology as part of its person-centred approach to care, noting that technology can be used 'to link people and services and promote self-care and wellbeing'.[100]

6.126 In its 'stepped care' approach to the provision of mental health services, the Commission saw a place for e-mental health and technology to assist individuals to manage their own care, as well as being a more flexible service delivery mode:

> A stepped care approach supports Australians to take greater responsibility for their own mental and physical wellbeing. A new service paradigm is needed to support that choice and responsibility. Significant advances occurring in e-mental health provide the opportunity to encourage a society where self-help is more fully integrated in the system, and that people know where to go and how to get access to the specific information and support they need. It does not obviate the need for face-to-face care when necessary, but it does reduce the need for expensive services for those things which people can do for themselves, or with their families or other support people. That creates efficiencies but also enables cost-effective use of the time and skills of clinical and other professionals—and frees up the valuable personal time of individuals.[101]

6.127 The Commission saw e-mental health as a means of implementing its recommendation in relation to improving 'service equity for rural and remote communities through place-based models of care'.[102] The recommendation reads:

> Include services that are mental health-specific, delivered through health and other non-health portfolios, e-mental health and other phone and online services, as well as broader services which contribute to the physical health of those with a mental illness.[103]

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100 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 44.

101 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 47.

102 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 84.

103 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 84.

6.128 The Commission also envisaged a role for e-mental health in its recommendation regarding the promotion of self-help options to assist people, their families and communities to support themselves and each other, and improve ease of navigation for stepping through the mental health system.'[104]

6.129 In regards to this recommendation, the Commission suggested that e-mental health could be one of the ways in which the promotion of resources and support mechanisms could be achieved:

> Drawing on the expertise of the mental health and community sectors—including e-mental health providers—to develop, disseminate and promote a suite of resources and supports for self-help and online services, and evidence of effectiveness of these supports.
>
> - This could include a 'Mental Fitness Ready Reckoner' for people, their families and other support people to explain psychological distress and mental health.
> - Distribution should be through various channels including social media, eHealth and telehealth, as well as through general practices, pharmacies, community centres, Centrelink offices, schools and workplaces.[105]

6.130 Mr Heath of SANE Australia agreed with the Commission's view that e-mental health should be part of the community-based, or 'upstream' services:

> It is critical that the spending on mental health should align with the burden of disease. At the moment, it is tracking at about seven per cent in terms of spending, 14 per cent in terms of burden. We need to have greater investment upstream, especially in the online and digital services. We are still not connecting with around half the people that have mental illnesses and we cannot do that in the ways that we have done in the past. The online world provides an excellent opportunity to do that. Within that environment, there is a huge untapped resource of peer-to-peer support that is available.[106]

6.131 Associate Professor Proudfoot of the Black Dog Institute told the committee that her organisation had done research which demonstrated the effectiveness of e-mental health in providing support for individuals suffering mental ill-health:

> I would like to say that, apart from it being available 24/7 to enable those in need of support and to assess risk factors in real time, there is a strong body of evidence worldwide demonstrating the clinical and the cost effectiveness

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104 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 87.

105 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 87.

106 Mr Jack Heath, Chief Executive Officer, SANE Australia, *Committee Hansard*, 26 August 2015, p. 39.

> of e-mental health programs for mild to moderate depression and anxiety, insomnia, alcohol and drugs, as well as suicide prevention. Controversially, there have been trials which show for these mild to moderate conditions that e-mental health programs are as effective as face-to-face therapy. The other great advantage is that they translate to real world conditions, and research, both ours and international, has shown that they do improve work and social functioning. They do not just reduce symptoms; they improve work and social functioning. This means that fewer people need to be referred to secondary and tertiary services.
>
> We have done some cost effectiveness analyses as well. We considered a fully-automated program—that is, without clinician support—but tailored to individuals, and it was about half the cost of antidepressant medication and about a sixth of the cost of face-to-face CBT [Cognitive Behaviour Therapy]. They are available; they are effective, but to date they have not been integrated into a stepped care model or into primary care. That was one of the recommendations from the National Mental Health Commission.[107]

6.132 Mr Woodward, the Executive Director Lifeline Research Foundation, Lifeline Australia, also supported the use of e-mental health, alongside telephone helpline services and web-based services. Mr Woodward explained that there needed to be clear priorities in the use and management of e-mental health and telephone helplines:

> In relation to the mental health system, we have made three points. The first is that there should be more recognition for teleweb and helpline services as components of the wider mental health system—not as projects or innovation trials or as short-term funded services, but as part of the overall system—and that they should be provided with programmed and continued funding on that basis. The second point is that improvements are possible in the makeup and operation of helplines and teleweb services in Australia through improved coordination and the operation of those services in an overall model of service drawing on public health principles to delineate the roles and specialities across the existing services and making the services more responsive, more accessible and less confusing to those who wish to contact and use the services. The third point is that we have recommended that there be work done with the helplines and teleweb sector to identify how that model of service and care should operate and the roles to be performed—rather than government making ad hoc or isolated decisions about one service's role or funding without reference to the impacts on others.[108]

Committee view

6.133 The committee supports the Commission's recommendations regarding e-mental health.

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107 Associate Professor Judith Proudfoot, Head of eHealth, Black Dog Institute, *Committee Hansard*, 26 August 2015, p. 41.

108 Mr Alan Woodward, Executive Director, Lifeline Research Foundation, Lifeline Australia, *Committee Hansard*, 28 August 2015, p. 16.

6.134 The committee agrees that e-mental health should be seen as an important element of the overall solution for improving equity in delivery of mental health services to rural and remote communities. It must be effectively integrated with community-based mental health services, support, and deliver ownership by the local community.

Recommendation 12

6.135 The committee recommends that the government's response to the National Mental Health Commission's report supports the Commission's findings and recommendations in relation to e-mental health.

Chapter 7

Mental health services and the NDIS

The NDIS is fantastic. There are plenty of people with disability who have fluctuating needs. It is not just a mental health issue. But there is certainly a completely different approach to assessment when you are talking about people with an intellectual disability and people with physical disability than when talking about people who have experience of mental illness. It is very different.[1]

Mr Jeffery Cheverton, Deputy Chief Executive Officer
Brisbane North Primary Health Network

Introduction

7.1 The National Disability Insurance Scheme (NDIS) represents a fundamental reorientation of the disability support arrangements for Australians with a permanent and significant disability.

7.2 In one sense the underlying approach of the NDIS and the Commission's recommendation are the same. Both envisage support services that are organised around an individual's needs.

7.3 As discussed in Chapter 2, there is a substantial range of mental illnesses experienced across the Australian population—ranging from mild and moderate to severe and persistent.

7.4 For people with a permanent disability arising from a severe mental illness, the NDIS will provide effective, person-centred non-clinical support. In terms of overall numbers, this cohort represents a relatively small proportion of the overall population—in the order of 60 000 Australians.

7.5 However, there are other groups whose mental illness does not fit neatly under the NDIS because of the episodic nature of their condition.

7.6 This chapter examines these issues and focusses on the potential service gaps which may emerge under the NDIS. The chapter also looks at the progress of the NDIS rollout to date in the trial sites of the Hunter and Barwon areas.

Commission's view

7.7 The Commission's report identified the benefits that may flow from the transition to the NDIS for people living with acute mental illness:

> There is potential for the NDIS model to be an empowering one for people living with severe mental illness, because it gives a level of choice and control over funding and support which generally is not currently available.

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1 Mr Jeffery Cheverton, Deputy Chief Executive Officer, Brisbane North Primary Health Network, *Committee Hansard*, 18 September 2015, p. 8.

> The NDIS also has potential to enable people to access educational, recreational and social opportunities which they otherwise may not have.[2]

7.8 The report goes on to note the difficulties posed for mental health by the definition of 'disability' under the *NDIS Act 2013*:

> Under section 24 of the *National Disability Insurance Scheme Act 2013*, a person with a mental health disorder meets the disability requirements if the person has "one or more impairments attributable to a psychiatric condition", "the impairment or impairments are, or are likely to be, permanent" and "the person is likely to require support under the National Disability Insurance Scheme for the person's lifetime" (among other conditions). This potentially is problematic for people with severe impairment but with episodic illness, particularly where the emphasis in mental health is not on permanent impairment but rather on recovery and leading a contributing life.[3]

7.9 The Commission identified 'potential gaps' that could develop during the implementation of the NDIS:

> There are serious concerns about the potential gaps which might grow under the NDIS. While those who are eligible for the top tier (Tier 3) in the system are expected to be provided with better, wrap-around supports (in non-clinical areas), people currently supported by mental health services may be left significantly worse off if they are not assessed as having a 'permanent disability' and therefore do not qualify for Tier 3. There needs to be a significant Tier 2 package in place to ensure people are supported and do not end up falling back on the mental health system. There also are related issues about support for carers of people who are eligible for the NDIS.
>
> The unanswered questions about mental health and the NDIS cannot wait until the scheme is implemented. Re-engineering to fix the problems will be too difficult and ineffective, and for too long, people with a mental illness have borne the brunt of patch-up jobs. At a minimum, support for people who currently access existing programmes must be maintained until this issue is resolved.[4]

7.10 While positive about the impact the NDIS would have on access to support for people with acute mental illness, the Commission ultimately recommended that urgent clarification be provided for people with a mental illness under the NDIS:

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2 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 62.

3 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 62.

4 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, p. 34.

> Urgently clarify the eligibility criteria for access to the National Disability Insurance Scheme (NDIS) for people with disability arising from mental illness and ensure the provision of current funding into the NDIS allows for a significant Tier 2 system of community supports.[5]

Witness perspectives

7.11 Many witnesses welcomed the NDIS for the benefits it could provide to individuals with severe and persistent mental illness. The comments from witnesses echoed the findings of the Commission in calling for urgent clarification around the implementation of the NDIS, in light of the issues which had been raised through the NDIS trial sites.

