CHAPTER 8

SHORTFALLS AND GAPS

8.1 Evidence to the committee indicates that while the COAG Plan has increased access to some mental health care, services remain patchy and inconsistent. The funding contributed to mental health services through the COAG Plan was significant, however the effect of the funding and the adequacy of services in general varies across different areas, among different illnesses and across different population groups.

8.2 Ms Powell, from the West Australian Mental Illness Awareness Council, captured the diverse picture with regard to progress in mental health services:

> If you are talking severe persistent mental illness, I do not think there is any change. If you are talking abut episodic, one-off doses of depression, we have seen huge initiatives in the last couple of years and there have been improvements there. If you are talking about illnesses which are not necessarily severe and persistent—say, somebody who might have episodic bouts of depression—for a lot of them I am still hearing them say that it is about the same, unless they have been linked to the non-government sector.[1]

8.3 In this chapter the committee considers some of the key gaps and shortfalls that remain in the services available for people experiencing mental illness. The following chapter looks at specific groups of people whose needs are not being met by current services.

Housing and supported accommodation

8.4 Although increased access to stable accommodation was listed among the four outcomes of the COAG Plan, the need for more affordable and supported accommodation for people with mental illness was a key issue raised throughout the inquiry. Housing was high on the priority list across jurisdictions.[2] The Mental Illness Fellowship of Australia reported the results of a survey of its members which found that among over 2000 responses, housing and associated support was raised as the

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1 *Proof Committee Hansard*, 7 May 2008, p. 57.

2 See for example, Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, p. 1; Western Australian Association for Mental Health, *Proof Committee Hansard,* 7 May 2008, p. 1; Mental Health Coalition of South Australia, *Proof Committee Hansard,* 8 May 2008, p. 3; Mental Health Council of Tasmania, *Proof Committee Hansard,* 31 March 2008, p. 7; NSW Consumer Advisory Group – Mental Health Inc, *Proof Committee Hansard,* 27 March 2008, p. 48; Victorian Government, *Submission* 41, p. 9; Australian Association of Social Workers, *Proof Committee Hansard*, 20 May 2008, p. 38; Mental Health Community Coalition ACT, *Proof Committee Hansard,* 16 May 2008, p. 19; Mental Health Council of Australia, *Proof Committee Hansard,* 20 May 2008, p. 81.

most important issue.[3] Without housing, other efforts towards recovery are either limited or ineffective. For example, Ms Colvin, Head of the Council of Official Visitors in WA noted that people living in private psychiatric hostels need accommodation first before they can even start to access some of the new community-based initiatives, such as PHaMs.[4]

Extent of the shortage

8.5 The committee heard about the extent of the accommodation crisis in some areas. For example, Sisters Inside had purchased tents for women in Townsville to sleep with their children in a park, because no accommodation was available.[5] The Government of Western Australia gave a number of indicators of the extent of accommodation shortages for people with mental illness in the state. These included:

- WA currently needs 1,100 housing units for its Independent Living Program and there are 745 available. Demand is expected to increase to 1,300 housing units by 2012, by which time 930 will be available, leaving an accommodation gap of 370 housing units.
- A survey of all publicly funded designated mental health inpatient facilities found that around 303 people could be discharged if intermediate care and/or accommodation were available.
- Research indicates that up to 85 per cent of people who are homeless have a mental illness, and some 11,697 people were homeless in WA in 2001.[6]

8.6 The Northern Territory Mental Health Coalition explained that due to the lack of accommodation with high levels of support, consumers with complex care needs are being placed in in-patient facilities, not because they need to be but because there are no other alternatives.[7] In Queensland, Dr Groves noted that analyses of in-patient care in Queensland consistently show that around 30 to 40 per cent of people would not need to be there if sufficient supported accommodation was available.[8] In Western Australia Ms Colvin reported on a survey of Graylands hospital which found that of the 166 beds, 45 patients could have left if there was somewhere for them to go.[9]

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3 *Proof Committee Hansard*, 8 May 2008, p. 36. The next most important priority areas were employment options and opportunities, education for consumers and carers, research and issues relating to social security.

4 *Proof Committee Hansard*, 7 May 2008, p. 66.

5 Sisters Inside, *Proof Committee Hansard,* 26 March 2008, p. 73.

6 Department of Health, Government of Western Australia, Additional Information, 9 June 2008, pp. 9–10.

7 Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, p. 2.

8 *Proof Committee Hansard*, 16 May 2008, p. 55.

9 *Proof Committee Hansard*, 7 May 2008, p. 68.

8.7 Ms Colvin also referred to 'ghosts on the wards'; people who can be in locked wards for a year or more because there is no other suitable accommodation.[10] Similarly, Ms Williams, Mental Health Advocate, described the situation in Tasmania:

> There is a gap area in accommodation in Tasmania for these people who live in our mental-health facility. Every time you go there, the Mental Health Tribunal says, 'This person's being held unlawfully; it's not appropriate to their needs; they shouldn't be locked up.' The reply is, 'We've got nowhere else to send them; there's nowhere else to put them.' That is a continual problem. We have a large number of people presently in Tasmania who have been locked up for well over a decade.[11]

8.8 Also in Tasmania the committee heard that a crisis accommodation centre in Hobart was turning away around 80 people a month, with even fewer services available in regional areas of the state. Ms Swallow, Mental Health Council of Tasmania, said:

> …some of those people are ending up in police custody if they create enough of a noise, and they will say that it is their strategy to be kept warm and fed.[12]

8.9 It is clear that adequate housing for people with mental illness remains a major gap in the community-based care currently available. The effects are evident among a variety of groups: those with mental illness who are being held in hospitals because there is nowhere else for them to go; those who have no housing options and are homeless; and those that are surviving in less than therapeutic accommodation environments.

Types of accommodation needed

8.10 A range of accommodation types are needed to span the continuum of care necessary to support people with mental illness in the community. This includes long-term facilities, step up and step down facilities, supported accommodation with different levels of assistance through to general housing. Mental Health Coalition of South Australia representatives highlighted the need for not only more accommodation services, but for these to be linked to community and clinical mental health care:

> Not everyone is necessarily capable of moving from an acute situation into self-sustaining independent living, so we have a continuum of housing and accommodation needs that are not yet fully addressed. That goes to housing stock, the models of accommodation, the manner in which those models are delivered…and how those services are linked, not only to the focus of the

10 *Proof Committee Hansard*, 7 May 2008, p. 68.

11 *Proof Committee Hansard*, 31 March 2008, p. 46.

12 *Proof Committee Hansard*, 31 March 2008, p. 7.

> plan—which has been very much around community based services—but also to the acute and state-based mental health services.[13]

8.11 Mr Apsen commented on gaps in this continuum in Tasmania:

> …at a state level there is much too great a gap between acute hospital care and community living. I would classify the continuum of living that people with mental illness are able to do in four categories. One is hospital acute care. At the other end of the spectrum is independent community living of the nature that I am sure we in this room all enjoy. In between there needs to be some form of high care with professional support. At the moment—in Tasmania certainly—there are quite a range of non-government organisations available giving low-care supported accommodation. The gap between hospital care and that NGO care is one that concerns me.[14]

Funded initiatives

8.12 Some of the initiatives in the COAG Plan show that governments are aware of how important it is to address supported accommodation shortages. In some areas money has been put into providing more accommodation, across the spectrum required. For example, the Northern Territory allocated $5.5 million under the COAG Plan to establish an eight-bed mental health residential subacute care facility in Darwin and a similar service in Alice Springs.[15] The ACT's COAG Plan initiatives included a 24-hour supported accommodation step-up, step-down facility for youth with mental illness and the ACT Government has also allocated funding for an adult step-up, step-down facility.[16] In WA the committee heard that the Health Department in partnership with the Department of Housing and Works is rolling out a program including a spectrum of accommodation and support:

> There is a full range, from intermediate care, which is step up/step down, through to independent living in the community, including the Independent Living Program, which of course does provide a measure of support.[17]

8.13 In South Australia the government is moving away from its reliance on an institutional base and inpatient services to a stepped model of care. Mr Wright, Director of Mental Health Operations, explained that following the South Australian Social Inclusion Board's 2005-06 report *Stepping Up*, the state is developing 24-hour supported accommodation, community rehabilitation centres and intermediate care (step-up, step-down care) in addition to acute and secure care.[18]

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13 *Proof Committee Hansard*, 8 May 2008, p. 3.

14 *Proof Committee Hansard*, 31 March 2008, p. 11.

15 *Proof Committee Hansard*, 1 May 2008, p. 46.

16 *Proof Committee Hansard*, 16 May 2008, p. 29.

17 *Proof Committee Hansard*, 7 May 2008, p. 102.

18 *Proof Committee Hansard*, 8 May 2008, p. 78.

Further commitments required

8.14 The dominant theme presented in evidence was that despite such initiatives, more accommodation is needed. For example, the Northern Territory Mental Health Coalition noted the funding in the NT for 24-hour supported community-based services, but commented:

> The process of rolling out has been slow here because of staffing issues, and lots of other things. There are things in place that will improve it, but there need to be more of them.[19]

8.15 Similarly, Ms Springgay, Mental Illness Fellowship of Australia, commented:

> I think the HASI program in New South Wales is a good basis, but it is insufficient to meet the needs that exist. Western Australia also has a program, but again it is insufficient to meet all of the demand, as I understand it.[20]

8.16 In Western Australia the committee heard that funding is not always the limiting factor to providing more accommodation:

> They provide the money and the model and whatever, but the actual building, finding land and getting tradespeople to do the building has caused major delays.[21]

8.17 The committee was reminded of the very strong link between mental illness and homelessness. Witnesses from Richmond Fellowship expressed concern that the needs of this group has 'slipped under the radar screen of mental health'. Mr Miller, PHaMs Manager, observed that a whole-of-government approach working with the non-government sector is needed to alleviate mental illness and homelessness, given the complex issues involved and relationships between them. Mr Calleja, Chief Executive Officer, noted:

> The whole-of-government approach which is required needs to include departments, such as health, mental health, the Disability Services Commission, housing and work and others interfacing with the Commonwealth Department of Health and Ageing. And that is not happening at the moment.[22]

8.18 Ms Springgay, Mental Illness Fellowship of Australia, felt it was time for deliberate action between the federal and state and territory governments in relation to housing for people with mental illness. She noted that the Commonwealth-State Housing Agreement is due for review. Ms Springgay assessed:

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19 Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, p. 2.

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

21 WAAMH, *Proof Committee Hansard*, 7 May 2008, p. 4; see also Mr Thorn, Government of Western Australia, *Proof Committee Hansard*, 7 May 2008, p. 96.

22 *Proof Committee Hansard*, 7 May 2008, p. 33.

> I think there needs to be a quarantining of the funding, at least for a period of time, to establish the system, get the housing stock in place and maybe get a federal-state agreement about that, because again the states have ducked their responsibilities. One of the things that many of the states promised when they closed some of the big psychiatric institutions was that funding would go back into the provision of community services, and we all know that did not really happen…so the states, along with the federal government, really do have to face this.[23]

8.19 The evidence to the committee is clear that housing and supported accommodation remain a key shortfall in current mental health services. Without these kinds of fundamental support, other endeavours under the COAG Plan will be limited.

