INQUIRY INTO MENTAL HEALTH SERVICES IN AUSTRALIA

Terms of reference

1.1 On 28 March 2007, on the motion of Senator Lyn Allison, the Senate referred the matter of mental health services in Australia to the Community Affairs Committee for inquiry and report by 30 June 2008. Following the commencement of the 42nd Parliament, the Senate readopted the inquiry on 14 February 2008. The terms of reference required the committee to examine:

> (1) Ongoing efforts towards improving mental health services in Australia, with reference to the National Action Plan on Mental Health agreed upon at the July 2006 meeting of the Council of Australian Governments, particularly examining the commitments and contributions of the different levels of government with regard to their respective roles and responsibilities.
>
> (2) That the committee, in considering this matter, give consideration to:
>
> > (a) the extent to which the action plan assists in achieving the aims and objectives of the National Mental Health Strategy;
> >
> > (b) the overall contribution of the action plan to the development of a coordinated infrastructure to support community-based care;
> >
> > (c) progress towards implementing the recommendations of the Select Committee on Mental Health, as outlined in its report *A national approach to mental health – from crisis to community*; and
> >
> > (d) identifying any possible remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness.[1]

Interim report

1.2 This interim report outlines the committee's work to date and provides a broad summary of the themes arising in the evidence received. Given the scale of the reforms introduced in mental health, the substantial evidence provided to the committee and the committee's heavy workload with other concurrent inquiries, the committee will report in further detail and present its recommendations to the Senate by 25 September 2008.

The committee's work to date

1.3 The committee advertised the inquiry in *The Australian* and on its website. It wrote to many organisations and individuals inviting submissions to the inquiry. The

---

1 *Journals of the Senate*, 28 March 2007, No 140, p. 3707.

committee has received and published 55 submissions, together with a considerable volume of additional information received at and after public hearings which is listed at Appendix 1. It has also received a further 4 confidential submissions.

1.4 The major emphasis of the terms of reference referred to the Council of Australian Governments' (COAG) *National Action Plan on Mental Health 2006-2011*. When the matter was originally referred the Action Plan had been in place for only a short period of time. The committee determined that the Plan needed time to be bedded down before any worthwhile assessments could be made. The committee decide to seek submissions and conduct a roundtable in 2007, deferring public hearings until 2008.

1.5 The roundtable discussion was held in Canberra on 10 August 2007 with representatives from a range of peak bodies, professional associations, consumer and carer organisations. Prior to commencing the public hearings, the committee received a briefing in March 2008 from the Department of Health and Ageing and the Department of Families, Housing, Community Services and Indigenous Affairs. During March, April and May 2008 the committee held nine public hearings, across each of the state and territory capital cities. Details of the public hearings are referred to in Appendix 2. The public submissions and Hansard transcripts of evidence may be accessed through the committee's website at http://www.aph.gov.au/senate_ca.

Australia/New Zealand Parliamentary Committee Exchange

1.6 In April 2008 the committee was selected by the Senate President to visit New Zealand as part of the Australia/New Zealand Parliamentary Committee Exchange Program. This exchange, undertaken from 14–17 April, had a major focus on mental health issues in addition to a number of other subject areas of specific interest to the committee.

1.7 The committee met with Ministers and party spokespeople from across the political spectrum, senior officers from relevant Departments and representatives from NGOs. The committee was especially interested in meeting with the New Zealand Mental Health Commission whose activities had been raised during the earlier Senate Select Committee on Mental Health. The meetings held during this exchange enabled committee members to gain a broad understanding of the operation of mental health services in New Zealand, as a comparison and contrast with Australia. Insights gained through the exchange have been valuable to the committee in conducting this inquiry.

State and territory governments' participation

1.8 The COAG *National Action Plan on Mental Health 2006–2011* specifically acknowledged that reforming the mental health system in Australia required commitment and coordination across all levels of government:

> The success of the Plan will require continuing effort by all governments. COAG has therefore agreed to new arrangements for the Commonwealth

> and States and Territories to work together to implement our commitments in the most effective way.[2]

1.9 Given this commitment, and that the terms of reference specifically required the committee to examine 'the commitments and contributions of the different levels of government with regard to their respective roles and responsibilities', the committee was keen for state and territory governments to actively participate in the inquiry.

