CHAPTER 2

POLICY CONTEXT

The COAG National Action Plan on Mental Health

2.1 On 14 July 2006, the Council of Australian Governments (COAG) agreed to a National Action Plan on Mental Health involving a package of measures and significant investment in mental health care by all governments, over five years. The *National Action Plan on Mental Health 2006–2011* (hereafter 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'.[1] The COAG Plan is reproduced at Appendix 3.

2.2 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.

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

- 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.

2.4 The state, territory and Commonwealth governments each adopted an Individual Implementation Plan, setting out the investment they would make against four of these target areas and listing the initiatives to be implemented. The Commonwealth Government's Individual Implementation Plan included 18 initiatives and involved $1.9 billion in new funding over five years, which was included in the

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

2006–07 Budget. The four largest budget initiatives in the Commonwealth's 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.[2]

2.5 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.[3] However, state and territory plans included a mixture of new and previously allocated funds.[4] In some cases initiatives included in the plans had already commenced.[5]

Table 1: COAG National Action Plan on Mental Health 2006–2011, Commitment ($million) by each government[6]

COAG Plan Target Area	Cwlth	NSW	Vic	Qld	WA*	SA^	Tas	ACT	NT
Promotion, prevention and early intervention	158.3	102.2	80.4	6.9	60.7	39.5	2.0	3.2	1.0
Integrating and improving the care system	1196.9	699.7	284.9	289.0	53.6	75.7	21.1	11.5	13.0
Participation in the community and employment, including accommodation	370.0	113.8	102.7	64.3	129.4	..	11.3	2.8	0.5
Coordinating care	..	..	..	..	..	..	..	..	..
Increasing workforce capacity	129.9	23.2	4.4	6.1	8.8	1.0	8.6	3.1	..

* Funding committed over six years ^ Funding committed over four years

2.6 In addition to the Individual Implementation Plans, two flagship initiatives aimed at better integrating services were announced under the remaining target area,

2 COAG Plan, pp. 9–11.

3 COAG Plan, p. i.

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

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

6 The National Action Plan on Mental Health 2006–2011 noted that each government was undertaking different actions, reflecting the 'differences in the range and scale of services that are already in place in each State and Territory'.

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.

Other developments

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

- The Queensland Government committed a further $528.8 million specifically to COAG Plan objectives in its 2007–08 Budget, bringing its total commitment against the Plan to $895.2 million;[7]
- 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;[8]
- 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;[9]
- 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;[10]
- The Western Australian Government allocated $84 million for new initiatives and further recurrent funding to extend key initiatives in the COAG Plan out to 2011;[11]
- The Commonwealth Government announced several new initiatives in the 2008–09 budget, including $85 million for a national perinatal depression plan and $35 million for a mental health nurses and psychologists scholarship subsidy measure.[12]

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7 Queensland Government, *Submission 49*, chapter 3.

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

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

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

11 *Proof Committee Hansard,* 7 May 2008, p. 90.

12 *Proof Committee Hansard,* 16 May 2008, p. 76.

The COAG Plan and the National Mental Health Strategy

2.8 The COAG Plan was a further step in a long process of mental health service reform in Australia. The move away from an institution-based mental health system to a community-based system, which focuses on supporting individuals to live in the community, has been cemented in Australian health care policy since the National Mental Health Strategy commenced in 1992 with the *National Mental Health Policy*. Since then, the further documents in the National Mental Health Strategy (NMH Strategy) have affirmed this approach. These documents include:

- the National Mental Health Plan 1992;
- the Second National Mental Health Plan; and
- the National Mental Health Plan 2003–2008.

2.9 The Senate Select Committee on Mental Health noted in its 2006 report that the NMH Strategy vision was for a continuum of care responsive to individual needs, operating within the general health care system and integrated with wider social services. However, the Strategy was 'not prescriptive as to which community services were essential, the appropriate "mix" of services, the coordinating structure to oversee the integration of services or the resources to support a continuum of care'.[13]

2.10 As demonstrated in the Select Committee's report and numerous others, the development of community-based services in Australia fell drastically short of what was needed to fully implement the policy of deinstitutionalisation. The numbers of people with mental illness who are homeless, in prisons, living in poverty and unable to get treatment until the most acute stages of illness are a testimony to the long under-resourcing of community-based mental health care and support. Despite over a decade of the National Mental Health Strategy, Mr Cheverton from the Queensland Alliance Mental Illness and Psychiatric Disability Groups assessed that 'the only thing that has really happened is that the large psychiatric hospitals have got smaller and wards have appeared in general hospitals'.[14]

2.11 The Select Committee on Mental Health reported its concern that:

> …the vague concept of community-based services since the inception of the NMHS reflects an underlying lack of commitment to the development of these services. The Strategy had a clear vision for the closure of psychiatric institutions and mainstreaming of acute psychiatric care, but not for the development of community services necessary to meet the needs that resulted from those policies.[15]

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13 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, p. 213.