Recommendation 16

8.20 The committee recommends that state and territory governments substantially increase funding to establish more long-term, step-up and step-down community-based accommodation for people with mental illness that is linked with clinical and psycho-social supports and rehabilitation services.

Workforce shortages

8.21 The effect of workforce shortages on the provision of mental health services was a common theme raised across all jurisdictions, particularly with regard to remote areas.[24] Workforce capacity issues are affecting government and non-government providers. Examples provided to the committee indicated the extent of the effect of workforce shortages. For example, the Western Australian Council of Official visitors described a new intermediate care unit which is designed to take 18 consumers each for around a three month stay. However the unit opened with only eight residents due to staff shortages. Ms Colvin reported:

> I had been hearing as an official visitor for months about how this residence was all up, the painting was done, the new television was in; but then they could not open it because they did not have enough staff.[25]

8.22 Several jurisdictions pointed to the problems of competition for scarce workers. Particularly in rural and remote mining communities, public mental health services and community sector organisations are not able to offer competitive remuneration to attract staff. Witnesses in Darwin, Perth and Hobart also noted the disparity in remuneration between the government health sector and non-government

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

24 See for example, Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, p. 1; Carers SA, *Proof Committee Hansard*, 8 May 2008, p. 60; Mental Health Coalition of Tasmania, *Proof Committee Hansard*, 31 March 2008, p. 4.

25 *Proof Committee Hansard*, 7 May 2008, p. 67.

organisations, arguing for an increase in funding to NGOs to enable them to attract and retain staff.[26]

8.23 Survey results presented to the committee by the Western Australian Association for Mental Health (WAAMH) give basis to concerns about mental health workforce retention. The survey of mental health, drug and alcohol, women's health and domestic violence sectors found that 55 per cent of staff expected to stay with their current employer one year or less, and 35 per cent expected to stay in the sector for less than two years. The primary reasons for leaving included better wages and salaries, promotional opportunities elsewhere and stress or the desire for less stress.[27]

8.24 In the context of the desperate need for staff, there were also concerns about standards and quality, including ensuring that staff are well trained. There were also concerns about the wellbeing of existing staff. Ms Colvin observed:

> Double shifts are common; they are used all the time. That is of great concern to the council: tired and overworked staff cannot provide quality care, no matter how well trained they are. That is when rights tend to get abused too, because people are tired, they are overworked and so on. It can also lead to burnout…[28]

8.25 NGO providers, although pleased to see money being provided for community-based mental health services, are stretched in delivering programs. Ms Richardson, Carers SA, noted the limited pool of workers and that with a number of programs being funded concurrently NGOs are 'probably all fighting for the same people'.[29] Witnesses from Ruah Community Services in Perth emphasised that it is important for community organisations to have professional staff. They commented on the 'incredible and complex' situations of their clients, who often have multiple disorders, and the importance of professional staff to hold programs together. Ms Carmody, Executive Manager of Ruah Community Services, noted that funding for NGOs needs to build the capacity of the sector, including indexation of salaries to a level able to attract staff. Ms Carmody commented:

> The Commonwealth and states are saying we should have this community infrastructure for people with mental illness but they are not giving us the resources to create that sort of provision.[30]

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26 For example Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, p. 1; Ruah Community Services, *Proof Committee Hansard,* 7 May 2008, p. 30; Richmond Fellowship, *Proof Committee Hansard*, 7 May 2008, p. 45; Mental Health Council of Tasmania, *Proof Committee Hansard*, 31 March 2008, pp. 4–5.

27 WAAMH, *Proof Committee Hansard*, 7 May 2008, p. 5 and Additional Information, Survey Results—Sector Comparisons.

28 *Committee Hansard*, 7 May 2008, p. 67.

29 *Committee Hansard*, 8 May 2008, p. 60.

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

8.26 The Mental Health Coordinating Council in New South Wales noted that there is very little funding for industry planning and development for the mental health NGO sector. Ms Bateman recommended:

> …that the Commonwealth dedicate funds under the 'increasing workforce capacity' action item of the National Action Plan on Mental Health 2006-11 to develop a national approach to workforce development in the mental health NGO sector in consultation with the NGO state peak alliance, Mental Health Australia.[31]

8.27 Professor Calder, First Assistant Secretary Department of Health and Ageing, outlined that the Commonwealth Government is aware of capacity issues within the mental health NGO sector and is taking steps to alleviate the problem. She said:

> To begin to address capacity issues, $6 million has been allocated to the non-government organisation capacity building grants program. The program is to support mental health NGOs to increase their organisational capacity to respond to the increased demand that has been placed on their services as a result of the additional government investments in the sector.[32]

Funded initiatives

8.28 Increasing workforce capacity was one of the five action areas within the COAG Plan. Nearly all states and territories listed at least one initiative in this area in their Individual Implementation Plans. These varied greatly, for example, from $1.0 million one off funding for peer support workers in South Australia, to $11.0 million for the mental health workforce (including psychiatry, nurses and allied health) and $12.2 million for Aboriginal mental health trainees in New South Wales.

8.29 It was clear that funding alone cannot solve the challenges associated with workforce shortages. In Queensland, the committee heard that the state government had increased funding for clinical mental health services by about $150 million, but had trouble filling the positions, with the Department looking overseas for recruits.[33] Dr Groves, Director of Mental Health Services in Queensland, reported:

> We actively went to the UK to get additional positions. That was a successful process for us. We had 134 people whom we interviewed and offered positions to. Some of them have already translated into accepting positions in Queensland… But that is a short-term, stop-gap measure. What we are looking at is addressing in the medium to long term how to get more people back into the mental health workforce. It is a significant challenge for all states and territories.[34]

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31 *Proof Committee Hansard*, 27 March 2008, p. 35.

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

33 The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, *Proof Committee Hansard*, 26 March 2008, p. 7.

34 *Committee Hansard*, 16 May 2008, p. 47.

8.30 Dr Patchett, Director of Mental Health in the WA Department of Health explained that WA had completed two recruitment drives in the UK in the past year, with about 120 mental health professionals recruited through these processes.[35] Other witnesses in Perth noted some difficulties with overseas recruitment of staff, including the time delay involved with migration processes and linguistic and cultural complexities that can arise in service provision.[36]

8.31 In Tasmania, the state government noted that it had allocated $8.5 million for 'workforce inducements' as part of the COAG Plan, which is being implemented as part of the rollout of two industrial agreements for allied health services and nurses. However, Mrs Bent, Deputy Secretary Department of Health and Human Services, commented in relation to this funding:

> It has probably made recruitment somewhat easier because we are not falling behind national standards in terms of salaries and allowances. But the issue for us is still the limited number of health professionals that we train in the state. For example, we do not train occupational therapists. While we have made some changes in mental health nursing in recent times in conjunction with the university, we still have some issues about how we can attract nurses into mental health nursing.[37]

8.32 The largest budget workforce initiative in the COAG Plan was the Commonwealth commitment of $103.5 million for 'Additional Education Places, Scholarships and Clinical Training in Mental Health'. This involved funding for 420 mental health nursing places, 200 post-graduate psychology places, and 25 full-time and 50 part-time post-graduate scholarships to nurses and psychologists.[38] The Australian Association of Social Workers (AASW) critiqued this initiative for failing to include other allied health professionals important to mental health care in Australia, such as social workers and occupational therapists, and also for failing to address workforce shortages for the NGO sector.[39]

8.33 The COAG Plan action items and initiatives reflect that governments are clearly aware of the workforce shortages in mental health. The effects of these shortages on service delivery, however, remain a major problem and a key barrier to improving the provision of mental health care.

Tertiary training

8.34 The AASW also commented on the 'Mental Health in Tertiary Curricula' initiative ($5.6 million) which provided funding to increase the mental health content

35 *Committee Hansard*, 7 May 2008, p. 99.

36 *Committee Hansard*, 7 May 2008, p. 68.

37 *Committee Hansard*, 31 March 2008, p. 26.

38 COAG National Action Plan on Mental Health, p. 11.

39 *Proof Committee Hansard*, 20 May 2008, p. 38.

in tertiary curricula and thus improve the skills of the tertiary trained workforce. AASW noted that mental health content in social work qualifying courses had been dropped from the core content of a lot of courses, becoming elective or optional. Through a project conducted by AASW with the COAG initiative funding there is now core basic mental health content for all social work qualifying courses. Dr Gerrand, a member of AASW, explained:

> There is a two-year timeframe to implement this. It does provide for social work graduates getting the necessary knowledge and skills to recognise if someone has a mental health problem, irrespective of the practice setting whether they are working in mental health services, child protection, acute health or whatever, and to respond appropriately.[40]

8.35 In contrast, the Australian College of Mental Health Nurses remained concerned about the mental health content in nursing qualifications:

> …the educational preparation for mental health nurses in Australia is a growing concern for the college. It has been since nursing education commenced in the universities in the 1980s. Bachelor of Nursing degrees provide comprehensive nursing education, albeit with a significant decrease in the mental health content in undergraduate programs. Such preparation is not adequate for practice in mental health and provides a risk to the quality of nursing provided to mental health consumers.[41]

8.36 Mr Santangelo, President of the College, considered that post-graduate qualifications are the basis for obtaining the 'knowledge, attitude and skills to be able to provide a safe, adequate service delivery in what is a specialist and complex field of care'. However, the time and expense involved in obtaining post-graduate qualifications acts as a disincentive to pursuing this speciality, and post-graduate qualifications are not mandatory for employment in the mental health field.[42]

8.37 Dr Freidin, RANZCP, observed that all workforces across the mental health system are short of staff. In relation to psychiatrists he noted that about a third of first-year intake positions across the country are not filled. Dr Freidin suggested that the low uptake is due to a range of factors, including the low appeal of psychiatry compared with other medical specialisations. He noted that in private practice, psychiatry is not a financially advantageous speciality. He also observed that resident doctors get their psychiatric training in 'fairly stressful, acute units and emergency departments which scare them away'. Dr Freidin commented that the College has projects underway to broaden psychiatric training into private practice settings.[43]

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40 *Proof Committee Hansard*, 20 May 2008, p. 39.

41 *Proof Committee Hansard*, 20 May 2008, p. 47.

42 *Proof Committee Hansard*, 20 May 2008, p. 47.

43 *Proof Committee Hansard*, 1 April 2008, p. 43.

Expanding the vocational workforce

8.38 The Community Services and Health (CSH) Industry Skills Council observed that vocational training is often not given the attention it deserves when looking at mental health sector workforce shortages. Ms Lawson, CEO of the Council explained that about 80 per cent of the mental health workforce are vocationally prepared and not tertiary qualified.

