CHAPTER 9

SPECIFIC GROUPS

9.1 Some groups of people find it particularly hard to get the mental health care that they need. Much of the funding in the COAG Plan was for generic services. While some initiatives were targeted to particular groups, evidence to the inquiry indicates that more needs to be done to provide mental health care that meets the needs of specific groups. In this chapter the committee considers several groups of people for whom current services remain inadequate.

Indigenous Australians

9.2 Submissions to the inquiry consistently raised concerns about the mental health care available to Indigenous Australians. It was argued that Indigenous Australians have not been given priority in mental health policy and that they remain largely alienated from current services, which are either not available or culturally inappropriate.[1]

9.3 The Aboriginal Medical Services Alliance Northern Territory (AMSANT) discussed with the committee the mental health needs of Indigenous Australians, particularly in remote communities. Representatives proposed that new ways of providing mental health care are needed. While acknowledging new funding for mental health and alcohol and other drug (AOD) services, representatives considered that integrated service provision through primary health care settings would be a more effective way to use the money in remote communities:

> We believe the most effective and efficient way to provide these services is to ensure they are community based and operating through existing primary healthcare service infrastructure. The creating of multiple service providers, especially in remote communities, is making the service system unnecessarily complex and more fragmented.[2]

9.4 In effect, AMSANT proposed 'one stop shop' primary health care centres which would be run under Aboriginal control and include mental health and AOD services. AMSANT described the required services as 'centred on multidisciplinary social, emotional wellbeing health teams including a strong Aboriginal workforce'.[3]

9.5 AMSANT provided examples of mental health care working effectively in the way they advocate:

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1 Community Mental Health Peaks, *Submission 39*, p. 8.

2 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 19.

3 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 20.

> Where we do have integrated Aboriginal health services, we have a system in place where large numbers of people come through clinics, they get screened, they get referred, mental healthcare plans are done and then psychologists and social workers see people and can access the item numbers. It works beautifully but it is only happening in probably two services because they had existing funds—not through COAG mental health money but pre-existing money—that has enabled them to capitalise on the mental healthcare planning items.[4]

9.6 AMSANT were concerned that the community-based mental health services being funded by the Commonwealth under the COAG Plan have not been integrated with the primary healthcare system.[5] Modelling conducted by AMSANT set out the primary health services that could be provided in an integrated fashion from current service funding, and those services that would require additional funding. The latter included services such as universal home visitation and social and emotional wellbeing services. In AMSANT's view, these services could also be integrated into primary health care settings if current mental health and AOD funding, including COAG Plan funding, were pooled with other primary health funding. AMSANT estimated that funding of $3,600 per capita is needed to provide the necessary integrated care and that this level could be achieved by re-apportioning current spending:

> The money is in the system. But the way it is being spent under the 19 program areas, the way it is departmentalised and the way it is going out for competitive tendering means that it is not being applied in a needs based planning framework.[6]

9.7 Existing service infrastructure and workforce shortages are important considerations in the provision of mental health care for Indigenous communities. AMSANT noted that primary healthcare services provide the only available infrastructure for mental health care in remote communities.[7] Models such as the Better Access initiative, which relies on private providers and a fee-for-service system, and PHaMs which relies on NGOs, have inherently limited uptake as providers are just not available.

9.8 Competitive tendering was considered to be an inappropriate mechanism for distributing funding and services to Indigenous communities, with the potential to fragment an already small service sector.[8] AMSANT observed that 'you will not get remote Aboriginal health services working up tenders and competing in that sort of

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4 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 24.

5 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 22.

6 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 21.

7 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 21.

8 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 23.

process to attract these funds'.[9] In some cases, there have been no providers tendering for community-based programs such as PHaMs.[10] AMSANT advocated that such unspent funding should be offered to the remote primary healthcare sector, for example to help fund psychologists, social workers and Aboriginal family support workers as part of primary healthcare teams.

9.9 Despite initiatives in the COAG Plan aimed at increasing the mental health workforce within Indigenous communities, shortages remain.[11] Ms Lawson, Chief Executive Officer of the Community Services and Health Industry Skills Council reported:

> Examples that have been given to us—for example, from the Northern Territory—are that they have over 60 vacancies just in the public system for Aboriginal health workers at the moment, and those sorts of numbers seem to be common across Australia...[12]

9.10 Ms Lawson commented that the training and skilling issues for Indigenous mental health workers can be different to other parts of the sector, with the need to consolidate the skills and experiences that existing workers have:

> They might have done a part of a course in social and emotional wellbeing or some bits of courses over the last several years, but they have not made up to a whole qualification yet. So part of the challenge we have in implementing these new qualifications is getting some of those workers who have the skills but not yet the recognised qualifications up to speed to meet the new standards that are required for mental health.[13]

9.11 The Senate Select Committee on Mental Health in its report set out the many inadequacies in mental health care for Indigenous Australians. These included, for example: lack of research and understanding of Indigenous mental health needs and appropriate responses, the absence of culturally appropriate diagnostic tools, lack of government support and funding to deliver culturally appropriate services, lack of training and support for Indigenous mental health workers, the importance of Aboriginal run services, inadequacy of specialised services to assist Indigenous communities to deal with co-occurring disorders, and the need to support Indigenous emotional and wellbeing programs and value self-determination.[14]

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9 AMSANT, *Proof Committee Hansard*, 1 May 2008, pp. 23 and 35.

10 AMSANT, *Proof Committee Hansard*, 1 May 2008, pp. 23–24.

11 The Commonwealth, New South Wales, South Australia and Northern Territory Individual Implementation Plans each included initiatives targeting Aboriginal mental health services.

12 *Proof Committee Hansard*, 27 March 2008, p. 91.

13 *Proof Committee Hansard,* 27 March 2008, p. 91.

14 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, pp. 459–472.

9.12 Evidence to this inquiry indicates that such shortfalls have not been adequately met through initiatives under the COAG Plan. Further, the evidence suggests that funding a range of individual programs, particularly through competitive tendering, is not going to provide the integrated care that is needed.

Culturally and linguistically diverse communities

9.13 The dearth of services for people from culturally and linguistically diverse backgrounds (CALD) was identified as a key shortfall in the range of mental health services currently available.[15] The Western Australian Association for Mental Health noted that while efforts have been made over recent years to educate mainstream services about providing mental health care to CALD consumers, the common approach remains to refer CALD consumers onto specialist services, which are few and far between.[16] Ms McGrath Director of Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS) in Adelaide pointed to some of the gaps in mainstream services for CALD consumers, such as the need for trained, accredited and supported interpreters. She noted:

> It is quite appalling to me that in 2008 it is still common for a GP to refuse to provide an interpreter for a consultation with one of his patients because it is too expensive and time consuming. It is still common for a hospital clinic to be unable to provide an interpreter because they do not have a budget line for this service, or to find that practice managers and admin staff do not even know how to book an interpreter.[17]

9.14 Mr Murdoch, Deputy Director of the Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS) in Sydney acknowledged that mainstream service providers have shown 'a lot of willingness' to engage in training and professional development around working with CALD consumers. However, in an already stretched workforce, it is difficult for providers to take the time out from working directly with clients to undertake the training, skills development and clinical supervision needed to work more effectively with refugees and others from diverse backgrounds.[18]

9.15 Many of the gaps and shortfalls in mental health services for the population in general are heightened in relation to CALD communities. For example, general shortages in housing and accommodation further the housing stress experienced by new arrivals to Australia. Mr Murdoch explained:

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

16 Western Australian Association for Mental Health, *Proof Committee Hansard,* 7 May 2008, p. 3.

17 *Proof Committee Hansard,* 8 May 2008, p. 59.

