The Senate

# Standing Committee on Community Affairs

## Towards recovery: mental health services in Australia

September 2008

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# ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| AASW | Australian Association of Social Workers |
| ACA | Australian Counselling Association |
| AGPN | Australian General Practice Network |
| AHMAC | Australian Health Ministers Advisory Council |
| AMHCN | Australian Mental Health Consumer Network |
| AMSANT | Aboriginal Medical Services Alliance Northern Territory |
| AOD | Alcohol and Other Drugs |
| APS | Australian Psychological Society |
| ATAPS | Access to Allied Psychological Services |
| BPD | Borderline Personality Disorder |
| CALD | Culturally and Linguistically Diverse |
| CASP | Comprehensive Area Service Psychiatrists Network of NSW |
| COAG | Council of Australian Governments |
| CSH | Community Services and Health (Industry Skills Council) |
| CTO | Community Treatment Order |
| DoHA | Department of Health and Ageing |
| DVA | Department of Veterans' Affairs |
| FaHCSIA | Department of Families, Housing, Community Services and Indigenous Affairs |
| FPS | Focussed Psychological Strategies |
| IDC | Interdepartmental committee |
| MBS | Medicare Benefits Schedule |
| MHCC ACT | Mental Health Community Coalition ACT |
| MHCSA | Mental Health Coalition of South Australia |

| | |
|---|---|
| MMHA | Multicultural Mental Health Australia |
| NGO | Non-government organisation |
| NMHS | National Mental Health Strategy |
| PACFA | Psychotherapy and Counselling Federation of Australia |
| PFA | Police Federation of Australia |
| PHaMs | Personal Helpers and Mentors |
| RANZCP | Royal Australian New Zealand College of Psychiatrists |
| SANDAS | South Australian Network of Drug and Alcohol Services |
| STARTTS | Service for the Treatment and Rehabilitation of Torture and Trauma Survivors |
| STTARS | Survivors of Torture and Trauma Assistance and Rehabilitation Service |
| VMIAC | Victorian Mental Illness Awareness Council |
| WAAMH | Western Australian Association for Mental Health |
| WAMIAC | West Australian Mental Illness Awareness Council |

# EXECUTIVE SUMMARY

Mental health services in Australia received significant focus and a major injection of funds in July 2006 when the Council of Australian Governments agreed to the *National Action Plan on Mental Health 2006–2011*. The plan helped put mental health high on the agenda at both state and federal levels and responded to a number of the issues that had been raised by the Senate Select Committee on Mental Health in its comprehensive inquiry. The COAG National Action Plan recognised that mental health was not just a health portfolio responsibility, but required coordination across areas of government and a broad, community-based response. The plan put desperately needed money into the mental health community sector. It also increased access to some clinical services. COAG recognised that connecting all these services is fundamental to improving Australia's mental health care.

COAG's commitment was widely welcomed but overdue. The numbers of people with mental illness who are homeless, in prisons, living in poverty and unable to get treatment until the most acute stages of illness are testimony to the long under-resourcing of community-based mental health care and support.

Nearly two years into the National Action Plan on Mental Health, positive responses to some of the initiatives are clearly evident. Access to previously underutilised members of the mental health workforce, such as psychologists and other allied health providers has improved. Many non-government organisations have new funding to help provide a range of community-based supports. Programs have been established which try to reach people that have not been receiving services in the existing patchy and fragmented system.

However, there are a number of important aims that have not been achieved. The National Action Plan on Mental Health failed to set out a vision for Australian mental health services into the future with a plan for how to get there. Mental health care varies markedly across the states and territories and without a clearly articulated national framework and implementation plan will remain so.

Consumers have not been given a priority voice in formulating policy and implementing programs. Support for consumer advocacy, training, peer support and consumer-run services is yet to translate into the resources and capacity building needed to assist consumers in these roles.

People in some areas still receive more service than others. Fewer mental health professionals are available outside the major cities and even within cities services are not evenly distributed. Access to some mental health care, such as services funded through Medicare under fee-for-service arrangements, is heavily dependent on the distribution of service providers.

Some groups of people, including those with the most complex needs, are not getting the kinds of services they need. There are concerns that new mental health programs

are not helping those people experiencing the most severe illnesses, due to cost or other barriers. Many services remain oversubscribed and even people in immediate crisis may be turned away.

People with mental illness still report poor treatment and abuse. Stigmatisation and discrimination still occur. These messages are not new. Governments, and Australian communities, need to look seriously at improving the human rights experiences of people with mental illness.

Much of the new funding for mental health initiatives has been to generic services and more needs to be done to provide mental health care that meets the needs of specific groups, such as Indigenous Australians, people from culturally and linguistically diverse backgrounds, youth, aged, people in prison and people living in rural and remote communities.

The range of services needed to support people with mental illness to live in the community span state and Commonwealth areas of responsibility. In particular, affordable housing and supported accommodation are keystones to furthering other efforts towards improving mental health outcomes. Employment is an important part of recovery for many people with mental illness, but services and supports to achieve this goal are still inadequate. While governments have recognised the need for better coordination, consumers, carers and service providers are disenchanted by failures in coordination between the levels of government.

Workforce shortages around Australia are affecting mental health services. Governments have invested money, and initiatives are in place to try to supply more workers to the sector, but competition remains stiff, workloads are heavy and in many areas remuneration non-competitive.

Minimal attention has been paid to evaluation and outcome measurement of new mental health initiatives. Given a history of under-funding, many in the sector are keenly aware of the importance of using the available money to greatest effect. People want to know how well the new initiatives are working and whether other service structures would provide better mental health to the community.

Efforts towards improving mental health services in Australia remain a work in progress. The committee commends the Australian, state and territory governments for recognising mental health as a priority and for the significant investment made through the COAG *National Action Plan on Mental Health 2006–2011*. This is an important step in the process of mental health service reform in Australia, but there is more to do.

The committee has made a number of recommendations aimed at setting a clearer future for mental health in Australia, providing greater accountability, improving the programs and services that already exist and addressing some of the remaining gaps and shortfalls. The committee considers that further investment, leadership and cooperation are required to achieve an adequate community-based, recovery-focussed mental health care system in Australia.

# RECOMMENDATIONS

## *Mental health policy and forward planning*

### Chapter 2

### Recommendation 1

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

### Recommendation 2

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

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

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

## *Enhancing and developing the COAG Action Plan on Mental Health*

### Chapter 3

### Recommendation 3

3.17 The committee recommends that each state and territory COAG Mental Health Group include consumer, carer, non-government organisation and private sector representatives within its membership. The committee further recommends that each COAG Mental Health Group make publicly available a quarterly

progress report outlining the work undertaken in the state or territory against each commitment in the *National Action Plan on Mental Health 2006–2011.*

**Recommendation 4**

3.57 The committee recommends that FaHCSIA track unspent funding under National Action Plan community initiatives rolled out through NGOs. The committee recommends that any underspent funds in sites selected for National Action Plan programs be quarantined for use in those areas and distributed through other mental health programs or direct purchase of services from public health or other providers.

**Recommendation 5**

3.76 The committee recommends that COAG review the progress of the Care Coordination initiative in each state and territory prior to the completion of the *National Action Plan on Mental Health 2006–2011*, including an assessment as to whether allocated funding is needed to enable the aims of the initiative to be achieved.

**Recommendation 6**

3.77 The committee recommends that each state and territory government include in its reports to COAG the number of people in the Care Coordination target group that have actually been offered a clinical coordinator and community coordinator.

**Chapter 4**

**Recommendation 7**

4.46 The committee recommends that in purchasing non-government organisation services for future mental health initiatives, Australian, state and territory government departments do not rely exclusively on open tenders but also develop other procurement models such as collaborative and select tenders.

**Recommendation 8**

4.47 The committee recommends that the following issues be considered in future funding rounds:

- the weighting given to local knowledge and linkages when assessing tenders;
- opportunities to increase collaboration;
- reducing the information burden associated with tendering for multiple programs; and
- addressing sustainability of services.

## Chapter 5

### Recommendation 9

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

### Recommendation 10

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

### Recommendation 11

5.51 The committee recommends that FaHCSIA in conjunction with selected Personal Helpers and Mentors providers as a matter of urgency develop and promote best practice methods for managing demand for the Personal Helpers and Mentors program.

### Recommendation 12

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

## Chapter 6

### Recommendation 13

6.82 The committee recommends that the post-implementation review of the Better Access initiative gives particular attention to the referral pathways in the Better Access initiative, whether consumers are effectively moving between the providers involved and whether any structural changes or additional funding are required to improve care management and coordination.

### Recommendation 14

6.104 The committee recommends that as part of the post-implementation review of Better Access a working group be established to simplify arrangements by which NGO employed psychologists and other eligible allied health professionals can use Better Access Medicare items.

6.105 The committee further recommends that the Australian Government fund a series of information workshops for relevant NGOs, explaining the outcomes of the working group and the available mechanisms for NGOs to make use of the Better Access Medicare items.

**Recommendation 15**

6.133 The committee recommends that the post-implementation review of the Better Access initiative consider the concerns and issues about the initiative listed in this report (paragraph 6.132). In particular, the committee considers that assessment of the outcomes for consumers using the initiative is paramount. The committee further recommends that the findings of the post-implementation review be made publicly available.

### *Addressing service gaps and shortfalls*

**Chapter 8**

**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.

**Recommendation 17**

8.62 The committee recommends that the Australian Government strengthen mental health consumer representation, through funding consumer-run organisations to provide independent advocacy at state, territory and Commonwealth levels and to provide peer support, information and training to their members.

**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.

**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.

**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.

**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*.

**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.

**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.

**Chapter 9**

**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 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.

**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.

# CHAPTER 1

# INTRODUCTION

## Terms of reference

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

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

## Interim report

1.2 On 19 June 2008 the committee tabled an interim report, outlining its work on the inquiry to that point and providing a broad summary of the themes arising in the evidence received. The interim report provided a succinct summary of the progress made towards achieving the aims of the National Mental Health Strategy and the recommendations of the Senate Select Committee on Mental Health, and the service gaps and shortfalls that remain.

1.3 Given the scale of the reforms introduced in mental health, the substantial evidence provided to the committee and the committee's heavy workload with other

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

concurrent inquiries, the committee undertook to provide a final report to the Senate by 25 September 2008.

1.4 The interim report set out the context for this inquiry, which is not repeated here. In particular the committee noted the findings of the comprehensive inquiry undertaken by the Senate Select Committee on Mental Health, which reported to the Senate in March and April 2006. As stated by the committee in its interim report, this inquiry was not intended to repeat the comprehensive examination undertaken by the earlier select committee. Rather, in accordance with the terms of reference, the committee focussed on the Council of Australian Governments' (COAG) National Action Plan and the progress made in mental health service reforms and the service gaps and shortfalls that remain. The COAG National Action Plan is discussed further in chapter 2 of this report.

## Conduct of the inquiry

1.5 The committee advertised the inquiry in *The Australian* and on its website. It wrote to many organisations and individuals inviting submissions to the inquiry. The committee received and published 62 submissions, together with a considerable volume of additional information received at and after public hearings which is listed at Appendix 1. It also received a further nine confidential submissions.

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

1.7 The roundtable discussion was held in Canberra on 10 August 2007 with representatives from a range of peak bodies, professional associations, consumer and carer organisations. Prior to commencing the public hearings, the committee received a briefing in March 2008 from the Department of Health and Ageing (DoHA) and the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). During March, April and May 2008 the committee held nine public hearings, across each of the state and territory capital cities. In August 2008 the committee held an informal meeting with a number of clinicians and consumer representatives to discuss issues raised during the public hearing of 8 May 2008 and in a submission from the Coalition of Australian Mental Health National Consumer and Carer Advocacy Peak Bodies.

1.8 Details of the committee's public hearings are referred to in Appendix 2. The public submissions and Hansard transcripts of evidence may be accessed through the committee's website at http://www.aph.gov.au/senate_ca.

### *Australia/New Zealand Parliamentary Committee Exchange*

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

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

## Structure of the report

1.11 The committee has not undertaken in this report to review every initiative within the COAG National Action Plan on Mental Health. The report focuses on those new initiatives about which the committee received most comment, broader issues such as the policy context and coordination of the reforms and the key areas where shortfalls and gaps remain. The report is set out in 9 chapters. This chapter provides an overview of the conduct of the inquiry. Chapter 2 describes the current policy context for mental health reform in Australia, including the fit between the COAG National Action Plan on Mental Health and the National Mental Health Strategy. Chapter 3 looks at coordination of mental health service delivery; a major element in the COAG National Action Plan. Chapter 4 considers community-sector investment and initiatives. Chapter 5 looks at the Personal Helpers and Mentors Program, which was the largest of the community-sector initiatives funded in the COAG National Action Plan. Chapters 6 and 7 consider two of the major initiatives in the COAG Plan aimed at improving access to clinical care: the Better Access initiative and new funding for mental health nurses. Chapter 8 identifies remaining service gaps and shortfalls and chapter 9 looks at specific population groups for whom services remain difficult to access.

## Acknowledgments

1.12 The committee again acknowledges and thanks all those who assisted with its inquiry, by making submissions, attending hearings and giving evidence, providing additional information and other forms of assistance. The generosity with which they contributed to the inquiry reflects their commitment to improving mental health services across Australia and to making a difference in the lives of people who experience mental illness and those who care for and support them. The committee acknowledges this commitment and ongoing effort. The committee looks forward to the recommendations contained in this report being adopted as part of the ongoing collaborative effort to improve mental health in Australia.

# CHAPTER 2

# POLICY CONTEXT

## The COAG National Action Plan on Mental Health

2.1 On 14 July 2006, the Council of Australian Governments (COAG) agreed to a National Action Plan on Mental Health involving a package of measures and significant investment in mental health care by all governments, over five years. The *National Action Plan on Mental Health 2006–2011* (hereafter the COAG Plan), aimed to 'deliver a more seamless and connected care system, so that people with mental illness are able to participate in the community'.[1] The COAG Plan is reproduced at Appendix 3.

2.2 The COAG Plan was directed at four outcomes:

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

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

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

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

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

2006–07 Budget. The four largest budget initiatives in the Commonwealth's Individual Implementation Plan were:

- $538 million for better access to psychiatrists, psychologists and general practitioners through the Medical Benefits Schedule;
- $284.8 million for new personal helpers and mentors;
- $224.7 million for more respite care places for families and carers;
- $191.6 million new funding for mental health nurses.[2]

2.5 The state and territory individual implementation plans together contained 124 initiatives and brought the total funding commitment in the COAG Plan to approximately $4 billion.[3] However, state and territory plans included a mixture of new and previously allocated funds.[4] In some cases initiatives included in the plans had already commenced.[5]

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

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

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

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

2 COAG Plan, pp. 9–11.

3 COAG Plan, p. i.

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

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

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

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

### *Other developments*

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

- The Queensland Government committed a further $528.8 million specifically to COAG Plan objectives in its 2007–08 Budget, bringing its total commitment against the Plan to $895.2 million;[7]
- The Victorian Government allocated an additional $41.2 million in its 2007–08 Budget for new mental health initiatives and growth funding, as well as $21.7 million for capital works;[8]
- The South Australian Government announced $43.6 million for mental health reform in response to the SA Social Inclusion Board's report *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007–2012* and a further $50.5 million in the 2007–08 State Budget;[9]
- The ACT Government committed an extra $12.6 million for mental health services in its 2007–08 Budget and $8.75 million in its 2008–09 Budget;[10]
- The Western Australian Government allocated $84 million for new initiatives and further recurrent funding to extend key initiatives in the COAG Plan out to 2011;[11]
- The Commonwealth Government announced several new initiatives in the 2008–09 budget, including $85 million for a national perinatal depression plan and $35 million for a mental health nurses and psychologists scholarship subsidy measure.[12]

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

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

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

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

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

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

## The COAG Plan and the National Mental Health Strategy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### *State and Territory variation*

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

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

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

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

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

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

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

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

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

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

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

## Future policy direction

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

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

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

2.24 Dr Gerrand commented further:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### *The New Zealand experience*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### *Mental health commissions*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### *A recovery focus in mental health policy*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## Concluding comment

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

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

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

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

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

**Recommendation 1**

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

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

**Recommendation 2**

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

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

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

# CHAPTER 3

# COORDINATION

3.1 Coordination is a fundamental focus of the COAG Plan. The Leaders' Forward to the Plan stated:

> The Plan provides a strategic framework that emphasises coordination and collaboration between government, private and non-government providers in order to deliver a more seamless and connected care system, so that people with mental illness are able to participate in the community.[1]

3.2 Coordination was addressed in the COAG Plan at two key levels: the strategic coordination needed to ensure that investment by different levels of government is delivered in the most effective way, and the grassroots integration and connection between services needed to coordinate health and community support services for individuals with mental illness.