14 *Proof Committee Hansard,* 26 March 2008,p. 5.

15 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, p. 214.

2.12 In this context, the fit between the COAG National Action Plan and the NMH Strategy is not clear. The elements of the COAG Plan are certainly aimed at improving access to mental health services in the community and the Plan allocated substantial expenditure to community-based services. Whether the COAG Plan, combined with other state, territory and Commonwealth initiatives, provides the amount and breadth of services required is much less certain.

2.13 With the third National Mental Health Plan expiring this year, the future of the National Mental Health Strategy is unclear. In July 2008 the Australian Health Ministers agreed to the development of a fourth National Mental Health Plan and to bring stakeholders and experts together for a 'broad discussion of reform in the sector'.[16]

2.14 Dr Brown, Director of Mental Health ACT, suggested that any such plan may take a somewhat different approach to the earlier plans:

> We have also had more recently the evaluation of the third plan, with some international experts providing an assessment of the success or otherwise of that particular plan. I think it is fair to say that one of the comments that came out as part of that evaluation was that the plan tried to do too much and to be all things to all people and was not able to succeed in doing that. Some of the discussion that has informed the fourth plan development is that we need to target what we believe we can achieve in a time frame and focus on delivering on those as well as we can, rather than trying to do everything all at once.[17]

2.15 The Mental Health Council of Australia was blunt in its assessment that the National Mental Health Strategy, various National Mental Health Plans, the COAG Plan and policy recommendations such as those coming from the Senate Select Committee on Mental Health do not come together to give a clear direction for mental health services in Australia.[18] Despite the various plans and documents, Mr Crosbie, Chief Executive Officer of the Mental Health Council was pragmatic about the underlying driver of mental health services in Australia:

> Currently, service providers are, by and large, the people who determine the services. Who is the biggest service provider of mental health in Australia? It is state government acute services. You asked me: who drives mental health in Australia? It is state government acute services. Whose interests, by and large, are represented at COAG meetings or at the mental health standing committee? It is state government acute services. In many ways, the experience of consumers and carers and people at the community level is that either you fit into the service system or you do not.[19]

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16 Australian Health Ministers' Conference, Communique 22 July 2008, p. 2.

17 *Proof Committee Hansard,* 16 May 2008, p. 41.

18 *Proof Committee Hansard*, 20 May 2008, p. 93.

19 *Proof Committee Hansard*, 20 May 2008, p. 93.

2.16 In a similar vein, Ms Bateman, CEO of the Mental Health Coordinating Council in NSW indicated that those working in the sector will embrace whatever resources are available. She commented on the introduction of the COAG Plan in the context of the National Mental Health Strategy:

> I think it has been confusing for the sector. They did overlap and one seemed to take off in a different direction. Have we lost anything? I would not put it that way. I think there is a willingness for people to move towards what is on the table at the time.[20]

2.17 The committee was given a clear indication that the current policy environment is uncertain for mental health providers, consumers and carers, but that all remain committed to working to achieve better outcomes for people with mental illness.

State and Territory variation

2.18 Mental health policy in Australia sits within the context of the federated system. While reforms such as the National Mental Health Strategy are articulated at a national level and with the cooperation of all jurisdictions, the reality remains that implementation has been variable in light of each state and territory's own policy context and history. The COAG National Action Plan, whilst a cross jurisdiction endeavour, consciously noted the different state and territory contexts within which it would be implemented. The Plan noted four times, in relation to four of the key outcomes, that:

> Each jurisdiction is undertaking different actions to strengthen their mental health services as part of their Individual Implementation Plan. This diversity reflects the differences in the range and scale of services that are already in place in each State and Territory.[21]

2.19 Mental health policy in Australia has stopped short of articulating national service targets, and service systems remain quite varied across the jurisdictions. Ms Springgay, National Mental Illness Fellowship, observed:

> Different states have had different responses, clearly, and some have really taken reform on board. Others are still struggling to achieve the first of the National Mental Health Plans…[22]

2.20 Ms Springgay argued that a push for a nationally articulated framework is needed:

> We need national benchmarks for a start—based on population levels probably. That will be something for the states to move towards and to achieve within a certain time frame. So I would personally like to see a

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20 *Proof Committee Hansard*, 27 March 2008, p. 39.

