CHAPTER 5

PERSONAL HELPERS AND MENTORS

The Personal Helpers and Mentors program

5.1 The community program with the largest budget in the COAG Plan, and the one about which the committee received most comment, was the Commonwealth's Personal Helpers and Mentors program (PHaMs). PHaMs provides funding to non-government organisations to engage personal helpers and mentors to assist people with mental illness who are living in the community to better manage their daily activities. The COAG Plan stated that through PHaMs:

> People with a severe mental illness will be assisted in accessing the range of treatment, income support, employment and accommodation services they need.[1]

5.2 $284.8 million was allocated to PHaMs to engage 900 personal helpers over four funding rounds: 140 in the first round, 260 in the second round, 400 in the third round and 100 in the final round.[2] Each personal helper and mentor works with up to 10–12 consumers,[3] so the program has the capacity to assist some ten thousand people.

5.3 Funding is distributed to selected geographic sites through a competitive tender process. Each site employs around five personal helpers and mentors. The first two funding rounds have been completed and in 48 sites across the country personal helper and mentor workers are available to support people with mental illness in their recovery journey. The third funding round, although delayed, is underway with successful providers scheduled to be advised in November 2008.[4]

Support for the program

5.4 Witnesses applauded the funding and scope of the PHaMs program. Ms Carmody, Executive Manager of Ruah Community Services commented that PHaMs was the first program she had seen in Australia 'where we were serious about the size of the program'. She considered that the funding for five full-time employees per

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1 COAG Plan, p. 10.

2 FaHCSIA, www.facsia.gov.au/internet/facsinternet.nsf/mentalhealth/phm_faq.htm, accessed 30 July 2008.

3 *Proof Committee Hansard*, 26 March 2008, pp. 30 and 53; *Proof Committee Hansard* 7 May 2008, p. 39; *Proof Committee Hansard* 31 March 2008, p. 35.

4 FaHCSIA, www.fahcsia.gov.au/internet/facsinternet.nsf/MentalHealth/pham_program.htm, accessed 30 July 2008.

PHaMs site was 'not enough but it is the best I have ever seen in Australia in the last 20-odd years'.[5]

5.5 Similarly, Mr Calleja, Chief Executive Officer of Richmond Fellowship WA commented:

> …the Personal Helpers and Mentors program has the potential to transform the landscape in Australia. It is a really good program. Although we would like to see more funding, it is certainly a better funded program than maybe some of the equivalent ones across Australia from a state government perspective.[6]

5.6 PHaMS is a program with the potential and flexibility to engage those who have not been accessing services. Submitters and witnesses noted in particular that 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.

5.7 There are different pathways into the program, including self referral, with or without assistance from carers, family and friends and referral from other service providers. Open Minds, a PHaMs provider in Brisbane, estimated that about 40 per cent of people accessing PHaMs services self refer, with around 60 per cent referred by other service providers. Top End Mental Health Association, a PHaMs provider in Darwin, noted that it had received referrals through the rural and remote clinical team but that other services, such as the police, schools and the local in-patient unit also facilitated referrals.[7] Ruah Community Services in WA commented that its PHaMs program has had a lot of self-referrals and referrals coming through family members, compared with its existing Inreach program where referrals tend to come through the public mental health system or other allied health services.[8]

5.8 In addition to the self-referral pathway, some of the other strengths of the program mentioned by witnesses included:

- it has a recovery focus;
- it operates at a 'grassroots' level;
- there are flexible ways of entering the program, and delivering the program;
- there is no time limit on involvement in the program;
- the emphasis is on community support and social connection;
- it is non-medicalised/non-clinical;

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5 *Proof Committee Hansard,* 7 May 2008, p. 30.

6 *Proof Committee Hansard,* 7 May 2008, p. 46.

7 *Proof Committee Hansard,* 1 May 2008, p. 42.

8 *Proof Committee Hansard,* 7 May 2008, p. 79.