18 *Proof Committee Hansard*, 27 March 2008, p. 5.

> People who do not have a rental history, who are recently arrived in the country, will find it difficult in that sort of environment because they do not have a set of references from tenanting elsewhere, which other people will quite likely have, based on the fact that they have been resident in the country for however long it may be. For newly arrived refugee clients, that is quite a big problem.[19]

9.16 Ms Gould, a clinical psychologist from STARTTS pointed to the shortfall in education and awareness raising for this group:

> …we have seen fairly big gaps in the provision of information to communities and individuals and their families on issues about mental illness and refugees. For example, there is still quite a big stigma attached to seeking mental health services. This exists in a variety of communities, not just refugee communities, but perhaps particularly so in the refugee community. The mental health models we follow here are quite foreign to many people.[20]

9.17 Ms Gould suggested that more creative ways of raising mental health awareness, for example through radio or theatre, could be more effective for some groups, particularly where there are high levels of illiteracy.[21]

9.18 As with other mental health services, services for CALD communities need to involve consumers in service design and delivery, and there is a need for consumer advocacy. Ms McGrath spoke of some of the extra challenges in fostering consumer involvement in CALD mental health services:

> …the people who are available to provide representation as consumers usually end up being very few and very overburdened in that every service wants to use them, their language skills and their level of confidence and that kind of thing in working with Western systems. That can be a real issue because you can end up hearing the same voices over and over again. We actively seek them out, but it can be quite difficult particularly with cross-cultural stuff. For instance, in some communities it is not acceptable for the women to speak without the permission of the husband. So in fact you are always getting the husband speaking, and it is hard to get to the women.[22]

9.19 CALD communities are by there very nature diverse and there are different service needs within this population group. Some sub groups within CALD communities are particularly at risk of mental illness and have a particular need for more or better targeted services. Survivors of trauma and torture are one such group.

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19 *Proof Committee Hansard,* 27 March 2008, p. 14.

20 *Proof Committee Hansard,* 27 March 2008, p. 2.

21 *Proof Committee Hansard,* 27 March 2008, p. 2.

22 *Proof Committee Hansard*, 8 May 2008, p. 67.

9.20 Witnesses acknowledged the additional Commonwealth funding that has been allocated to torture and trauma treatment services ($12 million over four years) outside the COAG Plan.[23] Mr Murdoch commented that the new funding had helped to reduce waiting lists for services in New South Wales.[24] He described the increase in funding, given the low starting point in the sector:

> That, taken in conjunction with existing funding, was certainly a substantial increase for funding of counselling services for torture and trauma survivors here in New South Wales. The base funding had been in the order of $500,000 through the program of assistance to survivors of torture and trauma. The additional funding has been in the order of a further $1 million. So that has certainly been something we welcome.[25]

9.21 Although appreciating the increased funding, Ms McGrath explained that the combined increase in funding from both federal and state governments provided a total of 1.6 full-time equivalent staff across the whole of South Australia, leaving significant unmet need. Ms McGrath raised in particular the needs of children and young people from refugee backgrounds, an extremely high risk group for mental illness. Ms McGrath explained:

> There is a high incidence of severe torture and trauma history in this population, a large number of single-parent headed households, and a high incidence of family violence, poverty and parents with their own mental health issues. Commonly observed problems in the children include behavioural problems, resulting in disrupted schooling and antisocial behaviour, unemployment, homelessness, isolation, alienation, suicide and self-harm. All the risk factors are there and all the behaviours that one would expect are actually happening.[26]

9.22 Ms McGrath observed that schools, both mainstream schools and schools for new arrivals, are having a lot of difficulty as they are not resourced to provide the counselling, group programs or professional support needed for refugee children, or the training and debriefing needed for teachers.

9.23 Another group within CALD communities identified as being particularly at risk of falling through the gaps in current services was older people. Professor Malak highlighted the circumstance of elderly people from culturally and linguistically diverse backgrounds with mental health problems:

> I know we are strongly concerned about people detained in detention centres, but I remind myself and everyone about the one million old people being detained in their homes without support. They suffer from loneliness; they suffer from mental illness; they drug themselves. That is a group

23 *Proof Committee Hansard,* 27 March 2008, p. 5.

24 *Proof Committee Hansard,* 27 March 2008, p. 7.

25 *Proof Committee Hansard,* 27 March 2008, p. 5.

26 *Proof Committee Hansard*, 8 May 2008, p. 58.

> which I am really frightened that we are going to ignore, and then they will die. For this group, when they arrived after the Second World War or the Holocaust, there were no services available, and there are no services available to them up to now.[27]

9.24 As discussed above, many of the service shortfalls experienced by CALD communities reflect wider shortfalls apparent in the broader mental health care system. However, CALD communities also have distinct service needs and requirements. Witnesses noted that the COAG Plan did not include services for CALD communities. Ms Cassaniti, Coordinator Transcultural Mental Health Centre, did not necessarily see this as an omission, provided that mainstream services were funded, trained and designed to meet the needs of diverse communities:

> …the national action plan did not include cultural and mental health, and I would like to think that is due to the fact that Australia is moving to a viewpoint that we are culturally diverse. I would like to think it was not an omission but rather that it was about the fact that we are diverse. That is the language that we are trying to move towards. If that is not the case, I would like cultural and mental health back in there so that we constantly get reminded. I think we are still probably two decades away from actually achieving the view that we are all culturally diverse and that all our services have to basically work from the framework that Transcultural Mental Health has.[28]

9.25 Certainly the evidence presented to the committee suggests that mainstream services are not yet providing adequate mental health care to meet the complex needs of many CALD groups and further development is needed. Specialist services are few and far between and funding to allow them a greater geographical reach is required.

Youth

9.26 The Senate Select Committee on Mental Health reported on the significant need for youth mental health services in Australia. Importantly, it noted that the age group from early teens through to early twenties had the highest incidence of mental illness of all age cohorts and the lowest rate of access to services.[29] The traditional health service paediatric-adult divide was seen as inappropriate for mental health services, with many young people either falling through the gaps in the transition between target groups, or finding themselves in inappropriate service settings. Appalling accounts of treatment in emergency departments and other mainstream settings were relayed to that committee.

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27 *Proof Committee Hansard*, 27 March 2008, p. 19.

28 *Proof Committee Hansard*, 27 March 2008, p. 21.