Concerns regarding transition of mental health programmes to NDIS

7.12 Mr David Meldrum, the Executive Director of the Mental Illness Fellowship of Australia (MIFA) explained the extent of the 'gap' in mental health services that may result in the transition to the NDIS:

> I want to concentrate…on the several hundred thousand people who will not be eligible for that scheme [the NDIS]…
>
> So we are talking about well over 400,000 people—by the most conservative estimate; some people would say the figure is something like 600,000—who access services because they need them desperately from time to time, maybe not continuously in the way that that last 56,000 people do, but from time to time they and their families need them desperately. They currently access a range of clinical services, but I am particularly concentrating here on the funding for the services in the non-clinical area—things like Partners in Recovery, Personal Helpers and Mentors, day-to-day living programs, respite care for carers, a whole range of programs that are funded by the Commonwealth and a whole range of programs that are funded by every state and territory. In the case of the Commonwealth, all of the dollars for all of the programs I just mentioned have been rolled into the NDIS. The problem is that the majority of the clients of all of those programs will not get a service under the NDIS…[6]

7.13 Mr Meldrum went on to state that 8000 of the 10 000 clients receiving mental health support through MIFA members would be excluded under the NDIS:

> For the people we are trying to assist—and across our MIFA membership we are dealing with about 10,000 people at any given time—we think about 8,000 of those 10,000 will find the door closed next 1 July… but we also want it to be recognised that if we leave things standing as they are and we do not find some way to maintain the current programs while implementing

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5 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Summary, p. 16.

6 Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia, *Committee Hansard*, 26 August 2015, p. 18.

> the NDIS we are actually cutting several hundred thousand people out of the existing services from next 1 July.[7]

7.14 These sentiments were echoed by Mr Ivan Frkovic, the Deputy Chief Executive Officer of service provider Aftercare:

> People are really concerned that existing services, such as Personal Helpers and Mentors and Partners in Recovery, which are helping them to maintain lives in the community to some level and degree, will disappear [with the introduction of the NDIS]. Some of them will qualify for an NDIS package... Our estimate is that probably between 70 and 80 per cent, particularly Personal Helpers and Mentors, potentially will not qualify.[8]

7.15 Mr Frkovic told the committee that he was not confident in the NDIA's estimation that 80 per cent of people from some PHaMs programmes would become participants in the NDIS:

> …we have something like 40 to 45 PHaMs programs across the country, so we know that population very well. When you look at the definition of severe and persistent mental illness and complex psychosocial disabilities we can clearly see about 20 per cent of them fit that characteristic. That was the way that program was designed. It was not designed to be totally that very challenging group; it was designed to be a wider cohort. So in a sense we are saying it should not be more than 20 per cent of them fitting. That is the way the two programs have been designed. It is a highly contested space. A lot of people in the National Disability Insurance Agency say, 'No, we are enrolling up to 80 per cent of people from some PHaMs programs.' I am yet to see the proof of that but if they were I would be alarmed because that is dramatic mission creep. They should not be going out to people who are coping well most of the time and giving them small packages of care. That is not what the NDIS is about.[9]

7.16 In particular Mr Frkovic expressed concern over the number of participants included in the NDIS trial sites, particularly the NSW Hunter region:

> All I can say is that we keep on looking at our PHaMs programs and keep on seeing the same results. I am very up to date with what is happening in the Hunter, which is the most advanced area in terms of transition. I was talking to people there only last week and they said it is something like 25 per cent at the moment of people in PHaMs programs are being found eligible, so we know we are in the ballpark.[10]

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7 Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia, *Committee Hansard*, 26 August 2015, p. 18.

8 Mr Ivan Frkovic, Deputy Chief Executive Officer, National Operations, Aftercare, *Committee Hansard*, 26 August 2015, p. 19.

9 Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia, *Committee Hansard*, 26 August 2015, p. 30.

10 Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia, *Committee Hansard*, 26 August 2015, p. 30.

7.17 Similarly, Mrs Narelle Hand, a Program Manager at Anglicare raised questions about those current PHaMs programme clients being able to access help under the NDIS:

> The Personal Helpers and Mentors program [PHaMs], which I feel is of such fantastic benefit, is a psychosocial support program. This program is at risk of being defunded and being represented under the NDIS. Our concern is that many people in our program may not be eligible for NDIS packages. We have been attending all of the consultations that have been rolled out in the Hunter region and the evidence that has come back is that at some stage it might be that only 20 per cent of the participants we currently have will be eligible for those packages. Our concerns are that the people who are not eligible will fall through the gaps.[11]

Concerns relating to confusion about the NDIS framework and funding

7.18 Ms Pamela Rutledge, the Chief Executive Officer of service provider RichmondPRA explained that a key issue in the transition to the NDIS was the sources of the NDIS funding:

> …there is a major national systemic issue around the NDIS which is to do with where the money is coming from in each state and territory, so we are experiencing some unanticipated consequences of the fact that in New South Wales the money was historically disability service money, in Victoria it was historically mental health money and it is different in every state. It is part of the bilateral agreements. This puts the National Disability Insurance Agency in a very difficult position in trying to create a national framework of eligibility and support until we can get some greater clarity around that broader issue. The NDIS is intended to fund disability supports for people, including people with a psychosocial disability, but it grew out of the broader disability sector. There is a lack of definition about what is a disability support for a person with a mental health issue compared to what has traditionally been a health support for those people. That is the piece of work that many of us are trying to get engagement with.[12]

7.19 A further issue for the NDIS is confusion around the NDIS framework and what it will fund for people with mental ill-health. Ms Rutledge explained that while the PIR programme will transition easily into the NDIS, there was confusion around other programmes and their recipients:

> I think it is sort of clouding and confusing the whole framework about what it is that the NDIS will provide and fund for people with a long-term severe and persistent psychosocial disability and what will remain as a Health funded support. That is where I think we start to get into this confusion about: where will support for all the people who do not get tier 3 packages sit? We do see that the Partners in Recovery model is really well positioned to be reframed to go on being funded as part of the solution, not only for

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11 Mrs Narelle Hand, Program Manager, Anglicare, *Committee Hansard*, 26 August 2015, p. 42.

12 Ms Pamela Rutledge, Chief Executive Officer, RichmondPRA, *Committee Hansard*, 26 August 2015, pp 30–31.

> supporting the tier 3 packages but also for trying to fund the level 2 and provide some block funding for ongoing support for people who do not get their tier 3 packages, but it is a very big, clouded picture at the moment, and there is a need for some really detailed and committed work. Many people are involved in it, but it is really hard to see how we are going to get traction in that space. I think the next year is really crucial about getting that traction.[13]

7.20 Mr Jack Heath, the Chief Executive Officer of SANE Australia argued that the NDIS had started with good intentions and the mental health sector had embraced the policy in the hope that it would bring additional funding to support those with mental ill-health:

> In terms of the National Disability Insurance Scheme, we see this as a highly problematic area when it comes to mental health. We started off in a very well intentioned way. We as a sector accepted an inadequate or improper policy framework that required people to go and plead their disability, which is completely opposite to a recovery model. We did that because we thought there were going to be huge amounts, billions of dollars, that would go to 56,000 people who have got very severe needs and who we desperately want to help. Our concern is that it is now looking like that additional support for those people is going to come off the back of potentially 625,000 people, as identified by the National Mental Health Commission, who themselves have very severe mental health needs. We thought there was going to be a huge bucket of additional funding for NDIS; that bucket seems to be shrinking and potentially disappearing.[14]

7.21 Ms Susan King, the Director of Advocacy and Research at Anglicare Sydney agreed with Mr Heath's comments:

> We are also very concerned that with the growth of the NDIS there may well be defunded mental health services. We want to be assured that national systematic and adequately funded early intervention approaches remain, because we understand the depth of the problem, particularly in the areas in which we operate.[15]

7.22 Mr Frkovic told the committee that the uncertainty and confusion surrounding the NDIS implementation was having consequences for those trying to access services:

> This is creating uncertainty at the moment and increasing anxiety and levels of relapse amongst people… A lot of these programs are due to finish in June next year: 'What happens beyond June? Where do I go?' So, it is creating problems for the participants themselves—the individual

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13 Ms Pamela Rutledge, Chief Executive Officer, RichmondPRA, *Committee Hansard*, 26 August 2015, pp 30–31.

14 Mr Jack Heath, Chief Executive Officer, SANE Australia, *Committee Hansard*, 26 August 2015, p. 39.

15 Ms Susan King, Director, Advocacy and Research, Anglicare Sydney, *Committee Hansard*, 26 August 2015, p. 42.

> consumers—families and carers. They are saying, 'What do we do in this situation?'…we have staff who are really struggling in terms of what happens to them. When you think about it, we have 450 staff, and a lot of people are wondering what happens beyond June next year. That whole system that is currently working is being unravelled from a whole range of perspectives, which I think is causing us some major challenges in terms of ongoing support for people with mental illness, and their families.[16]

7.23 Mr Quinlan of Mental Health Australia advocated for mechanisms to be put in place to assist users of services and programmes to navigate the transition to NDIS, and to ensure that there was no barrier to people seeking to access help. Mr Quinlan explained by way of example:

> If Sebastian, who is on the PHaMs program at the moment, comes into my NDIA tomorrow for assessment and is refused—I say, 'Sorry, Sebastian; you can't have the NDIS service and, by the way, your PHaMs service has been enrolled'—he walks out the door entitled, under the current agreement between state and federal governments, to a continuity of service, a guarantee of service. Governments have agreed that Sebastian is entitled, but Sebastian walks out the door with no mechanism to tie him to that guarantee. A very simple process, in my view, would be for the NDIA not to say, 'Good luck, Sebastian; you're on your way,' but to say, 'Here is the state or the Commonwealth program to which you are now entitled.' That would be a very simple mechanism to turn that guarantee of service, which governments have happily committed to, into some sort of concrete action on the ground, because otherwise I fear there are going to be a lot of people falling through the cracks.[17]

7.24 Similarly, Dr Gerard Naughtin, the Chief Executive of Mind Australia told the committee that there was confusion amongst consumers and their families about what the NDIS entailed for them. Dr Naughtin suggested that the communication around the benefits of the NDIS for those with mental ill-health was not being made clear:

> …we are not at this stage really effectively marketing to this particular group within the NDIS the real positive advantages that the NDIS will deliver. There needs to be more thought in relation to more effective marketing for specific population groups and particularly the groups that are potentially eligible due to mental ill health…many people are not getting that message—and then starting to think constructively about how they might engage and use that.[18]

16 Mr Ivan Frkovic, Deputy Chief Executive Officer, National Operations, Aftercare, *Committee Hansard*, 26 August 2015, p. 19.