- it values peer support; and
- there is recognition of support worker development, with some of the program funds able to be used to train staff.[9]

5.9 The committee heard that the activities undertaken by PHaMs workers and their clients are many and varied, with flexibility to suit an individual's recovery plan. Some examples given to the committee included:

- supporting someone to increase social activity and exercise, by helping them to participate in a local sports club;
- accompanying someone to other appointments to help reduce anxiety levels;
- helping link someone into clinical services through a GP referral to psychological services;
- assisting someone to re-establish family links and secure permanent, long-term accommodation;
- assisting people with independent living skills, including meal planning, nutrition and cooking;
- preparation for employment, including assistance with using public transport and personal presentation;
- case management and coordination;
- assisting someone to participate in volunteering, who had 'not got out and about for many years'.[10]

5.10 A more detailed case study presented by UnitingCare Wesley Port Adelaide illustrated the strengths of the program, such as the open referral process, early intervention and ability to connect with community groups. Elements of the case study are presented below:

> We had two clients referred to us at about the same time—both were women in their 40s and both had issues relating to obsessive compulsive disorder and hoarding. The first lady had been removed from her home twice through council and sanitary orders due to having animal and rubbish hoarding. No support service was available to her and she did not come through adult mental health services until after the second order, when she

9 See The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, *Proof Committee Hansard*, 26 March 2008, p. 14; Open Minds *Proof Committee Hansard*, 26 March 2008, pp. 50–51; Ruah Community Services, *Proof Committee Hansard*, 7 May 2008, p. 39; WAMIAC, *Proof Committee Hansard*, 7 May 2008, p. 57; Mental Health Coalition of South Australia, *Proof Committee Hansard*, 8 May 2008, p. 3; Mental Illness Fellowship of Australia, *Proof Committee Hansard*, 8 May 2008, p. 37; UnitingCare Wesley Port Adelaide, *Proof Committee Hansard*, 8 May 2008, p. 56; Mental Health Coordinating Council, *Proof Committee Hansard*, 27 March 2008, p. 35.

10 *Proof Committee Hansard*, 26 March 2008, p. 57; *Proof Committee Hansard*, 7 May 2008, pp. 39–42, 47; *Proof Committee Hansard*, 8 May 2008, pp. 64-65.

> had a complete breakdown and was brought to the attention of adult mental health. Subsequently, she is now under an administration and treatment order, has $15,000 of debt with council clean-up fees and reports feeling depressed and anxious about her situation. The second woman was referred to us as a result of us promoting [PHaMs] to a community centre. This woman had exhibited hoarding behaviours inside and outside of her house that, as she had described, had escalated out of control, but she did not know where to go to get help. The community centre was able to recognise this and contacted us because we had had face-to-face contact with them.
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> …As for the second woman, she has been able to clear out a lot of her rubbish by herself. She has been able to get a proper diagnosis and timely treatment, through a clinician and through the psychosocial support package that we offer. Before and after photos of her house show that she is definitely making inroads. Housing SA has said that her tenancy is no longer at risk because she is showing a huge effort in her clean-up and they have no concerns at present.[11]

Concerns about the program

5.11 While responses to the basic PHaMs concept were overwhelmingly positive, some concerns were also expressed but the committee considers they can be easily addressed. Witnesses noted that the program was in its early days, but were concerned about the following:

- the stigmatisation that might result from being involved in the program, even when a person does not have a diagnosed mental illness;
- lack of clarity as to what the program will involve and what exactly personal helpers and mentors will do;
- lack of clear service standards or benchmarks;
- ensuring that the program is not paternalistic;
- the potential for personal helpers and mentors to over-ride the rights of people with a mental illness, in their efforts to do good;
- the possibility of using the PHaMs funding more effectively, through more regulated and structured programs.[12]

5.12 Representatives of the Australian Mental Health Consumer Network also noted that the program had changed names since the original proposition, from 'recovery support workers' to 'personal helpers and mentors'. Ms Connor, Executive Director, stated:

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11 Ms Karen Bradbury, Acting PHaMs Team Leader, *Proof Committee Hansard*, 8 May 2008, p. 57.

12 See for example Mental Health Advocate, Advocacy Tasmania Inc, *Proof Committee Hansard*, 31 March 2008, p. 48; Tasmanian Community Advisory Group on Mental Health *Proof Committee Hansard*, 31 March 2008, p. 51.