8.39 The CSH Industry Skills Council observed the shift from delivery of services directly by government organisations to delivery by NGOs. Accompanying this shift in service provision has been recognition of the need for new types of qualifications:

> In the last 18 months of our research, industry have told us they need a higher level worker than the certificate IV worker so we are now building a diploma level worker for mental health for industry to use. We would expect that new qualifications framework to be endorsed by the end of this year. Following the endorsement, it is then up to individual employers to do the work that they have to do from an industrial relations perspective to integrate that into new career and workforce models.[44]

8.40 As well as the need for new types of qualifications, there is also the issue of the actual shortage of workers coming into the sector. Ms Lawson reported that the number of people who are in vocational training is insufficient to supply the number of workers that the sector is asking for to deliver services.[45] This is partly related to historical underinvestment in the mental health sector. Without funding to support jobs in the sector, training organisations had been limited in their ability to supply workers. Ms Lawson explained that vocational training is strictly tied to job outcomes and that 'training providers will not deliver training where there are no jobs'.[46] Now that increased funding has been allocated to mental health services provided through NGOs, training organisations will be able to respond.

Consumer involvement

8.41 The Senate Select Committee on Mental Health reported on the importance of consumer participation in all levels of the mental health system, noting that the National Mental Health Strategy endorsed this approach. It found that the extent of consumer participation remained too limited. Like the Select Committee, evidence to this inquiry underscored the importance of consumer participation. UnitingCare Wesley Port Adelaide's experience in employing consumer consultants demonstrated the effect that consumer participation can have in service delivery:

> As a result of incorporating consumers in the organisation, a lot of our policies and a lot of our practices have changed. The consumer consultants, as we call them, have been sitting on panels that employ people. They can

44 *Proof Committee Hansard*, 27 March 2008, p. 94.

45 *Proof Committee Hansard*, 27 March 2008, p. 90.

46 *Proof Committee Hansard*, 27 March 2008, p. 95.

> advise the potential support worker as to what they will be involved with. The way that some of our files have been drawn up has changed. The satisfaction survey was redesigned by the consumer consultants. A lot of information has been brought back. We have changed a lot of our work practices as well.[47]

8.42 Some witnesses were satisfied that consumers are being involved in mental health service reform, just not to the full extent possible. For example, the Northern Territory Mental Health Coalition commented:

> There are consultations and interview processes and that sort of thing to get people involved. There are consumers who sit on boards, consumers who sit on committees and consumers who are involved in consultation processes. So it is happening, but we just need to make sure that it continues and increases.[48]

8.43 Mr Crosbie, Chief Executive Officer, Mental Health Council of Australia singled out a positive example of consumer engagement at the highest level:

> I sit with consumers, carers and two ministers on the advisory group that is helping develop the National Mental Health and Disability Employment Strategy. I have rarely in my career…been involved in advisory committees where the ministers concerned come to sit at the table and listen to the issues being raised by people, then make the effort to go out publicly, and in many ways to be accountable, to hear from people what the issues are.[49]

8.44 However, others saw the need for a fundamental shift in the approach to consumer engagement in Australia.

Shortfalls in consumer involvement

8.45 The Australian Mental Health Consumer Network felt that a key aspect of the National Mental Health Strategy that has been lost over time, particularly with the introduction of the COAG Plan, was a focus on consumer involvement.[50] In particular, the Network observed a trend towards engaging with secondary organisations, rather than primary consumer organisations or groups. Ms Connor, Executive Director, assessed that consumer participation in Australia has 'gone back 10 years or more'.[51]

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47 *Proof Committee Hansard*, 8 May 2008, p. 66.

48 Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, p. 4.

49 *Proof Committee Hansard*, 20 May 2008, p. 82.

50 See also Mental Health Coordinating Council and Council of Social Services of NSW, *Submission 23*, pp. 3 and 27 and *Supplementary Submission 23*, p. 5; Natioal Mental Health Consumer and Carer Forum, *Submission 27*, p. 6.

51 *Proof Committee Hansard*, 26 March 2008, p. 37.

8.46 Ms Collins from Victorian Mental Illness Awareness Council (VMIAC) also expressed deep frustration and disappointment at the approach to consumer engagement:

> Consumer participation in this state and this country is confined to the department putting together a document, and then we all get to comment on the document. We never start from scratch or are given the ability to start from scratch and build on from that, and I think that is one of the main reasons why, in 20 years time, if I am still alive, I will be back at another Senate inquiry and we will be talking about the same things again.[52]

8.47 Consumer involvement is conspicuously absent from the COAG Plan. Ms Oakley, from New South Wales Consumer Advisory Group commented:

> …our constituents are concerned that the Commonwealth and state implementation plans do not identify how mental health consumer and carer participation in state and service policy development and service delivery and planning will be addressed. Indeed, we consistently hear from consumers and carers about the lack of genuine opportunities to participate, both in the consumer's own treatment and care and in the broader system.[53]

8.48 Similarly, the National Mental Health Consumer Carer Forum identified consumer and carer involvement as a key shortfall in the COAG Plan. They advocated:

> …that the unique expertise of the consumer and carer voice be strengthened and there be increased opportunities for consumers and carers to participate in meaningful ways at the policy and service delivery levels. That is, at the highest policy, design and delivery levels, as well as the associated organisational capacity that would be there to enable that to happen.[54]

8.49 Mr Wright, Director of Mental Health Operations South Australia, was able to draw on his experience in New Zealand as a contrast with South Australia:

> I can certainly say, having come from New Zealand where it was very well embedded, that South Australia has been slow to embrace the whole role of consumers. Although there are a number of consumer positions that have been established over the last two years, they are probably 10 years later than they needed to be.[55]

8.50 In Western Australia, the Western Australian Mental Illness Awareness Council (WAMIAC), commented that consumer participation is quite good at a systemic and high-end level, but that it is sorely missing at the individual service

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52 *Proof Committee Hansard*, 1 April 2008, p. 19.

53 *Proof Committee Hansard*, 27 March 2008, p. 49; see also ACT Government, *Submission 37*, p. 2; Community Mental Health Peaks, *Submission 39,* p. 8.

54 *Proof Committee Hansard*, 20 May 2008, p. 66.

55 *Proof Committee Hansard*, 8 May 2008, p. 93.

level. Ms Powell commented that 'consumers are not being respected for their own illness, their knowledge, their own lived experience and their own expertise in their illness'. She noted that most consumers do not even know what an individual care and management plan is, let alone have a copy of one.[56]

Valuing and supporting consumer involvement

8.51 Evidence to the inquiry indicated that, while at some levels there is awareness of the importance of involving consumers in policy, service design and delivery, this is not matched by the funding and support to actually facilitate such involvement. Consumers need opportunities to develop the skills to be effective advocates and advisers. Ms Willoughby, Health Consumers Alliance of SA Inc, explained:

> …there is a misunderstanding in the community at large that consumers, just because they have experienced a mental illness, have the capacity and the skills to give feedback to services about their experience…But the reality is that at the moment in South Australia, and I would imagine across Australia, there are very few opportunities, other than through the mainstream educational opportunities, to learn the skills to be, in effect, change-agent policy advisers.[57]

8.52 Similarly, Ms Oakley, NSW Consumer Advisory Council, commented:

> …our experience is that consumers attending those committees need to have a certain level of skill, a certain level of confidence and a knowledge base to be able to actively and genuinely contribute. So part of that challenge is providing the funding, the training, the resources and the support for those people.[58]

8.53 Consumer representatives, while struggling to ensure a place at the policy table, are also not always afforded genuine respect for their time and commitment. Ms Powell, WAMIAC, observed that consumer participation is totally unfunded and relies on the 'love, passion and drive' of consumers themselves.[59] Ms Shipway, Carer Co-Chair of the National Mental Health Consumer and Carer Forum commented:

> Whilst we do it, I think, for the best of intentions and altruistically, it would obviously be a stronger and a more ongoing voice if we knew that, for example, remuneration could be depended upon when we went to meetings at a state level and that we could expect to get sitting fees, in the same way as other people are paid to be there.[60]

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56 *Proof Committee Hansard*, 7 May 2008, p. 54.

57 *Committee Hansard*, 8 May 2008, p. 68.

58 *Proof Committee Hansard*, 27 March 2008, p. 53.

59 *Proof Committee Hansard*, 7 May 2008, p. 63.

60 *Proof Committee Hansard*, 20 May 2008, p. 67.

8.54 Ms Connor and Ms Speed, from the Australian Mental Health Consumer Network also noted that consumers are often the only members not paid for their involvement in committees.[61]

8.55 Witnesses provided a range of examples which illustrated the difference between awareness of the importance of consumer involvement, and actually putting this into practice. In Tasmania Ms Swallow, from the Mental Health Council of Tasmania explained that although the state government had been 'looking at a framework of a carer-consumer liaison position and regional positions to support that', the framework had not yet been put into practice. Witnesses in Western Australia noted that there was no independently funded consumer advocacy group in WA and only one or two consumer consultants in the public health system.[62] Gippsland Advocates for Mental Health Inc commented that consumer advocacy is particularly difficult in rural and remote areas and for people not currently engaged with mental health services. They recommended an expansion of the Community Visitor program to enable Community Visitors to become individual advocates for people with mental illness.[63]

Consumer run services

8.56 Despite the welcome investment in community-based services under the COAG Plan, witness highlighted a particular gap in the availability of consumer-run support services. Consumers and carers are in a unique position to contribute to recovery support, but there are few examples of consumer-run support services Australia wide.

8.57 The Brook Recovery, Empowerment and Development Centre in Brisbane provided an excellent example of a consumer run service, designed as a drop in centre linked with clinical and other supports. However it is one of only a couple of such centres in the country.[64] Ms McLaren, a peer support worker at the Centre described to the committee her experiences:

> I would just like to say that peer support does work; it really does. I was very ill for many years and since I have accessed this centre I have not been back in hospital for five years. That is pretty impressive. Peer support encourages people into education and to have a sense of community, and to have hope. That is really important.[65]

61 *Proof Committee Hansard,* 26 March 2008, p. 35.

62 WAAMH *Proof Committee Hansard*, 7 May 2008, pp. 4, 16–17; Richmond Fellowship, *Proof Committee Hansard*, 7 May 2008, p. 32.

63 *Submission 20*, p. 3.

64 *Proof Committee Hansard*, 26 March 2008, p. 90.

65 *Proof Committee Hansard*, 26 March 2008, p. 82.

8.58 Ms Collins, VMIAC, commented that there is a lack of appreciation for the skills these services require and the recovery assistance they provide:

> People are just dropping in, having coffee, making friends, having a smoke, talking about their week and stuff like that—switching off from mental illness. My perception is that there is an attitude that it is not a highly skilled activity, when in actual fact it is a highly skilled activity to keep people who are struggling on disability pensions and all those sorts of things engaged and happy and communicating with each other.[66]

8.59 In WA the committee heard about the Body Esteem program, a peer facilitated program, for women with eating disorders. Mrs Stringer, Manager of Women's Healthworks, commented that the program was developed based on consumer inquiries. It employs consumers and consumers also work in volunteer roles. The program does not offer treatment, but refers consumers to specialised eating disorder treatment services. Ms Stringer observed that the program has been beneficial to women 'assisting them to develop insight into eating behaviours and associated difficulties and to make positive changes in a range of life domains'.[67]

8.60 Mr Smyth, Assistant Secretary DoHA, informed the committee that in 2007 DoHA commenced a scoping study to look at consumer-run organisations around Australia. The study included looking at:

> …what actual formal training availability was out there for consumer leaders, peer support workers et cetera. Some states have some; some do not. We were looking to how you might even develop a nationally consistent approach to better engage consumers in the mental health workforce.[68]

8.61 The committee is encouraged to hear about DoHA's pursuit of this issue and looks forward to the scoping study leading to greater support for consumer training and development of consumer-run services. The committee considers that the lack of attention to consumer involvement is a major weakness in the COAG Plan. Of the many groups working to improve mental health services in Australia, the consumer voice is often the least heard. The committee recognises that consumers are a diverse group of people, with a broad range of perspectives and views. However this should not prevent consumers from being supported to have a strong presence in decision making, as do other diverse groups such as health professionals and community organisations.