1.10 The Chair of the committee wrote to all state Premiers and territory Chief Ministers inviting written submissions to the inquiry. The committee was pleased to receive submissions from the governments of the Australian Capital Territory, Northern Territory, South Australia, Tasmania, Victoria, Western Australia and Queensland. The lack of response from the Government of New South Wales has considerably limited the committee's ability to assess the progress of mental health reforms in that state and nationwide. It is disappointing, given the stated inter-government commitment at the time of the COAG National Action Plan, that the New South Wales Government chose not to make a submission to the inquiry.

1.11 The committee was further hindered by the governments of New South Wales and Victoria declining to participate in public hearings. This contrasted with the Queensland Government, which although unable to participate at the committee's Brisbane hearing subsequently enabled the Director of Mental Health with Queensland Health to participate in a later hearing in Canberra.

1.12 Improving mental health services in Australia requires the combined commitments of state, territory and federal governments. This has been clearly stated and agreed on numerous occasions.[3] Such commitment includes going beyond funding separate government initiatives, to cooperatively review how change is progressing and whether services are improving. The committee is disappointed that some state governments chose not to fully contribute to the inquiry, and disturbed as to what this may indicate about the strength of the inter-government commitment to implementing and evaluating mental health service reforms provided for under the COAG National Action Plan.

Context for the inquiry

1.13 As indicated in the terms of reference, the committee's inquiry followed the inquiry of the Senate Select Committee on Mental Health, which reported to the Senate in March and April 2006. That committee was established to comprehensively examine mental health in Australia. This inquiry was not intended to repeat the comprehensive examination undertaken by the earlier select committee. Rather, in accordance with the terms of reference, the committee focussed on the COAG

2 COAG, *National Action Plan on Mental Health 2006–2011*, p. i.

3 For example, Australian Health Ministers, *The National Mental Health Plan 2003–2008*; COAG, *National Action Plan on Mental Health 2006–2011*.

National Action Plan and the progress made in mental health service reforms and the service gaps and shortfalls that remain.

The Senate Select Committee on Mental Health

1.14 The select committee's report added to those of a number of other organisations that have examined mental health services in Australia and found them wanting.[4] The select committee found a service sector urgently in need of resources and renewed focus and coordination. Some of the major problems highlighted included: inadequate resources and underutilisation of existing resources, inadequate community based care, acute care services in crises, inadequate focus on prevention and early intervention, great geographic disparity in the quality of care, and service silos and gaps. The select committee found that people with mental illnesses were still stigmatised and marginalised, and situations remained where their human rights were abused. Consumers and carers struggled to have their voices heard in the design, conduct and evaluation of treatment. The select committee commented that the experiences related to it, and the facts set out for it, 'were depressingly similar' to those presented in a report ten years earlier.[5]

1.15 The select committee, in its two reports, made 91 recommendations for action. Some of these recommendations were directed to the Council of Australian Governments, some to the Australian Government and some to state and territory governments. The first report set out key directions, including substantial increases in mental health funding, the establishment of community-based mental health centres and multi-disciplinary treatment teams, and funding of national bodies for monitoring and accountability, consumer and carer advocacy and mental health research.

1.16 The second report made a suite of targeted recommendations in the following areas: monitoring and research, consumers' rights and roles, prevention and intervention, community treatment, non-government organisations, workforce and training, crisis response, treatment responses, housing, families and carers, payment for mental health care, the justice system, dual diagnosis, children and youth, older people, culturally and linguistically diverse communities and refugees, rural and remote communities, and Indigenous communities.

1.17 To date, neither the previous nor current Australian Government has formally responded to the select committee's report and recommendations. The committee requests that this response be made expeditiously.

---

4 For an overview of other contemporary inquiries and reports see Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, pp 11–14.