21 COAG National Action Plan, pp. 3, 4, 5 and 6.

22 *Proof Committee Hansard*, 8 May 2008, p. 41.

> national audit based on those benchmarks within a certain time frame so that we see that there is buy-in, because I think that many of the states have ducked funding in this sector for far too long and the consequences are beginning to show in our communities.[23]

2.21 While some attempts at a national approach have been made, such as the agreement of the National Mental Health Standards, governments have been criticised for failing to implement the standards in practice and to hold services accountable for their performance. A common theme in evidence to the committee was the need for a clearer national policy direction in mental health and more consistent implementation.

Future policy direction

2.22 While the COAG National Action Plan put much needed funding into the mental health sector, it was criticised for lack of vision and articulation of a reform agenda.[24] Indeed the Plan essentially presents a list of initiatives and programs, rather than a vision for the future with steps for how to get there. At this stage the future policy direction for mental health services seems unsettled. Ms Hocking, from SANE Australia commented:

> I still maintain and many agree that the very first [National Mental Health Plan] is one that we could revisit and try to implement. It was never fully implemented in the first place. We seemed to sort of move without notice almost from the very first mental health plan. I think that the lack of a coherent plan is a major disadvantage and a coherent one is definitely needed.[25]

2.23 The Australian Association of Social Workers (AASW) identified the lack of an agreed national blueprint for a comprehensive mental health service system as a major gap in the COAG National Action Plan. Dr Gerrand, a member of the AASW commented that there is no document which sets out 'what we are actually aiming to provide across Australia'.[26]

2.24 Dr Gerrand commented further:

> The important thing about having a national blueprint is that it is then possible to identify where the gaps are in services. That is a major problem at the moment. When you look at the national action plan and then you go to each of the states, you see the states just list out what they are doing. There is not a sense of saying: 'This is a national blueprint. This is what we

23 *Proof Committee Hansard*, 8 May 2008, p. 41.

24 The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, *Proof Committee Hansard,* 26 March 2008, p. 4.

25 *Proof Committee Hansard*, 1 April 2008, p. 4.

26 *Proof Committee Hansard*, 20 May 2008, p. 36.

> identified as a gap in our state response and this is how we are going to plug it or cover it'.[27]

2.25 The AASW considered that such a blueprint should include both clinical treatment and disability support services and cover both the public and private sector.

2.26 The lack of a clear policy framework flows through to funding models. While all the evidence to the inquiry supported the increased funding that has been allocated to mental health services, there was not a clear consensus as to whether the COAG Plan provides for the best use of the money. Witnesses were unclear as to how much commitment there is to changing and revitalising mental health services, or whether new funding will inevitably be added onto existing systems despite identified deficiencies. Professor Hickie commented:

> We face a real problem at the moment with whether the new moneys will go into new services or whether large amounts of new moneys will go into backing old service models, largely the small-business models of the providers through Medicare style insurance and fee for service, or will lead to new services and sustainability.[28]

2.27 Professor Hickie went on to point out the lack of national focus:

> … it is a national organisation problem—agreeing what it is that we are trying to achieve and then having agreed implementation mechanisms. At the moment each is doing what it traditionally does. The Commonwealth is doing its traditional fee-for-service stuff; the states are doing their traditional acute care stuff. We have not yet seen significant practice reform.[29]

2.28 The recommendations of the Senate Select Committee on Mental Health were aimed at giving some clarity as to what a future community-based system of mental health care in Australia would look like. For example, the committee recommended the establishment of community-based mental health centres employing multidisciplinary teams, distributed on the basis of population need. The committee also recommended the development of defined mental health regions and definition of benchmark ratios of mental health providers to population.[30] Without a clearly articulated national framework and implementation plan, mental health service reform in Australia stands to remain ad hoc and disparate across the states and territories.

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27 *Proof Committee Hansard*, 20 May 2008, p. 37.