29 Senate Select Committee on Mental Health, *A national approach to mental health — from crisis to community*, p. 417.

9.27 The headspace National Youth Mental Health Foundation (headspace) is the biggest development in youth mental health since the Senate Select Committee on Mental Health conducted its inquiry. Although it sits outside the COAG Plan, the committee was pleased to hear about the work being done by headspace.

headspace

9.28 Headspace's key aim is to reduce the impact of mental illness and substance use problems on young people aged 12 to 25. It is a consortium model involving the University of Melbourne, ORYGEN Research Centre, the Australian General Practice Network, the Australian Psychological Society and the Brain and Mind Research Institute. Headspace has $69 million in Commonwealth funding over four years; $54 million for the establishment of the headspace foundation and $15 million for allied health services. Mr Tanti, Chief Executive Officer, explained that headspace has been running for just over two years and is aiming to transition 'into an independent not-for-profit entity that is accountable to a board'.[30]

9.29 Mr Tanti outlined some of headspace's defining characteristics, including:

- a strong early intervention focus;
- emphasis on evidence-based intervention;
- a focus on social recovery, not just clinical services;
- looking at the whole-of-life opportunity for each young person, such as employment and vocational opportunities;
- being relevant and appealing to youth and addressing their concerns, such as the importance of confidentiality and dialogue;
- providing integrated services within the headspace sites.[31]

9.30 Headspace has endeavoured to ensure that consumers play a central part in the direction of the initiative, through its youth reference group. This is a group of 28 young people who have varying experiences of mental health either themselves or through their families. Mr Nathan Frick, Chair of the youth reference group explained its role:

> Our aim is to work with other young people and to report back to headspace and give them direction and clear guidance as people who have been through the system—who either work in it, are affected by it or are still involved in it in one way or another. Until services like headspace are given continual funding and opportunities to develop young people, I think we are going to have a major generational issue. hY NRG, the headspace Youth National Reference Group, and headspace are well on the way to making that change, but it is a long-term commitment and a long-term goal. I do not

30 *Proof Committee Hansard*, 20 May 2008, p. 2.

31 *Proof Committee Hansard*, 20 May 2008, pp. 4–5.

> want my kids to be going down the path of self-harm and suicide, because there is an alternative.[32]

9.31 So far 30 headspace sites have been funded. Eight of these are up and running and 4,000 young people have been seen through the sites.[33] Each site is based on a consortium model, with drug and alcohol, mental health, vocational and educational services usually forming the core of the consortium. Other partners depend on the site, with some having up to 22 or 23 consortium partners.[34] Mr Tanti described the integrated services headspace is aiming to provide:

> Again, it is about an integrated platform so that young people can get whatever help they need at the site and we do not necessarily have to refer them. Obviously, there are a range of services within the headspace site, but there is also the back-up of a whole range of specialist state services that young people can access through the headspace site. We are trying to create a seamless system and strengthen the system of care.[35]

9.32 The youth focus of headspace is a big shift from existing service arrangements, requiring strong leadership. The AGPN commented:

> I think headspace is a really ambitious agenda because you are talking about quite complex health service development and change. It is a population group where services have typically been divided into child and adolescent. You are talking about that 12 to 25 age group that straddles both. Are services well organised to support that group? Probably not. The success of headspace…really is so dependent on good local governance, good local community engagement and change management.[36]

9.33 As well as physical sites, the headspace website is a key entry point for young people. Mr Tanti noted that the website is receiving around 1,000 hits per day. He described the role of the website:

> Our website is specifically designed to engage young people and promote help-seeking; to provide information ranging from very simple facts to the latest in evidence for clinicians, the general public, families, carers et cetera; and to provide details of the 30 headspace sites. Obviously the website is critical for those young people who do not live near a headspace site.[37]

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32 *Proof Committee Hansard*, 20 May 2008, p. 4.

33 *Proof Committee Hansard*, 20 May 2008, p. 5.

34 *Proof Committee Hansard*, 20 May 2008, pp. 4 and 13.

35 *Proof Committee Hansard*, 20 May 2008, p. 5.

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

37 *Proof Committee Hansard*, 20 May 2008, p. 6.

Funding

9.34 Mr Tanti described the funding model underlying the headspace sites as a 'public-private hybrid'. The headspace grant funding provides for the refurbishment of site buildings and administrative staff, with services provided by consortium partners. These arrangements will differ with some partners working on site and some providing periodic service on a fee-for-service basis. Mr Tanti commented:

> In a sense, you are asking the state based services to come together to deliver a service and you are looking at the private practitioners, whether they are GPs, psychiatrists or allied health practitioners, coming together to form headspace. You have state funded clinicians and federally funded services all coming together to provide services from the one hub.[38]

9.35 Dr Gurr pointed to problems in the funding model for headspace. He reminded the committee that health professionals need to be understood from a business perspective and not only a service perspective:

> [Headspace] was the one-stop-shop idea of getting the GPs to go and then working with the NGOs and also having state clinicians there. But the trouble is that the model was flawed because, again, it provided some infrastructure money to start with but it was then assumed that you were going to keep the whole program going by charging facility fees to keep the infrastructure there. It did not understand that GPs are small business people in their own surgeries, and they do not particularly want to go to the one-stop shop. They are happy for you to employ people on sessions, but they are not going to leave their practices. What they want is the virtual team, and they want relationships.[39]

9.36 Mr Tanti acknowledged the competing demands that need to be managed and the difficulty in keeping headspace services both low cost and sustainable:

> …hinging access to allied health off GP mental health plans is creating a restriction in timely access because of low GP numbers. The relatively low level of rebate for treatment by an allied health practitioner is also having an impact. We are very keen for our services to be low-fee or no out-of-pocket but obviously we are reliant on private practitioners and that can be problematic. I think it is adding to our difficulty in terms of recruiting allied health. You might need to charge an amount of out-of-pocket expenses. The only way to contain that really is for us to offer consulting suites free of charge, which means that we impact on our capacity to offer a sustainable model.[40]

9.37 Professor McGorry pointed out the costs of attracting service providers to headspace in the current environment of workforce shortages, noting that it is

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38 *Proof Committee Hansard,* 20 May 2008, p. 6.

39 *Proof Committee Hansard,* 27 March 2008, p. 71.

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

'important to have financial, professional and all sorts of other incentives which require money'.[41] Ultimately, keeping the headspace service low cost or free to the young people that need it will require 'an ongoing contribution from the federal government and ideally also from state governments as well'.[42]

9.38 In considering issues of costs and sustainability, Mr Frick emphasised the importance of looking at 'the additional costs to the community without a service such as headspace'. He illustrated, from his own experience:

> Personally, I had over 12 months off work. I have had numerous physical ailments because of my mental health that put me back into the public health system. So there are costs on those two fronts alone. Because I live in a rural and remote area, to access a clinical psychologist I have to fly to Darwin, which costs the state government roughly $600 a go. At one point I was having to see one every two weeks. My detraction alone is probably near the $50,000 to $100,000 mark. I, by definition, am not a bad case. If you put that into the scheme of 4,000 people, and even if you average it out at $20,000 per head, that is a lot of money.[43]

9.39 Certainly the gains for individuals and the community from supporting services which address mental illness early are clear. This is particularly so for youth, where onset of mental illness is most common, where incidence of mental illness is high and traditional service usage is low. Headspace brings together the best in clinical and social support to provide the kind of integrated service recommended by the Senate Select Committee on Mental Health. The committee commends all those involved in headspace for their work so far and recommends that Commonwealth, state and territory governments commit to ensuring that headspace has a viable recurrent funding base.