17 Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia, *Committee Hansard*, 26 August 2015, p. 31.

18 Dr Gerard Naughtin, Chief Executive, Mind Australia, Committee Hansard, 28 August 2015, p. 28.

Response from the Department of Social Services

7.25 In response to these concerns about the continuity of service for existing clients who are assessed as not NDIS eligible, Dr Nick Hartland, the Group Manager of the National Disability Insurance Scheme within the Department of Social Services explained that continuity of service had been a part of the intergovernmental agreements for the NDIS trial stage. This means that:

> If they [a client of a service or programme being rolled into the NDIS] are receiving a program at the moment and their program gets rolled into the NDIS and they are not eligible for the NDIS—or, alternatively, they do not get the same service offer—the government is committed to providing, outside the NDIS, continuations of service. We keep working with our colleagues in health and watching our own programs to make sure that happens. We have not yet heard of cases where that commitment is not being met... Also, it is relevant that for many of these people the reason they do not get an NDIS package is that their needs are not high enough to get into the scheme. They might have a need but it is not the type of need that is best addressed by an individually funded support package.[19]

7.26 In additional to the continuity of service arrangements, Dr Hartland told the committee that the NDIS has the capacity for funding outside of the individually funded programmes, such as PHaMs:

> In addition to the continuity-of-support guarantee, as you would be aware, there is capacity in the NDIS to fund programs outside of individually funded programs. We have toyed with various names for this. We have called it tier 2—which, of course, meant nothing to anyone who did not know what tier 1 and tier 3 meant—so we have now tried to call it 'information linkages and capacity building'. Unfortunately, that is about as opaque as tier 2. We move forward gradually into these policy areas and we hope we are making progress, but there is capacity for the scheme to fund support for people who do not get the individual package.[20]

7.27 Mr James Christian, the Group Manager of Disability, Employment and Carers in the Department of Social Services told the committee that, contrary to what other witnesses had said, the Victorian and NSW trial sites had shown high eligibility rates:

> **Mr Christian:** …it may be a little more reassuring to know that in Barwon [in Victoria] and the Hunter [in NSW] of those PHaMs clients who are currently eligible it has been assessed that 80 per cent of them are eligible for NDIS.
>
> **Senator McLUCAS:** That is very important. So 80 per cent are eligible from the PHaMs client group.

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19 Dr Nick Hartland, Group Manager, National Disability Insurance Scheme, Department of Social Services, *Committee Hansard*, 26 August 2015, p. 62.

20 Dr Nick Hartland, Group Manager, National Disability Insurance Scheme, Department of Social Services, *Committee Hansard*, 26 August 2015, p. 62.

Mr Christian: Yes.[21]

7.28 Later Mr Christian clarified his answer by letter to the committee:

> The clarification I am making is that it is "80 per cent of PHaMs **clients who have applied** to access the NDIS are being assessed as eligible". Not all PHaMs clients have made an NDIS access request.[22]

7.29 Dr Hartland could not provide a precise answer when asked about what work had been done to identify the number of people who will fit into that Tier 2 group but not get a Tier 3 package and will need to be able to be in touch with the NDIA or with mental health services on an ongoing basis:

> …there is a group of people who have a disability and have a support need, and then a smaller group who need an individually funded package, and the difference between the two is about 200,000 people. Mental health would be a part of that cohort. We have not gone much further than that at this stage. To some degree we would be relying on the finalisation of the planning framework to get a feel for the actual numbers outside of that, and we would also be relying on where we think we are going to get to in relation to numbers of people with a mental illness who have an individually funded package. The NDIS was budgeted for on the basis that basically 57,000 to 60,000 people with a mental illness would have an individually funded package. Whether it ends up at that we will, of course, still have to wait and see. We are on track for something close to that but perhaps slightly under, and I think we would need more information from the population planning framework to then make an assessment about the tier 2 effort. So, no: we do not have an answer. We have a feel for it but not a precise answer. [23]

7.30 In fact the work of the Department of Social Services to determine the number of those in Tier 2 may be made more difficult by the government's decision not to have an eligibility criteria for Tier 2, or as it is now called, Information, Linkages and Capacity Building (ILC). In answer to a question on notice, the Department of Social Services advised:

> Tier 2 of the National Disability Insurance Scheme (NDIS) is now called Information, Linkages and Capacity Building (ILC), to reflect the range of support available. ILC will not have eligibility criteria, so there is no estimate of the number of people who will access this support. Both NDIS participants and non-NDIS eligible people with a disability may access ILC…[24]

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21 Mr James Christian, Group Manager, Disability, Employment and Carers, Department of Social Services, *Committee Hansard*, 26 August 2015, p. 62.

22 Mr James Christian, Group Manager, Disability, Employment and Carers, Department of Social Services, letter of clarification, 3 September 2015. Original emphasis reproduced.

23 Dr Nick Hartland, Group Manager, National Disability Insurance Scheme, Department of Social Services, *Committee Hansard*, 26 August 2015, p. 66.

24 Department of Social Services, Question on Notice from the 26 August 2015 public hearing.

Committee view

7.31 The committee supports the NDIS and the benefits it can deliver for those afflicted by severe and persistent mental illness. The committee notes the progress of the rollout in the trial sites, and the issues which have come to light as a result. The committee thanks witnesses for their insightful comments about the NDIS and the implementation to date, and notes that witnesses have been able to advise the committee based on their collective expertise and experience.

7.32 The committee believes that the NDIS has the potential to provide significant support to those with mental illness. Already, programmes such as PIR and PHaMs make a large difference in the lives of those suffering from mental illness. Part of the evidence provided by Anglicare Sydney included a powerful example of the difference that the right support can make to someone living with mental ill-health:

> …one case study that we have permission to disclose today. The participant is a middle-aged single lady. She was admitted to hospital with severe depression and anxiety. Leading up to this she had lost her job. She was not able to pay her rent. She became homeless and lived with different friends. She was discharged from hospital and tried to find support. She found out about our PHaMs program and referred herself. That is another benefit of this program—you can refer yourself.
>
> Her goals were to find stable housing and to finish her university degree. She had been enrolled for some years but, due to her mental health, she was unable to complete the course. During her involvement with PHaMs, she received intensive support in managing her anxiety and depression and addressing issues related to finances and housing. She was able to access stable housing, which was a major breakthrough for her. Our PHaMs workers offered weekly support and later fortnightly support in managing anxiety in relation to social situations and the completion of her university degree. Initially it seemed impossible for this participant to be able to complete her degree and the PHaMs worker employed different strategies to help improve motivation and structure so that she could finish her work.
>
> She experienced regular major depressive episodes, including suicidal ideation, but with the support of the PHaMs worker and her psychiatrist she managed to get through the crisis and did not require any hospital admissions. Her depressive episodes became less regular with time and, in consultation with her doctor, she stopped her medication.
>
> The participant was able to complete her university degree, which improved her confidence, and following on from this she began to reconnect with friends and relatives. PHaMs played a major part in supporting this participant when she was not able to manage most aspects of her life due to severe depression and anxiety. She has achieved a much improved quality of life, which she deserved, and her mental health has been so much more

> stable. This is just one of…thousands of stories from PHaMs that have been achieved.[25]

7.33 Examples such as this leads the committee to conclude that the impact of programmes like PHaMs and PIR cannot be underestimated. These programmes are the embodiment of the findings of the National Mental Health Commission's review: that community-based, targeted, early-intervention allows an individual to live with mental illness and actively contribute to the social and economic life of the community. Without such programmes, the result for the individual can be dire, and the cost to the health system can increase exponentially if the individual is forced to access acute care or income support.

7.34 The committee believes that the testimony from witnesses and the insights of the Commission demonstrate that there is an urgent need for the government to clarify the support available for people with a mental illness, whether under the NDIS or through an external programme or service. The confusion and uncertainty needs to be alleviated as it is already impacting on both service providers and access to services for those seeking help.

7.35 The committee urges the government to respond positively to the findings of the Commission, and to the committee's evidence.

Recommendation 13

7.36 The committee recommends that the government immediately clarify how Tier 2 or Information, Linkages and Capacity Building (ILC) will be implemented and how many people it will support.

7.37 The committee recommends that the government share available information on the workings of Tier 2 or ILC in order to quell the disquiet in the community and ensure that individuals do not lose access to much-needed services.