5 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, p. 19. The report mentioned was the Human Rights and Equal Opportunity Commission report *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993 (generally known as the Burdekin Report).

1.18 Of the states and territories, only the ACT Government in its submission to this inquiry set out a comprehensive response detailing its position on each of the select committee's recommendations.

1.19 However, developments in policy and programs indicate that governments have responded, at least in part, to some of the issues raised in the select committee's inquiry and recommendations. These developments are discussed below.

The COAG National Action Plan on Mental Health

1.20 Towards the conclusion of the select committee's inquiry, in February 2006, the Council of Australian Governments recognised that mental health was 'a major problem for the Australian community' and that additional resources were required 'from all governments to address the issues'.[6] COAG tasked Senior Officials with preparation of an action plan to be brought forward for its consideration. The action plan was to address many of the issues that had been raised throughout the select committee inquiry.[7]

1.21 At its meeting in July 2006, COAG adopted the *National Action Plan on Mental Health 2006–2011* (hereafter the COAG Plan), including two flagship initiatives and a separate individual implementation plan for each state, territory and the commonwealth government. The COAG Plan aimed to 'deliver a more seamless and connected care system, so that people with mental illness are able to participate in the community'.[8]

1.22 The COAG Plan was directed at four outcomes:

- reducing the prevalence and severity of mental illness in Australia;
- reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery;
- increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention; and
- increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

1.23 In order to achieve these outcomes, the plan set out five target areas for action:

---

6 Council of Australian Governments' Meeting, 10 February 2006, http://www.coag.gov.au/meetings/100206/index.htm#mentalhealth, accessed 8 April 2008.

7 Council of Australian Governments' Meeting, 10 February 2006, http://www.coag.gov.au/meetings/100206/index.htm#mentalhealth, accessed 8 April 2008.

8 COAG, National Action Plan on Mental Health 2006–2011, p. i.

- promotion, prevention and early intervention;
- integrating and improving the care system;
- participation in the community and employment, including accommodation;
- coordinating care; and
- increasing workforce capacity.

1.24 The two flagship initiatives in the COAG Plan were aimed at better coordinating care. The first, entitled 'Coordinating Care', was to make available to each person with serious mental illness a clinical provider and community coordinator, to provide integrated clinical management and ensure connection to non-clinical services. The second, 'Governments Working Together' required the establishment within each Premier or Chief Minister's department of a COAG Mental Health Group, to oversight how commonwealth and state and territory initiatives would be coordinated.

1.25 The Commonwealth Government's Individual Implementation Plan included 18 initiatives in the other four target areas. These initiatives involved $1.9 billion in new funding over five years, which was included in the 2006–07 Budget. The four largest budget initiatives in the Commonwealth Individual Implementation Plan were:

- $538 million for better access to psychiatrists, psychologists and general practitioners through the Medical Benefits Schedule;
- $284.8 million for new personal helpers and mentors;
- $224.7 million for more respite care places for families and carers;
- $191.6 million new funding for mental health nurses.[9]

1.26 The state and territory individual implementation plans together contained 124 initiatives and brought the total funding commitment in the COAG Plan to approximately $4 billion.[10] However, state and territory plans included a mixture of new and previously allocated funds.[11] In some cases initiatives included in the plans had already commenced.[12]

Other developments

1.27 Several governments pointed out that they had made additional major investments in mental health services since the COAG Plan. Some examples include:

9 COAG Plan, pp 9–11.

10 COAG Plan, p. i.

11 Department of Health and Ageing, *Submission 45*, p. 7.

12 See for example COAG Plan, Individual Implementation Plan on Mental Health Western Australia, p. 26.

- The Queensland Government committed a further $528.8 million to COAG Plan objectives in its 2007–08 Budget, bringing its total commitment against the Plan to $895.2 million;[13]
- The Victorian Government allocated an additional $41.2 million in its 2007–08 Budget for new mental health initiatives and growth funding, as well as $21.7 million for capital works;[14]
- The South Australian Government announced $43.6 million for mental health reform in response to the SA Social Inclusion Board's report *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007–2012* and a further $50.5 million in the 2007–08 State Budget;[15]
- The ACT Government committed an extra $12.6 million for mental health services in its 2007–08 Budget and $8.75 million in its 2008–09 Budget.[16]