Recommendation 17

8.62 The committee recommends that the Australian Government strengthen mental health consumer representation, through funding consumer-run

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66 *Committee Hansard*, Tuesday 1 April 2008, p. 19.

67 *Proof Committee Hansard*, 7 May 2008, p. 20.

68 *Proof Committee Hansard*, 16 May 2008, p. 102.

organisations to provide independent advocacy at state, territory and Commonwealth levels and to provide peer support, information and training to their members.

Employment

8.63 Part of the continuum of care and recovery journey for people with mental illness involves assistance with education, training and employment. Ms Carmody, from Ruah Community Services, commented on this part of mental health care:

> If we want to get people with mental illness out of the welfare dependency trap we need to, again, ensure a good widespread set of programs that help people get education, training and work opportunities.[69]

8.64 Ruah Community Services' experience shows that people with mental illnesses want to work. Over half of the 235 people that Ruah worked with on an ongoing basis in 2007 said that employment was one of their key goals.[70]

8.65 Although there are historically low levels of unemployment in Australia and workforce shortages in a range of areas, many people with mental illness are still not obtaining employment.[71] Ms Miliotis summarised:

> The reality is that it is not about their capacity; unfortunately, it is around stigma and barriers more than it is around workplace safety or other barriers.[72]

8.66 In addition to generic programs to improve community awareness and address stigma, some witnesses considered that employers need further education about how to support employees with mental illness and the options that are available.[73] Further supports are also needed for people with mental illness seeking work, as there are long waiting lists for the existing specialist employment placement services for people with mental illness.[74]

8.67 Ms Carmody noted that Australian and international experiences provide plenty of evidence about the practices needed to address the barriers to education,

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69 *Proof Committee Hansard*, 7 May 2008, p. 31.

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

71 Mental Illness Fellowship of South Australia, *Proof Committee Hansard*, 8 May 2008, p. 31; Mr Derek Wright, Government of South Australia, *Proof Committee Hansard*, 8 May 2008, p. 82; Western Australian Association for Mental Health, *Proof Committee Hansard*, 7 May 2008, p. 2.

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

73 *Proof Committee Hansard*, 1 May 2008, p. 38.

74 For example, Ruah Workright in Western Australia, *Proof Committee Hansard,* 7 May 2008, p. 39.

training and work for people with mental illness; it is now a matter of actually providing the supports required.

Welfare to work

8.68 Several witnesses raised concerns that Commonwealth Welfare to Work provisions and experiences with Centrelink are counter-productive to the efforts of the COAG Plan. Concerns included:

- lack of effective mechanisms to support a gradual transition to employment, including the barriers raised by threshold working hours above which support payments are affected;
- the focus on short term vocational training to facilitate a rapid return to work, at the expense of longer term capacity building and re-engagement with family and society;
- potential loss of Disability Support Pension being a disincentive for trying to participate in paid work;
- onerous participation reporting guidelines and the stress generated by risk of 'breaching', which can increase the risk of relapse for people with mental illness;
- the need for specialist job capacity assessments and assessors;
- the lack of consultation with a person's health professionals in making a job capacity assessment;
- widespread lack of knowledge amongst mental health professionals about Welfare to Work, despite major implications for consumers and carers;
- inappropriate application forms, which are designed more for physical and intellectual disability;
- the restriction that only people with mental illness who are using medication are eligible for financial case management;
- lack of access to Centrelink collected information for research purposes;
- negative experiences with Centrelink, including the requirement to attend in person rather than make appointments over the telephone;
- the need for better education and training among Centrelink staff about mental illness; and
- the need for outreach workers to visit isolated people with mental illness who are unable, due to their illness or geographic location, to attend Centrelink offices in person.[75]

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75 WAAMH, Additional Information, *Welfare to Work, Submission to the Hon Brendan O'Connor Minister for Employment Participation*, p. 6; Richmond Fellowship, *Proof Committee Hansard,* 7 May 2008, p. 37; MHS Consumer and Carer Council Members, *Submission 5*; National Mental Health Consumer and Carer Forum, *Submission 27*, pp. 8–9.

8.69 The Western Australian Association for Mental Health (WAAMH) considered that difficulties with Welfare to Work arrangements for people with mental illness arise through a range of contributing factors. For example, medical professionals such as psychiatrists are not fully appreciative of the need for forms to be completed in such a way as not to disadvantage consumers, and capacity assessors may have no appreciation or training in mental illness and the possible impact on a person's day-to-day living. Also, fear of the system among people with mental illness can generate problems in itself:

> They hear rumours, they may not turn up for appointments and then, when they get letters breaching them, it compounds it and they may not seek help.[76]

8.70 In Western Australia, the Centrelink Mental Health Consultative Committee has been formed to address and resolve issues experienced by people with mental illness using Centrelink.[77] The committee was established in April 2006 and includes representatives of a range of organisations involved in employment for people with a mental illness, such as the Commonwealth Rehabilitation Service, ACE National Network, state specialist employment services, as well as consumer and carer consultants, state government representatives and key state Centrelink staff. The Western Australian Association for Mental Health chairs the committee. Mr Calleja, from Richmond Fellowship WA commented that the committee had a slow start, but 'as time has passed, that committee has worked much more closely on looking at individual issues that could be managed by the bureaucracy within the constraints of the Welfare to Work policy'. Mr Calleja remarked that he was pleased the Department of Employment and Workplace Relations was finally involved in the Committee and 'there is a much more collaborative kind of interaction going on'.[78] WAAMH commended Centrelink in WA for its initiative around 'vulnerability flags' and related follow up, indicating that the flags have achieved a high level of success in Western Australia, partly because issues have been able to be addressed through the Centrelink Mental Health Committee.[79]

8.71 The Department of Education, Employment and Workplace Relations (DEEWR) explained that vulnerability indicators can be viewed by both Employment Service Providers and Centrelink. Flagged vulnerabilities must be taken into account by service providers before reporting any participation requirement breeches to Centrelink and also by Centrelink when investigating failures to meet participation requirements. DEEWR advised that as at 30 June 2008 there were 67 999 job seekers

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76 Western Australian Association for Mental Health, *Proof Committee Hansard*, 7 May 2008, p. 10.

77 Western Australian Association for Mental Health, *Proof Committee Hansard*, 7 May 2008, p. 2.

78 *Proof Committee Hansard*, 7 May 2008, p. 37.

79 WAAMH, *Committee Hansard*, 7 May 2008, p. 10 and Additional Information, *Welfare to Work, Submission to the Hon Brendan O'Connor Minister for Employment Participation*, p. 6.

across Australia with a vulnerability indicator on their record because of psychiatric problems or mental illness within the last six months. Among this group, 6 377 people had a participation failure applied and 308 people received an eight week non-payment penalty while the 'psychiatric problem or mental illness' indicator was current. DEWR explained that under a new compliance system to be introduced from 1 July 2009 job seekers who continually fail to meet participation requirements will no longer automatically face an eight week non-payment penalty. Rather, further assessment will be undertaken to 'identify any underlying barriers to participation'.[80]

8.72 The committee notes the concerns about welfare to work requirements raised throughout the inquiry. Several times throughout the inquiry committee members urged witnesses to raise specific problems experienced by those with mental illness under the welfare to work arrangements with their state or territory Senators, so that these issues could be taken up with Centrelink.[81] The committee also notes the positive response to the Centrelink Consultative Committee on Mental Health established in WA.

Recommendation 18

8.73 The committee recommends that Centrelink develop Mental Health Consultative Committees, modelled on the Western Australian Centrelink Mental Health Consultative Committee, within each of the other states and territories. The committees recommends that the Centrelink Mental Health Consultative Committees include consumer and carer representatives, representatives of the state and territory community mental health peak bodies, state and territory specialist employment services, the Commonwealth Rehabilitation Service, ACE National Network, state Centrelink offices, the relevant state government department of employment and the Australian Government Department of Education, Employment and Workplace Relations.

Community awareness

8.74 Community education and mental health promotion were seen as a major gap in the COAG Plan.[82] While organisations like SANE and beyondblue were acknowledged for their efforts in raising awareness and educating people about seeking treatment, wider promotion programs addressing the myths and stigma associated with mental illness were called for. Some progress has been made, particularly in relation to depression and witnesses commended high profile Australians for talking publicly about their experiences.[83] Less change is evident in

80 DEEWR, Answers to questions on notice, 19 September 2008, pp. 2–3.

81 See for example, *Committee Hansard*, 7 May 2008, p. 10; *Proof Committee Hansard,* 16 May 2008, p. 20.

82 The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, *Proof Committee Hansard*, 26 March 2008, p. 3.

83 Ms Barbara Hocking, SANE Australia, *Proof Committee Hansard*, 1 April 2008, p. 7; Mental Illness Fellowship of Australia, *Proof Committee Hansard,* 8 May 2008, p. 39.

attitudes towards people with psychotic illness.[84] Certainly stigmatisation and, in some instances, vilification of people with mental illness still happens.[85]

Public awareness and destigmatisation

8.75 There was consensus in the evidence that focus and effort on stigma reduction needs to be maintained. Mr Wright, Director of Mental Health Operations in South Australia, made some pertinent observations about Australia's investment in mental health public awareness:

> I think stigma and discrimination is still an issue. Australia did some really good stuff—not being Australian, I can say this—in the mid-nineties around antidiscrimination. You had a number of TV campaigns but you then stopped doing it. Certainly the work that I saw at that time showed that it was making a significant difference. I think we are back to where we were prior to that.[86]

8.76 Ms Swallow, from the Mental Health Council of Tasmania felt that while there has been an increased awareness of mental illness, this needs to extended to educate the community about supporting people with mental illness to live meaningfully within society:

> I think some of the initiatives such as beyondblue and even some of the things that are happening with headspace have made significant shifts in the community about understanding that mental health is an issue for all of us and that we are all affected in one way or another if somebody has a mental illness. I think one thing that needs to be focused on is building onto that so that people have a greater understanding of what mental health and wellbeing and mental illnesses are and how they affect people's ability to be in the workforce, to remain in education and to have sustainable affordable housing options available to them. They are significant issues affecting our community.[87]

8.77 Ms Powell, from the Western Australian Mental Illness Awareness Council (WAMIAC) and Professor Malak, Multicultural Mental Health Australia, both commented on the disconcerting fact that discrimination comes not only from the general community but also from workers within mental health services.[88]

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84 Ms Barbara Hocking, SANE Australia, *Proof Committee Hansard*, 1 April 2008, pp. 2 and 7; Mental Illness Fellowship of Australia, *Proof Committee Hansard,* 8 May 2008, p. 39.