Senator Deborah O'Neill

Chair

25 Mrs Narelle Hand, Program Manager, Anglicare, *Committee Hansard*, 26 August 2015, pp 42–43.

Appendix 1

Witnesses from mental health hearings[1]

The committee held three hearings focusing specifically on mental health on 26 and 28 August and 18 September 2015. However, mental health organisations have participated in the committee's other hearings

Wednesday, 26 August 2015 – Canberra

National Mental Health Commission

Mr David Butt, Chief Executive Officer and Commissioner

Ms Jacqueline Crowe, Commissioner

Professor Allan Fels, Chair

Ms Sally Goodspeed, Executive Director

Professor Ian Hickie, Commissioner

Roundtable One – mental health groups and service providers

Mr Ivan Frkovic, Deputy Chief Executive Officer, National Operations, Aftercare

Professor Malcolm Hopwood, President, Royal Australian and New Zealand College of Psychiatrists

Mr David Meldrum, Executive Director, Mental Illness Fellowship of Australia

Mr Andrew Peters, Chief Executive Officer, Royal Australian and New Zealand College of Psychiatrists

Mr Frank Quinlan, Chief Executive Officer, Mental Health Australia

Mr Sebastian Rosenberg, Senior Lecturer, Brain and Mind Centre, University of Sydney

Ms Pamela Rutledge, Chief Executive Officer, RichmondPRA

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1 The hearings and witnesses listed in this appendix relate to the committee's public hearings focusing on mental health and related issues on 26 August 2015 (Canberra), 28 August 2015 (Sydney), and 18 September 2015 (Brisbane). A full list of the committee's hearings and witnesses is at the committee's website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Public_Hearings.

Roundtable Two – mental health groups and service providers

Ms Tracy Adams, Chief Executive Officer, BoysTown

Mr Peter Bewert, Executive Manager Care Services, Salvation Army Aged Care Plus

Mr John Dalgleish, Manager, Strategy and Research, BoysTown

Mrs Narelle Hand, Program Manager, Anglicare

Mr Jack Heath, Chief Executive Officer, SANE Australia

Mr Christopher John, Chief Executive Officer, United Synergies

Ms Susan King, Director, Advocacy and Research, Anglicare Sydney

Professor Mike Kyrios, President, Australian Psychological Society

Professor Lyn Littlefield, Executive Director, Australian Psychological Society

Mrs Karen Phillips, Manager, National Standby Response Service, United Synergies

Associate Professor Judith Proudfoot, Head of eHealth, Black Dog Institute

Mrs Nicola Rosenthal, Business Development Manager, Salvation Army Aged Care Plus

Roundtable Three – federal government departments

Department of Health

Ms Janet Anderson, First Assistant Secretary, Health Services Division

Mr Mark Cormack, Deputy Secretary, Strategic Policy and Innovation

Ms Colleen Krestensen, Assistant Secretary, Mental Health Policy Branch

Ms Fiona Nicholls, Assistant Secretary, Mental Health Services Branch

Department of Social Services

Dr Russell Ayres, Branch Manager, Mental Health

Mr James Christian, Group Manager, Disability, Employment and Carers

Dr Nick Hartland, Group Manager, National Disability Insurance Scheme

Mr Eddie Bartnik, Strategic Adviser, National Disability Insurance Agency

Friday, 28 August 2015 – Sydney

Roundtable One – mental health consumers and carers

Ms Lyn Anderson, private capacity

Mrs Pauline Ferkula, private capacity

Mr Sunny Hemraj, private capacity

Miss Rachael Laidler, private capacity

Ms Kerin O'Halloran, private capacity

Mr David Peters, private capacity

Mr Robert Wellman, private capacity

Roundtable Two – mental health groups and service providers

Ms Victoria Blake, Research Coordinator, ReachOut Australia

Mr Malcolm East, Deputy Principal, St Philips Christian College, Gosford

Ms Christine Morgan, Chief Executive Officer, Butterfly Foundation

Ms Sue Murray, Chief Executive, Suicide Prevention Australia

Ms Ka Ki Ng, Senior Policy Officer, Mental Health and Wellbeing Consumer Advisory Group

Ms Hayley Purdon, Deputy Chair, Lived Experience Network Leadership Group, Suicide Prevention

Ms Deepika Ratnaike, Director of Research and Policy, ReachOut Australia

Mr Matthew Tukaki, Board Member, Suicide Prevention Australia; Chairman, National Coalition for Suicide Prevention

Mr Alan Woodward, Executive Director, Lifeline Research Foundation, Lifeline Australia

Roundtable Three – mental health groups and service providers

Mr Jonathan Harms, CEO, Mental Health Carers Arafmi NSW Inc.

Ms Jane Henty, Executive Officer, Mental Health Carers Arafmi Australia

Mr Brendan Maher, General Manager, R U OK?

Dr Gerard Naughtin, Chief Executive, Mind Australia

Ms Rebecca Reynolds, Executive Director, National LGBTI Health Alliance

Ms Jaelea Skehan, Director, Hunter Institute of Mental Health

Rural Health Research, Centre for Rural and Remote Mental Health

Professor David Perkins, Director and Professor

Private capacity

Professor Philip Mitchell

Friday, 18 September 2015 – Brisbane

Brisbane North Primary Health Network

Mr Jeffery Cheverton, Deputy Chief Executive Officer

Ms Pauline Coffey, Executive Manager, Commissioned Services

Ms Nicola Bristed, Private capacity; and Consumer Evaluator, Partners in Recovery Program

Primary Health Care Advisory Group

Dr Steven Hambleton, Chairman

Queensland Mental Health Commission

Dr Lesley van Schoubroeck, Queensland Mental Health Commissioner

Mental Health Commission of New South Wales

Mr John Feneley, Commissioner

Roundtable One – mental health consumers and carers

Mr Gregory Cutts, private capacity

Mrs Lesley McDonald, Carer, Consumer and Carer Engagement Group

Ms Nicole Sutherland, Consumer Engagement Committee, Metropolitan North

Roundtable Two – mental health groups and service providers

Dr Michelle Blanchard, Head, Projects and Partnerships, Young and Well Cooperative Research Centre

Ms Marj Bloor, Mental Health Carers Arafmi Queensland Inc.

Dr Greta Galloway, Independent Researcher; Consultant, Alan Webster Consultancy/Centacare

Mr Gary Hubble, Manager Far North Queensland Partners In Recovery, Centacare Cairns

Mr Majid Khan, Senior Project Officer, Mental Health in Multicultural Australia

Ms Monica O'Neill, Director, Metro North Mental Health

Ms Sharon Orapeleng, Senior Project Officer, Mental Health in Multicultural Australia

Mr Hamza Vayani, National Project Manager, Mental Health in Multicultural Australia

Ms Jody Wright, Executive Officer, Mental Health Association Queensland

Appendix 2

Submissions in relation to mental health[1]

19 Alzheimer's Australia

20 The Royal Australian and New Zealand College of Psychiatrists

23 NSW Consumer Advisory Group – Mental Health Inc.

41 Social Determinants of Health Advocacy Network

60 Australian Psychological Society (APS)

67 Australian Council of Social Service

88 National LGBTI Health Alliance

112 TasCOSS

114 Mental Health Council of Tasmania

118 Mental Health Professionals Network Ltd

135 National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSILMH)

141 Ms Judith Maher, Health Consumers NSW

152 South Australian Network of Drug and Alcohol Services (SANDAS)

163 SANE Australia

164 R U OK?

165 ReachOut Australia

166 Suicide Prevention Australia's Lived Experience Network

169 Suicide Prevention Australia

170 Orygen – The National Centre of Excellence in Youth Mental Health

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1 The submissions listed in this appendix relate specifically to the committee's inquiry into mental health and related matters. A full list of submissions received by the committee is available on the committee's website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Submissions.

Appendix 3

Additional information and answers to questions on notice[1]

Additional Information

9 Clarification of response given to the committee at a public hearing on Wednesday, 26 August 2015 by Mr James Christian PSM, Group Manager, Disability Employment and Carers Group, Department of Social Services

10 Additional information - newspaper article - supplied by Mr Sunny Hemraj and referred to in his evidence at the committee's hearing on 28 August 2015, Sydney

Tabled Documents

57 Tabled by Professor Allan Fels, Chair of National Mental Health Commission at a public hearing in Canberra on 26 August 2015

58 Tabled by Mr Frank Quinlan, Chief Executive Officer of Mental Health Australia at a public hearing in Canberra on 26 August 2015 - Opening Statement.

59 Tabled by Mr Peter Bewert, Executive Manager Care Services, Salvation Army at a public hearing in Canberra on 26 August 2015 - Opening Statement

60 Tabled by Mr Christopher John, Chief Executive Officer, United Synergies (Standby Response) at a public hearing in Canberra on 26 August 2015 - Cost Effectiveness of a Community-Based Crisis Intervention Program for People Bereaved by Suicide.

61 Tabled by Mr Christopher John, Chief Executive Officer, United Synergies (Standby Response) at a public hearing in Canberra on 26 August 2015 - Press clip from Weekend Australian 22/03/2014.

62 Tabled by A/Professor Judith Proudfoot, Head of eHealth, Black Dog Institute at a public hearing in Canberra on 26 August 2015 - Proposed Suicide Prevention Framework for NSW.

63 Tabled by A/Professor Judith Proudfoot, Head of eHealth, Black Dog Institute at a public hearing in Canberra on 26 August 2015 - The Digital Dog (Improving mental health through technology)

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1 The additional documents, tabled documents and answers to questions on notice listed in this appendix relate specifically to the committee's inquiry into mental health and related matters. A full list of submissions received by the committee is available on the committee's website: www.aph.gov.au/Parliamentary_Business/Committees/Senate/Health/Health/Additional_Documents

64 Tabled by A/Professor Judith Proudfoot, Head of eHealth, Black Dog Institute at a public hearing in Canberra on 26 August 2015 - The Black Dog Institute Stepped Care pathway.

65 Tabled by A/Professor Judith Proudfoot, Head of eHealth, Black Dog Institute at a public hearing in Canberra on 26 August 2015 - A World - Class Integrated Approach to Suicide Prevention. Also tabled was the 2014 Black Dog Institute Annual Report (Available online)

66 Tabled by Hunter Institute at a public hearing in Sydney on 28 August 2015 - Prevention First - A Prevention and Promotion Framework for Mental Health.