3.3 The evidence to the committee indicates that despite the efforts made under the COAG Plan, coordination of mental health care in Australia remains inadequate. This chapter first reviews evidence about strategic coordination. This includes the existing government forums for coordination and advice, coordination across different levels of government and the fit between the COAG Plan and the different service structures across the jurisdictions. Second, the chapter discusses the 'care-coordination' initiative and coordination in the provision of services to people with mental illness.

## Government forums for coordination

3.4 Several government forums have been established to improve coordination in the implementation of mental health initiatives across Australia. These forums are discussed below.

### *COAG Mental Health Groups*

3.5 The COAG Plan recognised that improving mental health services in Australia requires the combined efforts of Commonwealth, state and territory governments. The Plan 'called upon governments to work together in a way that had no clear precedents in mental health'.[2] Under the COAG Plan flagship initiative 'Governments Working Together' each state and territory was to form a COAG Mental Health Group, convened by the Premier or Chief Minister's Department. These groups were to provide a forum for 'oversight and collaboration on how the different initiatives from the Commonwealth and State and Territory governments will be

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1 COAG Plan, p. i.

2 Queensland Government, *Submission 49*, p. 79.

coordinated and delivered in a seamless way'. The groups were to 'involve Commonwealth and State and Territory representatives and engage with non-government organisations, the private sector and consumer and carer representatives'.[3] Each group was required to report back to COAG after six months and then at regular intervals.[4]

3.6 DoHA reported that COAG Mental Health Groups have been formed in each jurisdiction. They are made up of Commonwealth and state or territory government department officials, with NGOs, the private sector, consumers and carers being engaged to varying degrees across jurisdictions. DoHA advised that, on average, each COAG Mental Health Group meets quarterly.[5]

3.7 The committee's hearings indicated that there is great variability in the composition of the groups, regularity of their meetings and extent of involvement and communication with stakeholders. In some jurisdictions the groups are working effectively while in others there was confusion as to the existence, membership and role of the state COAG Mental Health Group.

3.8 The Queensland COAG Mental Health Group meets regularly, has a dedicated website and produces a quarterly newsletter providing information about progress under the COAG Plan. The terms of reference of the group, its membership and activities are publicly available. It includes non-government, private sector and consumer and carer representatives as well as Commonwealth and state government representatives. In the ACT the COAG Group is made up of Territory and Commonwealth Government representatives and is supported by a reference group comprised of consumers, carers, community agencies and relevant government representatives. Both groups meet quarterly.[6]

3.9 Victoria reported that its COAG Mental Health Group has been formed and involves representatives of key Commonwealth and Victorian agencies.[7] In Western Australia, NGO stakeholders were aware of their state's COAG Mental Health Group and had received newsletters from the group.[8] In New South Wales, stakeholders were also aware of the relevant group and some community members had been invited to its

3 COAG, National Action Plan on Mental Health 2006–2011, p. 6.

4 COAG Plan, p. 6.

5 *Proof Committee Hansard,* 16 May 2008, p. 75.

6 *Proof Committee Hansard,* 16 May 2008, p. 30; *Submission 37*, p. 1.

7 *Submission 41*, p. 5.

8 *Proof Committee Hansard,* 7 May 2008, p. 51.

first meeting, but there had been no further contact.[9] The NSW Consumer Advisory Group had offered to provide consumer representation to the COAG Mental Health Group, but had received no response.

3.10 In South Australia, the Mental Health Coalition of South Australia (MHCSA) commented that the COAG Group had not been particularly effective in engaging broader stakeholders in discussions. Mr Harris, Executive Director, noted that 'It is not necessarily a good thing to just engage senior departmental people in that kind of process. There is more to the system than just the state government provided component'.[10] Indeed several of the NGOs and advocacy groups in South Australia were not aware of the COAG Mental Health Group's existence.[11]

3.11 COAG Mental Health Groups in some jurisdictions have been derived from existing stakeholder groups, perhaps suggesting why they were not readily identifiable. In South Australia, Mr Wright explained the COAG Mental Health Group is organised by the state's Social Inclusion Board.[12] It includes FaHCSIA, DoHA, state mental health services and other providers.

3.12 In Tasmania there was also confusion among stakeholders as to the existence of the COAG Mental Health Group, with some stakeholders unsure whether they were themselves members.[13] The state government clarified that its COAG Mental Health Group only includes state and Commonwealth officials, but that:

> There is another group which was an existing group for the state to use as a consultative forum for their partners, consumers and carers. The Mental Health Council is on that group, along with other non-government organisations involved with education, police, justice and general practice. That group is more like a working and advisory group.[14]

3.13 In the Northern Territory, stakeholders such as the Aboriginal Medical Services Alliance NT (AMSANT) were clear about the COAG Group's existence and its membership and were satisfied that the process is working satisfactorily. However, despite the intergovernmental coordination that the COAG Groups are intended to foster, AMSANT representatives expressed concern that divisions still existed

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9 Ms Jenna Bateman, Mental Health Coordinating Council, *Proof Committee Hansard,* 27 March 2008, p. 46; Transcultural Mental Health Centre, *Proof Committee Hansard,* 27 March 2008, pp. 31–32; Mental Health Coordinating Council, *Proof Committee Hansard*, 27 March 2008, p. 40; NSW Consumer Advisory Group – Mental Health Inc, *Supplementary Information,* Response to questions raised at hearing 27.3.08, dated 4.6.08.

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

11 *Proof Committee Hansard,* 8 May 2008, p. 76.

12 *Proof Committee Hansard,* 8 May 2008, p. 91.

13 *Proof Committee Hansard,* 31 March 2008, p. 5.

14 *Proof Committee Hansard,* 31 March 2008, p. 28.

between health services funded by DoHA and community services funded through FaHCSIA.[15]

3.14 The level of engagement of the COAG Mental Health groups with stakeholders outside of government was an area of concern. The Mental Health Coordinating Council of New South Wales recommended that the structure of all state COAG committees be revised to include representation from the NGO sector, to 'ensure that the philosophy and approach of NGOs as a component of the service system does not lose priority in future service planning'.[16]

3.15 Specific concerns were raised about the lack of representation of consumers on state COAG Mental Health Groups. Queensland is the only state that has a consumer member on its COAG Mental Health committee.[17]

3.16 While state and territory COAG Mental Health Groups may inevitably differ in their structure and approach, the committee considers that there is room to enhance the visibility of these groups and their role in coordinating not only across government departments but with non-government agencies, the private sector, consumers and carers. If the NMHS policy of including consumers and carers at all levels of decision making is to be more than rhetoric, the COAG Mental Health Groups are a key place to start. The committee commends the Queensland Government's approach of including a broader range of representatives, in addition to government officials, directly in its COAG Mental Health Group. It also sees merit in using the COAG Mental Health Groups, as Queensland has done, as a central point for communicating the progress made by each state and territory against the COAG Plan.

**Recommendation 3**

**3.17 The committee recommends that each state and territory COAG Mental Health Group include consumer, carer, non-government organisation and private sector representatives within its membership. The committee further recommends that each COAG Mental Health Group make publicly available a quarterly progress report outlining the work undertaken in the state or territory against each commitment in the *National Action Plan on Mental Health 2006–2011.***

### *National Advisory Council on Mental Health*

3.18 The announcement in April 2008 of the creation of a National Advisory Council on Mental Health reflects the priority that has been given to mental health at the national level.[18] The Council is expected to provide the Australian Government

15 *Proof Committee Hansard,* 1 May 2008, p. 33.

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

17 *Submission 49,* p. 61; *Proof Committee Hansard,* 26 March 2008, p. 34.

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

with independent expert advice on mental health and to assist the coordination of Commonwealth, state and territory mental health services so as to improve support for people with mental illness and their carers.[19] It has been allocated $2.4 million, from within the existing health budget, over three years from 2008–09.

3.19 The membership of the National Advisory Council on Mental Health, announced in June 2008, is as follows:

- Chair: John Mendoza, former CEO of the Mental Health Council of Australia, and author of the seminal Not for Service report;
- Michael Burge, consumer consultant/advocate for the Toowoomba District Mental Health Service;
- Neil Cole, Associate Professor in the Monash Medical School, who has had bipolar disorder, and is a former Victorian Member of Parliament;
- David Crosbie, current CEO of the Mental Health Council of Australia;
- Alan Fels, Dean of the Australia and New Zealand School of Government, whose daughter has schizophrenia;
- Ian Hickie, Professor of Psychiatry at the University of Sydney and Executive Director of the Brain & Mind Research Institute;
- Lyn Littlefield, Executive Director of the Australian Psychological Society;
- Helen Milroy, descendant of the Palyku people in the Pilbara, Child and Adolescent Psychiatrist, Associate Professor and Director for the Centre for Aboriginal Medical and Dental Health at UWA;
- Dawn O'Neil, Chief Executive Officer of Lifeline Australia; and
- Rob Walters, GP and former chair of the Australian Divisions of General Practice.

3.20 The committee is strongly of the view that it is important that this Council is able to function independently and provide independent advice, as has been clearly indicated by the Government. Mr Crosbie, Chief Executive of the Mental Health Council of Australia cautioned:

> My one initial cautionary note is that I hope that it is independent of government. In that sense I do not mean that it be public; I would hope that it is independent in its capacity to work within government.[20]

3.21 Mr Crosbie suggested that the Australian National Council on Drugs provides an example of the kind of body required, being an advisory committee that is auspiced outside of government but able to work within the confidential structures of government.[21]

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19 Budget Paper No.2 2008–09, p. 213.

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

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

### *Other government forums coordinating mental health policy*

3.22 Several other bodies exist within the structures of government aimed at coordinating policy and programs in mental health. These include:

- The Mental Health Standing Committee of the Australian Health Ministers Advisory Council (AHMAC);[22]
- An Interdepartmental Committee (IDC) on COAG mental health implementation; and
- DoHA's Stakeholder Reference Group.

State governments also have their own structures for coordination, such as state-based interdepartmental committees.

3.23 The Mental Health Standing Committee of AHMAC includes officials from each state's lead department in mental health, DoHA, FaHCSIA, the Department of Veterans' Affairs (DVA), consumer and carer representatives, the private mental health alliance and an official observer from New Zealand.[23] The recent inclusion of FaHCSIA within the Standing Committee is a positive reflection of governments' recognition that mental health and illness is not just a health responsibility; it requires a broader community based response.

3.24 The IDC was established in mid 2006, to coordinate across the Commonwealth Government portfolios involved in implementing the COAG Plan. It is chaired by DoHA, and includes participants from Prime Minister and Cabinet, the Department of Education, Employment and Workplace Relations, FaHCSIA, Centrelink, Human Services, Attorney-General's Department, Treasury, Department of Veterans' Affairs and Australian Bureau of Statistics.[24] DoHA considered that the IDC has worked well:

> This committee has been a very valuable forum for all of us, both for progressing individual measures and for ensuring that we identify all opportunities for collaboration and information sharing. The adoption of a whole-of-government interagency approach, which is a first for mental health, has significantly enhanced outcomes across our several portfolios and has brought a greater understanding of the role of the community service sector in achieving better outcomes for people with severe mental illness in particular.[25]

The committee notes that a whole-of-government approach is integral to improving mental health services.

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22 DoHA, *Submission 45*.

23 DoHA, Supplementary information received 2 April 2008.

24 DoHA, Supplementary information received 2 April 2008.

25 *Proof Committee Hansard*, 16 May 2008, p. 75.

3.25 The establishment of the National Advisory Council on Mental Health, changes to the AHMAC Mental Health Standing Committee membership, establishment of the COAG Mental Health Implementation IDC and development of the COAG Mental Health Groups, are all a positive reflection that mental health is now higher on the policy agenda across government departments at state and federal levels. However, evidence to the committee suggests that coordinating mental health services across different areas of responsibility still remains a critical issue.

## Coordination across areas of responsibility

3.26 Submitters and witnesses emphasised that the range of services needed to support people with mental illness to live in the community fall within both state and Commonwealth areas of responsibility. They were disenchanted by failures in coordination between the levels of government and the opportunities that have been lost when funding from one level has not taken into account the existing services and gaps generated by the other level. These concerns are discussed in the following sections.

3.27 The silos between areas of responsibility and levels of government create considerable frustration for those trying to deliver services and for the people that need support. Mr Calleja, from the Richmond Fellowship in Western Australia, raised the example of employment for people with mental illness:

> There is a significant policy gap by the state in relation to connecting with the employment strategy generally. The traditional state-Commonwealth divide applies. The state says 'That's a Commonwealth issue,' and the state forgets that these are real, living people. Their lives do not depend on whether there is a state-Commonwealth boundary, so there is really a need from the health department, in particular, to engage better with the thinking around employment…[26]

3.28 Indeed mental health care requires services in a range of areas such as accommodation, employment, disability services and social inclusion, that work with clinical health care. The Mental Health Coalition of South Australia looked towards the coordination of mental health initiatives with these other areas of support. Mr Harris, Executive Director, suggested that this kind of integration, across different areas of responsibility, should be a focus in the next generation of COAG initiatives.[27]

3.29 While coordination across levels of government was a focus of the current COAG Plan, progress has been slow. The Mental Health Community Coalition ACT commented:

> Care coordination is critical to achieving comprehensive care for individuals with mental illness, and clearly we need that at the government level and at the individual level, as the national action plan identified. But I

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

27 *Proof Committee Hansard,* 8 May 2008, pp. 3 and 7.

> think it is fair to say that it remains quite a challenge for us to achieve that at the government level, in having strategic and integrated planning, when we are talking about services funded across two levels of government and across at least three or four departments in each level of government. So we have not quite cracked that nut as well as we might like.[28]

3.30 Similarly, Mr Quinlan, Executive Director of Catholic Social Services observed:

> Whilst the COAG National Action Plan on Mental Health certainly provides a step in the right direction, neither Commonwealth-state operations nor the links between community and clinical operations are systematically coordinated. In relation to the Commonwealth-state relations, this threatens the creation of gaps and overlaps as well as administrative red tape.[29]

3.31 Mr Wright, from the South Australian Government, commented that state and Commonwealth agencies are not working together as well as they should:

> I think we probably waste a lot of time and energy—the Commonwealth do and the states do—in terms of the discussions that we have with our non-government sector and our primary care sector, only to find that money has come from the Commonwealth to fund something which might be at odds with the work that we are doing. I guess part of that is about ensuring that some dialogue goes on. I think we all have the same sort of end goal in mind.[30]

3.32 The Tasmanian Government observed that state governments need to be kept aware of Commonwealth initiatives and how they fit with state programs:

> …as you roll out the initiatives based around GPs and individual psychologists and nurses—and social workers if you look at the funding in that area—that is done on very much an individual basis, through the Medicare Benefits Scheme. So it becomes necessary for us to keep abreast of who is doing what and where in a far-flung rural state. Part of our issue is trying to understand what it is that we can add value to and how we can do it…making sure we focus on the people for whom we are the most appropriate port of call—the people who have severe and enduring mental illness, requiring joined-up case management type systems—and whether it is more feasible for us to actually work with our GPs and other primary care providers to provide services with them.[31]

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28 *Proof Committee Hansard,* 16 May 2008, p. 31.

29 *Proof Committee Hansard,* 16 May 2008, p. 65.

30 *Proof Committee Hansard*, 8 May 2008, p. 88; see also Government of Victoria, *Submission41*, p. 9.

31 *Proof Committee Hansard*, 31 March 2008, p. 30.