85 Ms Barbara Hocking, SANE Australia, *Proof Committee Hansard*, 1 April 2008, p. 2.

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

87 *Proof Committee Hansard*, 31 March 2008, p. 7. See also Ms Williams, Tasmanian Mental Health Advocate, *Proof Committee Hansard*, 31 March 2008, p. 47.

88 *Proof Committee Hansard*, 7 May 2008, pp. 54–55 and *Proof Committee Hansard*, 27 March 2008, p. 26; see also National Mental Health Consumer and Carer Forum, *Submission 27*, p. 5.

8.78 Ms Hocking, from SANE Australia, noted that people's attitudes to mental illness are more favourable when they know someone who has a mental illness. Therefore a key to stigma reduction is developing programs in which 'people get to know people with a mental illness and get to understand more about it'.[89]

8.79 New Zealand's *Like Minds, Like Mine*, *Whakaitia te Whakawhiu i te Tāngata* program was highlighted as an example of a large scale public awareness program with positive results. Like Minds, Like Mine was a comprehensive program incorporating both national television and radio advertising and grassroots community action. The mass media campaign was rolled out in three phases starting in 2000 with a series of advertisements showing famous and well-known faces of people who had experienced mental illness. The second phase used short documentary-style advertisements focussing on famous New Zealanders who had featured in the first phase. The third phase focussed on ordinary people who had experienced mental illness, portrayed through the eyes of their family and friends to show them as a whole person. Public relations activities such as a website, newsletter, media booklet and posters all supported the mass media campaign. In addition 26 regional providers worked in conjunction with the program to address discriminatory attitudes and behaviours at a local level. Evaluations of the program showed that people 'remembered the advertisements, talked about them, thought about their messages, and changed their views about mental illness'.[90]

8.80 As the New Zealand experience suggests, stigma reduction and education are key areas for involving consumers directly.[91] Ms Miliotis, Mental Illness Fellowship of SA, suggested this is particularly the case for young people:

> For young people—around awareness, around mental illness—to have a peer be able to talk about their experience has an authenticity and a connection that a media campaign or a glossy brochure does not bring.[92]

8.81 Ms Miliotis commented further on the dearth of mental health public information resources available for young people, particularly in rural areas:

> We go to all regions of country SA, and the schools are screaming for connections. Often we are the only service they will see in a 12-month period, and they are desperate for us to come back in the next three months let alone, funding permitting, a year later. What they are asking for is general information about mental health, but they are also increasingly asking: 'What are the early indicators? What are the early signs and symptoms? What can we do as communities and as individual students to

89 *Proof Committee Hansard*, 1 April 2008, p. 8.

90 New Zealand Mental Health Commission, 2007, *Te Haererenga mo te Whakaōranga, The Journey of Recovery for the New Zealand Mental Health Sector*, pp. 194–196.

91 *Proof Committee Hansard*, 7 May 2008, p. 84.

92 *Proof Committee Hansard*, 8 May 2008, p. 40.

> look out for our mates and to look for when something is not right in ourselves?'[93]

8.82 As the quote above indicates, with increased public awareness many individuals and communities are taking on the issue of mental illness and want to be part of prevention and early intervention. Indeed Professor Hickie observed from his participation in the 2020 Summit that 'young people around Australia brought to that conference that their highest priority was the rolling out of a youth form of mental health first aid'.[94] Information resources are needed in order to harness this goodwill and intention so that communities and individuals can make a difference, particularly at the early onset stages of mental illness.

8.83 Ms Springgay, from the Mental Illness Fellowship of Australia, pointed to a particular information gap in relation to psychotic illnesses. She said:

> …the more debilitating illnesses have less public awareness and, indeed, less awareness of the onset and what happens, and so there is a lot of confusion and not knowing what is happening at the time of onset. It often happens…in adolescence; the symptoms that are part of the illness are often mistaken for adolescent behaviour or whatever. I think there is a great deal that could be done about educating the public as to what those illnesses involve and to create some insight as to what typical behaviours might be occurring and…the degree to which those symptoms appear. The public could really benefit from a similar program to beyondblue.[95]

8.84 The COAG Plan included several initiatives related to public awareness, such at the Commonwealth's 'Alerting the Community to the Links between Illicit Drugs and Mental Illness' initiative and aspects of the 'Early Intervention Services for Parents, Children and Young People' initiative. States included a range of initiatives, such as 'Promoting Mental Health', a contract with beyondblue in South Australia and 'Community Education' through schools and other agencies in the ACT. However the COAG Plan stopped well short of a nation-wide stigma reduction and education campaign as recommended by the Senate Select Committee on Mental Health.

8.85 The committee considers that this remains an important shortfall. The committee notes in particular the gap in public awareness and stigma reduction in relation to psychotic illnesses. While Victoria has specifically targeted funding to early psychosis programs, awareness and access to services around the country is sadly inconsistent. In the committee's view, this is an area where individuals and communities can be better resourced and equipped to help achieve early intervention and to make a significant difference to the way that people experience mental illness.

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93 *Proof Committee Hansard*, 8 May 2008, p. 40.

94 *Proof Committee Hansard*, 20 May 2008, p. 24.

95 *Proof Committee Hansard*, 8 May 2008, p. 39.

Recommendation 19

8.86 The committee recommends that the Australian Government provide funding for a public awareness program focussed on psychotic illnesses, to be targeted to adolescents and young adults, their peers, parents and teachers.

Comorbidity services

8.87 Comorbidity refers to the circumstance where a person is diagnosed with two or more physical and/or mental illnesses and often is associated with people suffering from both mental illness and alcohol or other drug problems. Mr Banders, South Australian Network of Drug and Alcohol Services (SANDAS), noted that comorbidity has a 'very poor prognosis and heavy costs for individuals, families, communities and institutions such as healthcare and justice systems'.[96] People with comorbidity experience 'higher rates or homelessness, social isolation, infections and physical health problems, suicidal behaviour, violence, antisocial behaviour and incarceration'.[97] The Senate Select Committee on Mental Health noted that given the pervasiveness of comorbidity (or 'dual diagnosis') it should be considered the 'expectation not the exception' for people receiving treatment for either mental illness or substance abuse disorders.[98] As such, services need to be designed and funded to meet the needs of people with complex, co-morbid conditions.

Funded initiatives

8.88 In some states the committee heard about progress being made to address gaps between mental health and alcohol and other drug (AOD) services. For example, in the Northern Territory the NT Council of Social Services is starting up a project to build relationships between AOD organisations and mental health organisations.[99] The NT Government also noted that COAG alcohol and drug funding of around $15.9 million over three years plus an additional $8 million over three years had been allocated to the Territory.[100]

8.89 In Western Australia, WAAMH observed that there had been some improvement in services for people with dual diagnosis following funding to the NGO sector.[101] Representatives noted that at the NGO level both the mental illness and AOD sectors work together effectively, for example through joint training.[102]

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

97 *Proof Committee Hansard,* 8 May 2008, p. 21.

98 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community,* p. 370.

99 Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, p. 8.

100 *Proof Committee Hansard*, 1 May 2008, p. 53.

101 *Proof Committee Hansard*, 7 May 2008, p. 4.

102 *Proof Committee Hansard*, 7 May 2008, p. 15.

8.90 In South Australia, SANDAS outlined progress being made under the Commonwealth's COAG Plan initiative 'Improved Services for People with Drug and Alcohol Problems and Mental Illness' ($73.9 million). Mr Banders explained that the initiative is for capacity building for NGOs to deal more effectively with comorbidity, with funding targeted specifically at alcohol and drug agencies and peak organisations.[103] He expressed concern that final funding allocation under the first component of the initiative had been delayed, with 30 agencies across Australia waiting to find out if they had received funding. Applications had been made in September 2007, with submissions resubmitted following the federal election, and as at May 2008 agencies had not been notified of the outcome.[104]

8.91 SANDAS itself has been funded to work with drug and alcohol NGOs to help them build capacity and also to develop strategic partnerships within the sector. It has established a comorbidity reference group including senior people from across the sectors.[105] Mr Banders provided an example of the capacity building that is needed:

> Seventy per cent of our clients in that particular service have comorbid conditions, and that would be common across the non-government sector, but we have not had the capacity and the time to go out and get someone from mental health services to come and work with us or our clients. The capacity-building stuff will give us a chance to really develop policies, practices and procedures that will cement in place some of those relationships.[106]

8.92 The committee acknowledges the efforts being made to address comorbidity service shortfalls, in particular recognition of the need for capacity building within the NGO sector.

Remaining gaps

8.93 However, comorbidity still remains a key area where people are falling through the gaps in services and consumer groups pointed to the shortfall. The Northern Territory Mental Health Coalition observed that there is 'still a gap between mental health and AOD services for people with dual diagnosis' in the Territory, with consumers ending up in a 'revolving door process'.[107] The West Australian Mental Illness Awareness Council commented on the 'distinct administrative separation between drug and alcohol issues and mental health issues', with consumers turned away from each service.[108] The Mental Health Community Coalition ACT commented that in the ACT 'the two services still tend to operate separately, and we are still

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103 *Proof Committee Hansard*, 8 May 2008, pp. 18–19.

104 *Proof Committee Hansard*, 8 May 2008, p. 19.

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

106 *Committee Hansard*, 8 May 2008, p. 24.

107 Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, p. 2.

108 *Proof Committee Hansard*, 7 May 2008, p. 55.

hearing reports of people with dual disorders being passed between the two services'.[109]

8.94 In Tasmania:

> One of the significant issues for people who have comorbidities with alcohol and drugs and mental health is that the police will pick them up and take them into emergency where a psychiatrist will come and do an assessment and say: 'No, it is a drug induced psychosis. We cannot admit them here.' There is nowhere for them to go in terms of alcohol and other drug rehab services in Tasmania, so they often get put in lockup.[110]

Criticisms of the COAG Plan approach

8.95 Witnesses for the Royal Australian New Zealand College of Psychiatrists said that the College was 'somewhat disappointed' by the way money for drug and alcohol and other services had been distributed under the COAG Plan, in terms of the allocation to NGOs. Dr Freidin explained:

> We would certainly prefer to see drug and alcohol money going to NGOs rather than not going anywhere at all…Our major concern is that it seemed to reinforce the separation of drug and alcohol treatment from mental health treatment. We would have preferred that it go into the one organisation, which to our mind was the one for state funded community mental health services.[111]

However, Dr Freidin did note that some of these organisations on the ground have 'excellent working relationships and do work very collaboratively'.[112]

8.96 Some of the broader critiques of the COAG Plan were particularly evident in relation to comorbidity services. First, comorbidity services are an example where coordination is needed between Commonwealth initiatives and state and territory services. Mr Banders highlighted that there is 'considerable diversity in the structure, pattern and evolution of services in each state'. Some states use NGOs extensively for the provision of AOD services while in other states the majority of such services are provided by the state government.[113] As such, Commonwealth comorbidity programs directed at NGOs will have different potential in different areas, depending on the existing service arrangements.

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109 *Proof Committee Hansard*, 16 May 2008, p. 16.