> As consumers, we do not really need a personal helper. We do not need to be 'helped' in that way—supported, yes. I suppose that is just semantics, but to consumers it is very important that we are supported in our recovery journey and not helped along the way.[13]

5.13 Some of the main concerns discussed in relation to PHaMs were whether the program is being accessed by those with the most complex needs, the limited coverage of the PHaMs sites, whether providers are trained and equipped to meet the needs of people with severe mental illness and how the program will be evaluated. These issues are discussed in the remainder of this chapter.

Who is the program for and is it reaching them?

5.14 The COAG Plan stated that PHaMs would assist people with 'a severe mental illness'. Because people do not have to have a diagnosed mental illness to access the PHaMs program it has the potential to reach people who have not been in contact with other services, including the clinical services where a diagnosis might have been made. While this is a positive, providers also need to be careful to ensure that the program is reaching the people it was designed to help, that is, those whose lives are severely affected by mental illness and not others who, for other reasons, may need assistance.

5.15 Eligibility for the program is defined around functional limitations. Thus the eligibility screening process looks at the difficulties that someone is experiencing in their life that are reasonably attributed to problems with their mental health.[14] All PHaMs providers use a standard eligibility screening tool, developed by DoHA in consultation with psychiatrists, psychologists, GPs and others. The tool is designed to identify people whose life is severely affected.[15] Ms Desailly, from Open Minds, described the screening tool as follows:

> It is a series of questions, many of which are trying to ascertain the person's functional limitations, looking at how they manage in different facets of their life, whether it be using public transport, performing household tasks or having interactions with other people. We conduct that assessment then we input all of that data into the eligibility screening tool, and it basically tells us whether that person is eligible for the program or ineligible.[16]

5.16 The Australian Mental Health Consumer Network (AMHCN) was concerned that the program had shifted over time away from its original intention. AMHCN representatives understood that originally PHaMs was to be focussed on people with severe and persistent problems who were not already connected to services. Part of the

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13 *Proof Committee Hansard*, 26 March 2008, p. 28.

14 See Mr Bernard Wilson, CEO, Open Minds, *Proof Committee Hansard*, 26 March 2008, p. 55; Mr Evan Lewis, Group Manager, DoHA, *Proof Committee Hansard*, 16 May 2008, pp. 90–91.

15 Mr Evan Lewis, Group Manager, DoHA, *Proof Committee Hansard*, 16 May 2008, p. 91.

16 *Proof Committee Hansard*, 26 March 2008, p. 56.

role of the PHaMs worker would be to facilitate access to the health system to have the person assessed. AMHCN representatives considered that the program had not evolved in this way.[17]

5.17 Mr Lewis, Group Manager FaHCSIA, noted that from the information available FaHCSIA estimates that around 92 per cent of PHaMs clients do have a diagnosed mental illness. For those that do not have a diagnosis he said 'there is a referral pathway and there is a recognition that we should give people clinical care as soon as possible'.[18] Mr Lewis also indicated that FaHCSIA would continue to monitor the percentage of people in the program that do have a diagnosed mental illness, with 90 per cent providing a 'fairly good target'. Nevertheless, this information alone does not indicate the severity of the illness of those participating in the program.

5.18 Dr Groves, Director of Mental Health in Queensland, also expressed some concern about who the program is actually reaching:

> One of the difficulties I still have is that many of the people who access the PHaMs project are people who have mild to moderate forms of illness, not severe forms of illness or high levels of disability. We had hoped that this program was really about trying to assist those people that fall through the gaps. People with mild to moderate illness usually should have the wherewithal to be able to access services, and we were hoping this program might be orientated towards the people who have more difficulty with that, or [need] more support for that. Without being able to get in and interrogate the data, what we have seen suggests to us that maybe some of that might not have worked well.[19]

5.19 The experience of the Mental Illness Fellowship of South Australia suggests that at least some PHaMs providers are focussed on meeting the original intention of the program. Ms Miliotis described the Fellowship's experience:

> It would be very easy to find people to fill the books. What we are aware of is that PHaMs are very keen on finding people with severe mental illness who have a functional limitation—quite a severe functional limitation—as a result of their psychiatric disability, diagnosed or otherwise, and who potentially have fallen between the cracks. So we have taken a careful approach to that but we are well over halfway.[20]

5.20 The Northern Territory Mental Health Coalition also observed that while there are still people with mental illness who are not getting services, community organisations are 'stepping out in the communities' and starting to reach people who had not traditionally received services.[21] TEAM Health, a PHaMs provider in the

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17 *Proof Committee Hansard,* 26 March 2008, p. 28.