67 Tabled by Hunter Institute at a public hearing in Sydney on 28 August 2015 - Background Document

68 Tabled by Professor David Perkins, Director and Professor of Rural Health Research, Centre for Rural and Remote Mental Health at a public hearing in Sydney on 28 August 2015 - Key Issues in Rural and Remote Mental Health. Also tabled were Glove Box Guide to Mental Health, Volume 3 - linking rural people to the help they need and research-based solutions for rural communities.

69 Tabled by the Butterfly Foundation at a public hearing in Sydney on 28 August 2015 - Paying the Price - The economic and social impact of eating disorders in Australia

70 Tabled by Butterfly Foundation at a public hearing in Sydney on 28 August 2015 - Executive Summary - Cost-effective interventions for eating disorders

71 Tabled by The Butterfly Foundation at a public hearing in Sydney on 28 August 2015 - Paying the Price - Executive Summary

72 Tabled by Mr Malcolm East, Deputy Principal, St Philip's Christian College, Gosford at public hearing in Sydney on 28 August 2015

73 Tabled by Mr John Feneley, Commissioner, NSW Mental Health Commission at the committee's hearing on 18 September 2015, Brisbane. The documents include Mr Feneley's opening statement, proposed suicide prevention framework, and paper on Keeping the Body in Mind Program - smoking and mental illness

Answers to Questions on Notice

36 Answers to questions on notice - public hearing 26 August 2015, Canberra - Department of Social Services

38 Answer to question on notice - public hearing 26 August 2015, Canberra - Royal Australian and New Zealand College of Psychiatrists

39 Answer to question on notice - public hearing 26 August 2015, Canberra - National Mental Health Commission

40 Answer to question on notice - public hearing 26 August 2015, Canberra - Mental Illness Fellowship of Australia

Appendix 4

Personal stories from mental health carers and consumers

At its public hearings on 28 August (Hurstville, Sydney) and 18 September (Redcliffe, Brisbane), the committee held roundtables for mental health carers and consumers. These roundtables allowed people to share their lived experiences with the committee.

The committee thanks all the roundtable participants who gave their time and talked openly about their experiences with the committee.

The committee believes that the evidence it heard from carers and consumers on 28 August and 18 September should be given prominence in its report, and so these stories are reproduced in this appendix.

Ms Lyn Anderson, private capacity, 28 August 2015, Sydney[1]

I have been a carer for 26 years for my son, who has very severe schizophrenia. There are a lot more mental health services now than there were 26 years ago. My problem is they are not reaching the very seriously mentally ill, who live in isolation and who do not engage with services—they are the ones who need it the most. Most people who are seriously ill do not believe they have a mental illness. If they do acknowledge they are ill, there is stigma attached to the mental illness and mental health services. They want to be treated normally and people outside mental health are the only ones who do that.

The answer is more outreach services to reach these people, and peer workers, but the problem with services is that they require consent prior to engaging with people. They want the signed consent. PIR have come across a way to do this, with an extended period of engagement. This means that they build up trust with people before they get consent and then they are happy to sign the consent form.

The problem is that these seriously unwell people live alone, without support services. They sit at home on their own all day and no-one takes any notice of them. They only appear on the radar when they appear in hospital or they die. It is cheaper to support people well in the community than to have them go into hospital at $1,200 or $1,500 a day, and death due to lack of support and care is a disgrace. Services are the problem, because relatively well consumers are easier for services to work with. Services can tick all the boxes to show that clients are on the way to recovery and this, then, is evidence they can use to gain funding. The service should fit the client, not the client fitting the service.

Services also report about themselves, which is not right. I worked in a service organisation and 50 per cent of my time was spent filling out forms to report on how well I was doing, not being out in the field looking after people. The NDIS is going to be no different, because it will require consent before it will engage with people. I see the NDIS as a hope for the really severely mentally ill people, but, if this consent problem is not going to be resolved with more flexibility, it is just going to perpetuate the problem that we have now.

I have to personally go outside the mental health service to get services for my son. After 26 years I went and employed someone to take him out for four hours a week—which is what disability services do. Disability services are far better organised than mental health. The only care you get in mental health, if you are very seriously ill, is medication—not support. It is not always a matter of more money; it is a matter of organising the services better—flexibility around consent and organisations not assessing themselves. People who are severely mentally ill do need one-on-one care and time spent with them, as well as outreach.

1 Ms Lyn Anderson, private capacity, *Committee Hansard*, 28 August 2015, pp 1–2.

Mr Sunny Hemraj, private capacity, 28 August 2015, Sydney[2]

Yes, I took a different approach. I thought I would share a bit of my story.

The people I support are surrounded by tragedy as a direct result of mental illness. I am a forensic consumer representative and have been since 2001. I guess as a forensic health consumer I have spent about two years in total within the civilian hospital system; a year and a half in the general prison population, prior to my transfer to the forensic unit; as well as 14 years within the forensic and mental health system. On top of that, I have worked within mental health in various roles for almost a decade. So I have seen a lot more than most people have.

I recall sitting in Long Bay jail hospital, where I heard a fellow patient's story. Another patient remarked how tragic that story was. Another remarked, 'This place is full of tragedy'. The people that I support, as well as myself, have lost someone very dear to them. It is usually their carer. The vast majority of people come from a wide-ranging background; we are talking about politicians' children, people with masters degrees, grandparents. We had a couple of blokes in their seventies. People without criminal backgrounds have all gone through this; it does not discriminate. We have the full gamut of society. The tragedy about this is that I, like many others, finally received the medical treatment I needed after I had reached the end. The cost of this medical condition—mental illness—for the individual, families and society, I am sure would be less if prevented.

My role as representative of those in the prison system with a mental illness has seen me witness a new tragedy emerge, and that is the interaction between ice and mental illness. The lines have been blurred. Prior to ice, there were little sections you could put people in, if you like, in terms of treatment. Ice has come in and thrown all theories out the window.

What surprises me is when I look back at my high school days and see that I was taught how to rescue someone drowning—a surf-lifesaving certificate. I was able to give people basic medical first aid in order to manage injuries, at least until an ambulance came. I played rugby. I could at least treat someone with basic injuries on the field. But when my incident happened back in 1996, neither I nor anyone around me really understood, nor were taught the science of, mental illness.

Going back to 1996, no-one knew that this was an illness—they thought it might have been me acting strange or whatever—and it slowly got out of control. With most other conditions—for example, the flu—you can sort of pick up signs and encourage a person to get help.

I am a smoker. Sometimes I feel like a leper if I smoke in public. I have friends who will cover themselves with sunscreen to avoid a tan. Years ago, both were quite cool; it was quite cool to smoke and it was quite cool to get a tan. Extensive and effective advertising campaigns have taught the dangers of smoking and skin cancer, and it has been extremely effective. Yet mental health awareness is often left for celebrities to

2 Mr Sunny Hemraj, private capacity, *Committee Hansard*, 28 August 2015, pp 3–4.

come out and talk about. So you do not really get an extensive campaign either destigmatising the illness or making people aware of it. For instance, bullying is something that is coming out a bit more, but we have a wide range of illnesses which have just as devastating an effect.

The prevention and effective treatment of mental illness is more than dealing with just a medical condition. In the case of suicide, crimes, or even the loss of one's ability to live a normal and fulfilling life, it is about the prevention of tragedies.

As I said right at the beginning, mental illness can sometimes have its sting, but the world I see is very tragic. I know people who have lost people such as husbands, wives and sisters. There is one case where a friend of mine, whom I met in the system, killed his sister but his parents continued to support him. They supported the killer of his sister. They brought him back into the house. They wanted him back, because they understood that this was not, as some people think, a cheap way through to the system. I have been in the system for 14 years.

In 2012, my story was featured in *The Sydney Morning Herald* where I was asked to compare the prison system to the forensic system and the outcomes. I have now actually had a chance to make something of myself. If you go into the prison system with an illness, you would not even want to think what would happen. There was a news story last night in Victoria; that was something that we fear. People go into the prison system and they just get worse and worse and, in the end, it reinforces the stigma that people have. I remember watching that story; I think his name is Sean Price. As I said, the word 'tragedy' surrounds me and that is what we would like to avoid by prevention awareness and education.

Miss Rachael Laidler, private capacity, 28 August 2015, Sydney[3]

Yes, as a mental health consumer. Firstly, thank you for welcoming me here to speak to you today. I would like to thank Sunny for his input. If there were better promotion and awareness of mental health issues then I do not think I would have had such a struggle, so that is what I want to kind of focus on today. When I was 16, I was diagnosed with bipolar disorder. I had never in my life met anyone with a mental illness before and I knew nothing about them. I vaguely remember discussing mental illness in PDHPE in year 8 or 9. We spent maybe four hours on it in total in my entire time at high school. By the time I was 16, I could not even name three illnesses for you. Nowhere in my school or my community could I anonymously look for information about illness and the numerous community supports that were available to me.

From my initial diagnosis with a GP, I was referred to a psychiatrist. My family and I put our trust in a doctor. We thought, 'Well, you've been practicing medicine for years; you must know what's best'. These initial meetings with clinicians were the first time I ever encountered mental illness, and I did not have the knowledge or the courage necessary to put up my hand and say, 'I don't understand,' or, 'This doesn't feel right; let's try something else.' Over the next three years, my family spent an exorbitant amount of money on medication and private psychiatry sessions. I put my faith in a doctor who gave me no plain English description of my illness or medicines, gave me no information regarding my rights as a client, and suggested no alternative treatments such as psychology, group therapy, art therapy, or mindfulness practice, all of which have proven to be invaluable to my recovery. After three years, I fell through the cracks. The psychiatrist was my only mental health support, and she was often interstate or overseas and uncontactable. One day I missed an appointment, I never called to reschedule and she never called me. I had been forgotten.