1.28 Individual state and territory government submissions provide further detail about these additional investments.[17]

Themes in evidence

1.29 Evidence to the inquiry indicates that progress has been made against many of the initiatives in the COAG Plan, but that widespread gaps and shortfalls in Australia's mental health care remain. A broad summary of the issues raised with the committee during its inquiry is given here. The committee is at this point simply reporting the major themes presented in evidence; it is not presenting its views, conclusions or recommendations. Clearly there are further related issues and details to consider. The committee will consider the evidence presented to it in further detail and report to the Senate at a later date.

Progress

1.30 The COAG Plan made progress in a number of areas towards achieving the aims of the National Mental Health Strategy and the recommendations of the Senate Select Committee on Mental Health. It helped **put mental health high on the agenda** across government departments, at both state and federal levels. It recognised that mental health was **not just a health portfolio responsibility**, but required a broader, community-based response.

---

13 Queensland Government, *Submission 49*, Chapter 3.

14 Victorian Government, *Submission 41*, p. 3.

15 South Australian Government, *Submission 34*, p. 7.

16 ACT Government, *Submission 37*, covering letter and *Proof Committee Hansard*, 16 May 2008, p. 29.

17 The submissions are available through the Committee's website at http://www.aph.gov.au/senate_ca

1.31 The recent announcement of the creation of a National Advisory Council on Mental Health reflects the priority that has been given to mental health at the national level.[18] The Council is expected to provide the Government with independent advice from experts on mental health and will assist the coordination of Commonwealth, State and Territory mental health services so as to improve support for people with mental illness and their carers.[19] It is important that the membership of this Council includes consumers and carers and that the Council is able to function independently and provide independent advice as has been clearly indicated by the Government.

1.32 The COAG Plan **put desperately needed money into the mental health community sector**. Many non-government organisations now have new funding to help provide a range of community-based services.

1.33 The new community-based program with the largest budget, and the one about which the committee received most comment, is the Commonwealth's Personal Helpers and Mentors program (PHaMs). This program provides funding to the non-government sector and was designed to engage 900 personal helpers and mentors to assist people with a mental illness who are living in the community to better manage their daily activities.[20] The first two funding rounds of the program have been conducted and in 48 sites across the country personal helper and mentor workers are available to support people with mental illness in their recovery journey. So far around 400 personal helpers and mentors have been engaged, well short of the program target.[21] Non-government organisations are keen for progress to be made on the third PHaMs funding round, reflecting the positive experience with the program so far and the need for further services of this kind.

1.34 There is widespread support for the PHaMs program, particularly the peer support component, which in many areas provides a service that was lacking. Consumers can self refer into the program and do not have to have a formal diagnosis. As such it provides a pathway into services from outside the traditional, clinical settings. It is a program with the potential and flexibility to engage those who have not been accessing services. However, there are also concerns as to how PHaMs sits with other local services, its limited geographic coverage, whether it is being accessed by those with the most complex needs and whether providers are trained and equipped to meet these complex needs.

1.35 The COAG Plan **markedly increased access to some clinical services**. In particular, more than 726,000 people have been able to access cheaper primary mental health care under new Medicare arrangements.[22] Previously underutilised members of

---

18 The Hon Nicola Roxon MP, Minister for Health and Ageing, Media Release 11 April 2008.

19 Budget Paper No.2 2008–09, p. 213.

20 COAG Plan, p. 10.

21 *Proof Committee Hansard*, 16 May 2008, p. 79.