28 *Proof Committee Hansard*, 20 May 2008, p. 22.

29 *Proof Committee Hansard*, 20 May 2008, p. 32.

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

The New Zealand experience

2.29 The experience of mental health service reform in New Zealand since the 1990s provides something of a contrast with Australia. In New Zealand a Mental Health Commission was established in response to the 1996 Mason inquiry, which showed the widespread problems associated with under-funded, under-developed mental health services and a demoralised workforce.

2.30 In 1998 the Mental Health Commission produced a 'blueprint' for the development of mental health services in New Zealand. The Blueprint document was adopted by government and set resource and access targets for adult, child and adolescent mental health and Maori and Pacific mental health and addiction services.[31] The Mental Health Commission has reported regularly on progress against the Blueprint. It now provides two publications, one on staffing levels and the other on access to mental health and addiction services. The committee learned whilst in New Zealand that the Commission is developing a new outcomes-based monitoring framework, now that inputs such as funding, workforce and service accessibility are being tracked much more consistently.[32] Recently the Commission released *Te Hononga 2015: Connecting for Greater Well-being*, a vision document providing a 'destination picture' of the mental health and addiction sector in New Zealand to 2015.

2.31 Despite the clear targets and accountability for funding of New Zealand's mental health services, the aims of the 1998 Blueprint have not been fully realised. A decade on New Zealand has achieved around 75 per cent of the funding required to meet the service targets.[33] Underspends have been attributed to lack of capacity in the sector and workforce shortages. However, New Zealand's 'ring-fence' policy of quarantining mental health funding means that such underspending is transparent. Under the ring-fence policy surpluses are accumulated and re-applied to mental health services, not returned to general revenue.[34]

2.32 There is still significant unmet need for services in New Zealand, with the 2006 National Mental Health Survey estimating that only 39 per cent of affected people had visited a health service in the past 12 months.[35] The Commission estimates that only 1.9 per cent of the population has access to publicly funded mental health

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31 Mental Health Commission, 1998, *Blueprint for Mental Health Services in New Zealand: How Things Need to Be.*

32 New Zealand Health Commission – Issues and Background, Briefing for the Australia/New Zealand Parliamentary Committee Exchange Program.

33 Mental Health Commission, 2007, *Te Haererenga mo te Whakaōranga 1996–2006*, The Journey of Recovery for the New Zealand Mental Health Sector, pp. 18 and 82.

34 Mental Health Commission, 2007, *Te Haererenga mo te Whakaōranga 1996–2006*, The Journey of Recovery for the New Zealand Mental Health Sector, p. 21.

35 New Zealand Health Commission – Issues and Background, Briefing for the Australia/New Zealand Parliamentary Committee Exchange Program.

services in any six month period, well below the 3 per cent Blueprint benchmark.[36] Constraints to increasing service access have included limited capacity within the sector to get new services up and running, workforce shortages and increased system costs. Importantly, the Commission's review of mental health reform in New Zealand noted that making quality improvements to services had taken funding, with better services resulting in a trade-off against increased access. The Commission stated:

> The available evidence suggests that after a decade more resources are being spent on each service user, each mental health worker sees fewer individual service users than previously, and a higher quality service system is in place.[37]

2.33 New Zealand's experience provides some important insights for Australia. While the aims of the Blueprint have not been fully achieved, the existence of the Blueprint has allowed shortfalls to be measured and assessed. Mr Wright, Director of Mental Health Operations in South Australia, observed from his experience in New Zealand:

> Through the mental health blueprint—which identified, if you were running a reasonable mental health system, what you actually required—and because that was approved by the government, New Zealand has seen ongoing guaranteed funding going into mental health for the last five or six years…That has made a significant difference to their services, and would not have happened if we did not have a mental health commission. You do need something in Australia, and there has certainly been a push for a mental health commission…I am not sure how that would function with six different states and two different territories.[38]

2.34 Several witnesses noted the important role that the Mental Health Commission has provided in the mental health reform process in New Zealand. The role of mental health commissions in New Zealand and Canada are summarised briefly below.

Mental health commissions

2.35 Professor Rosen, from the Comprehensive Area Service Psychiatrists Network NSW (CASP), outlined the role of New Zealand's Mental Health Commission as follows:

> …there are three legs of the commission in New Zealand. One is accountability, measurement of what is happening and what is not happening, costing the gaps and getting governments to commit, as they come into power, to fund those gaps. That has happened in New Zealand

36 Mental Health Commission, 2007, *Te Haererenga mo te Whakaōranga 1996–2006*, The Journey of Recovery for the New Zealand Mental Health Sector, p. 82.