3.33 Commonwealth funding through the COAG Plan has been able to create some shifts towards community-based care in states where this was not so forthcoming. Ms Bateman, CEO of the Mental Health Coordinating Council in New South Wales commented:

> I am a big fan of the fact that we have two funding streams at the moment. I am a really big fan because New South Wales has a long history of being very clinically focused in terms of the way it approaches mental health…these programs have allowed a space for NGOs to develop, grow and rebalance the system. I am nervous that if programs like PHaMs and Support for Day to Day Living in the Community were to come under the state government at this point in time, we would lose some of the value of NGOs—that is, those different referral pathways and accessing people who do not want to access clinical services.[32]

3.34 In South Australia, the MHCSA also noted the different focus of state and Commonwealth initiatives, observing that both are important:

> I think the characterisation that we would have is that the state, in general, is coming from a model where they are focused on supporting people who are already engaged with the state system, whereas the COAG initiatives are much more about people who present wherever they come from…I think that, in terms of moving towards better integration, it needs to be acknowledged that both of those approaches are valid and that if you moved one way or the other you would be disenfranchising, potentially, a range of people who need the services.[33]

3.35 While Commonwealth funding may have been able to shift the service make-up to some extent in some states, witnesses also noted that it is important that state governments do not abdicate their responsibility to provide community-based services. In South Australia, Ms Richardson, Community Services Manager with Carers SA noted the absence of state funding for carers in the COAG Plan. She wanted to ensure that Commonwealth funding was not seen by the state 'as a way to no longer have to fund the carers'.[34] Ms Richardson's concern points to the need for sound scrutiny and reporting of mental health expenditure, to ensure that new money provided by each level of government is going to greater service provision, and not being used by other levels of government to draw down their contribution. Certainly in some states, such as Queensland, it is clear that the state government has markedly increased its funding to mental health services in addition to the money allocated in the COAG Plan. Continued monitoring of the funding provided by different levels of government, and the distribution of this funding across different types of care and support, is required over time.

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32 *Proof Committee Hansard*, 27 March 2008, p. 41.

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

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

### *The COAG Plan and existing initiatives*

3.36 Witnesses to the inquiry were concerned that the COAG Plan had been developed and implemented without adequate consideration of the programs and initiatives that already existed. Ms Hughes, Carers Australia commented:

> I do not think enough work was done in what I would call the service development side of some of these initiatives. What I mean by that is that we need to look at what already exists in states, territories and nationally. Some of these programs already exist in a different way, and they could have built up and enhanced the existing programs. Sometimes I feel like we have started from scratch.[35]

3.37 Ms Hocking, from SANE Australia, questioned the COAG Plan's piecemeal approach and whether this was the best use of funding:

> My concern is that there are so many little splotchy things around the place and, unless we are talking with each other, we could end up with a real patchwork that does not make a quilt…just lots of little patches all over the place and then an awful lot of time and effort required to stitch them all around the edges rather than to make a new quilt in the first place. That is not to say that they are not welcome when they appear, but I do not think that we are making best use of the available funds and that is because there is not that initial planning and coordination.[36]

3.38 Some witnesses suggested that the rollout of new programs under the COAG Plan had not actually helped in coordinating services for consumers:

> The new COAG moneys provide new silos of funding but they are not actually connected. There is no connection between those funding streams and the evidence that says this is the way we should be organising things. I work with our local NGOs. They have got their helpers and mentors funding and in New South Wales we have the Housing Accommodation and Support Initiative, HASI, the Support for Day to Day Living in the Community program and the headspace program as well. But all of these things are set up in such a way that we are actually causing a disintegration rather than an integration.[37]

3.39 Indeed some submitters raised concerns that with so many new programs on the ground, many people involved in the sector are not aware of the full range of services that exist or which are the most appropriate for different consumers. This was apparent at the committee's hearings, with some witnesses not aware of programs such

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

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

37 Dr Gurr, Chair, Policy Committee, Comprehensive Area Service Psychiatrists Network of New South Wales, *Proof Committee Hansard*, 27 March 2008, pp. 60–61.

as PHaMs.[38] The MHCSA called for consistent information about where Commonwealth funded programs are available, who is eligible and how consumers can access the programs.[39] Representatives from the Queensland Alliance Mental Illness and Psychiatric Disability Groups, suggested that a 1800 number would be helpful, as a central point providing information about all the different programs available.[40] Similarly, the Mental Health Community Coalition ACT advocated a national information telephone service:

> Currently, it is just a maze out there, a jungle, and people with mental illness and their families often have no idea where to go or where to find out information, and it is often by accident or police intervention that they end up with help. We envisage a 24-hour national line that anyone anywhere can call, whether it is a person with mental illness or a family member or a friend, and say, 'What exists locally?'[41]

3.40 Mr Quinlan, Executive Director of Catholic Social Services commented that because there is no systematic coordination, community-based organisations have had to rely on their relationship-building skills to establish connections with the more clinically based mental health services that their clients require.[42]

3.41 The committee also heard positive examples indicating that increased capacity in the broad mental health care system has improved linkages. Mr Harris, Executive Director Mental Health Coalition of South Australia, commented:

> …the kinds of approaches that are linking up the non-government supports with people who are engaged particularly with the acute care system have improved over the last few years. The capacity to support people has improved.[43]

3.42 The Western Australian Association for Mental Health (WAAMH) emphasised the importance of understanding the big picture in terms of how the various COAG initiatives fit together:

> A major concern has been the lack of information about the new services provided; who is doing what, and where? That caused confusion for many agencies. WAAMH ran a forum in February that clarified some of the issues, and in February or March we did actually receive an update on the

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38 See for example, Victorian Mental Health Carers Network, *Proof Committee Hansard*, p. 11; Service for the Treatment and Rehabilitation of Torture and Trauma Survivors; *Proof Committee Hansard*, 27 March 2008, p. 15; Carers Australia also commented that knowledge about PHaMS among carers is 'very limited', *Proof Committee Hansard*, 20 May 2008, p. 61.

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

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

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

42 *Proof Committee Hansard,* 16 May 2008, p. 65.

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

> current status of Commonwealth initiatives, which was very useful. Certainly, when we circulated it, people were reassured that there was some sense in the map that we had not seen before.[44]

3.43 Confusion within the sector about the various initiatives included in the COAG Plan, their fit together and progress further highlights the case for including a broader range of stakeholders on state COAG Mental Health Groups. Involving service providers and other stakeholders directly in the 'oversight and collaboration' on how state, territory and Commonwealth initiatives will be coordinated, gives them a much better chance of understanding and working with the plethora of initiatives. Governments also need to be prepared to better coordinate their funding. With resources to the mental health sector limited, wastage through duplication and lack of communication cannot be afforded. The committee considers that clearer mental health service benchmarks, as recommended in chapter 2 will assist levels of government in identifying service gaps and coordinating their programs.

***Legislative coordination and compulsory treatment orders***

3.44 One particular aspect of coordination raised with the Senate Select Committee on Mental Health and again with this committee was coordination of mental health legislation and community treatment orders across jurisdictions. Mr Wright, Director of Mental Health Operations in South Australia, coming from a background in mental health services in New Zealand and Scotland, neatly summarised the situation in Australia:

> I find it strange that, in a country with 21 million people, you have eight different mental health bills…it is a problem for consumers and it is clearly a problem for us because we have to negotiate seven different cross-boundary agreements. It means that, if someone is on a community treatment order in South Australia, it actually becomes quite difficult for them.[45]

3.45 Mr Aspen, pointed to some well publicised examples to demonstrate shortfalls in this level of coordination. He also drew on personal experiences to talk about the limitations of community treatment orders across state boundaries.[46] Mr Aspen advocated that all states enter into agreements in relation to community treatment orders, but observed that so far there had been 'insufficient political will' to make these agreements.[47]

3.46 Progress on cross-border agreements has been made in some areas. For example, the Northern Territory Government noted that it has now completed a memorandum of understanding with South Australia and has commenced negotiations

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

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

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

47 *Proof Committee Hansard*, 31 March 2008, p. 16.

with Western Australia to develop a similar agreement.[48] The Hon Gregory James QC, President of the New South Wales Mental Health Review Tribunal also commented on an agreement between the ACT and New South Wales as a good example of cross-border coordination. However, the Hon James observed that no such cross-border arrangements exist for forensic patients. He outlined the incongruous situation that it is much easier to have forensic patients transferred home to an international location than if their home is another state within Australia.[49]

3.47 Cross-border agreements recognising compulsory treatment orders (CTOs) are important for ensuring continuity in the treatment of some people experiencing severe illness. The Select Committee on Mental Health recommended that all jurisdictions implement legislative reform to ensure that CTOs could be given effect regardless of the state or territory that a person was located in at a given time.

3.48 While cross-border agreements go someway towards providing a national approach, they do not address the diversity in kinds of treatment and care received across jurisdictions. The Australian College of Mental Health Nurses called for nationally consistent mental health legislation:

> A national mental health act would also go a long way in ensuring consistent care and preservation of consumer rights across jurisdictions, and the college strongly supports this coming to fruition sooner rather than later.[50]

3.49 The Senate Select Committee on Mental Health also recommended that state and territory governments agree to harmonise Mental Health Acts relating to the involuntary treatment of people with mental illness. Submitters noted that progress has not been made on this type of integration.[51] The committee recognises that harmonising state and territory Mental Health Acts will have many advantages, including providing greater clarity and certainty regarding compulsory mental health treatment Australia wide. It encourages state, territory and Commonwealth governments to work towards achieving nationally consistent legislation as soon as possible. In the interim, the committee supports rapid finalisation of cross-border agreements between all states and territories.

## Recognising different service structures

3.50 The structure of the sectors which provide mental health services differ markedly across the states and territories and submitters noted that mental health initiatives have not been well coordinated to take account of these differences. For example, Queensland has moved to a model in which all funding to NGOs is provided

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

49 *Proof Committee Hansard*, 27 March 2008, p. 81.

50 *Proof Committee Hansard*, 20 May 2008, p. 48.

51 Mental Health Council of Australia, *Submission 22*, p. 5.

through Disability Services Queensland, with Queensland Health no longer having a role in NGO funding.[52] In the NT, mental health services are predominately delivered through the public sector, with a relatively under-developed NGO sector and 'extremely small' private mental health sector.[53]

3.51 Several governments raised concerns that the funding models underlying national COAG Plan initiatives did not account for differences in state and territory service structures. For example, the NT Government posited that:

> The funding parameters imposed by the Australian government at the time the national action plan was implemented did not sufficiently take into account the unique service delivery environment in areas such as the Northern Territory.[54]

3.52 The Northern Territory Government argued that because Northern Territory primary healthcare services were ineligible to apply for funding rolled out through competitive tendering, the jurisdiction was left at a disadvantage in accessing the Commonwealth funds distributed through NGOs.[55] The Aboriginal Medical Services Alliance NT noted that in some parts of the Northern Territory private providers have not tendered for programs such as PHaMs, so 'a significant amount of the money is unspent'.[56]

3.53 Several state and territory governments raised concerns that they were disadvantaged in terms of accessing the federal funding being distributed under Medicare through the Better Access initiative.[57] They argued that in areas with low numbers of GPs and few mental health professionals or allied health professionals, use of the initiative would be inherently limited. These concerns are discussed further in chapter 6.

3.54 The NT Government argued for more flexible funding arrangements, such as enabling NT Government primary health and public mental health services in rural and remote communities to be eligible for the Better Access initiative. Overall, the NT Government argued for a more flexible funding model in rural and remote areas, that 'looked at creating a critical mass that built on existing infrastructure'.[58] Several witnesses argued that available COAG Plan funding would be better used to

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52 *Proof Committee Hansard*, 16 May 2008, p. 45.

53 *Proof Committee Hansard,* 1 May 2008, p. 49.

54 *Proof Committee Hansard*, 1 May 2008, p. 48.

55 *Proof Committee Hansard,* 1 May 2008, p. 48.

56 *Proof Committee Hansard,* 1 May 2008, p. 23.

57 See for example Government of South Australia, *Proof Committee Hansard*, 8 May 2008, p. 88; Northern Territory Government, *Proof Committee Hansard,* 1 May 2008, p. 49; ACT Government, *Submission* 37, p. 4.

58 *Proof Committee Hansard,* 1 May 2008, p. 55.

strengthen and expand public area mental health services, rather than supporting a range of services organised through different private providers.

3.55 The committee is concerned that the assumptions about mental health service structures that underlie some Commonwealth initiatives in the COAG Plan may disadvantage areas most in need of new services. In areas where services are already limited or non-existent, NGO providers may not exist or have the capacity to tender for available funding. Areas without mental health professionals and allied professionals will not benefit from Better Access funding. These already disadvantaged areas stand to miss out on the opportunity for new services.

3.56 The committee considers it essential that take up of the Commonwealth COAG Plan initiatives across different areas is closely monitored. Alternative funding arrangements may need to be considered in areas where there is insufficient private sector capacity to rollout the COAG Plan initiatives. Importantly, funding allocated for particular areas should be quarantined for use in those areas; if sites have been selected on the basis of need, that need remains real despite a lack of tenderers. The committee considers that there is a case for allowing some programs to be provided through public mental health services in targeted areas where other health infrastructure is not available.

**Recommendation 4**

**3.57 The committee recommends that FaHCSIA track unspent funding under National Action Plan community initiatives rolled out through NGOs. The committee recommends that any underspent funds in sites selected for National Action Plan programs be quarantined for use in those areas and distributed through other mental health programs or direct purchase of services from public health or other providers.**

## Care coordination

3.58 As well as efforts focussed on coordination at a strategic and institutional level, the COAG Plan recognised that connecting the available services on the ground is fundamental to improving Australia's mental health care. The Plan recognised that people with severe mental illness and complex needs are most at risk of falling through the gaps in the care system. One of the COAG Plan flagship initiatives, 'Coordinating Care', was intended to provide a new system of linking care for individuals. The aim of the initiative was to give people with severe mental illness the 'ability to better manage their recovery by giving them clear information on who is providing their care, including information on how to access 24-hour support, and who can help link them into the range of services they need'.[59]

3.59 The focus of the initiative was adults aged 18–64 years with severe mental illness who have enduring symptoms, associated disabilities and/or complex and

59 COAG Plan, p. 5.

multiple service needs. Estimates indicated that around 50,000 people across Australia would be in this target group.[60] The COAG Plan stated that people within the target group would be offered a clinical provider and community coordinator from Commonwealth and/or state and territory government funded services. These people would be responsible for the clinical management of the person and for ensuring that the person is connected to the non-clinical services they need, for example accommodation, employment, education, or rehabilitation.[61]

3.60 The committee received different perspectives on the merits of this approach. People were agreed that, at a systemic level, service connection and integration is essential. In terms of how care for an individual is coordinated, there were different responses. Mr Cheverton, of the Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, advocated the consumer role:

> What people with mental illness are finding is that they have three other people who think it is their job to coordinate their care. Their case manager thinks he or she is doing it; their NGO think they are doing it; maybe their parent or husband thinks they are doing it. There is no space left for the person in that. It is very complex. There is not going to be one model. It has to be individualised, it has to be flexible and it has to be person centred and person directed.[62]

3.61 Similarly, the Health Consumers' Council expressed concern that care coordination roles can be seen as 'some kind of panacea'. Ms Drake, Advocate with the Council, cautioned that care coordination can become another workforce that 'does unto the people' it is intended to assist, without necessarily providing the assistance that they need. Ms Drake pointed out that there can be an assumption of incompetence among mental health consumers, with the risk that control over their own lives can be taken away from them.[63]

3.62 There have been very different approaches to 'care coordination' across the jurisdictions and concerns that a lack of allocated funding has limited progress. These issues are discussed below.

### *Funding*

3.63 No funding was allocated in the COAG Plan for the care coordination initiative. The committee was given to understand that rather than being a new program providing new services, with associated funding, care coordination was about a new model for service provision. It was intended that jurisdictions would look at

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60 DoHA, Supplementary Information dated 31 March 2008, 'COAG National Action Plan on Mental Health *Care Coordination Principles and Implementation Guidelines*', received 2 April 2008.