18 *Proof Committee Hansard,* 16 May 2008, p. 91.

19 *Proof Committee Hansard,* 16 May 2008, p. 62.

20 *Proof Committee Hansard,* 8 May 2008, p. 45.

21 *Proof Committee Hansard,* 1 May 2008, p. 5.

Northern Territory, felt that they are reaching people who had been 'falling through the gaps', including working with people with alcohol and other drug issues as well as mental illness and working in Aboriginal communities.[22]

People who are excluded

5.21 Concerns were raised that the eligibility requirements for PHaMS exclude some people. The Northern Territory Mental Health Coalition raised concerns that ex-prisoners with an existing court order and people with drug and alcohol issues who have not committed to addressing those issues, are not eligible for the PHaMs program. PHaMs providers clarified that since the second funding round they have been able to work with people coming out of prison.[23]

5.22 In relation to drug and alcohol addictions, FaHCSIA explained that people with both drug and alcohol addictions and mental illness are eligible for the program. However the screening tool includes a question about whether the person is 'prepared at least to do something about it as a statement of commitment to be involved in the process'.[24] Mr Lewis explained that the particular question had been designed on advice from the Australian Institute of Health and Welfare and is not about 'whether the person is going to stop taking drugs or stop using alcohol or any other instance of substance abuse'. FaHCSIA staff stated that they have been monitoring the number of people who are turned away from the program on the basis of their response to this question, with around 0.05 per cent unable to enter the program for this reason.[25]

Geographic coverage

5.23 One of the main limitations raised about PHaMs was that it was rolled out on a postcode basis.[26] In the first funding round, some of the geographic sites selected were clearly misplaced:

> In the first round a Westfield car park was one of the dedicated postcodes. People were having trouble filling PHaMs because the area that they were able to access people from just did not have a high level of need. There was another that was a university campus. So someone just had not done their homework, and I go back to the fact that they had not consulted local organisations in deciding where they were going to go.[27]

22 *Proof Committee Hansard*, 1 May 2008, p. 37.

23 Top End Mental Health Association Inc, *Proof Committee Hansard*, 1 May 2008, p. 5.

24 *Proof Committee Hansard*, 16 May 2008, p. 92.

25 *Proof Committee Hansard*, 16 May 2008, p. 92.

26 *Proof Committee Hansard*, 8 May 2008, pp. 38 and 56.

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

5.24 While the selection of postcodes was said to have improved in the second funding round,[28] issues remain. Mental Illness Fellowship of South Australia summarised the problem:

> …you have got people who, for all other intents and purposes, are eligible for the programs but by default cannot access them because they are living in suburbs in the wrong postcodes…We understand that there are moves to try to open up, but of course that is very difficult for people to understand who are facing such barriers and such difficulties and who see such a fantastic program and yet are not able to access it.[29]

5.25 Further to the postcodes restriction within individual sites, there was also concern about the limited and patchy coverage provided by the sites funded so far, with large parts of each state not covered by a PHaMs provider.[30] Mr Warner, from UnitingCare Wesley Port Adelaide, commented that the roll out of PHaMs did not 'seem to be equitable across the state', noting that country areas and areas with large culturally and linguistically diverse (CALD) and refugee populations were not receiving services.[31]

5.26 With the largest of the PHaMs funding rounds (for 400 workers in an additional 80 sites) currently underway and another smaller round (120 workers) scheduled for 2009, the effect of the limited geographic coverage of the program may diminish over time. However, Ms Bradbury, UnitingCare Wesley Port Adelaide commented that from the current position, 'it is difficult to see how the rest of those areas are going to be filled'.[32]

5.27 The underlying concept of geographic-based service distribution was questioned by some submitters. They argued that allocating funding around population groups with specific needs, such as CALD clients, older people, Indigenous people, youth, homeless people and rural and remote, rather than a generic population in a given area, may be a better way to use the available money.[33]

5.28 Based on the evidence that in many areas PHaMs is working well, that there is ongoing need and that the self-referral pathway is facilitating access by people who may not be involved with other services, the committee recommends an expansion of the program to enable access by those outside currently designated sites.