37 Mental Health Commission, 2007, *Te Haererenga mo te Whakaōranga 1996–2006*, The Journey of Recovery for the New Zealand Mental Health Sector, p. 83.

38 *Proof Committee Hansard*, 8 May 2008, p. 97.

> with huge enhancements compared to both the Australian public and private per capita funding combined. The second pillar is looking at the workforce and making sure that that is adequate. The third pillar is looking at community awareness, stigma and discrimination and dealing with that from a grassroots level up. That agenda is both for indigenous populations and for the wider population. We could learn from that.[39]

2.36 New Zealand's Mental Health Commission is an Autonomous Crown Entity, with its role established under New Zealand's Mental Health Commission Act. It is comprised of three Commissioners who are appointed by the Minister for three year terms. The Commission itself has a fixed term which has been extended three times, most recently in August 2007 when its term was extended to 2015. In addition to extending the life of the Commission, the Commission's functions were also reframed 'to align with the future direction of the mental health and addiction sector'. Revised functions include 'advocacy for the interests of people with mental illness and their families generally, fostering collaboration and dialogue about mental health issues, working independently and with others on destigmatising mental illness as well as stimulating and undertaking research'.[40]

2.37 Professor Rosen emphasised that a mental health commission can work effectively in a federated system, pointing to the Canadian mental health commission as an example. The Mental Health Commission of Canada was established in 2007 in response to the Canadian Standing Senate Committee on Social Affairs, Science and Technology report *Out of the Shadows at Last, Transforming Mental Health, Mental Illness and Addiction Services in Canada*. The report put forward a number of reasons for the establishment of a mental health commission, including:

- the commission would provide a much needed national focal point to keep mental health issues in the mainstream of the public policy debates;
- given the prevalence of mental illness, it was recognised as a truly national concern;
- no single level of government had the resources needed to deal with the full range of mental health issues on its own;
- the economic as well as the social implications of mental illness clearly made the case for a national response;
- managing issues which span ministerial and departmental boundaries was seen as 'notoriously hard' and a mental health commission would assist by facilitating the exchange of information on best practice;
- the commission would provide a mechanism for stakeholders in the mental health sector to exchange knowledge and information;

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39 *Committee Hansard*, 27 March 2008, p. 66.

40 Mental Health Commission, *New Roles for Mental Health Commission,* Media Release, 6 December 2006; Mental Health Commission, *About the Mental Health Commission*, www.mhc.govt.nz/about/index.html, accessed 28 March 2008.

- a national campaign to combat stigma and discrimination was needed and a mental health commission was the most effective mechanism for managing such a campaign.[41]

2.38 In its 2007 Budget the Canadian Government allocated $10 million over two years and $25 million per annum from 2009–10 to support the establishment of the Mental Health Commission of Canada. The Commission's Board is comprised of eleven non-government directors and six government-appointed directors. The Commission's role is focussed on three areas:

- developing a national mental health strategy, which Canada did not previously have;
- sharing knowledge and best practice, through creating an internet-based Knowledge Exchange Centre;
- undertaking public awareness and education, including implementing a 10-year national anti-stigma campaign.[42]

2.39 Professor Rosen and others have outlined some of the benefits of establishing an independent mental health commission in Australia, including:

- the ability to formally encompass human rights and antidiscrimination agendas for people affected by mental illness;
- having a mandate to monitor the adequacy of, and identify gaps in, mental health service provision, training, workforce, performance of management and government;
- the ability to provide continuity of purpose and goals for development of mental health services;
- the ability to pursue a positive practical agenda;
- the ability to operate at arm's length from ministers and government departments and work effectively with all stakeholders and agencies;
- reduce the need for continued external inquiries, by independently monitoring service adequacy and development;
- provide a mechanism to ensure that government investment is well made and widely appreciated.[43]

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41 Canadian Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last, Transforming Mental Health, Mental Illness and Addiction Services in Canada*, pp. 23–24.

42 Stephen Harper, *Mental Health Commission of Canada – Media Backgrounder*, 31 August 2007; Mental Health Commission of Canada, *Key Initiatives*, www.mentalhealthcommission.ca/keyinitiatives.html, accessed 28 March 2008.