Remaining shortfalls

9.40 Despite the efforts that have been made to provide youth mental health services through initiatives such as headspace, evidence to the committee indicates that mental health services for young people remain an area of shortfall. Most apparent, in the evidence provided to the committee, are deficiencies in in-patient services for this age group. The Council of Official Visitors commented on an inappropriate mix of ages in some inpatient settings:

> It is just inappropriate to have such a mix when they are already dealing with serious illness. You have got 11-or 12-year olds, and then you have got maybe 16-or 17-year olds who have come in off the street, who have got drug induced psychoses—that sort of thing.[44]

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41 *Proof Committee Hansard,* 20 May 2008, p. 14.

42 *Proof Committee Hansard,* 20 May 2008, p. 14.

43 *Proof Committee Hansard,* 20 May 2008, p. 14.

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

9.41 Similarly, witnesses in Tasmania noted that the state does not have designated child and adolescent inpatient facilities.[45] Mrs Boxhall, Executive Member, Tasmanian Community Advisory Group on Mental Health commented:

> All we have at the moment is acute, adult mental health facilities. It is highly inappropriate to have children in those facilities. It has happened and it does happen.[46]

9.42 In South Australia witnesses also spoke about the need for more designated youth services. Ms Willoughby, Health Consumers Alliance SA:

> …the need for a youth service is paramount. There are 16-year-olds who are incarcerated in adult mental health facilities, and that is not appropriate to their developmental needs.[47]

9.43 Mr Wright outlined that South Australia is currently reviewing its model of care for child and adolescent services, including discussion around changing early intervention services to cater for people through to age 24, rather than having to enter adult services from age 18. In relation to acute care, Mr Wright noted that there is more flexibility to design appropriate services for new buildings. For example, in the Glenside redevelopment South Australia is considering building the acute care beds in 'pods' rather than separate units. These would be six bed pods that can be isolated from the rest of the unit, and used in different ways depending on need.[48] In the ACT, government representatives noted that funding has been allocated to undertake the detailed design of a youth inpatient unit.[49]

9.44 The committee commends the focus of major initiatives such as headspace on early intervention and prevention among young people. This is a key group where investment and effort in prevention and the early stages of mental illness can reduce the massive personal and financial toll of mental illness throughout life. Efforts here, as for other population groups, need to be directed at community-based supports and clinical services that assist people to live meaningfully in the community and reduce the need for hospital admission. Nevertheless, the reality remains that for some young people the only mental health services available are within hospital settings. In-patient services need to recognise and respond to the particular needs of this group and look at ways to overcome the inappropriate paediatric-adult service division.

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45 Mental Health Council of Tasmania, *Proof Committee Hansard*, 31 March 2008, p. 8; Tasmanian Community Advisory Group on Mental health, *Proof Committee Hansard*, 31 March 2008, p. 55.

46 *Proof Committee Hansard*, 31 March 2008, p. 55.

47 *Proof Committee Hansard*, 8 May 2008, p. 75. Similar observations were made by Dr Laird in relation to the Illawarra region of NSW, *Submission 54*.

48 *Proof Committee Hansard,* 8 May 2008, p. 99.

49 *Proof Committee Hansard,* 16 May 2008, p. 30.

Aged

9.45 The intersection between aged care and mental illness was discussed by the Senate Select Committee on Mental Health, including the service silos that existed between aged care and mental health responsibilities.[50] Evidence to this inquiry suggests that mental health services for older people remain a shortfall in the current range of services.

9.46 Some witnesses observed that elderly people receiving mental health care in hospital settings are not receiving the aged care that they need.[51] Conversely, the committee also heard about people with mental illness in aged-care homes that are not receiving the mental health care they need. In some instances nursing homes do not accommodate people with mental illness, so older people remain in in-patient care with no other accommodation options. The lack of a psychogeriatric residential care facility was raised particularly in the Northern Territory.

9.47 Mr Wright from the South Australian government reflected that mental health care for the elderly remains an area for further focus:

> One of the things that we have identified—and this is no disrespect to any of my clinicians—is that we are not good at providing the kind of social ongoing support that our aged-care residents need. We also want to increase our community teams so that we can then have greater in-reach into the wider aged-care sector. That is in process.[52]

9.48 Witnesses also highlighted the needs of older Australians who are living alone, often isolated, often without resources to meet their needs and not receiving any treatment or support for mental disorders. Professor Malak provided an example of the kinds of small initiatives which can make a great difference to the lives of elderly people with mental illness:

> To start with, we can get them out of their homes and get them connected. There was a small project done in Sydney which was basically having a clinician hold a phone conference with 10 older ladies at home once a week. In the end, he stopped dealing with them and they continued the phone conference, giving them their only contact with outside. So over a phone conference the 10 ladies had a chat together. It just connected them with the community, identified their issue of need and gave them a little bit of respect.[53]

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50 Senate Select Committee on Mental Health, A national approach to mental health – f*rom crisis to community*, pp. 84–86 and 423–429.

51 Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, p. 2; Top End Association for Mental Health Inc, *Proof Committee Hansard*, 1 May 2008, p. 36.

52 *Proof Committee Hansard,* 8 May 2008, p. 80.

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

9.49 The committee notes the evidence to the inquiry regarding the circumstances of older people with mental illness and the ongoing gaps in services, particularly the need for better integration of aged care and mental health care.

Survivors of child sexual abuse and borderline personality disorder

9.50 Witnesses reminded the committee of the strong link between childhood sexual abuse and mental illness later in life and suggested that this is an area overdue for focus and attention.[54] The Mental Health Coordinating Council cited the findings of a 2003 report which estimated that the cost to taxpayers of child abuse and neglect in Australia was approximately $5 billion per annum. The MHCC stated:

> Child abuse and neglect are the root cause of many of Australia's social ills—substance abuse; welfare dependency; homelessness; crime, relationship and family breakdown; chronic physical and mental illness. If not effectively targeted, the life-long impact of child abuse will continue unabated, putting increased pressure upon already stretched government health and social services.[55]

9.51 Ms McMahon, Independent Chair of the Private Mental Health Consumer Carer Network, commented that while COAG allocated over $20 million dollars to alerting the community to the link between illicit drugs and mental illness, the link between sexual abuse and mental illness has been neglected. She proposed what is needed:

> …what I would like to see, as a matter of urgency, is a high-level task force, comprising national and state and territory governments, the private sector, key medical experts and consumers and carers, to look at an initiative to tackle the results of child sexual abuse in adults.[56]

9.52 Advocates for Survivors of Child Abuse commented on the severe shortages in current services:

> There is a serious lack of capacity in the Australian mental health workforce to treat adult survivors of childhood sexual assault. Although child abuse sits at the heart of the public mental health burden, trauma and dissociation are not part of core psychiatric or psychological curriculum in Australia. As a result, the majority of mental health professionals lack the

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54 See for example *Proof Committee Hansard,* 8 May 2008, p. 50; National Research Centre for the Prevention of Child Abuse, *Submission 10*; Mental Health Coordinating Council and Council of Social Services of NSW, *Submission 23*, pp. 22–23 and supplementary information "*Reframing Responses" Improving Services Provision to Women Survivors of Child Sexual Abuse who experience Mental Health Problems,* Mental Health Coordinating Council, August 2006.