110 *Proof Committee Hansard*, 31 March 2008, p. 4.

111 *Proof Committee Hansard*, 1 April 2008, p. 42.

112 *Proof Committee Hansard*, 1 April 2008, p. 42.

113 *Proof Committee Hansard*, 8 May 2008, p. 21.

8.97 Second, the COAG Plan comorbidity initiative is an example which highlights questions over the future strategy for mental health, after the COAG Plan. Mr Banders observed:

> It could be argued that the current round of funding under the COAG comorbidity initiative while helpful, lacks a long-term aspect beyond 2010-2011. The sustainability of increased capacity has not been clearly defined, nor is there any suggested funding approach to increase service levels in response to any increased demand arising from increased public awareness of changes to comorbidity capacity.[114]

8.98 Third, the broader issues around NGO tendering also relate to comorbidity services. Mr Banders said that the competitive tendering model is generally not underpinned by a policy of collaboration and that as a result, 'the move to holistic treatment approaches is very slow and the complexity of issues is rarely adequately dealt with'.[115]

Support for living in the community

8.99 The significant Commonwealth funding for community-based mental health initiatives in the COAG Plan was applauded by submitters and witnesses to the inquiry. At the same time, witnesses recognised that community-based services had been left under-developed for a long time and so there is further to go in creating the comprehensive community-based supports and clinical services needed to meet the needs of people with mental illness:

> We are saying that for 20 years the states and territories and the mental health reform process have basically ignored responses to the community-living issues associated with mental health and what we need is a strategically directed approach to doing that at Commonwealth levels—the Commonwealth now being the major provider of those services.[116]

Shortfalls and gaps

8.100 Numerous examples were given to the committee to demonstrate the overwhelming demand that exists for community-based services and the shortfall left by current services. For example, the Australian College of Mental Health Nurses explained:

> The current situation in many community mental health services around Australia is one where limited numbers of community mental health nurses are carrying the burden of huge case loads in an attempt to meet the demand. Case loads as high as 80 to 90 clients are not uncommon in some areas. It is little wonder that the 'revolving door' syndrome still exists.

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

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

116 Mental Health Community Coalition ACT, *Proof Committee Hansard,* 16 May 2008, p. 18.

> There is no longer adequate clinician time for relapse prevention measures such as psycho-educational programs and recovery based interventions.[117]

8.101 Catholic Social Services Australia also provided an example to demonstrate the demand that exists:

> After receiving funding and initial set up the programs were at capacity within four weeks of operation and now each area has over 20 people on the waiting lists. This was without advertising the program in any way and with referrals coming only from local GPs originally. It is not unusual for clients to wait a few months for a space in our program to become available. In the funded areas we are the only service providing mental health personal and social support in the community.[118]

8.102 The waiting lists and turn-away rates from services give an indication of the current shortfalls in community-based services. So too does the living circumstances of people with mental illness. Ms Williams, Mental Health Advocate in Tasmania commented:

> Their neighbours have nothing to do with them. They are lonely; they have nothing to do. If they had an intellectual disability a bus would be coming and picking them up in the morning and taking them to day services where they would do all these things—some of them are really good and some of them are really bad, but at least they are doing something—and the bus would take them home. As it is, they sit in their units all day, and there is nothing.[119]

8.103 For those severely affected by mental illness, the supports needed to live in the community can be extensive and intensive. This is the reality of deinstitutionalisation and the responsibility for such service provision cannot be shied away from. Mr Aspen commented on the kinds of services that are currently lacking:

> There is a need for 24-hour, seven-day-a-week support, not a telephone service because when people are unwell with mental illness they cannot cope with telephone calls. They cannot go to the GP. They find it too difficult to make appointments and keep appointments.[120]

8.104 Similarly Ms Oakley, Acting Executive Officer of the NSW Consumer Advisory Group pointed to the need for after-hours services:

> After-hours crisis services in the community are limited and in some regions of New South Wales do not exist. This results in a need for consumers to access emergency departments rather than remain in the community. Many consumers also need non-crisis after-hours services to assist them to remain in the community, and these are largely non-existent.

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117 *Proof Committee Hansard*, 20 May 2008, p. 49.

118 *Proof Committee Hansard*, 16 May 2008, p. 67.

119 *Proof Committee Hansard*, 31 March 2008, p. 47.

120 *Proof Committee Hansard*, 31 March 2008, p. 12.

> There is a need for a safe, non-hospital environment for people to go to when they feel overwhelmed with their mental health problems.[121]

8.105 The committee commends the investment made in community-based care through the COAG Plan, but notes that major gaps remain. More services, including both clinical and wider community supports, are required.

Beyond 'health' care

8.106 Witnesses pointed to the need for services which extend beyond specialist mental health care to include the many areas of disadvantage experienced by those with severe mental illness. Mr Quinlan, from Catholic Social Services Australia, observed:

> …there is an increased need for long-term and sustained support for people as they go through some kind of continuum towards stability or recovery, to have someone who can actually help them to engage in the various processes that might be required. Those might change from housing to income support, to legal issues, to employment issues, to mental health issues.[122]

8.107 The Mental Health Coalition of South Australia advocated for more comprehensive support in the home for people with mental illness:

> When we talk about support in the home, we are making sure that the focus is on supporting people where they live, and in all aspects of their lives, not just around the medical issues. The Commonwealth initiatives have started to do that, but there us a lot more to be done.[123]

8.108 The Mental Health Community Coalition ACT (MHCC ACT) called for a 'strategically directed national program' to advance community mental health reform. Rather than having different departments running different programs, MHCC ACT called for one program administered directly by FaHCSIA to provide a comprehensive suite of community mental health prevention, rehabilitation and recovery services. MHCC ACT advocated that such a program needs to include 'mental health housing and support, family and carer respite, home based outreach, social inclusion, employment support, psychosocial day and rehabilitation programs, mental health promotion, peer support and consumer advocacy'.[124]

8.109 The Mental Health Coalition of South Australia submitted that effort be put into 'citizenship and community capacity building'. Mr Harris explained:

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121 *Proof Committee Hansard*, 27 March 2008, p. 48.

122 *Proof Committee Hansard*, 16 May 2008, p. 72.

123 *Proof Committee Hansard*, 8 May 2008, p. 4.

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

> Community and community capacity building is an area in which nobody is really doing well. A focus on that would come if our focus was more about maintaining a well community as opposed to coming from an illness paradigm where you start with people who are not well and try to work from there. Community capacity building is the kind of thing where you look at where people go, where the natural supports for people are, and emphasise a mental health approach in those.[125]

'Community' based care?

8.110 Despite the long supported policy of a community-based system of mental health care, there was concern that at the state and territory level major funding components are being directed to hospital-based services. Dr Rosen, in New South Wales, for example commented:

> I think the problem is that most of the enhancements are hospital centred, either in in-patient units or in emergency departments—they are the big enhancements. I think the model is returning to fortress psychiatry, with staff being discouraged from moving outside the hospital boundaries to support families and individuals in their homes, whereas the evidence suggests that that is what we should be doing.[126]

8.111 He argued that this approach is being driven by economic concerns, not by health policy:

> Treasury and assets management parts of the health departments are having a big say in what the priorities in health facilities are. Their priorities are to consolidate onto hospital sites. This is exactly the opposite of where the evidence is going. It is exactly the opposite of what is happening in London and what is happening in terms of the planning and the expert reports in Australia.[127]

8.112 Mr Crosbie, Chief Executive Officer of the Mental Health Council of Australia, used an apt analogy to describe the need for more community-based services and the difficulties with developing those services when funding is being channelled into acute services:

> The states and others are in a very difficult position because there is a shortage of acute care. In many ways, they are like ambulance drivers at the bottom of the hill—there are too many bodies and not enough ambulances. We are saying that we need to spread some of the money up the hill to stop people falling off, but the bottom line is that there are still bodies at the bottom of the hill which need ambulances. I think we need to support the kind of move that is outlined in the National Health and Hospital Reform Commission report, and in other reports—that is, we need to bite the bullet

125 *Proof Committee Hansard*, 8 May 2008, p. 4.

126 *Proof Committee Hansard*, 27 March 2008, p. 64.

127 *Proof Committee Hansard*, 27 March 2008, p. 64.

> and look at stronger initial responses rather than waiting until people are either suicidal or homicidal before they can get appropriate mental health care. That is still the situation in many parts of Australia, and I think it is a bizarre situation.[128]

8.113 The Senate Select Committee on Mental Health in its report noted with concern the trend towards dismantling community-based mental health services and locating such services on general hospital sites. It recommended that state governments refrain from this practice.[129] Indeed, as Dr Gurr noted in this inquiry, the vast majority of people with mental illness are living in the community and this is where supports and services are required:

> Ninety-seven per cent of our clients, in the public sector anyway, are in the community at any one time—a very small proportion is actually in hospital—so how do we provide for them? Virtually none of our funding systems provides the right incentives…[130]

8.114 Along with overall levels of funding, the relative funding to hospital and to community-based services is central to many of the service issues within Australia's system of mental health care. Acute services are overstretched, but without more community-based services the demand on acute services will not abate. Through COAG Plan initiatives such as PHaMs and Better Access, the Commonwealth Government has backed the policy of community-based mental health care in Australia. The committee considers that further reform in this area can be made by state and territory governments.

Recommendation 20

8.115 The committee recommends that in negotiating the next Australian Health Care Agreement, the Australian and state and territory governments agree on mechanisms to ensure that community-based mental health services are prioritised in state mental health spending.

In-patient services

8.116 Given that some of the major initiatives in the COAG Plan related to community-based and primary care services, much of the evidence to the committee related to these areas. What evidence the committee did receive about in-patient and long-term care was dispiriting. It was consistent with the evidence provided to the Senate Select Committee on Mental Health, with little improvement evident. Yet again, the experiences point to the need for ongoing and better community supports. Ms O'Toole, from the WA Council of Official Visitors captured these views:

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128 *Proof Committee Hansard*, 20 May 2008, p. 84.

129 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, *Final report*, April 2006, p. 15.

130 *Proof Committee Hansard*, 27 March 2008, p. 60.

> In answer to your questions about the future of mental health, it is hard to stay positive. I think the community units that support that allow a much more supportive flow-through of people. For the people who stay long term, it is very hard. If they can be in environments where they are supported in the community, where there is a structure and a sense of community for them, there is a much better hope that they can maintain themselves in a rewarding way and not keep going downhill and coming back into the system again.[131]

8.117 Similarly, Ms Drake, from the Health Consumers' Council commented that at the 'pointy end' of mental health care she had not noticed a difference despite the funding coming into the system through the COAG Plan. She observed:

> I am hoping that new entrants into mental health may not be getting the experience that a lot people who have been in the system for a long time have had. Those are the people we see most often. I am crossing my fingers and hoping that is the case but, in terms of acute services, not necessarily.[132]

8.118 The committee received evidence about insufficient access to in-patient care, and inappropriate treatment and circumstances in some settings. Concerns were again raised that in-patient services remain over stretched to the point that people are not admitted unless they are suicidal.[133] Some of the other issues raised with the committee included:

- poor service culture and negative attitudes;
- confined environments and lack of space;
- inappropriate focus on a biomedical model of care and treatment, neglecting the consumer's experience and feelings of wellbeing and illness;
- absence of holistic patient assessments;
- lack of individual service plans, developed in consultation with the consumer, upon admission;
- lack of associated care, such as occupational therapy;
- lack of contact with patients, with mental health nurses remaining in nursing stations;
- lack of safety;
- physical and sexual abuse of patients;
- use of private security guards to restrain patients;
- breaching of patient's rights;

131 Council of Official Visitors WA, *Proof Committee Hansard*, 7 May 2008, p. 78.

132 *Proof Committee Hansard*, 7 May 2008, p. 83.