61 COAG Plan, p. 5.

62 *Proof Committee Hansard,* 26 March 2008, p. 22.

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

restructuring their existing service systems to facilitate a care coordination approach. Examples of the factors to be addressed in this restructure included how services could better work together to avoid duplication and minimise gaps, how services could be linked together more effectively, the governance arrangements required, the issues relating to privacy and information sharing that needed to be resolved, effectiveness of referral pathways and ways to track and manage the care provided to consumers.

3.64 There were different views about whether a new way of providing services could be achieved without designated funding. The WAAMH considered that in the long term, care coordination would become a central part of everyday work and be cost neutral, but that there were additional costs in the initial phases.[64] Representatives from Ruah Community Services, an NGO in Western Australia, commented that lack of funding for care coordination meant that progress in WA had been stripped down to a 'tiny, tiny pilot'. Representatives were concerned that 'care coordination was expected to improve with no additional resources', noting that the mental health system as a whole 'still does not have good case management and care coordination'.[65]

3.65 Mr Thorn, from the WA Department of Premier and Cabinet, considered that more contribution from the Commonwealth would assist the initiative:

> While we have not entirely done it without their help, I have to say their contributions to it have dropped away significantly in recent times.[66]

3.66 Some state governments have provided additional funding for implementing care coordination. For example the Queensland Government allocated $4.8 million for 20 Service Integration Coordinator positions to support the implementation of care coordination locally, as well as a full-time position with the COAG Mental Health Committee to drive the initiative state wide.[67] These positions were not to be case managers and the incumbents were not intended to have contact with individual consumers participating in the program. Rather, the coordinators were for engaging existing government, non-government and private sector local service providers to 'actively participate in the Care Coordination model'.[68] Dr Groves, Director of Mental Health, Queensland Health, noted:

> …whilst the Commonwealth was making an investment through the PHaMs measure, what we needed to do was have a process of getting care coordination throughout Queensland. We recognised that not everywhere in Queensland would necessarily get a PHaMs site and would not necessarily get them early on in the process. So what we have tried to do is look at how

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

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

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

67 DoHA, Supplementary Information dated 31 March 2008, 'Update on State-based COAG Mental Health Groups including progress with care coordination', received 2 April 2008.

68 *Submission 49*, p. 68.

> the Queensland government agencies work together in terms of providing services, linking to the public mental health sector and also into primary mental health care, because that is an important interface that we have invested in to try and strengthen it.[69]

3.67 While the care coordination initiative may be based in a big picture perspective of how mental health care should work and the issues that need to be addressed to make coordination a reality, the COAG Plan also made the commitment that:

> People within the target group will be offered a clinical provider and community coordinator from Commonwealth and/or State and Territory government funded services.

3.68 FaHCSIA reported that most jurisdictions have identified that the Commonwealth funded Personal Helpers and Mentors (PHaMs) will be the first providers to fill the role of community coordinators for the purposes of the COAG coordinating care initiative. However, FaHCSIA noted that the two programs are not interchangeable. There are somewhat different participation criteria for each initiative. For example, consumers have to have a clinical diagnosis before they are offered a community coordinator, whereas PHaMs participants do not have to have a formal diagnosis. Further, PHaMs has a maximum capacity of around 10,000 participants, whereas some 50,000 people may be eligible for care coordination. FaHCSIA commented that therefore 'it is important that other services are identified as having a role as community coordinators under the care coordination framework in addition to the Australian Government's commitment'.[70] As noted, most state and territory governments have not identified funding for this.

### *Implementation across the jurisdictions*

3.69 The Mental Health Standing Committee of AHMAC has endorsed principles and guidelines for the implementation of care coordination Australia wide. However the evidence to the committee's inquiry indicated the diversity in approaches to, and progress of, care coordination across the states and territories. In some states, such as New South Wales and Tasmania, care coordination was being trialled in selected sites using existing Commonwealth programs such as PHaMs. In New South Wales, over 100 clients were already participating in the program and issues involved in care coordination, such as privacy and information sharing, referral pathways and tracking of clients were being worked through. In other states, such as South Australia, little progress had been made beyond initial planning and framework development.[71]

3.70 In the ACT, officials reported that care coordination remained a challenge:

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69 *Proof Committee Hansard*, 16 May 2008, p. 46.

70 *Submission 28*, pp. 8–9.

71 DoHA, Supplementary Information dated 31 March 2008, 'Update on State-based COAG Mental Health Groups including progress with care coordination', received 2 April 2008.

> ACT is currently undertaking a pilot study on care coordination to examine how we can improve the coordination and address the many challenges that exist in trying to coordinate care where it involves multiple agencies. Some of those challenges are around the sharing of information, recording of information and, indeed, just the different expectations of different sectors and different agencies.[72]

3.71 The approach to care coordination in Tasmania was not clear, according to Anglicare representatives:

> I think what care coordination is in Tasmania is still a little bit unknown to me. I participated in one meeting where the Personal Helpers and Mentors Program in Launceston was also invited. It was really just an opportunity for both programs to talk about what they were doing and where they were at. As a manager of mental health services, I am still not really sure what I would call care coordination in Tasmania. It is a bit of a concern to me and something that NGOs and government services are likely to come back to and have a look at.[73]

3.72 Representatives from the Western Australian Government stated that they saw care coordination as 'fundamental to the delivery of mental health care'. Dr Patchett, Executive Director Mental Health, while noting that there was a long way to go, saw that individual care plans agreed with consumers should drive the care of individuals:

> What we should all be trying to do is to have a consenting cooperative agreement to go forward as to what care components are being delivered to each person in Western Australia.[74]

3.73 Although there are clear differences in how care coordination is viewed and being progressed across the states and territories, the evidence to the committee was definite that coordinating the services that do exist is fundamental to improving mental health care in Australia.

### *Concluding comment*

3.74 By including 'Care Coordination' as a flagship initiative, the COAG Plan took an important step in recognising that funding more services is not the only element to improving mental health care in Australia. Making sure that services fit together in response to individuals' needs and circumstances is equally essential. On the basis of the evidence given to the committee, care coordination is one of the lesser developed concepts in the COAG Plan. Its fit with other initiatives such as PHaMs and the likelihood of comprehensive implementation, without any specific funding, is not clear.

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72 *Proof Committee Hansard,* 16 May 2008, p. 31.

73 *Proof Committee Hansard*, 31 March 2008, p. 40.

74 *Proof Committee Hansard*, 7 May 2008, p. 89.

3.75 Care coordination is a particular area of the COAG Plan for further follow up and review. It will not be simple to evaluate the progress made in care coordination. For one, it is not simply an additional service which can be looked at in terms of dollars spent and service episodes provided. It requires a much more holistic view as to how mental health care is and is not working for individuals, including clinical services, in-patient and community-based care, psycho-social and other supports. Adding to the challenge is that care coordination is being approached differently across the states and territories.

**Recommendation 5**

**3.76 The committee recommends that COAG review the progress of the Care Coordination initiative in each state and territory prior to the completion of the *National Action Plan on Mental Health 2006–2011*, including an assessment as to whether allocated funding is needed to enable the aims of the initiative to be achieved.**

**Recommendation 6**

**3.77 The committee recommends that each state and territory government include in its reports to COAG the number of people in the Care Coordination target group that have actually been offered a clinical coordinator and community coordinator.**

# CHAPTER 4

# COMMUNITY SECTOR INVESTMENT

4.1 One of the main strengths of the COAG National Action Plan was that significant funding was finally channelled into community-based mental health services through NGOs. Such funding recognised that a broad range of supports, along with clinical care, are needed to assist people with mental illness to live in the community. However, the committee received evidence about strain within the NGO sector, due to the pace at which funding had been rolled out and successive rounds of competitive tendering.

4.2 In this chapter the committee considers the contribution of the COAG Plan to community-based mental health care in general. It first reviews support for the COAG Plan and the difference that funding to the community sector is making. The committee then considers evidence about the competitive tender process used to distribute funding for community-based programs. In the next chapter the committee considers in detail the largest of the COAG Plan community programs, the Personal Helpers and Mentors Program.

## Community sector funding

4.3 The COAG National Action Plan put significant money into the community sector, as outlined by the Mental Health Community Coalition ACT:

> The COAG Mental Health package 2006 allocated about $800 million mainly through FaHCSIA programs and some DoHA programs to community sector services. That initiative by itself more than met the combined allocation from the states and territories to specialist mental health community support provision. We think that that was a strategic development of an extremely high order in terms of the reform process.[1]

4.4 The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc commented on the increased funding:

> I think the amount of community based service that is available has increased radically. The fact that we were at such a small base means that perhaps to the broader public that is not so noticeable. In Queensland this year the amount of funding to the non-government sector has quadrupled. So the federal government in just one year is now investing more in non-government organisations than our state government. There has been a massive increase.[2]

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1 Mental Health Community Coalition ACT, *Proof Committee Hansard,* 16 May 2008, p. 17.

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

4.5 Many witnesses considered that the new funding was having a notable effect and had improved service access for some consumers.

### *Effect of the new funding*

4.6 The Mental Health Coordinating Council summarised that the Commonwealth funding to NGOs through the COAG Plan has had three substantial outcomes:

- it has increased assistance for people who are unable to get service from public health services because their illness is not acute and for those who do not wish to engage with clinical approaches;
- it has allowed the field of NGO mental health providers to increase, with capacity building in mental health occurring in a number of mainstream organisations as well as mental health specialist organisations; and
- there has been a rebalancing of the mental health system, with the role of NGOs being given greater value and recognition.[3]

4.7 In relation to this last point, Ms Bateman Chief Executive Officer of the Council, noted:

> Funding FaHCSIA and DoHA to do community mental health was a huge step towards creating a more balanced mental health system that understands that social inclusion, connection to family and friends, occupation and a decent place to live are as important as medication and clinical care to recovery from mental illness.[4]

4.8 Witnesses observed that some of the COAG federal initiatives were making a difference in terms of service availability. Ms Edwardson from the Queensland Alliance Mental Illness and Psychiatric Disability Groups commented:

> With some of this federal money coming down it has been really good to be able to say, 'Well, your first port of call is PHaMs [Personal Helpers and Mentors]. Here are the numbers to ring.' Whether or not they can take on all the people is a different story, but at least having an option to give people instead of sending them away empty-handed has been terrific. I know there are some people who have successfully got onto that program from referrals that we have done.[5]

4.9 Ms Carmody from Ruah Community Services in Western Australia commented on the difference for service providers:

> It has been uplifting and encouraging. We have seen some agencies that have been working on a shoestring resource base for their programs for

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3 Ms Jenna Bateman, CEO, Mental Health Coordinating Council, *Proof Committee Hansard*, 27 March 2008, p. 33.

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

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

> many years that have the opportunity now to extend that, such as through the Health and Ageing Support for Day-to-Day Living in the Community program. Groups like Richmond Fellowship and Ruah, which had a base already, have been able to apply for things like the Personal Helpers and Mentors program. We see more counselling opportunities happening for people.[6]

4.10 Mr Dempster, from the Northern Territory Mental Health Coalition described the energy created by new funding to the community sector:

> …there is a sense of, 'Let's go for it.' People are saying, 'Right, we're getting some things that we can do for people,' and consumers are saying, 'Okay, there's this option and that option.' So there seems to be a positive view about it. It is not all gloom and doom.[7]

4.11 Similarly, Ms Bateman observed a 'renewed energy, commitment and confidence' in the community sector stemming from the COAG Plan and relevant state government initiatives. She noted increases in NGO training, in the number of organisations implementing consumer outcome monitoring and quality improvement systems, improvements in professionalism and more involvement in research and linkages with universities and other academic institutions. Ms Bateman summarised that 'the COAG initiatives provided the sector with an enormous boost to morale and the opportunity to meet some of the glaring unmet need not targeted by state NGO programs'.[8]

4.12 Evidence to the committee suggests that in some areas the COAG Plan community funding has helped provide new paths to reach people who were not receiving mental health care and to provide some continuity of care. The Mental Illness Fellowship of South Australia commended the connections occurring between some of the COAG initiatives:

> …there are people in the community who do not see themselves has having a mental illness or do not want to connect with services. Things like the respite program allow us to come in at a different angle and offer some recreational, fun activities…we are working towards transitioning them into the PHaMs program…From there, often once they have built their confidence they enter the Support for Day-to-Day Living in the Community program or the activity programs options where people build skills or relearn skills in terms of social, recreational and recovery based programs.[9]

4.13 The committee was encouraged by the positive response within the community sector to the COAG Plan. At the same time, the committee's evidence indicates that further investment is required to develop and sustain adequate

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

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

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

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

community-based services. Some witnesses, such as Ms Colvin from the Council of Official Visitors in Western Australia noted that even with additional funding to the community sector, programs are not reaching those in desperate need:

> The people in hostels are the sorts of people we would expect to see getting access to these programs and we are just not seeing it. People in hostels sit around basically all day long with nothing to do. They have great difficulty, first of all, finding the programs and, then, getting transport to the programs. Sometimes they are not able to use the transport system, or the cost is prohibitive.[10]

4.14 The need for more community-based care is discussed further in chapter 8, Shortfalls and gaps.

## Competitive tendering

4.15 Despite the improved access to some services and positive outlook generated by the COAG Plan funding, the distribution of this funding has been somewhat tumultuous. The committee heard evidence that the rollout of large amounts of new funding through competitive grants has fractured the mental health community sector. Mr Cheverton of the Queensland Alliance Mental Illness and Psychiatric Disability Groups observed:

> …because all this money was put up incredibly quickly and through tender processes, the coordination and cooperation that was already there has diminished. The organisation that you had been working with down the street was suddenly your competitor on the Day to Day Living tender and then on the PHaMs tender and then on the Community Living tender. I think there are 18 federal initiatives, but there are 26 Queensland initiatives. So the experience of community organisations has been for wave after wave of tender applications, which takes a lot of time and energy away from service delivery and is, in some cases, a bit of a lucky dip.[11]

4.16 Similarly, Ms McGrath, representing Survivors of Torture and Trauma Assistance and Rehabilitation Service SA, considered that the tender process had been 'very destructive'. She explained:

> There are always going to be limited resources available for any type of human services or welfare services. What governments need to be doing is promoting cooperation not competition. Competitive tendering processes promote competition, and that means that services that should be working together actually cannot, or there are limits to how much and how well they can work together.[12]

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

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

12 *Proof Committee Hansard*, 8 May 2008, p. 76.

4.17 Mr Warner, UnitingCare Wesley Port Adelaide, agreed:

> …competitive tendering does create some form of friction. You keep a lot of your own knowledge to yourself; you will not spread it around. You are not going to share with another organisation the models that you have designed and spent months if not years of intelligence developing. Part of my philosophy in the organisation is that we are not there for ourselves; we are there for the clients. Really what we should be doing is spreading that information and intelligence around to all organisations so that we get the best model and the best practice to provide the best service to the consumer out there who is marginalised and disadvantaged.[13]

4.18 Some of the key concerns raised by NGOs about the competitive tendering process included undervaluing of local knowledge and collaboration when assessing tenders, the onerous amount of information required in the tender process, a perceived preference for generalist providers and the sustainability of services.

### *Valuing local knowledge*

4.19 Submitters were concerned that tender processes for COAG Plan community programs have favoured large organisations with the capacity to formulate tenders that suit the department's preference and criteria, rather than organisations with good local knowledge, linkages and an understanding of what is actually achievable.[14] Ms Bateman, CEO of the Mental Health Coordinating Council assessed:

> …the open tender process which occurred under COAG has worked against recognition of the importance of local connections in a number of areas, with tender-writing skills, rather than local connections, being prioritised in the awarding of tenders.[15]

4.20 Mr Quinlan, Executive Director Catholic Social Services Australia commented:

> …local services that have been part of the local community for many years, often offering a broad range of services, can lose out on a particular program to agencies that are essentially just coming into town to deliver that program. The merits of that could be argued both ways, but the impact on the local community can be enormous.[16]

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13 *Proof Committee Hansard,* 8 May 2008, p. 76.