22 Department of Health and Ageing, April 2008, *Medicare Subsidised Primary Care Mental Health Services Fact Sheet*.

the mental health workforce, such as psychologists, have been made more accessible. The Better Access initiative provides Medicare rebates for certain GP provided mental health services and consultations with psychiatrists. It also provides Medicare rebates for specified allied health professional consultations (psychologists, occupational therapists and social workers) where patients have been referred under a GP mental health care plan or by a psychiatrist or paediatrician.[23]

1.36 The Better Access initiative provides an example where shifts have occurred in mental health services since the select committee's inquiry. The cry for so called 'talking therapies' was a prominent theme in evidence to the select committee. Consumers and carers expressed frustration at rigid medical models and the dominance of pharmaceutical treatments. This theme was less emphasised in the current inquiry, indicating the shift that Better Access has made in recognising evidence-based talking therapies. These therapies are now more prominent and widely available than they were previously.

1.37 According to the COAG Plan, the Better Access initiative aimed to 'improve access to, and better teamwork between, psychiatrists, clinical psychologists, GPs and other allied health professionals'.[24] While extensive use of these professional services was clear, evidence of better teamwork between service providers was less conclusive. Certainly the initiative falls short of the select committee's recommendation, which was to establish community-based mental health centres staffed by multidisciplinary teams.[25]

1.38 A number of concerns were expressed about the Better Access initiative. For example, whether it is making services accessible for the most seriously ill, particularly as gap payments and the low rate of bulk billing among some providers mean that services can still be expensive. There are fewer mental health professionals outside the metropolitan areas, making service access inequitable. Further, there are concerns about how well the initiative is being monitored. Certainly uptake has been higher than originally foreseen and further budget allocation was necessary.[26] While use of the Medicare items provided under the initiative is being monitored, there is no information as to the effect of the services on people's mental health.

1.39 Funding for mental health nurses in the COAG Plan was also designed to improve access to care. Funding was provided for mental health nurses to work in a range of clinical teams including with private psychiatrists and in general practices. The aim was for mental health nurses to assist in coordinating care, managing

---

23 www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/better-access-through-mbs-1, accessed 10 June 2008.

24 COAG Plan, p. 9.

25 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, p. 476.

26 Senate Community Affairs Committee, *Additional Budget Estimates*, February 2008, 'Outcome 11 COAG Mental Health: Funding and Expenditure'.

medication and making links to other medical professionals and services. The committee heard examples where mental health nurses were being better utilised to improve service accessibility and coordination. However, the initiative has been undersubscribed, partly resulting from workforce shortages.

1.40 The COAG Plan **recognised that connecting all the available services is fundamental** to improving Australia's mental health care. The Plan recognised that people with severe mental illness and complex needs are most at risk of falling through the gaps in the system. While the Plan stated that people within the target group would be offered a clinical provider and community coordinator from Commonwealth and/or State and Territory Government funded services, there have been very different approaches to 'care coordination' across the jurisdictions. Concerns raised include the lack of funding for this initiative, how it fits with existing local services and whether better integration of services is actually occurring.

1.41 The COAG Plan **recognised that the commonwealth, state and territory governments need to work together** to provide mental health care. Each state and territory was to form a COAG Mental Health Group, convened by the Premier or Chief Minister's Department. These groups were to provide a forum for 'oversight and collaboration on how the different initiatives from the Commonwealth and State and Territory governments will be coordinated and delivered in a seamless way'. Coordinating mental health groups exist in each jurisdiction, however there is significant variation in the composition of the groups, regularity of their meetings and extent of involvement and communication with stakeholders. The Queensland COAG Mental Health Group meets regularly and produces a regular newsletter providing information about progress under the COAG Plan. In contrast, in some areas there was confusion as to the existence, membership and role of the state COAG Mental Health Group. The adequacy of the consultation of some COAG Mental Health Groups with consumers, carers and service providers was an area of concern.

Gaps and shortfalls

1.42 While there is widespread support for the COAG Plan initiatives and the new funding that has gone into mental health services, there is also broad agreement through the evidence provided to the committee that there is a lot further to go in creating an available, accessible, community-based mental health care system. There are a number of outcomes the COAG Plan has not achieved. It failed to set out **a vision for Australian mental health services** into the future. While the COAG Plan has been recognised for giving a higher priority and funding to mental health services, there is a lack of clarity as to how it fits with the National Mental Health Strategy and the intended direction once each of the Plan's initiatives has been implemented.