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

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

30 For example, Mental Health Coordinating Council, *Proof Committee Hansard*, 27 March 2007, p. 34.

31 *Proof Committee Hansard*, 8 May 2008, p. 57.

32 *Proof Committee Hansard*, 8 May 2008, p. 62.

33 See for example the discussion in *Proof Committee Hansard*, 27 March 2008, p. 30; Community Mental Health Peaks, *Submission 39*, pp. 6, 17, 60

Recommendation 9

5.29 The committee recommends that the Government give high priority to expanding the coverage and location of Personal Helpers and Mentors services across areas of unmet need in Australia.

PHaMs providers

5.30 Given the number of PHaMs providers across the country there is undoubtedly variation in their skills, experience and approach. The committee's inquiry gave insight into some of the issues facing PHaMs providers and the skills and abilities of PHaMs staff.

PHaMs staff

5.31 PHaMs providers across Australia have had different experiences attracting and retaining staff. Open Minds in Brisbane and the Mental Illness Fellowship of South Australia were examples of providers that had no difficulties recruiting high-calibre personnel, with a lot of interest in the program.[34] However, the Northern Territory Mental Health Coalition commented that PHaMs providers in the Territory have had difficulty attracting staff. They noted that services in the territory are rarely attracting new people, with 'poaching' occurring among the government and non-government services already in existence.[35] In such circumstances funding for new programs does not necessarily translate into increased service availability.

Peer support workers

5.32 Peer support was regarded as an integral component of the program. Currently the program aims for at least one in every five personal helpers and mentors to be a peer support worker, that is, a person with a declared lived experience of mental illness. Not all sites have yet met this goal.[36]

5.33 The Mental Illness Fellowship of South Australia exceeds the one in five peer support worker requirement, with five out of eight of its PHaMS staff having a lived experience of mental illness. Ms Miliotis observed that other workers also have a lived experience of mental illness, but choose not to publicly share that. The Fellowship noted that it conducts recruitment on the basis of merit, so 'if someone with a lived experience has got the position they have got it on merit in addition to bringing all those skills'. The Fellowship's experience was a good reminder that involving consumers in service delivery can and should be a normal experience. Indeed Ms

34 See Open Minds, *Proof Committee Hansard,* 26 March 2008, p. 54; *Proof Committee Hansard,* 8 May 2008, pp. 46–47.

35 *Proof Committee Hansard,* 1 May 2008, p. 6.

36 *Proof Committee Hansard,* 26 March 2008, pp. 54 and 59.

Miliotis commented that, given the philosophy of the Fellowship, they do not designate 'you are the peer worker and you guys aren't'.[37]

5.34 Ms Bugeja, Manager of the Brook Red Centre, a consumer run service with long experience in peer support work, noted that the recent increased focus on peer support workers has raised the need for training and support for these workers. The Brook Red Centre has had numerous requests from PHaMs providers and the hospital system for peer support training. Ms Bugeja noted 'I think it needs to be formalised and there need to be some standards around it, because there are some very different ideas with other services around what a peer workers' role is'.[38]

5.35 The issue of training and qualifications, not only for peer support workers but for all personal helpers and mentors, was pursued with witnesses and is discussed below. The committee returns to the issue of peer support and consumer run services generally in chapter 8.