14 For example, Sisters Inside, *Proof Committee Hansard,* 26 March 2008, p. 67; The Queensland Alliance Mental Illness and Psychiatric Disability Groups Inc, *Proof Committee Hansard,* 26 March 2008, p. 17; UnitingCare Wesley Port Adelaide, Survivors of Torture and Trauma Assistance and Rehabilitation Service and Carers SA, *Proof Committee Hansard*, 8 May 2008, p. 55.

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

16 *Proof Committee Hansard,* 16 May 2008, p. 69.

4.21 Mr Calleja, Western Australian Association for Mental Health (WAAMH), observed that a large number of agencies without a track record of delivering services in mental health had won tenders. He raised questions about how long it takes such agencies to start to deliver services and the initial learning required, particularly if agencies are to have a recovery focus.[17]

4.22 The Queensland Alliance Mental Illness and Psychiatric Disability Groups suggested that select, rather than open, tenders would be a better method of awarding funding. Submitters also advocated that local knowledge and history of involvement in a community be given greater weighting in the assessment of tenders. Ms Bateman, CEO of the Mental Health Coordinating Council suggested:

> …perhaps there should be consideration of a more select tender process where, if you are planning on putting services up in the northern area of New South Wales, organisations operating in that area are prioritised and there is, perhaps, a weighting for organisations that can actually demonstrate their local linkages, because to create local linkages takes time and energy.[18]

4.23 Ms Kilroy, from Sisters Inside, suggested that in assessing tender applications it is important to consider who the organisation is currently working with, what outcomes they have achieved in other programs and what evaluations they can provide.[19] Ms Carmody, from Ruah Community Services also advocated finding additional ways to assess a tender, not only on the written application.[20] Ms Bateman suggested that support for the tender from other local organisations could be taken into account:

> I think they should go to the smaller organisations or other groups and agencies in the local area and ask them to submit support for the organisation, because I think a lot of organisations can say they have links but when you actually come down to it they are pretty scant—it might have been a phone call two days before the tender went through or something like that.[21]

4.24 There was a common view that generic program models will not fit across the whole of Australia; the tender process needs to be sensitive to local need, to local knowledge and local linkages. At the same time, it was recognised that if NGOs do not exist in an area, that area may continue to miss out on services unless new providers, often large organisations, are encouraged to set up services.[22]

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17 *Proof Committee Hansard,* 7 May 2008, p. 51; See also Queensland Government, *Submisson 49*, p. 81.

18 *Proof Committee Hansard*, 27 March 2008, p. 37.

19 *Proof Committee Hansard,* 26 March 2008, p. 69.

20 *Proof Committee Hansard*, 7 May 2008, p. 51.

21 *Proof Committee Hansard*, 27 March 2008, p. 37.

22 *Proof Committee Hansard*, 27 March 2008, p. 42.

4.25 Mr Lewis, Group Manager FaHCSIA, stated that while there may be an impression that there is a preference towards awarding tenders to larger organisations, in his experience this is not the case:

> …over some four or five years, across three or four major programs of billions of dollars that I have been involved in, it has not always been the larger ones that have got the contracts. It certainly has not. In many cases, and certainly in the PHaMs situation, there are many smaller organisations who have the bona fides in terms of practice and experience, are genuinely new, are small and have done very well in the tender processes.[23]

4.26 While this may be the case, the committee's hearings gave some insight into the tension within the NGO sector that is running counter to the positive momentum derived from the availability of more funds for mental health programs. An energised, well resourced and inter-connected NGO sector stands to improve outcomes for people with mental illness; fracturing of the sector will not. In this context the committee urges efforts to improve the tendering process, such as increased transparency as to the weighting given to local knowledge and linkages and looking at improving opportunities for collaborative tendering.

### *Collaborative tendering*

4.27 The Australian Mental Health Consumer Network described circumstances where larger NGOs, without a local presence or experience in providing mental health services, turn to smaller NGOs *after* receiving funding, for advice and assistance in delivering the programs. Ms Gardner, a board member for WAAMH and Chairperson of the Bay of Isles Community Outreach in Esperance provided an example of the kinds of requests made of local NGOs:

> …other groups that have obtained funding do not have the capacity or experienced staff to man some of what they want to do and are looking for us to provide that training. We are such a small group that we cannot include that in what we are currently able to do, and they are not prepared to pay to employ other people to replace our staff while we try to do that…[24]

4.28 A more positive arrangement would be collaborative and alliance tendering, with larger NGOs able to auspice smaller NGOs that have specialist skills and local knowledge. Ms Richardson, Community Services Manager Carers South Australia, said 'I think the encouragement of collaborative partnerships with other organisations when they are working across the regions to be able to put in joint submissions would be very beneficial'.[25]

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23 *Proof Committee Hansard,* 16 May 2008, p. 87.

24 *Proof Committee Hansard,* 7 May 2008, p. 7; see also Australian Association of Social Workers, *Proof Committee Hansard,* 20 May 2008, p. 41.

25 *Proof Committee Hansard,* 8 May 2008, p. 76.

4.29 Mr Wright, Director of Mental Health Operations South Australia, saw opportunities for more collaborative tendering in South Australia:

> I have brought some new experience from New Zealand, where we have a non-government sector that has been up and running for a lot longer. I think we have learned a lot of things about how to get a new organisation to partner with a more experienced organisation and to put in a joint tender, with the view that we are developing the capacity of the new organisation. We still need to do that in South Australia.[26]

4.30 However, Mr Quinlan Executive Director Catholic Social Services Australia, saw challenges in collaborative tendering:

> …it is a very tricky process to realistically establish consortiums in the community between agencies that often have very different values bases, very different histories and very different raisons d'etre.[27]

4.31 Dr Gurr, CASP, raised concerns about grants based funding at a systemic level. Because of the rigid nature of contracted services, Dr Gurr argued that providers are not able to adapt in response to changing needs:

> You can end up with one organisation…swimming in money because they do not actually need to provide the level of service but they have been given the money for it. But their auditors will not let them use the money in some other way because it is not the purpose of the contract.[28]

4.32 Similarly, the Mental Health Coordinating Council argued that the long-term effect of current funding models will be 'a loss of responsiveness to the changing needs of the community served by the NGO'.[29]

4.33 Dr Gurr also noted that the current competitive tendering approach results in a plethora of providers all contributing elements to a person's support, care and treatment. He suggested that Australia may need to learn from other countries and look at more consolidated service provision:

> If we think about packages, we have got to get more sophisticated about how we think about purchasing packages. I think this is the issue in New Zealand. They have gone through this whole phase—they have experienced the purchasing and having multiple contractors providing for it—and they ended up with too much fragmentation. I think they are going back now towards saying, 'We need a bit more of a consolidated view about how we do this.'[30]

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

27 *Proof Committee Hansard,* 16 May 2008, p. 70.

28 *Proof Committee Hansard,* 27 March 2008, p. 61.

29 *Supplementary Submission 23,* p. 3.

30 *Proof Committee Hansard,* 27 March 2008, p. 61.

4.34 The committee is concerned that, following a history of underspending on mental health care delivered through the NGO sector, the injection of COAG Plan funds through competitive tendering has lead to fractures within the sector. The committee recommends that governments consider alternative forms of tendering which better promote collaboration and coordination.

***Onerous application process***

4.35 Some NGOs found the information requirements associated with tendering for community-based mental health programs quite onerous. The Northern Territory Mental Health Coalition commented that 'a lot of organisations, particularly the smaller ones, get scared off because there is so much to do and so much information to provide'.[31] Top End Association for Mental Health Inc observed that even though they are the largest NGO in the Northern Territory, they are still not a very big organisation and found the competitive tendering process 'extremely onerous'.[32]

4.36 Mr Quinlan suggested that much of the burden involved in applying for funding could be reduced if government departments coordinated with regard to the information required:

> It seems to me that, once you are deemed a suitable organisation to deliver Commonwealth programs, you should have jumped that hurdle. With appropriate regular accreditation you should not have to jump that hurdle every time you go for a particular funding grant. It should be similar at the state level. There could be enormous effort taken out of some of those tender processes if, on the funders' side, there was better coordination of information and effort so that agencies are not supplying the same information over and over again to a range of government departments that never speak to each other.[33]

4.37 Professor Calder, First Assistant Secretary DoHA, noted that while some of the details required in tender documents are about financial viability year to year and would need to be supplied repeatedly, there may be scope to reduce the demand for basic eligibility information. For example, it may be possible to establish a register of providers that have been assessed as meeting basic criteria. As eligibility requirements currently differ across departments, it would be a substantial undertaking to set up a consolidated register. The committee notes that it would greatly improve tendering processes if standardisation could be increased.

4.38 Mr Lewis, Group Manager FaHCSIA, noted that two reviews are underway which encompass some of the issues raised in the inquiry: a community grants review looking at how government does business with NGOs, and a red tape review looking at barriers to funding and issues such as pre-accreditation of providers for certain

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31 *Proof Committee Hansard,* 1 May 2008, p. 16.

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

33 *Proof Committee Hansard,* 16 May 2008, p. 71.

purposes. Mr Lewis summarised 'We are cognisant of some of the issues and trying to do something, and we are looking across all of our grants processes.'[34]

4.39 The committee looks forward to the outcomes of the reviews currently underway and considers that they should include mechanisms to reduce the information burden placed on NGOs that tender for multiple programs and standardise requirements for information across different government departments.

### *Meeting the needs of specific groups*

4.40 Some organisations were concerned that COAG Plan initiatives have been limited because they are generic and not targeted to specific population groups. Representatives from the Mental Health Coalition of South Australia were concerned that the tender specifications for community programs 'tend to encourage generalist applications and tend to exclude organisations that might have a specific expertise'. Examples included organisations that provide specialist services for people from culturally and linguistically diverse backgrounds, or for older people, which would find it hard to apply for current Commonwealth funding.[35] In Brisbane the committee heard from Sisters Inside, an organisation that works with women in prison and the justice system many of whom have mental illness and many of whom are not connected or engaged with mainstream health services. Ms Kilroy, from Sisters Inside commented:

> Because we are not specifically a fundamental mental health service we are actually not seen by the federal health department as an organisation that can provide those services. The money goes to the mental health services but those are services that the women actually move away from, do not engage with, and instead come to us.[36]

4.41 The committee suggests that in reviewing the COAG Plan community-based initiatives, the government give consideration to whether quarantining some funding for services targeted at specific population groups would achieve better mental health outcomes for the community than the current generic population approach. In chapter 9 the committee notes that the needs of a number of specific population groups are not adequately met by existing mental health initiatives.

### *Sustainability of services*

4.42 An issue raised by several service providers was the uncertainty that accompanies grants based funding. This included frustration when requests for tenders were delayed, such occurred with the third round of PHaMs funding, and concerns as to whether programs would be renewed beyond their initial timeframe. In South Australia, for example, the committee heard about organisations that were awaiting

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34 *Proof Committee Hansard,* 16 May 2008, p. 87.

35 *Proof Committee Hansard,* 8 May 2008, pp. 4 and 6.

36 *Proof Committee Hansard,* 26 March 2008, p. 67.

funding decisions for both COAG Plan comorbidity projects and projects under the National Drug Strategy. Although tenders for some programs closed in December, by early May funding announcements had not been made. Ms Edwards, Executive Officer South Australian Network of Drug and Alcohol Services (SANDAS), commented that organisations were losing staff as programs were not funded beyond the end of June and therefore positions could not be guaranteed.[37] This stop-start funding approach is not helpful to achieving a connected and consistent system of care.

4.43 Ms Cassaniti, Centre Coordinator Transcultural Mental Health Centre NSW, observed that short-term funding can actually have negative effects in a community:

> With anything, trickles of money can at times do more damage than good, because they set up issues that are not sustainable without ongoing money and they set up false hopes. I think the longer pilot periods—if there is no money to do the recurrent—are for a five-year period, so we can at least build some evidence around what works and what does not work.[38]

4.44 Anglicare Tasmania noted that there had been some improvements in sustainability, but saw room for further improvement, particularly when re-tendering for programs:

> In the last two years we have moved from what used to be pretty much one-year contracts to three-year contracts. There has been some progress in that regard. Some retendering processes look a bit odd, particularly in a small state where there are not that many players after all and you wonder whether it is worth the disruption, and each time there is a change from one provider to another there is a tearing down of infrastructure and relationships and a restarting. There needs to be an assessment of threshold need before you retender, given that something is established on the ground.[39]

## Concluding comments

4.45 Evidence to the committee's inquiry shows how pleased mental health NGOs are about the much needed new funding coming into the sector through the COAG Plan and the improvement in service access occurring in some areas as a result. However, the rollout of this funding has clearly had adverse consequences for the cohesiveness of the NGO sector. As with other parts of mental health care, continuity and coordination are critical to assisting people with mental illness in recovery. The sector needs to be supported in such a way as to promote this coordination.

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37 *Proof Committee Hansard,* 8 May 2008, p. 25.

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

39 *Proof Committee Hansard,* 31 March 2008, p. 39; See also ARAFMI Hunter, *Submission 2*, p. 12.

**Recommendation 7**

**4.46 The committee recommends that in purchasing non-government organisation services for future mental health initiatives, Australian, state and territory government departments do not rely exclusively on open tenders but also develop other procurement models such as collaborative and select tenders.**

**Recommendation 8**

**4.47 The committee recommends that the following issues be considered in future funding rounds:**

- **the weighting given to local knowledge and linkages when assessing tenders;**
- **opportunities to increase collaboration;**
- **reducing the information burden associated with tendering for multiple programs; and**
- **addressing sustainability of services.**

4.48 Beneath these specific concerns is the broader issue of the remaining gaps in community support services for people with mental illness. This is discussed in chapter 8.

# CHAPTER 5

# PERSONAL HELPERS AND MENTORS

## The Personal Helpers and Mentors program

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

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

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

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

### *Support for the program*

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

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1 COAG Plan, p. 10.

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

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

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

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

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

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

5.6 PHaMS is a program with the potential and flexibility to engage those who have not been accessing services. Submitters and witnesses noted in particular that consumers can self refer into the program and do not have to have a formal diagnosis. As such it provides a pathway into services from outside the traditional, clinical settings.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### *Concerns about the program*

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

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

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

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

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

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

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

## Who is the program for and is it reaching them?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### *People who are excluded*

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

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

## Geographic coverage

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Recommendation 9**

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

## PHaMs providers

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

### *PHaMs staff*

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

### *Peer support workers*

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

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

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

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

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

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

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

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

### *Qualifications and training*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Recommendation 10**

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

## Capacity

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

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

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

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

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

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

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

**Recommendation 11**

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

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

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

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

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

## Evaluation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Recommendation 12**

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

# CHAPTER 6

# BETTER ACCESS INITIATIVE

6.1 As well as initiatives aimed at assisting people with mental illness in their daily activities and participation in the community, the COAG Plan included initiatives focussed on improving access to clinical care within the community. Prime among these was the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medical Benefits Schedule initiative. In this chapter the committee considers support for the initiative, the use of Better Access so far, barriers to access such as cost and geography and other concerns about the implementation of the initiative. The committee then looks at provider eligibility for Better Access before turning to the matter of evaluation.

## The initiative

6.2 The aim of the Better Access initiative was to 'improve access to, and better teamwork between, psychiatrists, clinical psychologists and other allied health professionals'.[1] The initiative was the largest budget item in the COAG Plan, with $538.0 million allocated over five years. This amount was supplemented in February 2008, taking account of the strong early uptake of the program.[2]

6.3 The Better Access initiative provides Medicare rebates for certain GP provided mental health services and consultations with psychiatrists. It also provides Medicare rebates for consultations with specified privately practicing allied health professionals (psychologists, occupational therapists and social workers) where patients have been referred under a GP mental health care plan or by a psychiatrist or paediatrician.[3] The amount of the rebates for these services is set out in Table 1.

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1 COAG Plan, p. 9.

2 Funding for the Better Access initiative was supplemented to $773.8 million in February 2008, however was reduced by $29.7 million in the 2008–09 Budget. See Senate Community Affairs Committee, *Additional Budget Estimates*, February 2008, Tabled Document, 'Outcome 11 COAG Mental Health: Funding and Expenditure' and Budget Estimates *Committee Hansard*, 5 June 2008, p. 153.