1.43 The potential for the COAG Plan to make a substantial difference to the lives of those with mental illness depends heavily on wider supports that, if lacking, will compromise the efforts made under the Plan. In particular, **affordable housing and supported accommodation** are keystones to furthering other efforts towards mental health. Increased housing stress throughout the population puts further pressure on

already stretched services, making accommodation even more difficult to obtain for those with complex needs such as mental illness. Stable housing is conducive to health and wellbeing and, particularly for those with complex needs, housing and other supports need to be linked. While some of the state and territory Individual Implementation Plans allocated funding to supported accommodation and residential services, such as step-up and step-down facilities, critical shortages remain.

1.44 The COAG Plan did not give **consumers a priority voice** in formulating policy and implementing programs. The Plan itself appears to have had little direct consumer input and it did not set out principles or initiatives for promoting consumer involvement in service delivery and a recovery model of service. COAG Mental Health Groups were required to 'engage' and 'consult' with non-government organisations, the private sector and consumer and carer representatives. This falls short of the select committee's recommendation that all governments establish benchmarks for the employment of consumer and carer consultants in mental health services and that all service providers have formal mechanisms for consumer and carer participation.[27]

1.45 Perhaps reflecting efforts at cross jurisdiction coordination, mental health policy in recent years and the COAG Plan have been dominated by government-to-government negotiation and agreement. Witnesses identified capacity building and support for consumer advocacy as a shortfall in mental health service reform.

1.46 There is a clear need for more **consumer and carer run services**. Consumers and carers are in a unique position to contribute to training, education and awareness raising, advocacy and recovery support. There are a few excellent examples of consumer run support services, where great outcomes have been achieved by people with mental illness, including facilitating recovery and reducing hospital readmission and other service use over time. However, consumer and carer run services are few and far between, and in most areas there are none.

1.47 Despite the COAG Plan's focus on coordination, **coordinating mental health services** remains a critical issue. The articulated aim of 'a more seamless and connected care system' has not yet translated into common practice. This is evident at multiple levels. Further coordination is required across jurisdictions, within jurisdictions and in the actual delivery of services. Across the states and territories levels of mental health funding and provision of the services intended to accompany de-institutionalisation, including investment in community-based services, still vary greatly. A consistent, national approach has not been articulated. Differences in legislation across jurisdictions means that maintaining stable treatment across state boundaries can still be challenging.

27 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, p. 479.

1.48 Improved coordination can be achieved between commonwealth areas of responsibility, such as allied health professionals, employment programs and education and state responsibilities, such as in-patient care, residential services and corrective services. Both levels of government provide funding to non-government organisations to deliver mental health services and the fit between programs funded by each needs careful consideration. The demands on non-government organisations in tendering for and reporting on multiple programs, at both state and federal levels, can be onerous.

1.49 Within jurisdictions the structure of mental health services varies greatly. Some states and territories have a much higher proportion of their mental health funding and programs situated within government public mental health services, while others use non-government organisations and the private sector more extensively. These differences have implications for service delivery and how effectively some of the COAG initiatives can be rolled out and accessed. The fit between national programs and local contexts and services needs close attention.

1.50 At a service delivery level, there are still gaps and integration issues. Although COAG initiatives such as 'coordinating care' recognise the importance of linking up services in response to an individual's needs, this remains a real challenge. Coordination is important, not only across designated mental health services, but with wider supports such as accommodation, employment and income support. Linkages need to be made across public, private and non-government organisation services. With additional programs being rolled out into the community through the COAG Plan initiatives, the need for information about what services are available and linkages between them has become, if anything, heightened.

1.51 A particular issue raised with the select committee, and again in this inquiry, is the linkage of mental health and alcohol and other drug services. While some states are making progress, it remains a key area where those with complex and high levels of need are falling through the gaps.