55 Mental Health Coordinating Council, Additional Information 16 July 2008, p. 1.

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

> training and skills to ameliorate trauma-related mental health issues amongst children or adults.[57]

Borderline Personality Disorder

9.53 Several organisations wrote to the committee particularly raising the situation of adult survivors of child sexual abuse with a diagnosis of borderline personality disorder (BPD). Taking an unprecedented action, all three of the national mental health consumer advocacy peak bodies along with the national mental health carer advocacy peak body joined together to raise this issue for the committee's attention. The joint submission noted that 90 per cent of people with BPD are women, and between 70 and 95 per cent have histories of childhood sexual abuse, trauma and neglect.[58] Other people without these histories can also suffer from BPD.

9.54 The coalition of peak bodies outlined some of the effects of BPD:

> Many people with this mental illness find it difficult relating to others and to the work around them. This can be very distressing for the person and those who are close to them. This instability often disrupts family and work life, long-term planning, and the person's sense of self-identity. Impulsivity can be a feature of this mental illness with the abuse of alcohol and other drugs, excessive spending and gambling.[59]

9.55 The committee heard about the distressing impact of the illness on people, including extreme emotional responses to minor triggers, high rates of self harm, unsafe sexual behaviour and drug and alcohol use and apparent recklessness due to an inability to perceive danger. People suffering from the illness can be paranoid and suspicious and experience severe emotional swings and extreme attachment behaviours. Tragically, many suicides are associated with the illness. Orygen Research Centre noted that the suicide rate among people with BPD is 8-10%, which is 50 times higher than the general community.[60] Among young people, at least one-third of completed suicides are associated with symptoms of BPD. Estimates of the prevalence of BPD in the community vary, from 1-2 per cent to around 5 per cent, with onset usually in mid to late teens or in early adulthood.[61]

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57 Advocates for Survivors of Child Abuse, Additional Information, 3 July 2008.

58 Australian Mental Health Consumer Network, National Mental Health Consumer Carer Forum, Private Mental Heath Consumer Carer Network, Mental Health Carers ARAFMI Australia (Coalition of Australian Mental Health National Consumer and Carer Advocacy Peaks), *Submission 53*, p. 2.

59 ORYGEN Research Centre, Letter supporting *Submission 53*, dated 16 July 2008.

60 Coalition of Australian Mental Health National Consumer and Carer Advocacy Peaks, *Submission 53*, p. 4.

61 See for example Coalition of Australian Mental Health National Consumer and Carer Advocacy Peaks, *Submission 53*, p. 4; ORYGEN Research Centre, Letter supporting *Submission 53*, dated 16 July 2008.

9.56 Despite its prevalence and often extremely disturbing symptoms, BPD is not well known about or recognised. Recently the House of Representatives in the USA recognised the 'enormous public health costs' of BPD and the 'devastating toll it takes on individuals, families and communities'. Given the lack of awareness of BPD, the US Congress supported the designation of a Borderline Personality Disorder Awareness Month as a means of educating the nation about the disorder, the needs of those suffering from it, and its consequences.[62]

9.57 Importantly, the coalition of peak bodies and the clinicians that spoke with the committee noted that people with BPD can get better with appropriate, ongoing and often long-term treatment and support.[63] Professor Jackson, President of the Australasian Society for Psychiatric Research, stressed that effective treatments do exist for BPD, but are not widely known or available.[64] Clinicians advised the committee that these treatments are psycho-social. Services in emergency departments and secure in-patient units, where people with BPD often end up, are not therapeutic for them and can contribute to the cycle of admission, destruction and readmission prevalent among people with BPD.

9.58 People with BPD have so far been overlooked, or perhaps it is more appropriate to say deliberately excluded, from mental health services and mental health reforms. The Senate Select Committee on Mental Health reported on the marginalisation of borderline personality disorder within the existing service system, noting that:

> A diagnosis of BPD closes the door to already limited mental health services. It leads to social rejection and isolation. Sufferers are blamed for their illness, regarded as 'attention seekers' and 'trouble makers'. BPD is the diagnosis every patient wants to avoid.

That committee concluded that:

> Accessible, appropriate treatments for those experiencing BPD, and an end to marginalisation of the disorder within the community and the mental health sector, are urgently needed.[65]

9.59 As indicated by the coalition of peak mental health consumer and carer bodies, this urgent attention has not been forthcoming. The coalition noted that:

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62 United States Congress, House of Representatives, April 1 2008, H. Res. 1005, *Supporting the Goals and Ideals of Borderline Personality Awareness Month*, www.govtrack.us/congress/billtext.xpd?bill=hr110-1005&version=eh, accessed 28 August 2008.

63 Coalition of Australian Mental Health National Consumer and Carer Advocacy Peaks, *Submission 53*, p. 4.

64 Letter supporting *Submission 53*, dated 14 August 2008.

65 Senate Select Committee on Mental health, *A national approach to mental health – from crisis to community*, pp. 90 and 94.

> The National Mental Health Strategy established in 1992, articulated a way forward to reform mental health in this country. There is no mention of this group of consumers in mental health policy or the National Mental Health Strategy and sixteen years on, this is still not on the national agenda.[66]

9.60 Ms McMahon highlighted:

> We need to see state-wide borderline personality disorder services that really are sensitive to and supportive of adults who were the silent victims of child sexual abuse.[67]

9.61 While access to mental health services in general was an ongoing issue raised throughout the inquiry, access to services designed for people with BPD is particularly problematic. It is a chronic condition requiring integrated care and specialised services that just do not exist beyond the private sector. Adding to the service access issues is the remarkable situation that service providers and clinicians themselves marginalise and stigmatise people with borderline personality disorder. Some see people with BPD as too problematic, as attention seekers or as impossible to treat. The committee was advised that services need to be overhauled and clinicians called to account, with better awareness and training about the disorder and effective treatments. Importantly, given the nature of the illness and its disastrous impact on families and relationships, early intervention is a priority. Early intervention in BPD can not only to reduce the huge toll suffered by people with the illness, but also limit the repercussions among families, particularly the children of people with BPD.

9.62 The coalition of peak mental health consumer and carer bodies called for a national taskforce, charged with a number of objectives related to tackling the effects of childhood sexual abuse, trauma and neglect, reducing childhood abuse and neglect and addressing the severe research, public awareness and service shortfalls for people with BPD.[68] A number of organisations wrote to the committee broadly supporting this proposal, including the Australian Private Hospitals Association, Australian Health Insurance Association, SANE Australia, Advocates for Survivors of Child Abuse, Inanna Inc., Brave Hearts, the Mental Health Coordinating Council, ORYGEN Youth Health, headspace, the Royal Australian and New Zealand College of Psychiatrists, the Australian Psychological Society, the Australian Medical Association and the Australasian Society for Psychiatric Research. Consumers noted that it was a unique step in mental health care in Australia for health professionals to provide their support to a consumer driven reform.

9.63 There were some differences in the focus sought by the different organisations. Some were more targeted at child sexual abuse and mental illness

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66 Coalition of Australian Mental Health National Consumer and Carer Advocacy Peaks, *Submission 53*, p. 4.