43 A. Rosen, P. McGorry, G. Groom, I. Hickie, R. Gurr, B. Hocking, M. Leggett, A. Deveson, K. Wilson, D. Holmes, V. Miller, L. Dunbar, F. Stanley, 2004, 'Australia needs a mental health commission', *Australasian Psychiatry*, Vol 12, No. 3, pp. 213–219.

2.40 Representatives from a range of organisations, including ORYGEN Youth Health, the Mental Health Council of Australia, the Brain and Mind Research Institute, CASP and SANE Australia have expressed support for the establishment of a mental health commission in Australia.[44]

2.41 It is worth noting that in both New Zealand and Canada, the establishment of national mental health commissions occurred at the outset of mental health service reform processes. Indeed, the Mental Health Commission of Canada has the task of developing a national mental health strategy. Mental health reform in Australia has progressed beyond this initial stage, as illustrated by the sequence of National Mental Health Plans that have already expired. Along the way government advisory bodies have been established and peak advocacy bodies have formed, which have performed some of the roles of the mental health commissions outlined above. Nevertheless, aspects of the functions of the mental health commissions in New Zealand and Canada have been left under-developed in Australia. These include for example, formally monitoring the human rights experiences of people with mental illness, advancing community awareness and destigmatisation, and routinely and independently monitoring service adequacy.

A recovery focus in mental health policy

2.42 A view commonly expressed to the committee was that future mental health policy in Australia should be driven by a recovery focus. The Queensland Alliance Mental Illness and Psychiatric Disability Groups promoted recovery as the basic ethos for the entire mental health system, emphasising that the system should be focussed on consumer outcomes and consumer needs.[45] There was discussion in the evidence about how the term 'recovery' is coming to be used in the mental health sector.[46] Committee members were keen to assess whether there has been a change in the philosophy underpinning services, or whether 'recovery' has been adopted as a 'buzz' word over the top of existing services and ways of working.

2.43 Mr Harris, Executive Director of the Mental Health Coalition of South Australia described a recovery approach as follows:

> It is really about supporting people to get on with their lives despite illness. So it is a fairly simple concept in terms of seeing the endpoint, but when you are actually trying to support someone in that way it is a lot more

44 See above reference and also SANE Australia, *Proof Committee Hansard*, 1 April 2008, p. 8; National Mental Health Consumer and Carer Forum, *Committee Hansard*, 20 May 2008, p. 73.

45 The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, *Proof Committee Hansard,* 26 March 2008,p. 4.

46 See Richmond Fellowship Western Australia, *A common purpose: Recovery in future mental health services,* Joint Position Paper 08 for a discussion of the recovery concept.

> complicated. What the recovery model gives you is a set of principles to reflect on in your practice.[47]

2.44 Mr Miller, a peer support worker with Richmond Fellowship WA explained that the process of recovery is different for everyone:

> Recovery does happen. It is a different journey for everyone. Some people would like to be off their medication as part of their recovery; for me, taking my medication every day is an essential part of my recovery because it helps to keep me the way I like to be.[48]

2.45 Evidence to the committee suggests that recovery-oriented services need to become a central feature of the mental health system. It should not be assumed that all services are yet adopting a recovery framework. Mr Senior, Acting President of the Mental Health Coalition of South Australia, described the contemporary focus on recovery as the start of a journey. He argued that 'we need to continue to not only use the lexicon but also to grapple with what are the philosophical and values driven components to that'. Mr Senior assessed that:

> …we have some significant workforce issues to grapple with and a long entrenched culture to change, which will take, I suspect, another couple of decades.[49]

2.46 Similarly, Mr Wright explained that while South Australia has rewritten its models of care and provided a significant amount of training on recovery, there is still a lack of understanding about what recovery is. He said:

> I have to be honest. I still have clinicians who are of the view that once you have mental illness you will never recover. That is really sad, because recovery, as you know, is not about 'you will be free from mental illness'; it is about having a life worth living even with a mental illness. We still have a lot of work to do, although we do have many people on board.[50]

2.47 Mr Lamb, from Anglicare Tasmania, pointed to the need to properly understand the recovery concept. He emphasised that it should not be used as a leaver for reducing services, noting that many people will still need support 'probably for the rest of their lives because of the illness that they are living with'.[51]

2.48 Ms Carmody, Executive Manager Ruah Community Services, observed that with more people with mental illness coming forward and sharing their recovery stories, there is greater awareness that recovery is possible. However, she cautioned:

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47 *Proof Committee Hansard*, 8 May 2008, p. 9. See also Richmond Fellowship WA *Proof Committee Hansard*, 7 May 2008, p. 31.