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

**Table 1: Better Access Initiative, MBS rebates**[4]

| Service | Schedule fee | MBS rebate |
|---|---|---|
| Consultant Psychiatrist, Initial Consultation on a new patient | $235.05 | $199.90 |
| GP Mental Health Care Plan | $153.30 | $153.30 |
| GP Mental Health Care Consultation | $67.45 | $67.45 |
| Clinical Psychologist, Psychological Therapy long consultation | $132.25 | $112.45 |
| General Psychologist, Focussed Psychological Strategies long consultation | $90.15 | $76.65 |
| Occupational Therapist, Focussed Psychological Strategies long consultation | $79.40 | $67.50 |
| Social Worker, Focussed Psychological Strategies long consultation | $79.40 | $67.50 |

6.4 Referrals to allied health professionals under the Better Access initiative are initially for up to six consultations. A further six consultations are also available following a review by the patient's GP. Under exceptional circumstances, where there is a clinical need and the GP advises Medicare, patients are able to claim a further six consultations, bringing the total available to eighteen.[5] In addition, patients are also able to receive a rebate for up to twelve group therapy sessions.[6]

6.5 Clinical psychologists are able to provide a range of psychological therapies under Better Access. Only certain therapies, labelled as 'Focussed Psychological Strategies' (FPS), conducted by other allied health professionals are eligible for a rebate. These therapies are:

- Psycho-education (including motivational interviewing)
- Cognitive-Behavioural Therapy (including behavioural interventions and cognitive interventions)
- Relaxation strategies (including progressive muscle relaxation and controlled breathing)

4 As at April 2008. Selected items only are shown in the table and refer to in room consultations. Department of Health and Ageing, *Utilisation of Mental Health Medicare Items*.

5 Mr Smyth, Assistant Secretary, DoHA, *Proof Committee Hansard,* 16 May 2008, p. 81.

6 *Better Access to Mental Health Care Questions and Answers*, http://www.health.gov.au/internet/main/publishing.nsf/Content/coag-mental-q&a.htm, accessed 28 July 2008.

- Skills training (including problem-solving skills and training, anger management, social skills training, communications training, stress management, and parent management)
- Interpersonal Therapy (especially for depression).[7]

## Support for the initiative

6.6 Evidence to the committee's inquiry indicated widespread support for the Better Access initiative. Improved access to clinical services was viewed as a major achievement. Professors Hickie and McGorry have described the introduction of the Better Access rebates as a 'major step towards removing one of the most significant barriers to evidence-based care'. They commented that 'arguably, it is the most important and practical reform in Australian mental health care in the past 15 years'.[8]

6.7 Witnesses also hailed the subtle, structural change that Better Access is helping to facilitate. Government rebates for psychological and other allied health services have helped to effectively recognise the importance of 'talking therapies' in mental health care. For example, Ms McMahon, Chair of the Private Mental Health Consumer Carer Network commented, 'the better outcomes initiative has the capacity to shift the emphasis away from the traditional premise that medication is the only way to treat mental illness'.[9] She also commended the early intervention capacity in the program, as people are able to access psychologists early rather than having to 'wait until they end up in a mental health service'.[10]

6.8 The Australian Psychological Society also pointed to wider effects of the Better Access initiative, beyond individual treatment:

> The universal availability of psychological treatment through the nation's funded health system has possibly also contributed to a destigmatisation of help-seeking for mental health problems, which is an important development.[11]

6.9 The Mental Health Coalition of South Australia felt that by linking supports through GPs, Better Access assists people to self direct their own care. Mr Harris, Executive Director, commented that 'people can choose their GP. They might have a

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7 *Better Access to Mental Health Care Questions and Answers*, http://www.health.gov.au/internet/main/publishing.nsf/Content/coag-mental-q&a.htm, accessed 28 July 2008. Professor Jackson and Mr Rudd critiqued the appropriateness of this listing, *Submission 62*, p. 6.

8 Ian B Hickie and Patrick D McGorry, 'Increased access to evidence-based primary mental health care: will the implementation match the rhetoric?', *Medical Journal of Australia*, Vol 187 No 2, 16 July 2007, p. 101.

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

10 *Proof Committee Hansard*, 8 May 2008, p. 54.

11 Australian Psychological Society, *Submission 55,* p. 8.

family GP, or, if the first GP they go to is not very helpful, they can choose another one'.[12]

6.10 As such, while in many submissions and at hearings witnesses commended the Better Access initiative for the treatment it is making available to individuals, there was also recognition that it is playing a valuable part in addressing wider issues such as balancing the kinds of treatment available, destigmatising mental illness and contributing to consumers' ownership and control over their care.

## Use of Better Access services

6.11 So far the Better Access rebates have primarily been used by GPs and psychologists. Fewer referrals have been made to other eligible allied health professionals such as occupational therapists and social workers.

6.12 Data on use of the Better Access Initiative from its commencement in November 2006 to 30 June 2008, show that in this period there were:

- 799,608 GP mental health care plans
- 730,495 GP mental health care consultations
- 1,545,290 focussed psychological strategy (FPS) long consultations with general psychologists
- 810,847 psychological therapy long consultations with clinical psychologists
- 119,253 initial consultations with a consultant psychiatrist for new patients
- 86,275 FPS long consultations with social workers
- 14,843 FPS long consultations with occupational therapists.[13]

6.13 Concerns were raised that there is limited understanding that allied professionals other than psychologists are eligible to provide services under Better Access.[14] Overall, services provided by occupational therapists and social workers accounted for only 2.5 per cent of all Better Access usage. While referrals to these allied health professionals have increased over time, so too has use of the other Better Access items.[15]

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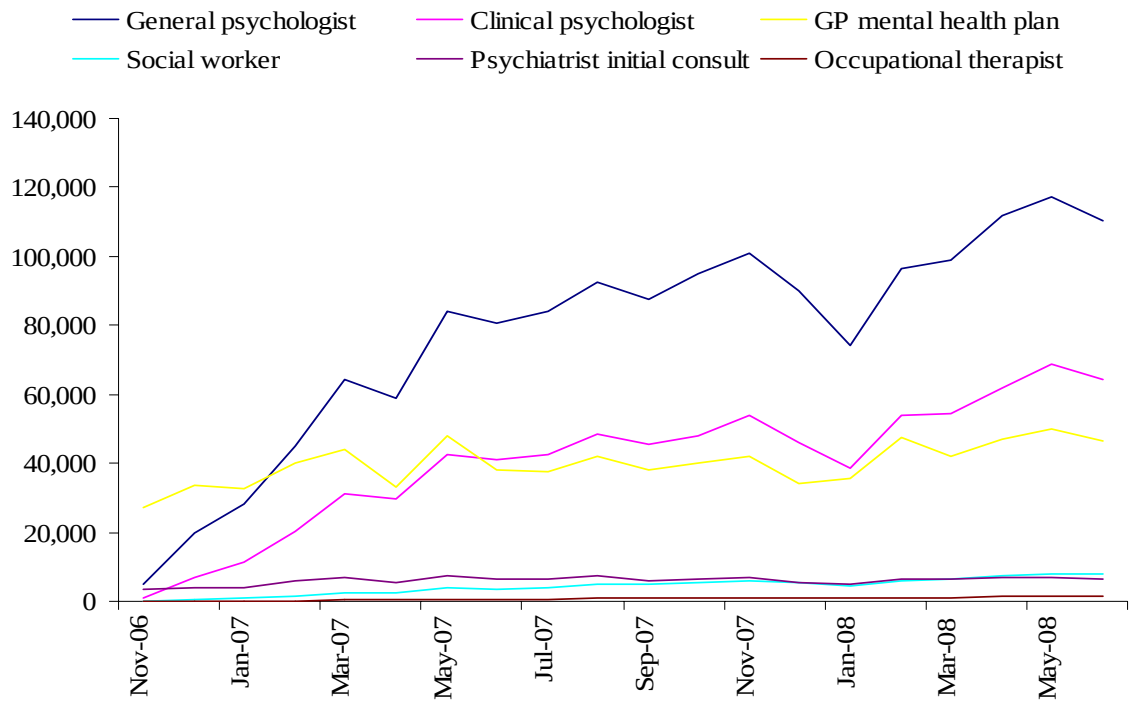
12 *Proof Committee Hansard*, 8 May 2008, p. 3.

13 Medicare Australia, www.medicareaustralia.gov.au/statistics/mbs_item.shtml, accessed 27 July 2008. Data refer to in-room consultations.

14 See for example SANE Australia *Proof Committee Hansard*, 1 April 2008, p. 1.

15 For a description of the increased use of Social Workers under the initiative see Australian Association of Social Workers, *Proof Committee Hansard,* 20 May 2008, p. 39.

**Figure 1: Use of Better Access, selected items**[16]




### *Diagnosis and treatments*

6.14 Referrals can only be made under the Better Access initiative for eligible mental health conditions. This includes a range of conditions, for example psychotic disorders, phobic disorders, anxiety disorders and depression, post-traumatic stress disorders, sleep disorders, sexual disorders, eating disorders, alcohol and drug use disorders, panic disorders and obsessive compulsive disorder.[17]

6.15 An Australian Psychological Society (APS) survey of its members collected information about the diagnoses for people accessing psychological services under the Better Access initiative. The most frequent presentations were depression (18 per cent), co-occurring depression and anxiety (17 per cent), anxiety (13 per cent), post-traumatic stress (6 per cent), adjustment disorder (6 per cent), psychosis, schizophrenia and bipolar (6 per cent), and drug and alcohol use disorders (6 per cent).[18]

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16 Medicare Australia, www.medicareaustralia.gov.au/statistics/mbs_item.shtml, accessed 27 July 2008. Data for allied health professionals refer to Focussed Psychological Strategy in-room long consultations.

17 For a full list see *Better Access to Mental Health Care Questions and Answers*, http://www.health.gov.au/internet/main/publishing.nsf/Content/coag-mental-q&a.htm, accessed 28 July 2008.

18 Australian Psychological Society, *Submission 55,* p. 5.

6.16 While DoHA did not yet have a detailed breakdown on the use of Better Access services, Mr Smyth, Assistant Secretary, indicated that the average number of consultations per patient was around five.[19] The surveyed APS psychologists reported 38 per cent of Better Access clients required one to six sessions, 47 per cent required seven to twelve sessions and 15 per cent required thirteen to eighteen sessions for completion of their psychological treatment.[20]

### *Group therapies*

6.17 The Western Australian Association for Mental Health (WAAMH) noted that there has been little use of the group activity items available under Medicare.[21] Indeed the large majority of services provided under the Better Access initiative have been for traditional in-room individual consultations. MBS items are available under Better Access for out-of-room services and group therapy sessions with Clinical Psychologists, General Psychologists, Occupational Therapists and Social Workers. However these kinds of treatment account for only 2 per cent of the Better Access services provided by allied health professionals.[22] Ms Hocking, from SANE Australia, suggested that there is little understanding that group activities and therapy are important.

6.18 Professor Calder, First Assistant Secretary DoHA, indicated that a planned post implementation review of Better Access would provide more information about the low use of the group therapy items, however it was possible that group therapy had previously been used more, because it was less costly than individual therapy.[23] With Better Access, presumably, comparatively more people are able to afford individual therapy.

6.19 The Mental Health Coordinating Council suggested that group therapy was not ideally placed within individual private practice:

> We note that the expanded options for access to mental health care under Medicare—such as group therapy, symptom management and psycho-education services outside of specialist consulting rooms and remote phone counselling—are almost negligible. We suggest that might be due to the fact that these options might be more appropriately placed within community services utilising a broad spectrum of mental health practitioners.[24]

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19 *Proof Committee Hansard,* 16 May 2008, p. 80.

20 Australian Psychological Society, *Submission 55,* p. 5.

21 See also Mental Health Community Coalition ACT, *Proof Committee Hansard*, 16 May 2008, p. 16.

22 Medicare Australia, www.medicareaustralia.gov.au/statistics/mbs_item.shtml, accessed 27 July 2008. Over the period November 2006 to June 2008.

23 *Proof Committee Hansard*, 16 May 2008, p. 82

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

6.20 Similarly, the Australian General Practice Network (AGPN) pointed to some of the difficulties in referring patients for group therapy noting that 'in theory it is possible; in practice it is quite difficult to actually get the numbers in the groups and make it viable economically when you have limited resourcing to do it'. Dr Wells provided an example where group therapy is working well, noting that this involves a clinical coordinator to make bookings and coordinate the therapy. Dr Wells concluded that 'service coordination infrastructure is really important if we want to see group therapy become more widespread and be more systemically taken up'.[25]

6.21 It is clear that there has been a great take up of the Better Access initiative, with millions of mental health care consultations having been provided under the initiative. However, use of some types of providers and some types of services are more common than others. In evaluating the initiative it will be important to assess whether barriers are preventing access to the most appropriate type of care available.

## Is Better Access providing 'new' services?

6.22 The committee received different views as to which groups of people and what kinds of needs the Better Access initiative is assisting. There was a concern that the Better Access initiative may not be providing new services, but rather more services to those already receiving some level of care. Some witnesses suggested that the initiative was meeting the needs of the 'worried well', rather than those with the most debilitating illnesses.

6.23 The Mental Health Council of Tasmania reported anecdotal accounts to this effect:

> Statements that are coming to us are that it is providing services for people who would be labelled middle class. So the people who would otherwise have accessed those services through government for free are no longer accessing them because they cannot get in to see anybody. I think it has had an adverse effect for a large part of our community.[26]

6.24 The Mental Health Coordinating Council reported:

> There was some feedback also from GPs that many of the clients using the MBS scheme represent those already accessing services privately, so we were concerned that this may be causing a shift from services for the seriously mentally unwell to those better able to access referrals and pay the gap.[27]

6.25 Dr Gurr, Comprehensive Area Service Psychiatrists Network of NSW (CASP) commented:

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25 *Proof Committee Hansard*, 16 May 2008, p. 10.

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

27 *Proof Committee Hansard*, 27 March 2008, p. 43.

> It is interesting how few of the people who are going and getting a referral from their GP and having the expensive plan written actually go back for a review. If you look at the number of reviews, you see that they are very low by comparison. That says to me that either people have gotten better or it is the easier end of the spectrum that is being looked after in that process.[28]

6.26 However, preliminary results of a survey conducted by the Australian Psychological Society (APS) suggest that the initiative is reaching new clients and people who are very unwell. In the survey of its members, the APS found that 72 per cent of clients that were referred under the Better Access initiative had never seen a psychologist before. Nearly half (46 per cent) of clients presented with a moderate disorder and over a third (35 per cent) had severe disorders. A smaller number (19 per cent) had mild disorders.[29]

6.27 The Private Mental Health Consumer Carer Network, based on feedback through its committees and members, also believed that more people were accessing services through Better Access. Ms McMahon commented that 'a whole range of people are now accessing mental health who never would have'.[30]

6.28 The Queensland Alliance Mental Illness and Psychiatric Disability Groups provided a slightly different perspective. Witnesses noted that, even if Better Access is not providing services to the most unwell, it may at least have an early intervention effect and also relieve pressure on state run and NGO services, freeing them up to provide focused assistance to those with acute needs.[31]

6.29 It is difficult to reconcile different views about who is, and who is not, benefiting from the MBS items without further information. It is clear that the initiative is being taken up and the APS data suggests it is being used by people with moderate to complex needs, many of whom were not previously receiving this kind of treatment. However, many witnesses observed from their experience that for those with severe illness combined with other disadvantages, whether through social, economic or geographic circumstances, services remain out of reach. Some of these barriers to access are discussed later in the chapter.

6.30 The committee commends the APS for it efforts in collecting information about the use of the Better Access initiative. Discussion about whether the initiative is reaching new clients and those with greatest need in part relate to whether the initiative is providing value for money. Comprehensive information about the use of the program, and the outcomes it is achieving for people, is needed in order to assess

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28 *Proof Committee Hansard*, 27 March 2008, p. 74.

29 Australian Psychological Society, *Submission 55,* p. 5.

30 *Proof Committee Hansard,* 8 May 2008, p. 53.