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

68 Coalition of Australian Mental Health National Consumer and Carer Advocacy Peaks, *Submission 53*, pp. 4–5.

generally, others focussed specifically on BPD. For example, the Royal Australian and New Zealand College of Psychiatrists commented:

> While not advocating any specific focus as to the clinical implications of childhood abuse, the College strongly supports the Coalition's position that your Committee recommend that governments, through COAG, consider establishing a process to investigate and address mechanisms to reduce the incidence of childhood sexual and other abuse, to recognise the longer-term implications of such abuse and to develop service arrangements and supports that better recognise and deal with the longer-term implications of that abuse.[69]

9.64 The Mental Health Coordinating Council noted:

> Whilst supporting the Coalition's call for Government recognition of adult survivors of childhood abuse, MHCC do not support such a strong emphasis on Borderline Personality Disorder (BPD) in this context, which is but one of the possible impacts of childhood sexual abuse.[70]

9.65 Several others also wrote to the committee raising the circumstances of adults who spent part or all of their childhood in institutional or other out-of-home care. Many of these people experienced extreme abuses as children, in addition to the long-term distress caused by severance from their parents. Submitters noted the prevalence of mental illnesses among institutional care leavers. They supported the call for more effort, resources and services to be devoted to the link between childhood abuse and mental illness and sought provision of services specifically targeted to this group.[71]

9.66 This committee is very aware of the insidious and devastating effects of child abuse that survivors experience throughout their lives. The committee notes the acknowledged link between childhood sexual abuse and mental illness. The committee is disturbed by the lack of progress in addressing the needs of people with borderline personality disorder since the Senate Select Committee on Mental Health. The committee also acknowledges the united call from across different elements of the mental health sector, including consumers, carers, service providers, support groups, researchers, clinicians, hospital providers and insurers, for action to be taken in relation to child sexual abuse and mental illness and borderline personality disorder.

Recommendation 24

9.67 The committee recommends that the National Advisory Council on Mental Health be funded to convene a taskforce on childhood sexual abuse and mental illness, to assess the public awareness, prevention and intervention initiatives needed in light of the link between childhood sexual abuse and mental

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69 Royal Australian and New Zealand College of Psychiatrists, Additional Information, 13 June 2008; see also the Australian Medical Association, Additional Information, 8 July 2008.

70 Mental Health Coordinating Council, Additional Information 16 July 2008, p. 3.

71 Dr Chamley, *Submission 57*; Alliance For Forgotten Australians, *Submission 58*.

illness and to guide government in the implementation of programs for adult survivors. The committee recommends that the taskforce report its findings by July 2009 and that COAG be tasked with implementing the necessary programs and reforms.

Recommendation 25

9.68 The committee recommends that the Australian, state and territory governments, through COAG, jointly fund a nation-wide Borderline Personality Disorder initiative. The committee recommends that the initiative include:

- **designated Borderline Personality Disorder outpatient care units in selected trial sites in every jurisdiction, to provide assessment, therapy, teaching, research and clinical supervision;**
- **awareness raising programs, one to be targeted at adolescents and young adults in conjunction with the program in Recommendation 19 (Chapter 8) aimed at improving recognition of the disorder, and another to be targeted at primary health care and mental health care providers, aimed at changing attitudes and behaviours toward people with Borderline Personality Disorder; and**
- **a training program for mental health services and community-based organisations in the effective care of people with Borderline Personality Disorder.**

The committee recommends that a taskforce including specialist clinicians, consumers, community organisations, public and private mental health services and government representatives be convened to progress and oversight the initiative.

Prisoners and others in the criminal justice system

9.69 The committee heard disturbing evidence about the situation of prisoners with mental illness in some jurisdictions. As well as concerns about treatment for inmates, the committee heard about a lack of support for ill people both during their engagement with the criminal justice system and upon release from prison.[72]

9.70 A survey of homeless people with mental disorders conducted by the Australian Housing and Urban Research Institute suggests the extent of service shortfalls. The survey found that just under half of the people surveyed had been in prison or juvenile detention. Only half of these people had received help with their mental health while in prison. At the completion of their last sentence, 20 per cent went straight onto the streets at discharge.[73]

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72 See for example Sisters Inside, *Proof Committee Hansard,* 26 March 2008; Mental Health Coordinating Council and Council of Social Services of NSW, *Submission 23*, pp. 14–15.

73 AHURI, based on research by Catherine Robinson AHURI UNSW-UWS Research Centre, 'Cycles of homelessness', *AHURI Research and Policy Bulletin,* Issue 39, March 2004.

9.71 Ms Collins, Director Victorian Mental Illness Awareness Council suggested that some people with mental illness are in prison because of systemic failings in mental health care and prevention. She provided a tragic example:

> …a young man with a diagnosis of schizophrenia went away on holidays with a mate. They had been mates since kindergarten. They were interstate, and he became unwell. They went to a hospital, and in less than 24 hours he was discharged. His Mum pleaded with the hospital to keep him there, but they would not. He killed his mate on the way back to the camp site. He was then arrested and thrown into prison. He had hearing and sight deficits. They took away his glasses, they took away his hearing aid and he hung himself.[74]

9.72 Such distressing examples point to the underlying gaps and shortfalls that remain in mental health care, including the preventative services, community-based supports and crises interventions that are needed to reduce the number of people with mental illness coming into contact with the criminal justice system. The Senate Select Committee on Mental Health reported on the 'unacceptably high' rate of mental illness among inmates in Australia, and this committee did not receive evidence to suggest that this situation has changed.

9.73 Sisters Inside emphasised the importance of independent monitoring of corrective services, to ensure transparency in the oversight of human rights. Ms Kilroy promoted the system of independent chief inspectors used in the UK, Ireland and Scotland and pointed to Western Australia as a good example in Australia:

> …in Western Australian there is a chief inspector that reports to parliament. They are independent in their own right. Here, we have a chief inspector, but they report to the Director-General of Queensland Corrective Services, so it is in house.[75]

9.74 Some jurisdictions described the efforts that they are making to improve mental health care within the criminal justice system. For example, the Northern Territory allocated $3.5 million to a number of initiatives including increasing the number of forensic health worker positions, increasing education about mental illness for correctional officers and plans for a new correctional centre including a 25-bed secure facility for people with mental illness or cognitive disability.[76] In the ACT, $11.6 million has been allocated for a 15 bed secure mental health inpatient unit, to be located on the hospital campus. Dr Brown commented on the health focus of the facility:

> I guess the philosophy behind having the in-patient unit not adjacent to the prison but on the hospital campus is to emphasise that when a person who

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74 *Proof Committee Hansard*, 1 April 2008, p. 26.

75 Sisters Inside, *Proof Committee Hansard,* 26 March 2008, p. 69; see also Australian Mental Health Consumer Network, *Submission 12*, p. 2.

76 *Proof Committee Hansard*, 1 May 2008, p. 47.

> happens to currently be resident in prison needs in-patient treatment it is actually a health intervention and that it will be run by the health facilities, obviously very mindful of all necessary security provisions and requirements but with the health needs clearly being the priority for that particular period of time.[77]

9.75 The committee acknowledges these efforts and the funding allocated by some other state governments to forensic mental health services in their COAG Plan Individual Implementation Plans.[78] Mental health care for prisoners remains effectively a state responsibility and the committee urges all state governments to further their efforts in meeting the complex mental health care needs of this population group.