133 *Proof Committee Hansard*, 1 May 2008, p. 2.

- the regular use of seclusion and forceful restraint, including a return to and increased use of mechanical restraints in some emergency departments;
- inadequate services, with bed occupancy levels exceeding acceptable standards;
- long waiting times in emergency departments;
- early discharge due to over demand; and
- lack of discharge services and follow up.[134]

8.119 Different initiatives relating to in-patient care were incorporated in state and territory COAG Individual Implementation Plans. In WA for example, the Council of Official Visitors commented that there had been a 'welcome decrease in the number of complaints received about treatment in emergency departments' reflecting the effect of WA's 'Emergency Department Mental Health Liaison Nurses and On-duty Registrars' initiative.[135] Several witnesses reported positively on a national project to reduce the use of seclusion and restraint in mental health services. Eleven beacon sites around Australia have been funded to implement strategies to reduce the use of seclusion and restraint and witnesses were hopeful about applying the lessons from the beacon demonstrations sites to other inpatient services.[136]

The Royal Women's Hospital

8.120 The committee heard one very positive example of developments in in-patient care from the Royal Women's Hospital in Melbourne. Philanthropic funding has enabled the Royal Women's Hospital to establish Australia's first multidisciplinary Centre for Women's Mental Health.[137] Dr Handrinos described the services the hospital now has, including:

- more nurses, doctors and psychologists, complementing the existing large social work department;

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134 See for example Ms Bayley, *Submission 47*; Ms Isabell Collins, Director of Victorian Mental Illness Awareness Council, *Proof Committee Hansard*, 1 April 2008; Ms Debora Colvin, Head of Council of Official Visitors WA, *Committee Hansard*, 7 May 2008, pp. 66, 69–70, 77; Ms Janne McMahon, Independent Chair, Private Mental Health Consumer Carer Network, *Proof Committee Hansard*, 8 May 2008, p. 49; Mr David Aspen, *Proof Committee Hansard*, 31 March 2008, p. 16; Tasmanian Community Advisory Council on Mental Health, *Proof Committee Hansard*, 31 March 2008, p. 50; NSW Consumer Advisory Group, *Proof Committee Hansard*, 27 March 2008, pp. 49 and 53; National Mental Health Consumer and Carer Forum, *Proof Committee Hansard,* 20 May 2008, p. 75.

135 *Proof Committee Hansard*, 7 May 2008, p. 66.

136 See for example Dr Brown, Director of Mental Health, ACT Health, *Proof Committee Hansard,* 16 May 2008, pp. 31 and 48; Mr Lovegrove, Consumer and Deputy Co-Chair, National Mental Health Consumer and Carer Forum, *Proof Committee Hansard,* 20 May 2008, p. 72; Ms Olsson, SA Branch President, Australian College of Mental Health Nurses Inc, *Proof Committee Hansard,* 20 May 2008, p. 31.

137 Submission 19, p. 5.

- one mental health clinician attached to each maternity outpatient session;
- psychologists and a psychiatrist in the oncology department;
- a psychologist and psychiatrist working in the special care nursery, to work with mothers and fathers whose children are born prematurely;
- a 24-hour on call service;
- expert mental health assessments; and
- capacity to improve the mental health skills of referring clinicians, including midwives, doctors, social workers, physiotherapists and dieticians.[138]

8.121 Dr Bayly commented on the difference the increased mental health staffing has made to other practitioners in the hospital. In terms of prevention and early intervention, she noted that clinicians are more likely to have conversations with their patients about their mental health circumstances if there is someone to refer the patient to or get help from. She observed 'there is an enormous sense of relief amongst the doctors, midwives, nurses and social workers in the hospital that that option is now available to us in house'.[139]

8.122 Dr Bayly also noted the effect of a multidisciplinary way of working:

> The attachment of the mental health staff to each of the other clinical teams means that everyone will have some exposure; it is not that the mental health issues are taken away and dealt with somewhere else in the centre. I think there will be much more exposure than there has been in the past to that kind of experience and discussion, just in the course of routine clinical care.[140]

8.123 Dr Handrinos suggested that this multidisciplinary approach can assist in changing the negative service culture and stigmatised approach that some other witnesses identified is prevalent amongst mental health service providers:

> I now attend the clinic of the obstetricians, the dieticians and so on and so forth. When patients are discussed, just having a presence and being able to explain and demystify a little helps enormously. [141]

8.124 Unfortunately, these kinds of multi-disciplinary services are not typical for in-patient care. Dr Handrinos commented that 'this level of staffing really should not be considered a luxury. We believe that all women's services should be able to offer this level of intervention'.[142] Indeed Dr Handrinos saw the need for better mental health services in all general hospitals, noting that areas such orthopaedic services,

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138 *Proof Committee Hansard*, 1 April 2008, p. 28.

139 *Proof Committee Hansard*, 1 April 2008, p. 29.

140 *Proof Committee Hansard*, 1 April 2008, p. 30.

141 *Proof Committee Hansard*, 1 April 2008, p. 31.

142 *Proof Committee Hansard*, 1 April 2008, p. 28.

respiratory services, intensive care and trauma units should all have mental health staff.

Standards and rights

8.125 Human rights issues have long been intertwined with questions about mental health care and treatment.[143] At the core of these considerations is the reality that treatment for mental illness is one of the few reasons, outside the criminal justice system, that a person can be detained against their will. The human rights of people with mental illness can also be affected at many other levels, for example through the treatment they receive or do not receive, experiences of stigma, marginalisation, discrimination and social disadvantage. The agreement of the *National Standards for Mental Health Services* in 1996 was heralded as an important step in upholding the human rights of people with mental health problems and illnesses. Since then there have been many calls for the Standards to be reviewed and updated and also concerns about the degree to which they have actually been implemented by service providers.

8.126 Indeed the 2007 National Mental Health Report stated:

> All states and territories agreed in 1998 to implement the Standards, but progress was slower than expected. By June 2005, 78% of services had completed the review process.[144]

8.127 It is disconcerting that nearly a decade after the standards were developed, 22 per cent of services had not been evaluated and, of those which had been reviewed, two per cent did not meet all the national standards.[145]

8.128 The Senate Select Committee on Mental Health made specific recommendations relating to the National Standards, including that all states and territories report on service providers' performance against the National Standards, that the Standards be reviewed and that performance indicators which focus on the effectiveness of treatment, discharge plans and follow up in the community be developed and implemented.[146]

8.129 A project to review the Standards commenced in November 2006 and reported in May 2008.[147] Professor Rosen outlined some concerns about the approach taken to reviewing the National Mental Health Service Standards. These included:

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143 See Senate Select Committee on Mental Health, *A national approach to mental health — from crisis to community,* pp. 27–28 for a brief overview of the Australian context.

144 Australian Government, *National Mental Health Report 2007*, p. 10.

145 Australian Government, *National Mental Health Report 2007*, Appendix 9, p. 149.

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

147 Australian Council on Health Standards, 'Review: National Standards for Mental Health Services', *ACHS News*, No. 24, Winter/Spring 2007, p. 7; DoHA, 'Review of Standards for Mental Health Services', www.achs.org.au/StndsMentalHealth, accessed 22 August 2008.

- Using the Australian Council on Healthcare Standards, rather than an independent consortium to conduct the review. Professor Rosen felt that there is too much incentive to focus on standards that are 'convenient for their accreditation process rather than a set of standards which will be acceptable to all the constituencies in the mental health field'.
- Discouragement of 'aspirational standards' which encourage services to go from operational and minimal standards to a more optimal way of operating.
- Reliance on voluntary input from mental health experts.
- Skewed involvement of mental health professionals, with no psychologists, no occupational therapists, no social workers, one nurse but five psychiatrists on the steering committee.
- Limited consumer and carer input to the steering committee.
- No Indigenous representation on the working groups, and general lack of consultation with the working groups.[148]

8.130 DoHA witnesses considered that the review had engaged in wide consultation including carers, consumers, private sector, peak bodies and all state and territory governments. Mr Smyth, Assistant Secretary, outlined the review process:

> The Commonwealth engaged ACHS to undertake a review of the mental health standards. There were three phases to that process, and quite a degree of consultation involved with it as well…That was pilot testing of those standards in a number of mental health services. The final report will go to the Mental Health Standing Committee for endorsement prior to going up the food chain to health ministers.[149]

8.131 Mr Smyth also noted that while the National Mental Health Standards were previously focussed on public sector health services, the review has included the private sector as well.

8.132 The National Mental Health Consumer and Carer Forum advocated for an independent body to monitor mental health care. Mr Lovegrove said:

> There should be some monitoring body that is able to oversee that the monitoring is taking place—not just in policy but at the operational level—and to look at what procedures and practices are in place to see that those sentinel events are not just a waste of suffering and tragedy of some person's life but consciously used and embraced as a means to improving and reforming the system.[150]

148 *Proof Committee Hansard*, 27 March 2008, pp. 68–69; see also Metal Health Coordinating Council, *Supplementary Submission 23*, p. 6.

149 *Proof Committee Hansard*, 16 May 2008, p. 104.

150 *Proof Committee Hansard*, 20 May 2008, p. 72.

8.133 The National Mental Health Consumer and Carer Forum along with several other witnesses, supported the mental health commission model in place in New Zealand and Canada and saw that such a body would be well placed to take up an independent monitoring role in relation to standards of care.[151]

8.134 The committee notes that the review of the National Standards for Mental Health Services has been published, with the revised standards to be endorsed by the AHMAC Mental Health Standing Committee Safety and Quality Partnerships Subcommittee. According to the review, the 'process for endorsement and decisions on strategies and processes for implementation and monitoring of the revised NSMHS will be made by DoHA'.[152]

8.135 The committee emphasises that the review is only a first step. Of critical importance is ensuring that all mental health services are evaluated against the standards, the findings of the evaluation are publicly reported and that mechanisms are put in place to ensure any breaches in standards are recorded, rectified and that services are held to account. As noted in chapter 2, the committee considers that mechanisms to monitor the human rights experiences of people with mental illness have been left underdeveloped in Australia. Accordingly, in Recommendation 2 the committee recommended that the National Advisory Council on Mental Health be funded to establish a standing committee to monitor the human rights experiences of people with mental illness.