48 *Proof Committee Hansard*, 7 May 2008, p. 34.

49 *Proof Committee Hansard*, 8 May 2008, p. 9.

50 *Proof Committee Hansard*, 8 May 2008, p. 92.

51 *Proof Committee Hansard*, 31 March 2008, pp. 39–40.

> …the problem is that once something becomes popular everybody will start putting it in their mission statements and in their program objectives. One thing we do know is that there is a whole way of working to be supportive of recovery and unless service programs and service systems have some of those very principles built in, which go right from management to your front-line staff, to the way people are treated and given information, and believe in the opportunities, it is just words.[52]

2.49 Mr Calleja, Chief Executive Officer Richmond Fellowship WA, agreed that recovery needs to permeate the policies, practice and procedures of entire organisations. He pointed to a critical gap between the rhetoric of recovery and the service delivery that actually facilitates recovery:

> The reality is that the state in WA uses the term 'recovery'—and I believe uses it in good faith…but recovery is actually expensive. If you are going to do proper recovery work, it costs more money and so the gap that exists is between what the state recognises is the value of recovery and what it is prepared to pay for in contracts for the non-government sector to allow it to occur...[53]

2.50 The committee is pleased to hear that the concept of recovery has received increased focus and is gradually permeating at least some mental health services in Australia. It notes and remains concerned by comments made regarding the cultural change still needed in some parts of the sector. Recovery is a core concept to consider and incorporate in setting the future direction of mental health services in Australia.

Concluding comment

2.51 Evidence to the committee's inquiry reflects current uncertainty about the direction of mental health policy in Australia. The fit between the COAG National Action Plan and the National Mental Health Strategy has not been articulated and there is caution as to the future of mental health services after the COAG Plan expires. While the COAG National Action Plan provides valuable investment in mental health services and includes a raft of initiatives, it is inadequate as a policy document setting direction for the future. The committee notes that with the completion of the *National Mental Health Plan 2003–2008* the Government is reviewing national mental health policy.

2.52 The committee considers it is necessary for the Commonwealth, state and territory governments to develop a new policy document for mental health services in Australia, potentially in the form of a new National Mental Health Plan. The committee considers that there are valuable lessons to be learnt from the transparency inherent in New Zealand's approach. Clear service and funding targets are a means to articulate what a community-based, recovery-focussed mental health system in

52 *Proof Committee Hansard*, 7 May 2008, p. 44.

53 *Proof Committee Hansard*, 7 May 2008, p. 44–45.

Australia should comprise. A refreshed mental health policy document should not simply focus on the initiatives that are already in place or scheduled to commence, but provide a vision and guidance for the future of mental health in Australia.

Recommendation 1

2.53 The committee recommends that the Australian Government, in consultation with state and territory governments and mental health stakeholders, develop a new national mental health policy document to succeed the National Mental Health Plan 2003–2008. The policy document should provide a clear vision of the services required in a community-based, recovery-focussed mental health system in Australia to 2015, including, but not limited to, mental health promotion and mental illness prevention and early intervention services, community-based clinical and psychosocial services, step-up and step-down transition services, crisis and acute services, as well as accommodation, education, training, employment and other community support services for people with mental illness. The policy document should include service, funding and consumer outcome benchmarks in each of these identified areas.

2.54 The Committee notes the contribution that the Mental Health Commission of New Zealand has made to mental health service reform in New Zealand. It also notes the establishment of the Mental Health Commission of Canada. The committee considers that while aspects of these organisations' function have been taken up by other bodies in Australia, some areas remain under-developed.

Recommendation 2

2.55 The committee recommends that the National Advisory Council on Mental Health be funded to establish standing committees in each of the following areas:

- **monitoring human rights abuses and discrimination against people with mental illness;**
- **advancing community awareness of mental illness and destigmatisation;**
- **monitoring service adequacy and progress towards an effective community-based, recovery-focussed system of mental health care.**

The committee recommends that each standing committee report directly to the National Advisory Council. In addition, the committee recommends that the National Advisory Council table the reports of the three standing committees in Parliament on an annual basis.