Over the next few years, I neglected my mental health. I was not taking any medication or looking for any treatment. From my experience with that particular psychiatrist, I came to believe that treatment was not going to help. Regardless of receiving the most expensive top-level care, there was nothing that doctors could do for me. I felt as though my future had been set and I was doomed to be an unemployed alcoholic high school dropout. Somewhere along the way, at about 19 years old, I developed a dependency on alcohol. It became the only way that I could interact socially and the only way that I could take a break from the anxiety and depression. I was absolutely exhausted.

At 21, I mentioned my illness to a friend in a passing conversation, and they suggested that I visit a headspace centre. The decision to visit headspace seemed so small to me at the time. I had no idea what kind of an adventure I was about to embark on. To quit drinking, to fix my sleeping patterns, and to start on new medication the clinicians at headspace referred me to a private youth mental health ward. I spent three weeks at St Vincent's hospital. The clinicians and doctors there were all very knowledgeable and good at their craft. I asked the doctors to perform numerous tests and scans of my

3 Miss Rachael Laidler, private capacity, *Committee Hansard*, 28 August 2015, pp 7–8.

lungs and liver that they really did not need to do. When they asked the question, 'Why do you want these scans?' I simply said, 'It is for my peace of mind.' They were happy to accommodate that and to help ease my anxiety.

The nurses were incredible and they do everything in their power to help you—not just as a patient, but as a person. I remember one particular nurse held my hand while I called a prospective employer. I was terrified and I had been putting it off for days, but she insisted, and I could not have made that call without her. She looked at me and did not see an illness—she saw a person. She understood my fear and she supported me through that. At a time when I thought very little of myself, it was an incredibly powerful thing to feel. I was admitted to St Vincent's Private Hospital with a specific goal, which was to get back my life and a healthy routine—and I did just that. There, I was able to find the support, structure, hope and holistic care that I needed.

Upon leaving hospital, I was offered a number of different supports and services. At my local headspace, I was offered a psychiatrist free of charge for medication and mood monitoring, and a mental health nurse to work with me for recovery planning, both in day-to-day life and in the whole big picture. These people listened to what I was feeling and what I was asking for help with. They explained everything to me in a way that I could understand—my illness, my treatments, even my right to say, 'No, I want to try something else.' They offered me opportunities for different treatments and therapies. They never pushed me to do something that I did not want to do. They encouraged me to try new things, while explaining the benefits and outlining the risks.

Having a greater understanding meant that I could make an informed decision about my own care. It made me feel like I had regained my agency and I had a say in my own future. When I sought out treatment or agreed to something they had suggested, I was not doing it because somebody told me that I should. I was doing it because I really wanted to and this, in turn, motivated me to work harder and get the most out of everything that they had to offer. Finally, after five years, I was an active participant in my own recovery. This is what really worked for me.

Soon, I was in a meditation group, an anxiety management course, a youth fitness group and an art therapy group. Personally, I found that working on my physical health was very helpful. Not only did it help with the energy levels and the poor sleep, but it helped me channel all of my nervous and anxious energy into something productive. Once I had cleared my head a little, I could think a problem through. I did not necessarily find all of these different options to be as helpful, but what is important is that I had the opportunity to try, and I am very glad I did.

Ever since I became sober two years ago, my dream has been to become a contributing member of society. All I ever wanted to do was get a job and know that I could hold a job. I yearned for the day that I could pay my own taxes! I wanted to earn the roof over my head and the shoes on my feet. At 21, I took on study for the first time in five years. I went into volunteer work. I got my first aid certificate. While everything that I tried was a challenge, the people at headspace kept my goals realistic, understanding that achieving something small might give me the confidence I needed to achieve something big. The treatments and therapies offered by services such as St Vincent's, headspace, Mind Plasticity, Creative Youth Initiatives, the BMI

and the Mind and Movement Centre were—and are—integral to my recovery. Utilising what I had learned there, I was able to manage and maintain my mental health while gaining work skills and confidence in the workplace.

Over the last however many minutes, I have given you a brief look at my story and how I got to where I am. I would like to emphasise that when I started my recovery journey I had no stable social supports. I had anxiety that made me physically sick. I had absolutely no idea how to find help and no hope for a future worth living. Between diagnosis and proper treatment I had a five-year wait—that is five years too long. That is five years that I could not hold a job or complete a TAFE course. That is five years I could have been living my life to the fullest—if I had learned more about mental health in school and if I had been aware of the community supports that were available to me. Over time, I found the treatments and therapies that helped me. I found them with the help of the clinicians and services that understood holistic care and offered me access to many different opportunities, where I could learn the knowledge and skills that I needed to take care of myself. Currently I am in part-time employment. I am volunteering for the Ted Noffs Foundation and working through a certificate IV business administration course. I am getting good sleep, I have my Ps on a motorbike, I have had one drink this year and I am looking forward to the future. I am eternally grateful for all the services that played a role in helping me achieve my dream.

Mr David Peters, private capacity, 28 August 2015, Sydney[4]

I would like to say thank you to Rachael for that awesome story—that was very uplifting—and thank you to everybody who has contributed today.

I am here today—and I guess I am reflecting some of what Sunny might have said and what Rachael has said—to talk about my experiences. I am a consumer; I have had a good 20-year history of drug and alcohol abuse. I have had what I guess one could say is quite a successful recovery for about four years now. My recovery journey has actually been quite amazing. I have done much study, I have created a program, which is a group that is aimed at people at risk of homelessness, and I am currently employed as the deputy CEO at Mental Health Carers Arafmi.

What I would really like to address today is how mental health issues can be increased as a result of sobriety from substance use—or abuse in my case. Over the last four years, while I have achieved much, my anxiety levels seem to have increased greatly. Sometimes I think that my anxiety is almost a consequence of my sobriety. The more success that I seem to achieve, the more anxiety appears to come along with it. On much reflection, I believe the anxiety was always there and, in fact, was most likely a large contributor to my life of addiction in the first instance—although the substances no doubt masked these issues over the years. Nowadays I simply do not have the aid of substances to mask my anxiety. It therefore appears that the anxiety will come to the forefront of my thoughts and my emotions. The way I deal with my feelings these days is that I have a very strong spiritual side. I regularly practice meditation and reflective techniques on myself, positive self-talk and so forth.

Developing more mental illness, such as anxiety and depression, can be a common theme among recovering addicts. Unfortunately, many addicts on their recovery journey find these feelings so overwhelming and often tend to relapse and fall back into the realm of substance addiction. This can create a great sense of hopelessness which can demotivate a person to make further attempts at sobriety.

I know there are many rehabilitation centres and treatment centres at present that do acknowledge and work on comorbidity issues—co-occurring issues of mental health coupled with substance issues—whilst in treatment. In my experience, the process of follow-up for the longer term effects of mental health issues resulting from sobriety is at best minimal. Often, a person who has completed a treatment program is sent into the so-called real world with minimal follow-up for the ensuing mental health issues that can follow. It is when a person has successfully completed treatment for drugs or alcohol that they are often in a fragile state of mind, and this is where issues such as anxiety and that sort of thing can surface. It is in this fragile state that a person truly needs support and help for them to continue on in their recovery journey.

Therefore, I very much see a great need for more community-based mental health treatment options to be available, specifically for those people who are recovering from substance addiction. I would propose the provision of a mental health or AOD worker or counsellor to be employed in community-based rehabilitation and treatment

4 Mr David Peters, Private capacity, 28 August 2015, pp 8–9.

services solely for the purpose of guiding and supporting a recovering addict through the longer term mental health issues that will surface as a result of their sobriety.

To cement this argument, I simply present myself today. I consider myself very lucky indeed. I have found employment within the mental health sector itself. I believe that has given me a firm understanding of who I am and what is happening to me in my recovery journey. I actually give credit to Arafmi for playing a major role in the success of my personal recovery.

Four years ago I was a mess, and here I am today talking to you. I would simply like others to have that same amount of support that I received. Thanks for your time. I hope that my words and my proposal will be of some benefit to those that need it. Thank you very much.

Mr Greg Cutts, private capacity, 18 September 2015, Brisbane[5]

Yes. The thing that really worries me at the moment is that, when we are released from hospital here in Queensland, we are told to go and see psychologists in the community and that. Most of us are on the disability support pension or some other government payment. The average price of a psychologist visit is $65. It is beyond us. What we would like to see is the government possibly allowing psychiatrists and psychologists to bulk-bill us. There are not many places in the community that we can go to. Nine times out of ten, we have to travel for up to two or three hours to find a certain person who can treat us.

If we can get somebody in our community who can do this, it is going to stop readmissions. That is one thing I find. In a lot of our readmissions—I talk to other people—it is: 'I can't get any help in the community. I've got to go back to the hospital.' There are resources being used that, for somebody who is sicker than we are—we have a relapse; we just need to talk to a professional who will give us guidance. We would love to be able to just walk into a psychiatrist's office without feeling the stigma: 'I've got to pay cash for this.' That is why we do not go. We have not got the money to pay for our treatment. But if we could just go and take our Medicare card in there and sit for a half-hour session—it does not have to go on for 12 months. Three sessions, I personally find, usually put me back on track and give me a new plan. That is one thing.

The other thing is that I would love to go back to the workplace, but I find it so hard now. I apply for a job and I am immediately made to have a medical. I am bipolar too, and I explain that I take a medication, that I am stable and I am able to do my job. Then the prospective employer will turn around and say, 'I'm sorry; we can't give you this job, because our insurance company won't touch you.' Everywhere we go, insurance companies are stopping us from working.