31 Queensland Alliance Mental Illness and Psychiatric Disability Groups, *Committee Hansard*, 26 March 2008.

whether this is the best way to provide primary mental health care. The issue of information and evaluation is discussed further at the end of this chapter.

## Barriers to access

6.31 While many witnesses commended successive governments for the Better Access initiative, concerns were raised that the initiative remains out of reach for some people including those with the most severe illnesses and in the most desperate circumstances. The following sections look at some of the barriers that need to be overcome to obtain the kinds of service offered through Better Access.

### *Costs*

6.32 One concern in relation to the Better Access initiative is that services may remain unaffordable for some people with the greatest needs. People who are homeless or in other financial difficulty may not have contact with the private medical system, or, if they do consult a GP, be unable to afford the allied care. Unless a practitioner bulk bills, patients remain liable for the gap between the schedule fee and the MBS rebate, plus any charges made by the practitioner above the schedule fee.

6.33 The average gap payments for the most common services under Better Access between November 2006 and December 2007 are provided in Table 2. Bulk billing rates among psychologists and psychiatrists remain comparatively low and correspondingly, out-of-pocket expenses for these services are higher, particularly for psychiatric services.

**Table 2: Better Access Initiative, costs to consumers**[32]

| Service | Bulk billing rate | Average co-payment |
|---|---|---|
| GP Mental Health Care Plan | 92.5 | $15.94 |
| GP Mental Health Care Consultation | 90.2 | $18.58 |
| Clinical Psychologist, Psychological Therapy Long Consultation | 25.9 | $27.97 |
| General Psychologist, Focussed Psychological Strategies Long Consultation | 30.4 | $33.41 |
| Consultant Psychiatrist, Initial Consultation on a new patient | 29.9 | $65.10 |

6.34 The different gap between the schedule fee and Medicare rebate for different providers, as set out in Table 1, is relevant when looking at bulk billing rates. Ms McMahon, Chair of the Private Mental Health Consumer Carer Network, pointed out

32 Department of Health and Ageing, *Utilisation of Mental Health Medicare Items*, 1 November 2006 to 31 December 2007.

that under Better Access, the Medicare benefit for GP provided mental health care is the same as the schedule fee with no 'gap'. As Ms McMahon commented 'one would assume that bulk-billing would be the way to go for GPs'.[33] Thus while GP bulk billing rates are high in comparison with the other service providers, it is perhaps surprising that they are not even higher.

6.35 In contrast, the Australian Association of Social Workers (AASW) pointed to the different level of rebate that social workers and occupational therapists receive, compared with other providers of psychological strategies. They said that this acts as a disincentive to bulk bill. Ms Sommerville, Mental Health Policy Officer, expanded:

> Social workers, with the underpinning values of social justice, have a natural inclination to do the best by our clients by addressing those in the most vulnerable positions. There is a natural inclination to want to bulk-bill, but to manage all the costs associated with private practice is quite difficult with the current rebates.[34]

6.36 Ms Debora Colvin, Head of the Council of Official Visitors in WA, commented that for the patients that Official Visitors see, there has been no change in access to psychologists, psychiatrists and GPs through the Better Access initiative. Official Visitors sees consumers who are involuntary patients, including those on community treatment orders, those who are accused of crime and are in authorised hospitals such as forensic units and those who live in licensed private psychiatric hostels.[35] Ms Colvin commented that these consumers are nearly always on disability benefits and are unable to pay gap fees. For those psychiatrists and psychologists that bulk bill, there are long waiting lists and many consumers have difficulty accessing GPs in the first place.[36]

6.37 Similarly Mr Quinlan, Catholic Social Services Executive Director, pointed out that for many clients any gap fee is going to put services out of reach:

> As one of our managers reflected, 'Due to the nature of our clients, it doesn't matter if the gap is $5 or $500; if they don't have it they can't afford it.' The cost of accessing external providers is a barrier for many of our disadvantaged clients because they just do not have the funds to resource a gap.[37]

6.38 The committee is concerned by evidence that suggests the Better Access initiative is not providing mental health services to those experiencing some of the greatest difficulties. While the Better Access initiative appears to have opened up access to previously underutilised service providers, the evidence to the committee

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

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

35 *Proof Committee Hansard,* 7 May 2008, p. 64.

36 *Proof Committee Hansard,* 7 May 2008, p. 65.

37 *Proof Committee Hansard,* 16 May 2008, p. 65.

reinforces the importance of maintaining well supported public mental health services. Even with government support, private care will remain unaffordable for some people most in need of mental health care.

6.39 The committee also notes that careful monitoring of gap payments over time is necessary to ensure that Better Access is making services more accessible and not simply more expensive.

### *Geography and workforce distribution*

6.40 Submitters and witnesses questioned the equity of access to services provided through the Better Access initiative across different regions of Australia. Witnesses noted that provision of services under the initiative is driven not on the basis of population need, but by workforce supply. The Mental Health Coordinating Council said:

> …distribution of services across Australia is not uniform, with some states making much higher levels of claims for the new services on a per capita basis, and the distribution of claims appearing to broadly match the distribution of health professionals.[38]

6.41 Data from Medicare Australia's website indicate the different use of Better Access services across the States and Territories, as shown below in Table 3. Use of the Better Access services in the Northern Territory was well under half that of the national average. Other differences across the states and territories suggest differences in workforce distribution and health system structures. For example, consultations with clinical psychologists were the most used item in Western Australia, whereas consultations with general psychologists were most common in the other states and territories. Tasmania, Western Australia and South Australia had a higher uptake of the occupational therapist services than the other states, while Victoria and New South Wales were the greatest users of social worker consultations.

38 *Proof Committee Hansard,* 27 March 2008, p. 43.

**Table 3: Use of Better Access per 100,000 population**[39]

| | NSW | Vic. | Qld | SA | WA | Tas. | NT | ACT | Aust. |
|---|---|---|---|---|---|---|---|---|---|
| GP mental health plan | 3969 | 4420 | 3377 | 3123 | 3274 | 3410 | 1447 | 3328 | 3782 |
| Psychiatrist initial consult | 560 | 613 | 560 | 680 | 462 | 385 | 240 | 506 | 564 |
| Clinical psychologist | 3740 | 4177 | 2027 | 3666 | 6965 | 5158 | 847 | 4014 | 3835 |
| General psychologist | 7258 | 10510 | 7216 | 3901 | 3186 | 6008 | 2136 | 6747 | 7309 |
| Occupational therapist | 71 | 78 | 45 | 84 | 88 | 131 | 0 | 22 | 70 |
| Social worker | 437 | 511 | 351 | 364 | 303 | 332 | 52 | 133 | 408 |

6.42 The ability of the Better Access initiative to improve service access beyond metropolitan areas was also questioned. For example, the dearth of psychiatrists and few psychologists in remote areas limits how much the initiative can help people with mental illness to access services in these areas.[40] AMSANT commented on the low numbers of clinical psychologists in rural and remote areas, and the heavy demand for their services. AMSANT suggested looking at options to upskill other existing health professionals already in these areas, particularly for the provision of Cognitive Behaviour Therapy:

> …there are a significant number of mental health professionals who are already in the Northern Territory who are not sufficiently qualified and are not eligible for the Medicare benefits. We think there needs to be an alternative pathway so that people like them could complete a very vigorous upskilling program.[41]

6.43 AMSANT also argued that in small jurisdictions like the NT and remote areas particularly, funding for allied health professionals is needed in the public sector:

> One thing that we do want to stress is that the public sector needs salaried psychologists and social workers who can access the items, not just the private sector, because the gap fees in the private sector are a very

39 Medicare Australia, www.medicareaustralia.gov.au/statistics/mbs_item.shtml, accessed 27 July 2008. Selected items only, for the period November 2006 to June 2008. Data for allied health professionals refer to Focussed Psychological Strategy in-room long consultations.

40 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 31; Government of Victoria, *Submission 41*, p. 8.

41 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 31.

> significant barrier to the very groups of people that the Senate [Select Committee] report said needed to be able to access CBT.

6.44 The AGPN also acknowledged the limitations of a fee-for-service model for people living in rural and regional Australia and for those who are economically disadvantaged. AGPN saw the need for a 'complementary funding model for allied mental health services' to improve access to care.[42]

6.45 The Australian Association of Social Workers noted that the distribution of social workers is better than the other allied health professionals included under Better Access, with over a third working in regional, rural and remote areas of Australia.[43] They considered that improvements could be made under Better Access to increase its use to people in rural and remote areas. For example, AASW suggested allowing longer consultation times for rural and remote social workers, given that consumers often have to travel a long way to access the service:

> They may come for their hour and then have to travel a long way back. If they had a longer consultation time then perhaps more could be achieved with less frequent sessions.[44]

6.46 Even within metropolitan areas, specialists are not evenly distributed. Dr Gurr, CASP, spoke about the situation in suburbs of Western Sydney:

> …these are areas where we do not get much benefit out of Medicare; the Commonwealth funding that is available just does not go to those areas. I am the only private practitioner in the City of Blacktown, which has a population of approximately 300,000 people, and I do three hours a month.[45]

6.47 Professor Calder, First Assistant Secretary DoHA, outlined some of the approaches that are being taken to improve access to psychological therapies in communities not well serviced by private Medicare eligible providers. For example, the Access to Allied Psychological Services (ATAPS) program is an initiative that enabled eligible GPs to refer patients to allied health professionals prior to the Better Access initiative. Funding for this initiative is distributed through the Divisions of General Practice. With Better Access now operating, Professor Calder outlined that ATAPS projects are being refocussed:

> The ATAPS refocusing and extension is to occur through a trial of telephone based therapy in rural and remote areas, the provision of better support and referral pathways for general practitioners managing patients at high risk of suicide and the provision of additional funds to rural and remote and outer metropolitan divisions of general practice that have unmet

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42 *Proof Committee Hansard*, 16 May 2008, p. 1

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

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

45 *Proof Committee Hansard,* 27 March 2008, p. 59.

> demand. It is anticipated that this will increase funding to over 50 per cent of rural and remote and outer metropolitan divisions. The government is also exploring models to target specific high-need groups, including homeless people and Indigenous populations.[46]

6.48 Mr Smyth, also from DoHA suggested that the current workforce distribution and gap payment barriers to allied health professional services are to some extent a reflection of the past full-fee system, with inequities expected to ameliorate over time. He said:

> …psychologists have generally been located in areas where people have been able to afford full-fee payment prior to the introduction of the Medicare items or they have had private health insurance arrangements for that. We really do expect over time that that will start to reduce as greater competition comes into the market and also as we see a greater distribution of psychologists in rural and regional Australia, as a number of the workforce measures…start to bite in the coming years.[47]

6.49 The committee discusses workforce shortages and issues of access to mental health care in rural and remote areas more generally in chapters 8 and 9. In relation to Better Access, the committee notes the different use of the program in different areas. Again, the committee suggests that this evidence emphasises the importance of well supported public sector mental health care. Better Access should not be viewed as the panacea to Australia's mental health care shortages.

### *Awareness*

6.50 Lack of awareness about the Better Access initiative among providers and the public is another potential barrier to access. Ms Powell from the West Australian Mental Illness Awareness Council (WAMIAC) questioned how consumers find out about the initiative if they do not have a GP. This is particularly relevant for people with a mental illness who are homeless, or for other reasons are largely outside the existing health system.[48] Similarly WAAMH raised concerns that many people are not aware that the Better Access program exists, and that some GPs are not using the initiative.[49]

6.51 Ms Colvin, Head of the WA Council of Official Visitors, pointed to lack of awareness and interest in the initiative among some health professionals:

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

47 *Proof Committee Hansard*, 16 May 2008, p. 80.

48 *Committee Hansard*, 7 May 2008, p. 56.

49 *Committee Hansard*, 7 May 2008, p. 5.

> I personally have had an experience on behalf of a consumer where I met with the psychiatrist. He had no idea about the initiatives by the government in this area and little or no interest either.[50]

6.52 While it is concerning to hear accounts of health professionals who are not interested in the services potentially available to assist their clients, the committee also heard from professional groups about the efforts they undertake to increase awareness of the initiative. For example, the AGPN explained that the divisions of general practice have a role in helping GPs to understand and use the new referral pathways available under Better Access. Ms Wells noted that:

> A common practice for many divisions would be to facilitate local peer networking and local multidisciplinary training networks among providers, and to give GPs choice about the range of new referral pathways that are now available to them through COAG mental health. Divisions systematically and routinely put together service provider directories…[51]

6.53 The committee encourages all health professional groups to continue their endeavours in raising awareness and improving understanding of the Better Access initiative.

## Concerns about the initiative

6.54 In addition to the specific barriers to access discussed above, submissions and witnesses raised some structural and implementation issues that are relevant in assessing whether the Better Access initiative is delivering the best possible mental health outcomes for the community. These are discussed below.

### *Distribution of resources across the states and territories*

6.55 Some state governments were concerned about the fee-for-service basis of the Better Access initiative. Different amounts of funding go into the different states and territories not on the basis of population or need, but on the basis of service usage which is at least partly driven by the availability of professionals and allied health professionals in the different areas. For example, the Government of Western Australia argued that it does not receive its per capita share of MBS payments and that elements of the initiative should be 'cashed out' to provide equitable contribution to all the states and territories. Mr Thorn, from the WA Department of Premier and Cabinet conceded that WA had received more than a per capita share of some of the other Commonwealth COAG Plan initiatives, such as 'Mental Health Services in Rural and Remote Areas', of which WA received 25 per cent of the funding. However Mr Thorn assessed that this increase did not make up for the loss experienced through Medicare payments. The WA Government assessed that over the first 16 months of the COAG Plan, Western Australia had received 7.7 per cent of all mental health MBS funding,

50 *Proof Committee Hansard*, 7 May 2008, p. 65.

51 *Proof Committee Hansard*, 16 May 2008, p. 9.

whereas a population based share would be 9.9 per cent.[52] The Governments of South Australia and Northern Territory had similar concerns, given the lower number of psychologists and other allied health professionals in rural and remote areas and, in the case of the NT, the 'extremely small' private mental health sector, limited availability of GPs and lack of bulk-billing for services.[53]

6.56 The committee notes the different levels of use of Better Access items across the states and territories and the concerns expressed by some governments about inequity in the distribution of funds through the measure. In reviewing Better Access it will be important for the Australian Government to consider the funding to states and territories through the initiative along with additional funding through other measures, with a view to evaluating the equity of funding distribution.

### *Public sector capacity*

6.57 Several state governments raised concerns that the Better Access initiative was drawing allied professionals out of the public sector workforce and therefore not necessarily increasing access to services, but rather reshuffling services to a more expensive part of the sector.[54] Other witnesses also presented this view. For example, Ms Swallow, from the Mental Health Council of Tasmania, commented:

> …a significant impact is psychologists exiting that system to set up in private practice because they can now access money through Medicare. It is having a significant flow-on effect.[55]

6.58 Although the committee did not receive any data on workforce movements, the professional associations reported their observations. Dr Freidin, from the Royal Australian and New Zealand College of Psychiatrists commented:

> There are certainly reasons for concern. There are a limited number of psychologists, particularly the most highly trained in the area—the clinical psychologists. Our experience currently is that psychologists who have been working full time in the public system are putting their toe in the water—they are cutting back from full time to three days a week, doing a day or two of private practice and seeing how it goes. Potentially, they may increase that if they find it to their interest or beneficial in other ways. Part of the difficulty is the disparity between the potential income through private practice and what they are paid as public employees, as well as the issue of there being a limited pool of highly trained mental health staff.[56]

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52 Department of Health, Government of Western Australia, Additional Information 9 June 2008.

53 *Proof Committee Hansard*, 8 May 2008, p. 88; *Proof Committee Hansard,* 1 May 2008, p. 49; see also ACT Government, *Submission 37*, p. 4.

54 See for example Tasmanian Government, *Submission 42,* p. 5; Victorian Government, *Submission 41.*

55 *Proof Committee Hansard*, 31 March 2008, p. 5.

56 *Proof Committee Hansard,* 1 April 2008, pp. 37–38.