Qualifications and training

5.36 While many witnesses acknowledged the program for having a recovery focus and for incorporating peer support, concerns were expressed about the adequacy of training provided to personal helpers and mentors. The Queensland Alliance Mental Illness and Psychiatric Disability Groups commented on skills needed to assist the people accessing the program:

> These people are not people who have occasional bouts of depression. They are people who are clearly identified as really high end users of the acute mental health system and probably other health systems as well. The expectation that you can have a day's training for somebody to proactively help this person return to some sort of better life is ludicrous.[39]

5.37 The Australian Mental Health Consumers Network was concerned that contracts with PHaMs suppliers do not specify what kind of training is necessary, but leave this for the organisation to determine. On the other hand, the Northern Territory Mental Health Coalition saw the fact that PHaMs is not prescriptive about training requirements as one of the benefits of the program.[40]

5.38 Several PHaMs providers, including the Richmond Fellowship and Ruah Community Services in Western Australia and Mental Illness Fellowship of South Australia commented on the high level qualifications of their personal helpers and

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37 *Proof Committee Hansard,* 8 May 2008, p. 45.

38 *Proof Committee Hansard,* 26 March 2008, p. 87.

39 The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, *Proof Committee Hansard*, 26 March 2008, p. 14

40 *Proof Committee Hansard,* 1 May 2008, p. 6.

mentors, with many having one or more tertiary qualifications.[41] Ms Miliotis commented that it would be difficult to undertake PHaMs work with less than a certificate IV qualification, given the direct mental health training required.[42] The Government of South Australia noted that in general it is moving towards a minimum qualification of certificate IV for non-government service providers.[43]

5.39 In contrast, UnitingCare Wesley Port Adelaide noted that two of its PHaMs workers do not have a certificate IV. Ms Bradbury, Acting PHaMs team leader, commented that they have 'between them more than 30 years experience in disability and mental health and personal support services' and considered that such experience more than outweighed a Certificate IV qualification.[44]

5.40 While recognising training, qualifications and experience in the sector witnesses also noted the skills and understanding that can be brought to the role from a lived experience of mental illness. As noted above, the PHaMs program explicitly recognises consumer involvement in service provision, through peer worker requirements. Mr Miller, of the Richmond Fellowship WA, reminded that committee that lived experience of mental illness and professional qualifications are not exclusive, with many individuals having both, and certainly PHaMs teams able to integrate a combination. He noted with reference to the local PHaMs teams:

> We have qualifications in education, psychology, social work and women's studies, and that combination of university qualifications and lived experience is really essential, I believe, to providing a good service.[45]

5.41 The AMHCN saw the opportunity to further enhance the combination of skills that come from both formal qualifications and lived experience of mental illness. AMHCN advocated the provision of consumer run training to other PHaMs and mental health workers. Ms Connor, Executive Director, explained:

> I would like consumer organisations to develop some training that workers in NGOs in the field could participate in so that they would understand what it was that the consumers needed and have an understanding of what it is like for people to live with a mental illness. After all, these workers are working with people with severe and persistent mental illness, so they need an understanding of where the consumer is coming from. There is no training like that available.[46]

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41 *Proof Committee Hansard*, 1 April 2008, pp. 35 and 39; *Proof Committee Hansard*, 8 May 2008, p. 46.

42 *Proof Committee Hansard,* 8 May 2008, p. 46.

43 *Proof Committee Hansard,* 8 May 2008, p. 82.

44 *Proof Committee Hansard,* 8 May 2008, p. 64.

45 *Proof Committee Hansard,* 7 May 2008, p. 35.

46 *Proof Committee Hansard,* 26 March 2008, p. 28.

5.42 The committee acknowledges that a range of factors must be balanced in considering the training and qualification requirements for PHaMs workers. Without specified minimum qualifications the program is able to draw on a wider pool of workers and has the flexibility to tap into the great breadth of lived experience and previous experience in the sector as well as formal training and qualifications that people have. The current arrangements place responsibility with individual PHaMs providers to ensure that their workers have the skills and abilities needed to perform the helper and mentor role effectively.

5.43 The committee considers that the key issue is whether consumers are being assisted in their recovery by their personal helper and mentor. It is important to ensure the program maintains high service standards, but this cannot be guaranteed only by looking at the qualifications of workers. The outcomes being achieved by consumers, their level of satisfaction and complaint are all relevant.