We are good people. We work hard. I worked so hard after I was discharged that I got my heavy vehicle licence back and my forklift licence. I was sleeping right. I was eating right. I was ready to go. It was just like a big hammer coming down and saying, 'You're not part of society anymore.' I understand that I am getting older now. I am at the end of my work cycle, but that to me is still five to 10 years away. It makes you feel so worthless out there. I would even take tomorrow, if they would give me one, a job as a cleaner in a mine or something like that. But, again, there are these insurance things.

Finally, often when we present to a medical facility, no matter what is wrong, if it is a medical condition, I have found that I have been refused treatment because I have a psychological disability. They will not treat the medical condition until you have had a psychological evaluation. It is wrong. If I have appendicitis, I have appendicitis. It has nothing to do with what is going on. If I am controlled and everything like that, I should be able to get my medical condition looked at. Anyway, that is all I have to say. Thank you so much for listening to me. I hope I have not bored you in any way.

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5 Mr Greg Cutts, private capacity, *Committee Hansard*, 18 September 2015, pp 28–29.

Ms Nicole Sutherland, private capacity, 18 September 2015, Brisbane[6]

Yes, I have got lots of important stuff. I was diagnosed six years ago with post-traumatic stress disorder, major depression and early psychosis. The government and the system has failed me my whole life except for now. I got brought up with a rebel gang family so I was subjected to floggings and starvation while I was young without the schools or anyone picking it up. My father was in and out of jail. Then we became teens and it became worse. I always thought I was in the wrong family so I ended up getting into the conservatorium of music. My parents never even came to watch me play once so it was my personal achievement. Things then began to get worse. I became that skinny my sister was concerned about anorexia. I went to the doctors and when the blood tests came back I went back and I was positive for amphetamines. I did not know how this could happen; I have never touched drugs. I went home to my family members. It was there that my mum admitted to putting speed in my Milo in order for me to do the farm work—I had to do my farm work.

I have been divorced for 16 years. During that marriage, the worst experience I was subjected to was I was raped by my husband and his two best mates and I lost my child that night. So he went and I thought the nightmares would end but the family, being so drug driven, started a speed lab. My mum put a knife up to my throat because I peeled too much skin off the potatoes. I used to have to go to their property at Lockyer Valley and I would work from morning till night without food or water brush cutting the mountain with lantana.

I then went into aged care because I have always respected our elders. I nursed for eight years until a few of my favourites passed away and I would say my mental health condition sort of caught up with me. It was then I went to doctors for two years. Changing antidepressants through a local GP was two years lost from me. A nurse said go to Prince Charles. I was admitted there and for two years was given different medications to get me out of the major depression and suicidal thoughts—I have had three attempts on my life. I still today cannot be trusted with no more than a week's supply of medication in case it triggers my brain.

My father put a gun to my head and that was the last straw. I was in a mental health facility where they were telling me to get over it and get on with life. I then got domestic violence orders with the support of our mental health system within Queensland and that was the best decision of my life. I had no family to look after me, I had a young daughter and I had no home. I became homeless because I could not work because of my illness. I was then four months in women's crisis accommodation before I was placed in a housing commission house five years ago. Since then, I have had to struggle with my mental illness.

I have had ECT treatment, which takes away everything. It is not short-term memory loss. I had to work so hard to learn how to spell again, to learn how to function. I was a year and a half in a foetal position. My daughter was looking after me and she was nine years old—my son had gone to live with his father. My carers were Queensland

6 Ms Nicole Sutherland, private capacity, *Committee Hansard*, 18 September 2015, pp 30–31.

Health. I had a psychologist, a psychiatrist and a case manager. Besides that, my daughter and I were left alone. I went to a lot of recovery focus programs that taught me about my illnesses and, through psychology, learned grounding techniques to take away those triggers and everything. Those triggers can still come back today. I can have a great day at work, put my professional face and do my job well. At the end of the day, I could go home and just go back into my little depressive ways.

I became a secretary of the consumer engagement group within the Prince Charles hospital and I started volunteering down at mental health. I did four years of volunteering at mental health in acute care and medium secure. I was then secretary for three years. I did not know how to use a computer but the library taught me. I now have a position as a consumer companion within Queensland Health but three hours a week is not enough to cut it for me. I am very passionate about mental health. I know we can change mental health. The funding cuts have really damaged mental health within the last two years. Us consumers know where we are going. We are going to a recovery focus. These programs have worked.

I went to Nundah House, which was set up with art programs. I hated art at school. I saw the good artists and thought, 'I cannot do that.' I drew a house that looked like a grade 1 had done it. I went back home and went back into my isolation for another two months. It then took courage to think 'You have got to get to get out of this house; you have got no-one to talk to.' I went and now I am an artist so I present my art throughout Queensland and it is sold to many hospitals. But this year it has been on hold because with my new position as a consumer companion I am at Caboolture Hospital where I do art therapy because if it was not for art therapy, I definitely would not be alive today. It was a place I could go, I could be with other people with mental illnesses and we could support each other.

In the hospitals, it is the consumers looking after the consumers. That is a fact because we have not got the funding for the nurses to take the time that we need. We go out of hospital still in our crisis, not as bad but still in crisis, and then we are left alone. It is either be strong or go downhill. Recovery programs have been working across Metro North. The RBH could a bit more look over their shoulder at us. The programs are educating them in hospital, where the non-government programs are for what they have to do to stay well when they are at home and to make sure they have got a community health team to present to during the first week after being discharged out of hospital. We also have our non-government organisation. With our GPs, our police and our nursing staff, I think it would take a good response to put some education and training in, not from professionals; take it from consumers like myself and let us speak and say how it should be run. We are human beings.

I worked in medium secure. People said, 'Were you scared? I was not scared; they are human beings. I have watched them recover. I see some of these consumers out in the community today, and we can do it.

We need the resources so we can do more awareness and education through the high schools. Send me in. I will volunteer. I still volunteer my services to Prince Charles, because I have grown fond of the consumers that come back and that. I have had consumers say to me as an art therapist, 'You're really good at this.' The men say, 'I'm

not doing art,' and I said, 'Well, if you don't want to do art, come and have a talk to us.' We had a good session, and it relieves the stress for the nurses from them pacing up and down because of the locked-door policies that never should have gone through. I have been in hospitals since the locked-door policy, and I feel like I am being treated like a prisoner, being locked in. I am a voluntary person, and I have been through enough hell in my life. There are consumers I speak to on many occasions—us older ones that have been in and out of the system and will not go in the system now because they know they will be locked in those wards.

So we need the resources. Okay, I am doing art therapy. Where is the budget for the art therapy? I went into Queensland Health and found a rec room that had tables. It had three pencils. The resources do not cover it. I have spent about $600 out of my own pocket within the last 12 months to build my own resources and material that I can use in the long term and for volunteers and other consumer companions to use.

It is vital that there be funding for this. At Caboolture Hospital we have eight beds that are not allocated because there is no funding and no nurses. Across Metro North, that is three hospitals, each with three consumers. That is nine people's lives a week we could be saving. I have lost so many consumers because they have presented and there are not beds and they have committed suicide. I light a candle and I deal with that myself.

So we need the funding for more nurses or, if you do not want to pay nurses because they are too expensive, consumer companions. It is the new way to go. The rapport is already there between consumers and consumer companions, because we have lived the experience; the nurses have not, and half the time the nurses will aggravate us, and then you get valium because you are agitated because they cannot understand where you are coming from, and they are discharging you out of hospital when you are still suicidal.

As for the community teams, we need more psychology within our community health teams. There are two at every lot. I am unfortunate enough to have psychology once a week, because it is going to take that much time to properly make me well, but I have learnt so much. I have learnt grounding techniques and everything. I find myself more qualified with my nursing experience and my mental health. I find myself more experienced than some of the nurses. All the consumer companions would love more hours, and it makes a better health system. We get the message. We make sure they know where they have to go when they are getting out.

Another thing is with Mental Health Week: why one day a week? Why have Mental Health Week once a year? Get the stories out there. The government does no TV. You show all the murders and what is happening and budget cuts and these politicians fighting. It is pretty simple when you get down to it. You just have to be passionate about what you are doing. We need the funding. Mental health problems are on the rise. You have to think of the ice epidemic and what effect it is going to have on our mental health system. It has just started, so you also have to bring that into perspective.

For me as a carer for a daughter, as a consumer and as a parent, the younger system, between CYMHS and headspace, is not good. I have taken my daughter to both, and

they cannot diagnose you till you are 18, so you have all that uncertainty, rigmarole and confusion between them. The adolescent cannot understand. There is more work to do there. As a mother I was disgusted with the adolescents. At Royal Brisbane Hospital the work they are doing up there with adolescents is wonderful.

Appendix 5

National Mental Health Commission – recommendations and findings

The Commission made nine findings and 25 recommendations in its report *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014. These are extracted below.

Summary of recommendations[1]

1. Set clear roles and accountabilities to shape a person-centred mental health system

> Rec 1. Agree the Commonwealth's role in mental health is through national leadership and regional integration, including integrated primary and mental health care.
>
> Rec 2. Develop, agree and implement a National Mental Health and Suicide Prevention Plan with states and territories, in collaboration with people with lived experience, their families and support people.
>
> Rec 3. Urgently clarify the eligibility criteria for access to the National Disability Insurance Scheme (NDIS) for people with disability arising from mental illness and ensure the provision of current funding into the NDIS allows for a significant Tier 2 system of community supports.

2. Agree and implement national targets and local organisational performance measures

> Rec 4. Adopt a small number of important, ambitious and achievable national targets to guide policy decisions and directions in mental health and suicide prevention.
>
> Rec 5. Make Aboriginal and Torres Strait Islander mental health a national priority and agree an additional COAG Closing the Gap target specifically for mental health.
>
> Rec 6. Tie receipt of ongoing Commonwealth funding for government, NGO and privately provided services to demonstrated performance, and use of a single care plan and eHealth record for those with complex needs.