The role of police

9.76 The Police Federation of Australia (PFA) noted that police are often 'in the front line' of caring for people with severe mental illness:

> Police are one of the few groups of workers that are available 24 hours a day seven days a weeks and are the first responders when someone is acting irrationally or likely to present a danger to themselves or others…They are, by virtue of their position, often the only emergency response agency to which the public can turn in times of crisis that can be relied upon to turn up within minutes of being called.[79]

9.77 The PFA was concerned that the COAG Plan, including the state and territory individual implementation plans, did not 'identify or even accept the level of responsibility currently being placed on police in respect to dealing with the mentally ill'. PFA recommended a number of arrangements to better incorporate the police perspective in mental health planning, including designating positions for police representatives on each of the state COAG Mental Health Groups and establishing Memoranda of Understanding (MOU) between the state and territories' respective Health Department, Ambulance Service, Police Forces and where appropriate Corrective Services. PFA recommended that these MOUs be formalised in the Individual Implementation Plans of the COAG Plan.[80]

9.78 Perhaps nothing highlights more clearly the failure of governments to adequately invest in the community-based supports needed following de-

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77 *Proof Committee Hansard*, 16 May 2008, p. 33.

78 For example, New South Wales allocated $6.5 million to expanding community forensic mental health services and $5.0 million to supporting people with mental illness in the prison system, Victoria allocated to $21.1 million to expanding the capacity of Thomas Embling Hospital, Queensland allocated $14.8 million to forensic mental health services and $10.9 million to mental health services in prisons, Tasmania allocated $12.5 million for psychiatric care and treatment in its secure mental health unit.

79 *Submission 17*, p. 1.

80 *Submission 17*, pp. 3–5.

institutionalisation than the numbers of people with mental illness coming into contact with the criminal justice system. With more supported accommodation and community-based integrated clinical and psycho-social services, care for people with mental illness can be positioned within the health and community sector and not with the police. However, the committee recognises the current reality that police are heavily involved in mental illness related issues. Given the COAG Plan's focus on coordination across areas of government, the committee supports the suggestions that police services be included in state and territory COAG Mental Health Groups, and that future state and territory mental health plans commit to the establishment and implementation of MOUs between state and territory Health Departments, Ambulance Services, Police Forces and where appropriate Corrective Services.

Rural and Remote

9.79 Inequity in access to mental health care in rural and remote areas, compared with the cities, was noted across the jurisdictions. As summarised by the Northern Territory Mental Health Council, this evidence is not new:

> There is a major gap in funding for people in the bush, for the most disadvantaged people in the country. This obviously needs to be addressed, and we all know about that one.[81]

9.80 The WAAMH noted that most of WA remained 'untouched' by the COAG Plan initiatives.[82] Organisations in the Northern Territory and South Australia both noted that the lack of services in remote areas means that people have to be taken out of their communities to access services, which is a traumatic experience.[83]

Workforce shortages

9.81 As well as the greater costs of providing services in remote locations, a key issue for service access is the absence of various providers within local communities. The WA Council of Official Visitors provided examples of staff shortages in Kalgoorlie:

> They still have no access whatsoever to a psychologist. They have no access to an occupational therapist. Apparently, the nurses are being trained in some occupational therapy now. There is one social worker for the whole of Kalgoorlie Hospital, but patients on the mental health side do not really get access to the social worker.[84]

9.82 Ms McMahon, Chair of the Private Mental Health Consumer Carer Network, suggested that greater financial incentives are needed to motivate health professionals

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

82 Proof *Committee Hansard*, 7 May 2008, p. 3.

83 Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, p. 3; Mental Health Coalition of South Australia, *Proof Committee Hansard*, 8 May 2008, p. 13.

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

to work in rural areas.[85] However, others considered that trying to attract qualified staff to some remote locations is not effective. Rather, efforts should be made to build capacity from within communities by providing 'training to consumers themselves and interested people within the community'.[86]

9.83 Representatives from the Government of Western Australia explained a proposal along these lines, to provide training for Aboriginal liaison workers within their own communities. The government recognised that relocating to Perth for training was not attractive to people in remote communities.[87]

E-technology

9.84 Ms McMahon also suggested better use could be made of technologies such as videoconferencing, reporting that 'we are told that the actual cost of setting up this type of equipment is not necessarily the issue; it is more around how the health professionals are reimbursed for their time in using that'.[88] As discussed in chapter 6, a number of witnesses pointed to a need to reimburse health professionals for case conferencing, as many will not engage in this kind of work at their own expense.

9.85 Professor Christensen informed the committee about the effectiveness of e-technology mental health initiatives. These initiatives, while important for the general community, have particular potential to help fill service gaps in rural and remote communities. As an example, Professor Christensen outlined a study conducted with people with high levels of depression who were living in the community and not in direct contact with mental health services. Over a six week period they were asked to go systematically through two websites, a depression information site and an automated behaviour site. Professor Christensen described the results:

> At the end of six months there was a significant difference in the levels of depression compared to the levels of depression within the control group who were not provided with these services. We found that the effects were sustained over 12 months without any additional intervention by us.[89]

9.86 Professor Christensen considered that while e-technology is effective, the way forward is to connect such services with clinical care services. Professor Hickie outlined some of the questions to consider in integrating e-technology:

> E-health is a critical part of what we need to consider in Australia for service development, and we have to work out the integration of those e-health services into the pathways of clinical services...What happens after a web hit? Then what? What can happen online? What happens with further

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

86 *Proof Committee Hansard*, 7 May 2008, p. 14.

87 *Proof Committee Hansard*, 7 May 2008, p. 100.

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

89 *Proof Committee Hansard*, 20 May 2008, p. 21.

> engagement? What happens if a person does not recover? What sort of services need to respond?[90]

9.87 The committee was given the impression that e-health technology has great potential in Australia and that further funding and research is required to incorporate e-technology into well integrated packages of care.

COAG Plan Rural and Remote initiative

9.88 The Commonwealth Government allocated $51.7 million to mental health services in rural and remote areas as part of the COAG Plan. This initiative was to provide funding for services provided by allied mental health professionals such as psychologists, social workers, occupational therapists and mental health nurses. The initiative was to be implemented through the Divisions of General Practice or other organisations such as Aboriginal and Torres Strait Islander primary health care services.[91]

9.89 The funding for this initiative was reduced by $15.5 million in the 2008–09 Budget over the six years to 2011–12.[92] Witness such as the AGPN expressed concern about this cut.[93]

9.90 Mr Smyth indicated that there had been some challenges spending the funds available through the program:

> There are some very critical aspects in relation to the employment of people that those organisations are able to identify as appropriate staff and the ability to engage them in a time frame that meets the financial arrangements of the program in terms of how it is managed. Because we are targeting some very difficult rural and remote areas, workforce issues is one of the key criteria that organisations have difficulty in sometimes meeting—getting appropriate staff who are willing to be engaged in some of those quite remote areas. That is one of the difficulties that the program faces.[94]

9.91 The mental health needs of people living in rural and remote communities and inequity in access to services have been spelt out on numerous occasions. As noted in other chapters of this report, it is important that initiatives such as Better Access be evaluated to ascertain whether they are improving service access in these areas. Other models of funding, such as Commonwealth and state and territory collaboration to bolster mental health capacity within public primary healthcare may be required.