1.52 **Sustainability of services is an issue**. Much of the community-based funding in the COAG Plan is short-term, contract funding for specific programs. Non-government organisations have raised concerns about the demands and effects of competitive tendering processes and there are questions about the future of programs after the budgeted funding expires.

1.53 There are some great, innovative models of care and some very resourceful service providers. However, many **services remain oversubscribed**. Even people in immediate crisis may be turned away. Some of the COAG initiatives which aim to better coordinate care can only be fully effective if services exist in the area for people to access. Despite the increase in funding which the COAG Plan achieved, many areas still need more mental health care.

1.54 Meeting the needs of the **most seriously ill** remains an area of concern. Acute care services remain under strain and it is too early to assess whether new community-

based initiatives are enough to in any way relieve the demands on in-patient services. Achieving a continuum of care remains an important goal. The committee heard some examples where community-based services have been able to link in with hospital in-patient services, but comprehensive discharge planning and associated supports were not held to be widely available.

1.55 Service standards are not uniform and people with mental illness still report instances of poor treatment and abuse. Systems for monitoring standards differ across jurisdictions, as do mental health acts. Concerns were raised about transparency and accountability. Ensuring the **rights of people with mental illness** remains an area requiring close attention.

1.56 **Services currently remain patchy and inconsistent** and people in some areas receive more service than others. The lower number of mental health care professionals in rural, regional and particularly in remote areas means that, even with Medicare rebates, their services are not consistently accessible. Services are structured differently across the states and territories and in some areas there is not a substantive non-government sector to fully utilise new funding for community-based services. Concerns were raised that COAG Plan funding to mental health services in rural and remote areas is inadequate to address the additional barriers these communities face in accessing mental health care.

1.57 Some groups of people, including those with the most complex needs, find it particularly hard to access the kinds of services they need. While COAG Plan initiatives put funding into some targeted programs, services are not widely available to meet the **needs of specific groups**.

1.58 Culturally appropriate and accessible mental health services are needed for Indigenous Australians. A whole range of interrelated issues, such as poverty, alcohol and drug use, abuse, physical illness, community loss and remote location mean that there are complex mental health needs in many Indigenous communities. Generic services are often inaccessible or inappropriate. Some COAG Plan funding was allocated through the Commonwealth and some state implementation plans to improve the capacity of Indigenous mental health services. However Indigenous mental health was identified as an area with significant unmet need requiring further investment, effort and new ways of working.

1.59 Culturally and linguistically diverse (CALD) communities require a range of specialised services to meet their mental health needs. Examples range from translated, appropriate information about services and rights, through to mental health trained interpreters and services with specialist abilities in the areas of trauma and torture. There are different needs within CALD communities, for example, refugees have a high risk of mental illness requiring special care and support. Services tailored to CALD communities remain sparse in the metropolitan areas and virtually non-existent outside the major cities.

1.60 Although promotion, prevention and early intervention was listed as a specific area for action in the COAG Plan, and each government funded initiatives under this banner, further services that meet the needs of young people with mental illness are required. The large majority of mental health problems emerge in adolescence and early adulthood, so this is a key group to engage for early intervention. The *headspace* National Youth Mental Health Foundation provides an innovative example of progress in youth mental health services. It is a consortium model with $69 million of Commonwealth funding, aiming to address the mental health needs of young people aged 12 to 25. Thirty *headspace* sites have been funded across each state and territory and are designed to provide a single entry point for young people to the range of clinical, community and other supports they need. The *headspace* website is a key information source and forum for engaging young people. While *headspace* is widely supported, witnesses pointed to the need for further recognition and support for youth services throughout the mental health system. Acute care was a particular example where basing services around children and adult populations fails to meet the specific needs of youth with mental illness.

1.61 People with comorbidity, the homeless, the elderly and people who have experienced sexual abuse and other trauma are other groups that were identified as having particular mental health care needs not adequately met by current services.