5.44 The committee acknowledges the knowledge and understanding that a lived experience of mental illness can contribute to PHaMs and other recovery work. It supports the suggestion that consumer-run training be developed for mental health workers to provide an understanding of the consumer experience. It considers that such training can contribute to breaking down the stigma and negative culture around mental illness that exists in some mental health services. Consumer-run training is also an important element to enhancing consumer representation and involvement in mental health service reform, discussed more generally in chapter 8.

Recommendation 10

5.45 The committee recommends that the Department of Health and Ageing, the Department of Education, Employment and Workplace Relations, the Mental Health Council of Australia and consumer representatives be funded to work together to develop a consumer-run training package for mental health workers focussed on the lived experience of mental illness. The committee recommends that the training be in a modularised format so that components can be delivered within existing NGO, vocational and professional training.

Capacity

5.46 None of the service providers that the committee spoke with were yet at maximum capacity for the PHaMs program, indeed some were still at an early set up stage. This meant they were able to keep taking on new participants. However, it is clearly possible that in time there will be more people wanting to use PHaMs than places available. Ms Bradbury, UnitingCare Wesley Port Adelaide, commented that information from FaHCSIA shows that around 50,000 people would be eligible for the program nationally, but that at full capacity only around 10,000 will be able to participate.[47]

47 *Proof Committee Hansard*, 8 May 2008, p. 63.

5.47 Providers generally had not decided what approach would be used by their organisation once PHaMs is at full capacity.[48] Will new participants be accepted on a first come first served basis? Will providers attempt to triage, so that those most in need are accepted first? Will time limits be set on participation? Addressing these questions will be important for how well PHaMs works into the future, particularly if it is to remain focussed on those who are outside existing service networks. The program needs to avoid setting up a context, unintentionally or otherwise, in which providers may be inclined to select less difficult participants over people with more challenging illnesses and circumstances.

5.48 UnitingCare Wesley Port Adelaide had put some thought into how it could manage over-demand for the PHaMs program:

> We certainly have thought about waiting lists. After just three months, we are at over 60 per cent capacity, so we know it is not far away. We do see some clients as having shorter-term needs than others, so there will be some people who will exit the program, we think, in six to 12 months—so there will be some flow-through. We have also thought about utilising the funds we have been provided with to have support group programs…so that, if we cannot provide a direct service one-to-one, as planned, we can link people into this service and into other group services and activities until we can manage them one-to-one. We also plan to keep in some sort of minimal phone contact with people who are on waiting lists and we hope that, in that way, as has happened with our GP Access South program, we can keep waiting lists to an absolute minimum.[49]

5.49 Mr Warner, Manager of Community Mental Health Programs at UnitingCare Wesley Port Adelaide, raised the important point that mental illness is often episodic in nature, so consumers may leave and need to re-enter programs. Managing demand for PHaMs will involve complex issues around the needs of those waiting to participate in PHaMs for the first time, as well as previous participants who need to re-enter the program. Witnesses noted that the Commonwealth does not have guidelines for managing demand for PHaMs, other than to try to link people into other appropriate services.[50]

5.50 The committee is strongly of the view that issues related to the capacity of the PHaMs program should be considered in reviewing the program so far, rather than waiting until people are, yet again, being turned away from services.

Recommendation 11

5.51 The committee recommends that FaHCSIA in conjunction with selected Personal Helpers and Mentors providers as a matter of urgency develop and

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48 See for example, Open Minds, *Proof Committee Hansard,* 26 March 2008, pp. 56 and 58; Anglicare Tasmania, *Proof Committee Hansard,*31 March 2008, pp. 35-36.

49 *Proof Committee Hansard,* 8 May 2008, p. 63.

50 *Proof Committee Hansard,* 8 May 2008, p. 64.

promote best practice methods for managing demand for the Personal Helpers and Mentors program.