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

91 COAG Plan, p. 10.

92 *Proof Committee Hansard*, 16 May 2008, p. 96; see also Community Affairs Committee, Budget Estimates, *Committee Hansard*, 5 June 2008, p. 153.

93 *Proof Committee Hansard*, 16 May 2008, p. 2.

94 *Proof Committee Hansard*, 16 May 2008, p. 96.

Carers

9.92 The ongoing need for support and services for carers of people with mental illness was reiterated throughout the inquiry. Some of the issues raised in relation to carers needs included the:

- economic and emotional strain of caring;
- need for meaningful respite and choice in the type of respite available;
- engagement of carers in care planning and clinical processes;
- need for services to be sensitive to the needs of the family unit as a whole;
- provision of information, training and education;
- need for carer support;
- need for carer advocates or carer consultants;
- effect on wellbeing and mental health of long-term caring;
- carers concerns about the care and wellbeing of their loved one when they die;
- need for support services for carers suffering suicide bereavement;
- avenues for complaints resolution and advocacy.[95]

Respite

9.93 One of the major initiatives in the COAG Plan designed to assist carers was funding of $224.7 million for 'more respite care places to help families and carers'. This was the third largest budget item in the plan and aimed to provide approximately 650 new respite care places to help families and carers of people with a mental illness or an intellectual disability. Priority access was to be given to elderly parents who live with and care for a son or daughter with severe mental illness or an intellectual disability.[96]

9.94 Concerns were raised that the initial funding under this initiative was provided to generic respite service providers and not to specialist mental health care providers. Ms Genvesi from the Victorian Mental Health Carers Network was concerned that not enough guidance had been given about educating existing providers about the mental health specific needs of carers and care recipients.[97] The WAAMH commented that while mental health consumers and carers have benefited from respite services, the

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95 ARAFMI Hunter, *Submission 2;* Ms Bayley, *Submission 47*; Victorian Mental Health Carers Network Inc., *Proof Committee Hansard*, 1 April 2008, p. 9; Carers SA, *Proof Committee Hansard,* 8 May 2008, p. 61; Australian Association of Social Workers, *Proof Committee Hansard,* 20 May 2008, p. 38; Carers Australia, *Proof Committee Hansard,* 20 May 2008, p. 56.

96 COAG National Action Plan on Mental Health 2006–2011, p. 11.

97 *Proof Committee Hansard*, 1 April 2008, p. 11.

forms for accessing respite are designed for other forms of disability and are 'very difficult to fill out when trying to access respite for mental health consumers'.[98]

9.95 Ms Swallow, Mental Health Council of Tasmania, outlined an initiative aimed at resolving some of the issues in the rollout of the respite initiative:

> FaHCSIA has a contract with VICSERV—and they have now subcontracted to the Mental Health Council of Tasmania—to look at family support and carer respite. It is really a project to look at the gaps in respite for carers in the state and opportunities to link them in with programs like carer respite. It has been very slow to start happening. I understand that the confusion was that [the respite initiative] was not really focused on mental health; it was more focused on other respite and carer issues. Hopefully this new project will address some of those issues.[99]

9.96 In South Australia, witnesses reported positive engagement with the respite initiative. Ms Richardson, Carers SA, said:

> The Commonwealth Respite and Carelink Centre have been working with existing organisations that they use through their brokerage program and also the new ones. They feel that it has been very successful. There have been about 75 new carers who have received a service through this program so far this financial year, and a quarter of them are brand new carers who have not had any support or any contact with the system in support of their needs.[100]

9.97 Several organisations noted that the Commonwealth COAG Plan respite initiative initially targeted older carers.[101] This created concerns given the burden carried by young people who care for parents or others with mental illness and who require special attention and respite services. Carers Australia argued that a lot more needs to happen to help young carers:

> From a policy point of view, this whole area of young carer support needs to be ongoing. There are some young carers who are at risk and there has been some commitment through FaHCSIA to fund an at-risk young carers program. Given the amount of need and the number of young people who require support in this area, the level of funding is pretty minimal. We have to do a lot more to try and get a national approach in schools and tertiary institutions about young carers.[102]

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98 *Proof Committee Hansard*, 7 May 2008, p. 7.

99 *Committee Hansard*, 31 March 2008, p. 8.

100 *Proof Committee Hansard*, 8 May 2008, p. 60.

101 See for example Mental Health Coalition of South Australia *Proof Committee Hansard*, 8 May 2008, p. 4 and Carers SA, *Proof Committee Hansard*, 8 May 2008, p. 61; Mental Health Advocate, Advocacy Tasmania Inc, *Proof Committee Hansard,* 31 March 2008, pp. 46– 47.

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

9.98 Ms Williams, Tasmania's Mental Health Advocate, felt that the respite funding had been misdirected. In her experience, there are few elderly people caring permanently for people with mental illness. She noted that in Tasmania alienation from family is a common experience for people with mental illness, with many living alone.[103] The Mental Health Coalition of South Australia noted that the age restriction had been relaxed, but commented that having to design programs with such restrictions in the first place indicates the resource-poor environment in which mental health services operate.[104]

9.99 Certainly funding for respite services was welcomed by many involved in the inquiry, however it was recognised that respite is not a panacea to the current burdens of caring for someone suffering from mental illness.[105] Better ongoing community services for those experiencing mental illness is needed to reduce the burden on carers in the longer term. Indeed the demands on carers and toll on their own mental health and wellbeing is another indicator of the shortfall in community-based treatment and supports to help people with mental illness live within the community.

Concluding comments

9.100 The committee is pleased to note the funding that has been allocated to meeting the needs of some specific population groups since the Senate Select Committee on Mental Health conducted its inquiry and made its recommendations. For example, the headspace National Youth Mental Health Foundation and the new funding for respite for carers are positive indicators of progress. However, some groups with significant need, such as CALD communities have been virtually left out of the COAG Plan. For other groups, such as Indigenous Australians, people in rural and remote areas and people with mental illness in the criminal justice system, various initiatives were included in the COAG Plan but critical service gaps and shortfalls remain.

9.101 Several of the major Commonwealth initiatives in the COAG Plan, in particular the Better Access initiative and the Personal Helpers and Mentors program are designed to meet the mental health needs of the generic population. Certainly there is a clear need for these kinds of services and plenty of demand. However the committee is not convinced that the needs of specific population groups with higher prevalence of mental illness or a need for particular kinds of services can be adequately met from such generic programs.

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103 *Proof Committee Hansard,* 31 March 2008, pp. 46– 47.

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

105 See for example Carers Australia, *Proof Committee Hansard*, 20 May 2008, p. 62.

Recommendation 26

9.102 The committee recommends that through COAG the Australian, state and territory governments coordinate and develop mental health plans and fund specific additional mental health services that address the existing shortfalls for Indigenous Australians, culturally and linguistically diverse communities, youth, aged and people in rural and remote communities.

Senator Claire Moore
Chair

September 2008