1.62 **Forensic mental health care** remains an area where there are service shortfalls. The select committee reported that the rate of mental illness amongst inmates 'is unacceptably high' and this committee did not receive evidence to suggest that this situation has changed.[28] As well as targeted services to provide health care to mentally ill prisoners, preventative services and community-based supports are necessary to reduce the numbers of people with mental illness coming into contact with the criminal justice system. Discharge and post-prison care, as with other transitional services, remain inadequate.

1.63 **Families and others who care for people with mental illness** are under strain. While it was acknowledged that the COAG Plan allocated funding for respite services, such services need to be designed to meet the specific needs of those caring for people with mental illnesses. The Commonwealth Government's support for respite under the COAG Plan targeted elderly carers, and concerns were raised that the needs of young carers have been overlooked. Further, respite is an inherently short-term form of assistance. Relieving the burden on carers in the longer term requires more community supports and treatment services for people with mental illness.

1.64 Community attitudes are changing, but **people with mental illnesses are still stigmatised**. The COAG Plan provided funding for some targeted awareness raising and promotion programs, such as 'Alerting the Community to the Links between Illicit Drugs and Mental Illness' and 'Early Intervention Services for Parents, Children and

28 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, Final Report, p. 16.

Young People'. However the COAG Plan stopped short of a nationwide mental illness stigma reduction and eduction campaign, as recommended by the select committee.[29] New Zealand's *Like Minds, Like Mine* campaign was held up as a positive example of a national mental health education initiative.

1.65 **Workforce supply, training and development** are essential to fulfilling on the commitments made in the COAG Plan. Initiatives such as Better Access, using new Medicare items, can only improve access to mental health care if there are adequate professionals available to provide the services. The mental health nurses initiative, which has been undersubscribed and now has reduced funding, shows the limitations of good initiatives when the workforce is inadequate to implement them. Skilled workforce shortages and associated competition for staff are also affecting the non-government sector, which is under strain implementing several major new mental health initiatives concurrently.

1.66 There are shortfalls in **employment strategies** for people with mental illness. Employment is important both for prevention in helping to maintain mental health, and as part of the rehabilitation and recovery journey for people with mental illness. Barriers to employment for people with mental illness continue to exist, such as stigma in the workplace and inadequate workplace supports. Concerns were also expressed about the ramifications of 'welfare to work' arrangements on the health and welfare of people with mental illness. The importance of reliable income support was emphasised. More broadly it was noted that social disadvantage needs to be addressed in conjunction with specific mental health initiatives.

1.67 The select committee promoted a substantial increase in funding for **mental health research**, recognising the importance of research to developing more effective treatments, understanding consumer needs, and developing better ways to deliver services. Little focus was given to research in the COAG Plan; it remains an area for ongoing attention.

1.68 The COAG Plan paid minimal attention to **evaluation and outcome measurement**. Currently, there are few outcome measures to show whether initiatives are working. Are fewer people experiencing mental illness? Are more people achieving recovery? To what extent are people with a mental illness able to go on to live out their potential and the possibilities they see for their lives? Efforts towards improving mental health services in Australia remain a work in progress and answering these questions will be important in assessing the contribution that the COAG National Action Plan has made.

29 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, Final Report, p. 15.

Concluding comment

1.69 There is widespread appreciation of the funding that has gone into mental health services through the COAG Plan, however there is caution at this stage as to how effective the new initiatives will be in filling existing service gaps and shortfalls. There is also widespread recognition that achieving a seamless and connected system of care that meets the mental health needs of the most seriously ill, let alone other Australians, will require further investment, leadership and cooperation between all those involved.

Acknowledgments

1.70 The committee acknowledges and thanks all those who have assisted with the inquiry to date, by making submissions, attending hearings and giving evidence, providing additional information and other forms of assistance. As with previous inquiries, consumers and carers have been generous in sharing their lives and experiences to help us better understand mental illness and the services that are being provided and those that are still required. Many individuals and organisations that participated in the inquiry have been contributing to mental health reform for decades. The committee thanks them for their dedication and willingness to contribute again through this inquiry.

Senator Claire Moore
Chair

June 2008