Evaluation

5.52 Concerns were raised that PHaMs has been rolled out without an evaluation process in place. Mrs Boxhall, Tasmanian Community Advisory Group on Mental Health commented:

> There needs to be some sort of measure as to how effective and how appropriate it is. There needs to be some evaluation process and some benchmarks in place. We are dealing with very vulnerable people in our community and I think that those benchmarks are absolutely essential.[51]

5.53 The Queensland Alliance Mental Illness and Psychiatric Disability Groups emphasised that such evaluation should focus on outcomes for consumers:

> It would be some form of annual collection whereby people would be able to talk about safety, wellbeing, feelings of belonging and inclusion, housing, employment, health status and those sorts of things.[52]

5.54 Open Minds hoped the PHaMs program would have an early intervention effect and that in the long term it would be proven 'that those who encounter the program have less acute episodes and are better informed and connected to keep well'.[53] It was not clear that the program will be evaluated in such a way as to provide this information.

5.55 Ms Bateman, Mental Health Coordinating Council noted that sound evaluation is important to make the case for ongoing funding for programs such as PHaMs:

> We know from HASI in New South Wales that the comprehensive evaluation of the program has been responsible for its ongoing funding. Without serious evaluation demonstrating effectiveness in terms of consumer and carer outcomes and coordination within the service system, it will be harder to maintain and increase support to these programs.[54]

5.56 Dr Gerrard, Australian Association of Social Workers, emphasised that evaluation of PHaMs must be independent:

> The independence is quite critical, and I say that having heard responses from those who have been involved in the implementation from the federal government side of initiatives such as the PHaMs who did not want to

51 *Proof Committee Hansard,* 31 March 2008, p. 52.

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

53 *Proof Committee Hansard,* 26 March 2008, p. 58.

54 *Proof Committee Hansard,* 27 March 2008, p. 34.

> hear…about anything that was going wrong with the program because they were so sure that it was the right way to go.[55]

5.57 Comments from providers suggest that the way the program has been set up and the reporting that is required will provide valuable information for evaluation. Ms Carlson explained the information that is already collected by providers:

> Some of the data will come automatically off the electronic assessment tool and some of that is just gathering your normal information around ages and types of diagnosis, referral points—those kinds of things. Most of the reporting will come off that, so that makes it a bit easier. The written is going to be providing case studies of how people's lives have changed as a result of being in the program—recovery journeys and so on. The other level of reporting in those formats is really about where we have not been able to respond to particular needs and what that has been about and giving some clear information around some of the barriers for the service, but also for participants of that program.[56]

5.58 Similarly, Mr Lewis, Group Manager FaHCSIA, commented on the volume of data that is automatically generated about PHaMs program participants, including gender, CALD background, diagnosis, progress and beginning and end recovery plans.[57] Ms Boyson, Acting Branch Manager, explained the concepts FaHCSIA is looking at to measure the effect the PHaMs program is having:

> The notion that we are working on at the moment…is how people are progressing through various life domains. For example, we will look at how people are progressing in terms of their capacity for self-management and self-care and how people are progressing with their capacity to link and engage with the community, for example.[58]

5.59 The evidence to the committee suggests that a lot of information will be collected and able to be used to evaluate the PHaMs program. What seems to be lacking is clear understanding and articulation of the form that such evaluation will take. The PHaMs program is a major Commonwealth investment in a key area that was critically lacking in Australia's system of community-based care. While there are positive views about the capacity and flexibility of the program to fill some of the existing service gaps, the committee considers it essential that the PHaMs program be soundly evaluated. Such evaluation should look in detail at who is accessing the program, to ensure the original intention of assisting those with severe illness most at risk of falling through the gaps in existing services is being met. Secondly, it is important that the evaluation focuses on consumer outcomes and whether the program is working to assist consumers in their recovery journey.

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

56 *Proof Committee Hansard,* 31 March 2008, p. 39.

57 *Proof Committee Hansard,* 16 May 2008, p. 94.

58 *Proof Committee Hansard,* 16 May 2008, p. 92.

Recommendation 12

5.60 The committee recommends that FaHCSIA develop and publish an evaluation framework for the Personal Helpers and Mentors (PHaMs) program. The framework should pay particular attention to who is accessing the program and to consumer outcomes. The committee further recommends that all evaluations of the program be made public. Such evaluation should not however delay the expansion and further rollout of PHaMs services.