Research

8.136 The Senate Select Committee on Mental Health noted the under-developed state of mental health research and monitoring of policy implementation in Australia. It recommended the establishment of a *Commonwealth-State Mental Health Institute* to enhance research, develop service targets and disseminate best practice service standards.[153] The evidence to the committee indicates that funding for mental health research in Australia remains inadequate. Several organisations compared the funding that is allocated to mental health research with drug and alcohol research. Dr Freidin commented:

> We want to make the point that virtually nothing is done. We compare it to drug and alcohol area, where there is a peak body that has government funding to research what is happening in the field as well as clinical interventions.[154]

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151 *Proof Committee Hansard*, 20 May 2008, p. 73. See chapter 2 for further discussion of the Mental Health Commission model.

152 The Australian Council on Healthcare Standards, *Review of the National Standards for Mental Health Services Final Report,* May 2008*,* p. 6.

153 Senate Select Committee on Mental Health, *Mental health services in Australia – from crisis to community*, p. 479.

154 *Proof Committee Hansard*, 1 April 2008, p. 45.

8.137 Mr Crosbie also compared the funding for drug and alcohol research:

> I would love to see the research capacity in mental health come close to the research capacity that we have in Australia around alcohol and drugs. We have a National Drug and Alcohol Research Centre, which does exceptional work, with over 100 staff. We have a National Drug Research Institute in Perth that does fantastic work. I think that has about 50 staff or more. We have a National Centre for Education and Training on Addiction in South Australia. That does excellent work. They are all funded out of the program area of DoHA, with core capacity funding.[155]

8.138 There are numerous areas in mental health requiring further research—a few of the current priorities mentioned by witnesses included looking at systems that can effectively integrate public and private care and researching the effects of the Better Access initiative.[156] In research areas where Australia is at the leading edge, such as e-health technology, support is needed to link research into service delivery.[157]

Evaluation

8.139 Submitters and witnesses to the inquiry were pleased to see the funding that has flowed to mental health services through the COAG Plan, but hesitant as to how far the COAG Plan will reach in filling existing service gaps and shortfalls. They agreed that sound evaluation of the COAG Plan is required.[158] Ms White, Executive Officer for the WAAMH summarised:

> I think we are at least standing still. I do not think we have really gone backwards. I am not sure how far we have gone forwards, but I think there have been some positive moves, not only with the COAG money from two years ago but also with the moneys having gone into a number of the initiatives under the Mental Health Strategy. An evaluation of whether they actually did what it was hoped they would do is still to occur.[159]

8.140 Generally witnesses were concerned that little attention has been given to evaluation of the COAG Plan so far. State Governments, although co-contributors to the COAG Plan, were not clear as to the intended evaluation. Mr Thorn, from WA Department of Premier and Cabinet, said 'I know that a plan is being prepared but I am not aware of what is happening with it being given effect'.[160]

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155 *Proof Committee Hansard*, 20 May 2008, p. 96.

156 *Proof Committee Hansard*, 1 April 2008, p. 45.

157 *Proof Committee Hansard*, 20 May 2008, p. 24.

158 See for example, SANE Australia, *Committee Hansard* 10 April 2008, p. 5; AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 28; WAMIAC, *Proof Committee Hansard*, 7 May 2008, p. 56; Professor Hickie, *Proof Committee Hansard,* 20 May 2008, p. 32; Community Mental Health Peaks, *Submission 39*, pp. 1–5.

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

160 *Proof Committee Hansard*, 7 May 2008, p. 55.

8.141 Dr Groves, Director of Mental Health in Queensland Health, indicated that while an evaluation is planned, the scope has not yet been determined:

> …the Commonwealth, through DoHA, commissioned a report to look at a costed proposal for the full evaluation of the COAG National Action Plan on Mental Health. Bearing in mind that, now COAG is closer to $5 billion, not $4 billion, the evaluation is clearly going to be quite complex, and my understanding is that the costed evaluation of this entire plan is somewhere in the order of $4 million or $5 million. As yet, I am unaware of whether the decision has been made to fund that national evaluation. We therefore have the states and territories going about starting their own evaluations without any agreement to how we evaluate those national parts of the plan where we are working together.[161]

8.142 Professor Whiteford, Principal Medical Advisor DoHA, explained the measures that are currently being collected to evaluate the COAG Plan:

> In the overall evaluation, there are 12 key performance indicators for the COAG National Action Plan on Mental Health…Essentially, they cover data we collect now around population outcomes, which are high level, such as suicide rates. There are indicators around services: mental health services or health services. There are four indicators around social and economic outcomes: participation, education and employment, or individuals with mental illness who might be ending up in the criminal justice system or homeless. They are the overall indicators around the action plan. In addition, each state and territory and the Commonwealth are providing information on how their specific measures are going in their jurisdictions. That is also fitting into an overall evaluation of the COAG action plan.[162]

This information is provided to COAG Senior Officials.

COAG progress reports

8.143 So far, evaluation and reporting on COAG Plan initiatives has largely been internal to the COAG structure. Dr Grove outlined:

> …when COAG was agreed it was requested that health ministers would supply by the end of 2007 a first annual report on COAG. That has been completed and has been forwarded to health ministers. In my view, it gives a very comprehensive snapshot of where all jurisdictions have gone in terms of COAG. My understanding is that, unfortunately, that has not yet got to COAG and certainly has not been made publicly available.[163]

8.144 Mr Smyth explained that any decision to make the reports public was at COAG's behest:

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161 *Proof Committee Hansard*, 16 May 2008, p. 51.

162 *Proof Committee Hansard*, 16 May 2008, pp. 102–103.

163 *Proof Committee Hansard,* 16 May 2008, p. 50.

> At the moment, there is discussion to seek to make those public, but that is a decision for COAG. Traditionally, as I understand it, COAG reports have not been made public.[164]

8.145 Since the committee's hearings the first COAG report on the National Action Plan has been publicly released.[165] The committee commends COAG and the Australian Health Ministers for making this report available and looks forward to future reports on the COAG Plan likewise being released. It is important that the COAG Plan, which was hailed as major step forward for mental health services in Australia, is transparent and accountable. Many providers in all different parts of the care system, as well as families, carers and importantly consumers themselves are working with the funding provided through the plan. They have a clear interest in the evaluations made of the plan.

Evaluating outcomes

8.146 Witnesses to the inquiry stressed that evaluation of the COAG Plan needs to look not only at expenditure and service usage, but primarily at the mental health outcomes for consumers. Mr Harris, Executive Director of the Mental Health Coalition of South Australia commented:

> …the focus of some of those measures really needs to be strongly on outcomes because I think there is a lot of need in the community—you might want to target them better. The key thing we see, though, is whether the outcomes are there to justify the expense of those measures.[166]

8.147 Ms Powell, from WAMIAC commented:

> What we see is outputs: the number of bed days taken, the number of visits to the psychologist and the number of visits to the GP. They are outputs; they are not about the experience. They are not about whether those visits have actually made an impact on our quality of life. They are not about whether we have actually got anywhere on our process to recovery.[167]

8.148 Mr Crosbie, Mental Health Council of Australia also stressed the importance of outcome measures:

> We still tend to have many plans and lots of reports about what is happening to the plans but no actual outcomes about what is happening to the people who are in services. There is no real attempt to collect the experiences of carers, consumers or people who are not accessing services who, we understand, account for about half of the people who experience

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164 *Proof Committee Hansard,* 16 May 2008, p. 103.

165 Australian Health Ministers' Conference, *Council of Australian Governments National Action Plan for Mental Health 2006–2011, Progress Report 2006–07,* www.coag.gov.au/reports/index.cfm.

166 *Proof Committee Hansard*, 8 May 2008, p. 3.

167 *Proof Committee Hansard*, 7 May 2008, p. 58.

> mental illness. There is a massive gap in information about what is actually happening around mental illness.[168]

8.149 The Western Australian Mental Illness Awareness Council commented that there was nothing in the COAG Plan to indicate how consumers would be involved in evaluation.[169] Ms Powell recognised that there are sensitivities that need to be taken into account when involving consumers in evaluation. For example, consumers may be hesitant to give negative feedback for fear that they will 'not get a service anymore at all'. Ms Powell stressed that any evaluation needs to be independent and suggested that involving peer support workers is a key mechanism for facilitating honest feedback. As Ms Powell observed, 'consumers say lots of things to each other that they would never dare tell the staff'.[170]

8.150 The Mental Health Council of Australia recommended the establishment of one or more Mental Health Centres of Excellence, dedicated to providing ongoing monitoring and program evaluation as well as developing Australia's mental health research capacity. MHCA suggested that ten per cent of mental health resources could be allocated to such centres, for monitoring and research.[171]

8.151 The committee's inquiry was, in general, characterised by a dearth of data. Information about Better Access and who the initiative is serving was limited. Information about shifts among psychologists from the public sector to the private sector was anecdotal. Information about service improvements through PHaMs, while consistent, was anecdotal. Outcome data was non-existent. Although the COAG Plan has several years to go and some argue it is early to be looking for results, it is certainly not too early to be asking whether processes are in place to measure and evaluate outcomes. Currently these appear to be lacking.

8.152 Given the need for an expansion of mental health research in Australia, the substantial monitoring and evaluation required with the rollout of the many initiatives under the COAG Plan and the importance of independent evaluation, the committee supports the development of a designated Centre of Excellence or Mental Health Institute to foster mental health research and evaluate existing programs.

Recommendation 21

8.153 The committee recommends that the Australian, state and territory governments develop as a matter of priority a framework for evaluating the consumer outcomes achieved by the *National Action Plan on Mental Health 2006–2011*.

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168 *Proof Committee Hansard*, 20 May 2008, p. 83.

169 *Proof Committee Hansard*, 7 May 2008, p. 55.

170 *Proof Committee Hansard*, 7 May 2008, p. 58.

171 Mental Health Council of Australia, *Submission 22*, p. 3.

Recommendation 22

8.154 The committee recommends that the Australian, state and territory governments jointly fund and establish a Mental Health Institute to foster research as recommended by the Senate Select Committee on Mental Health and to conduct ongoing monitoring and evaluation of mental health services across Australia.

Concluding comments

8.155 The committee's inquiry shows that despite the progress made under the COAG Plan, there is a lot further to go in creating an available, accessible, community-based mental health care system in Australia. The costs of mental illness to individuals, their families, the community and to the economy are substantial. Mental illnesses account for 13 per cent of the disease burden in Australia, third after cancer and cardiovascular disease, and nearly a quarter (24 per cent) of the disability experienced by Australians.[172] Developing and maintaining a service system that reduces, and where possible prevents, these costs is imperative.

8.156 The committee commends the Commonwealth, state and territory governments for recognising mental health as a priority area. It is encouraged by the commitment to achieving a seamless and connected system of mental health care shown in the COAG Plan. However, based on this inquiry, the committee considers that further investment, leadership and cooperation will be required to make the aims of the COAG Plan and the wider National Mental Health Strategy a reality.

Recommendation 23

8.157 The committee recommends that in reviewing the *National Action Plan on Mental Health 2006–2011* and developing future mental health policy, the Australian, state and territory governments give priority to addressing the shortfalls that currently exist in community-based mental health services, housing, education and employment for people with mental illness, comorbidity services, acute care and workforce supply to the mental health sector.

172 AIHW, 2008, *Mental Health Services in Australia 2005–2006*, p. 4; AIHW, 2008, *Australia's Health 2008*, p. 224.