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1 National Mental Health Commission, *Contributing lives, thriving communities – Report of the National Review of Mental Health Programmes and Services*, 30 November 2014, Volume 1, pp. 10–11.

3. Shift funding priorities from hospitals and income support to community and primary health care services

Rec 7. Reallocate a minimum of $1 billion in Commonwealth acute hospital funding in the forward estimates over the five years from 2017–18 into more community-based psychosocial, primary and community mental health services.

Rec 8. Extend the scope of Primary Health Networks (renamed Primary and Mental Health Networks—PMHNs) as the key regional architecture for equitable planning and purchasing of mental health programmes, services and integrated care pathways.

Rec 9. Bundle-up programmes and boost the role and capacity of NGOs and other service providers to provide more comprehensive, integrated and higher-level mental health services and support for people, their families and supporters.

Rec 10. Improve service equity for rural and remote communities through place-based models of care.

4. Empower and support self-care and implement a new model of stepped care across Australia

Rec 11. Promote easy access to self-help options to help people, their families and communities to support themselves and each other, and improve ease of navigation for stepping through the mental health system.

Rec 12. Strengthen the central role of GPs in mental health care through incentives for use of evidence-based practice guidelines, changes to the Medicare Benefits Schedule and staged implementation of Medical Homes for Mental Health.

Rec 13. Enhance access to the Better Access programme for those who need it most through changed eligibility and payment arrangements and a more equitable geographical distribution of psychological services.

Rec 14. Introduce incentives to include pharmacists as key members of the mental health care team.

5. Promote the wellbeing and mental health of the Australian community, beginning with a healthy start to life

Rec 15. Build resilience and targeted interventions for families with children, both collectively and with those with emerging behavioural issues, distress and mental health difficulties.

Rec 16. Identify, develop and implement a national framework to support families and communities in the prevention of trauma from maltreatment during infancy and early childhood, and to support those impacted by childhood trauma.

Rec 17. Use evidence, evaluation and incentives to reduce stigma, build capacity and respond to the diversity of needs of different population groups.

6. Expand dedicated mental health and social and emotional wellbeing teams for Aboriginal and Torres Strait Islander people

Rec 18. Establish mental health and social and emotional wellbeing teams in Indigenous Primary Health Care Organisations (including Aboriginal Community Controlled Health Services), linked to Aboriginal and Torres Strait Islander specialist mental health services.

7. Reduce suicides and suicide attempts by 50 per cent over the next decade

Rec 19. Establish 12 regions across Australia as the first wave for nationwide introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.

8. Build workforce and research capacity to support systems change

Rec 20. Improve research capacity and impact by doubling the share of existing and future allocations of research funding for mental health over the next five years, with a priority on supporting strategic research that responds to policy directions and community needs.

Rec 21. Improve supply, productivity and access for mental health nurses and the mental health peer workforce.

Rec 22. Improve education and training of the mental health and associated workforce to deploy evidence-based treatment.

Rec 23. Require evidence-based approaches on mental health and wellbeing to be adopted in early childhood worker and teacher training and continuing professional development.

9. Improve access to services and support through innovative technologies

Rec 24. Improve emergency access to the right telephone and internet-based forms of crisis support and link crisis support services to ongoing online and offline forms of information/education, monitoring and clinical intervention.

Rec 25. Implement cost-effective second and third generation e-mental health solutions that build sustained self-help, link to biometric monitoring and provide direct clinical support strategies or enhance the effectiveness of local services.

Appendix 6

Expert Reference Group – Members' biographies

MENTAL HEALTH ERG

Mental Health Australia

Mental Health Expert Reference Group Members

Kate Carnell AO
Role: Chair

Kate Carnell is currently the CEO of the Australian Chamber of Commerce and Industry (ACCI). ACCI, Australia's largest and most representative business organisation is the leading voice of business in Australia advocating for over 300,000 businesses across all industries.

Kate is well known and respected in the not-for-profit and business communities having served two years as CEO of *beyondblue* and previously four years as CEO of the Australian Food and Grocery Council.

Kate began her professional life as a Pharmacist. She owned and managed pharmacies for some 20 years, was the inaugural chair of the ACT Branch of the Australian Pharmacy Guild and went on to become National Vice-President of the Pharmacy Guild of Australia.

Professor Jane Pirkis
Role: Suicide prevention and mental health research

Professor Jane Pirkis (PhD) is the Director of the Centre for Mental Health in the Melbourne School of Population and Global Health. She has undertaken a number of policy-relevant studies of suicide and suicide prevention in Australia, including profiling the epidemiology of suicide and suicidal behaviour among the general population and among at-risk groups. She has a particular research interest in suicide and the media. She has also undertaken a number of evaluations of large-scale suicide prevention programs and mental health care initiatives.

Professor Harvey Whiteford
Role: Mental health planning and reform

Professor Whiteford is the Kratzmann Professor of Psychiatry and Population Health at The University of Queensland, one of the first private sector funded academic positions in mental health in Australia. In Australia he oversaw the implementation of the first national mental health plan as Chair of the National Mental Health Working Group and established the Queensland Centre for Mental Health Research where he is currently the Director, Mental Health Policy and Epidemiology Group.

Professor Nickolai Titov
Role: Teleweb service delivery

Nickolai Titov is the founding Project Director of the MindSpot Clinic, an Australia-wide online and telephone treatment service for people with anxiety and depression. This innovative Clinic provides low and high intensity stepped care and evidence-based psychological interventions. Nickolai's research and clinical work has been focused on the development

and evaluation of strategies for reducing barriers to treatments for people with high prevalence psychological disorders. He has developed and managed two virtual research clinics, and maintains active collaborations with researchers in five countries. Nickolai has developed and evaluated leading internet-delivered treatment interventions across 40 clinical trials with more than 4000 adults. He continues to supervise and train Postdoc, PhD, and higher degree students at Macquarie University.

Professor Thomas Callaly
Role: Regional service integration

Professor Tom Callaly is Executive Director and Clinical Director of Mental Health, Drugs and Alcohol at Barwon Health: Mental Health and Clinical Professor, Deakin University. He has had an interest in Leadership and Management in mental health, benchmarking and practical aspects of the implementation of routine outcome measures and in the use of ICT in improving mental health service delivery. He has a Masters in Business Leadership and is a Fellow of the Australian Association of Quality in Healthcare.

Professor Jane Gunn
Role: Primary mental health

Professor Jane Gunn is Professor and Foundation Chair of Primary Care Research. Prof Gunn is a general practitioner and Head of the Department of General Practice. She completed her PhD in 1998. In 2009, she was appointed to the National Health and Medical Research Council Research Committee. She leads a research program into mental health; focussing in particular on depression and multimorbidity. Her research harnesses the patient experience to drive health care reform. She is committed to person centred health care which places primary care at the centre of an integrated health care system.

Ms Julie Anderson
Role: Consumer representative

Ms Anderson is currently the Manager of Consumer Participation Strategy at Neami National. She has also previously been a Director, President and Vice President at Neami National. She is a member of Mental Health Australia's National Register of Mental Health Consumer and Carer Representatives and a graduate of the National Mental Health Commission's National Future Leaders in Mental Health Project.

Dr Peggy Brown
Role: State/Territory representative

Dr Peggy Brown is currently the Director General of ACT Health. She is also a Member of the Health Workforce Australia Board. She trained in Medicine and specialised in Psychiatry, and has significant clinical and administrative experience, having worked both within Australia and internationally. She has provided leadership in national mental health policy development and implementation over the past decade, including chairing the committee that oversees key national mental health safety and quality initiatives. From 2007 – 2009, she led a national project to reduce, and where possible, eliminate the use of seclusion and restraint in mental health services across Australia.

Prof Julio Licinio
Role: Strategic Professor of Psychiatry

Julio Licinio is the deputy director for Translation Strategy and Process and head of the Mind & Brain Theme at the South Australian Health and Medical Research Institute, and strategic professor of psychiatry at Flinders University in Adelaide, South Australia, as well as research professor of psychiatry at the University of Southern California in Los Angeles. His area of scientific expertise is pharmacogenomics, as well as the biology of depression, and he has edited books on both topics. He has also published considerable research on translational psychiatry, as well as on obesity and the possible link between obesity, depression, and antidepressants.

Dr Andrew Wilson
Role: Private Psychiatrist

Dr Andrew Wilson is a practising psychiatrist and Medibank's Executive General Manager of Provider Networks and Integrated Care. In his role at Medibank, Dr Wilson is responsible for managing claims expenses, provider contracting, claims auditing and improved model of care initiatives encompassing Medibank's relationships with hospitals and medical professionals Andrew has 25 years experience in the public health system, and remains a practising psychiatrist and lecturer.

Prof Brett McDermott
Role: Youth mental health

Professor Brett McDermott is a Child and Adolescent Psychiatrist. He is the Executive Director of the Mater Child and Youth Mental Health Service, a Director of *beyondblue*, a Professor at the Queensland University of Technology, and is a member of the Australian National Mental Health Disaster Response Committee. He is highly regarded for his knowledge and skills in a number of clinical areas including eating disorders and depression and his expertise with child and adolescent emotional trauma.

Dr Shane Langsford
Role: Psychologist

Dr Langsford is a psychologist who founded a consultancy service, PECS, in 1999. PECS conducts psychological, neuropsychological, psychometric, and educational assessments for children, adolescents and adults, and provides appropriate intervention relative to the outcome of the assessment, or as requested by the referring health/education professional.

Mr Mark Booth
Role: Ex-officio, Department of Health

Mr Mark Booth is currently the First Assistant Secretary, Primary Care Division at the Department of Health.