6.59 The results of a survey of public sector psychologists in Melbourne in 2007 support Dr Freidin's assessment. The APS reported that a third of surveyed psychologists intended to reduce their working hours to take up some private practice over the next two years. Among the more senior psychologists, 41 per cent intended to reduce their public sector hours. Among the psychologists intending to leave the public sector, the main reasons were increased opportunities and remuneration, greater flexibility and autonomy. Improvements to public sector employment conditions that may lead them to change their plans included improved remuneration, increased specialist psychology work, promotion opportunities, increased study/conference leave, additional annual leave, professional development, increased provision of private practice rights and research opportunities.[57]

6.60 The Australian Association of Social Workers noted that when the Better Access initiative was introduced less than 250 mental health social workers were registered for the initiative and by May 2008 there were close to 800.[58] Ms Sommerville suggested the source of the increase as follows:

> Social workers have been working in private practice for many, many years so I think initially those were the social workers coming on board. But increasingly so it is some working in public mental health who are just perhaps reducing one or two days in public mental health or adding some extra private practice time on to their already full-time position in public mental health.[59]

6.61 In the context of workforce shortages, movement of mental health professionals and allied health professionals from the public sector to the private sector is a key indicator to monitor. For some people, including many of those experiencing the most severe illnesses, public sector services often remain the only option.

### *Promoting team work?*

6.62 Although pleased to see money being allocated to primary mental health care, some witnesses questioned whether Medicare was the best way to use the available funds. Witnesses were concerned that the individual fee-for-service model underlying the Better Access initiative does not promote team work and integrated care. Mr Calleja, from Richmond Fellowship WA commented:

> The reality is that good recovery work is about integrated approaches to dealing with the whole person. If you have millions of dollars going into Medicare funded services that do not then have a connection to other aspects of a person's life, you have money siphoning off into a black hole.[60]

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57 Australian Psychological Society, *Submission 55,* p. 13.

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

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

60 *Proof Committee Hansard*, 7 May 2008, p. 47.

6.63 Similarly, Mr Crosbie, Chief Executive Officer of the Mental Health Council of Australia outlined:

> Collaborative care is always going to be better than individual care and every bit of research we know about mental health says that. In a sense, I am always concerned about models that privatise it down to an individual service practitioner level in any area of health, and then we rely on that individual service provider to in some way provide a service that they are being paid for without any sort of follow-up or any kind of review of how that is going in an ongoing way.[61]

6.64 Witnesses remarked that the current rebate system does not support an integrated approach among health professionals, let alone across clinical and non-clinical settings. Ms Oakley, NSW Consumer Advisory Council, said:

> …whilst people may be referred from their GP to the psychologist with a care plan in place, there is not always that consistent information sharing and updating, which is quite critical in managing the care of consumers.[62]

6.65 Dr Johnson, a member of the Royal Australian College of General Practitioners, gave the committee a sense of how collaboration occurs on the ground:

> Collaboration occurs in my own practice when I am able to set aside time. This might be to call another health professional to discuss the care of a person with mental health problems. One local psychiatrist that I work with will regularly send me a fax to notify me of medication changes to a mutual patient. Occasionally I can flag the psychologist who works in our practice for a brief discussion about the patients that we care for. These simple but extremely valuable interactions all occur alongside rather than within the current Medicare structure.[63]

6.66 The Medicare system does not fund collaborative efforts such as case conferencing or writing reports on joint clients.[64] Dr Gurr spelled out the business reality of the Better Access system:

> Medicare…if you are a psychiatrist, basically rewards you for doing things in an office for certain periods of time. You maximise your income by seeing people for 16 minutes exactly; for every minute that you go past that you start to lose money, comparatively. You do not get paid for liaison work. In discussing what is happening with a particular consumer and their relatives, you get paid less to talk to the relatives, you get paid nothing to talk to the GP and you get paid nothing to talk to another provider, whether it is a NGO, another discipline that is paid through Medicare or whatever. So there is no reward for properly communicating, yet the evidence in

61 *Proof Committee Hansard*, 20 May 2008, p. 86.

62 *Proof Committee Hansard*, 27 March 2008, p. 51.

63 *Proof Committee Hansard*, 1 April 2008, p. 63.

64 Mr Calleja, *Proof Committee Hansard*, 7 May 2008, p. 48; Australian Psychological Society *Submission 55*, p. 11.

> mental health is that you get the most effect if you provide continuity of care and seamless transition of care.[65]

6.67 Professor Jackson and Mr Rudd were concerned about the diverse mix of education and skill levels that exist among the different allied health providers eligible for Better Access. They submitted that some of these groups do not have the specialist clinical skills to diagnose and treat mental illnesses. Professor Jackson and Mr Rudd considered that multidisciplinary teams, rather than individual fee-for-service providers, would allow for 'a more comprehensive and integrated case approach, and arguably better risk management, especially where complex presentations are concerned'.[66]

6.68 Beyond integrated clinical care, witnesses also pointed to the need for coordination with other supports and services that people with mental illness need in their recovery journey. These also are not encouraged by the individual fee-for-service system. Richmond Fellowship WA advocated connecting the Better Access strategy to the community sector, to promote a three-way relationship between GPs, allied health professionals and community agencies. Mr Calleja considered that this connected model has a 'much better chance of actually helping a person in their recovery process.'[67] Similarly, Ms Carmody from Ruah Community Services commented that it is important for clinical counselling services to be 'linked to an integrated coordinated support care approach'.[68]

6.69 Professors Hickie and McGorry have consistently raised concerns about the individual fee-for-service basis of the Medicare-rebate system and its ability to provide maximum mental health care to the population. Some of the concerns they have raised include:

- there are no requirements or incentives for collocation of services, recognised internationally as one of the most important measures for promoting collaboration;
- there are no requirements for geographic distribution of services;
- there are no incentives for treating patients in greatest need at low or no additional cost;
- there are no incentives for seeing younger people early in their illness;

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

66 *Submission 62*, p. 5.

67 *Proof Committee Hansard*, 7 May 2008, p. 47.

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

- services delivered under the scheme will remain highly concentrated in communities with the capacity to pay.[69]

6.70 While extensive use of the Medicare rebates under Better Access is clear, less evident to the committee is an increase in collaborative care. The Select Committee on Mental Health in its recommendations to government prioritised integrated care. It recommended 'a new set of Medicare mental health schedule fees and rebates for combinations of private consulting psychiatrists, GPs and psychologists who agree to work together or in conjunction with mental health centres under integrated, collaborative arrangements in the management of primary mental health services'.[70] Given the mechanism used by Government to provide Medicare rebatable psychological services, the committee considers it important that the review of the Better Access initiative look at options for improving collaboration between eligible providers.

### *GP plans and referrals*

6.71 GPs are an important component of the mental health system as it currently functions in Australia. In 2006–07 one in ten consultations with GPs involved the management of a mental health related problem. This is equivalent to some 10.7 million GP consultations nationwide.[71] The Better Access system, by providing specific rebates for GP provided mental health services effectively recognised the role that GPs are providing in mental health care. The referral system under Better Access also aimed to help people with mental illness move through GPs to receive the specialist care that they need. However, the committee received different views as to how well GP Mental Health Plans are working. Ms McMahon considered that the GP Mental Health Plans were a progressive step:

> Whether they make it to a psychologist, an OT or a social worker, they are certainly being seen now in the GP sector…That is a formalised, structured plan now, whereas before there would have just been a long consult with a GP who would go through various issues. Now it is a formalised, structured plan…and one would assume it would have outcomes, goals and those sorts of things. [72]

6.72 The APS highlighted some issues with the GP Mental Health Plan process, based on the results of its survey of members. Surveyed psychologists reported that 27 per cent of GP Mental Health Care Plans did not reflect an accurate diagnosis and 33 per cent of psychologists believed that the GP's Mental Health Care Plan did not

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69 Ian B Hickie and Patrick D McGorry, 'Increased access to evidence-based primary mental health care: will the implementation match the rhetoric?', *Medical Journal of Australia*, Vol 187 No 2, 16 July 2007, p. 101.

70 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, p. 477.

71 AIHW, 2008, *Mental health services in Australia 2005–06,* p. xi.

72 *Proof Committee Hansard*, 8 May 2008, p. 53.

capture the most important features of a client's diagnosis and contributing issues. Psychologists needed to subsequently conduct their own full diagnostic assessment for 86 per cent of their Better Access clients.[73]

6.73 Dr Johnson, a member of the Royal Australian College of General Practitioners, saw the above statistics from a different view. She noted:

> …when people in psychological distress present in a primary care setting, it is not always apparent on the first or even the second or third visit what the diagnosis is, and it is also true that the diagnosis often evolves over time…You see someone who presents initially with depressive symptoms but, as you get to know them over time, it becomes clear that they may have, for example, bipolar disorder, or they may develop psychotic symptoms.[74]

6.74 Dr Johnson explained that some consumers do not want to divulge to their GP all the information that they might reveal to a mental health specialist. Given these kinds of considerations and that the minimum time to complete a Mental Health Plan is 30 minutes, Dr Johnson believed that it was positive that around two-thirds of GP plans were complete and captured the main issues.[75]

6.75 Similarly, Dr McAuliffe from the AGPN, did not see intrinsic problems with psychologists reviewing GP assessments:

> I think good clinical care means you always keep reviewing your diagnostic formulation and seeing whether you are providing the care that the individual needs, and that you are meeting the outcomes that are important to them and improving their health generally.[76]

6.76 However the APS considered that duplication in assessment and diagnosis wastes valuable resources that could be used for treatment services. The APS submitted that Better Access costs could be 'dramatically cut by reducing the role of the GPs in the assessment process and the requirement for them to write a Mental Health Care Plan', particularly given that as noted above the majority of psychologists will still undertake a full diagnostic assessment. The APS submitted:

> It is still suggested that GPs remain at the centre of patient care, and the 'gatekeepers' to treatment, by establishing that the patient has a mental health problem as part of a regular consultation and then referring the patient to a psychologist for a comprehensive assessment, diagnosis and treatment plan.[77]

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73 *Submission 55*; see also anecdotal evidence noted by Gippsland Advocates for Mental Health Inc about deficiencies in GP Mental Health Care Plans, *Submission 20*, p. 5.

74 *Proof Committee Hansard*, 1 April 2008, p. 66.

75 *Proof Committee Hansard*, 1 April 2008, p. 66.

76 *Proof Committee Hansard*, 16 May 2008, p. 11.

77 Australian Psychological Society, *Submission 55,* p. 11.

6.77 Diagnosis and care plans aside, some basic administrative processes in the Better Access initiative appear not to be working fully. Of concern, psychologists reported that 15 per cent of GPs did not activate the appropriate Medicare item number, with the result that clients could not claim a Medicare rebate. Nearly a quarter did not send a copy of the Mental Health Care Plan with the referral to the psychologist.[78] These occurrences certainly do not accord with the continuity of care and multidisciplinary approach that Better Access was intended to encourage.

6.78 Concerns were also raised about the amount of referral required back and forth through the GP. For example, if a patient is referred to a psychologist by their GP, but then assessed by the psychologist as requiring medication, the psychologist has to refer the patient back to the GP for them to refer onto a psychiatrist. Professor Littlefield, Executive Director of the APS, commented that it would be useful for psychologists to be able to refer directly to psychiatrists rather than back through the GP, noting:

> Any pathway that avoids a third step is not only useful but cost saving. Also, consumers tell you they do not want to tell their story multiple times.[79]

6.79 The committee agrees that provision for psychologists to refer Better Access patients directly to psychiatrists would simplify the care pathway for consumers. However, it is important that the GP be notified of any such referrals, to ensure that all providers involved in the person's care are aware of their current treatment.

6.80 Evidence from Professor Hickie and Professor Christensen suggests that referral pathways under Better Access are breaking down, with patient management and follow up needing to be prioritised:

> …something like 80 per cent of people who see a GP and need help, get a plan with their GP, if their GP is involved in the scheme, and those people are then referred. Sixty-six per cent of those people tend to turn up at the psychologist, say, for the program of CBT, and only 22 per cent actually get back to the GP. That is because nobody is there saying, 'Did they get to the psychologist?' The psychologist gets them and they do a very good job, then they refer them back, but the actual figures, from reading these unpublished reports, is that 22 per cent get back.[80]

6.81 The evidence to the committee suggests that the Better Access initiative itself has 'gaps' which consumers may fall through. Seeing a GP and setting up a Mental Health Care Plan is a first step in a treatment process, but of itself does not guarantee that consumers actually receive the planned treatment and support. Here, as in other areas of mental health care, connections between the different services and providers are paramount.

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78 Australian Psychological Society, *Submission 55,* p. 6.

79 *Proof Committee Hansard*, 1 April 2008, p. 50.

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

**Recommendation 13**

**6.82 The committee recommends that the post-implementation review of the Better Access initiative gives particular attention to the referral pathways in the Better Access initiative, whether consumers are effectively moving between the providers involved and whether any structural changes or additional funding are required to improve care management and coordination.**

### *GP training*

6.83 Some witnesses were concerned by what they saw as a 'watering down' of the training requirements for GPs under Better Access.[81] Prior to Better Access another program, Better Outcomes, provided an avenue through which GPs could refer patients to psychologists under Medicare. Under Better Outcomes, GPs who had completed level one training, a six hour course in managing mental health disorders, could refer patients to allied health professionals with a minimal out-of-pocket expense. GPs who had completed level two training, that is twenty hours of training in psychological treatment, could deliver focussed psychological strategies as claimable items under the MBS. As only one in five GPs had undertaken level one training, many consumers were not able to be referred under Medicare to a psychologist or allied health professional.[82]

6.84 Professor Littlefield, APS, commented on the Better Outcomes training:

> I believe in the Level 1 training that was there for Better Outcomes, which taught diagnosis. That was the three-step process that led to diagnosis and the development of a mental health plan. That was a very good training package. I think that would be very helpful to do.[83]

6.85 However, others noted that the kind of training that was provided under the Better Outcomes initiative did not necessarily actually lead to better outcomes for patients, as there was no evidence to show the training was then applied in practice. Dr Gurr, CASP, commented:

> I have done lots of training of GPs, I have been involved in all this Better Outcomes work and so on, I know that I can run any number of sessions, but they still will not actually apply the stuff because there is no supervision in practice. There is nobody to actually work with them in their practices on dealing with their difficult patients.[84]

6.86 Similarly, Dr Johnson, Royal Australian College of General Practitioners, commented:

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81 *Proof Committee Hansard*, 8 May 2008, p. 15.

82 Senate Select Committee on Mental Health, *A national approach to mental health – from crisis to community*, p. 145.

83 *Proof Committee Hansard*, 1 April 2008, p. 50.

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

> …people outside of general practice often make the assumption that, if we run a training event—be it five hours, six hours or 20 hours—and GPs go to that, that will change behaviour. Yet the evidence is not very strong that it happens that way.[85]

6.87 More broadly, submitters commented on the need for medical practitioners to be able to bridge across medical based treatment and clinical perspectives to the community and psychosocial support needed to assist people with mental illness in their recovery. The Mental Health Coordinating Council commented:

> We support the concept of the GP as the most stable provider for clinical care, but the scheme fails to include a mechanism through which the GP can be upskilled to manage assessment and care plans and monitor consumer symptoms or work closely with the NGO sector to ensure the client's social, employment and other needs are met.[86]

6.88 Mr Senior, Acting President Mental Health Coalition of South Australia, observed that the 'GP model is still very much a medical, clinically driven model'. He saw room for further increasing the capacity of GPs to engage and assist individuals in the recovery journey in all areas of their life.[87]

### *Specific groups*

6.89 The committee received evidence about weaknesses in the Better Access initiative for specific population groups. These issues are canvassed below. In chapter 9 the committee considers shortfalls in mental health services for these groups more generally.

#### *Children*

6.90 The APS raised a specific issue regarding the treatment of referred children. The APS explained that currently it is not possible under Better Access to claim a Medicare rebate for a session with the parent of a child who has been referred for treatment, unless the child is present. The APS submitted that:

> Provision of psychological services to the parents of a child who has been referred is an essential and often the most effective component of the treatment of the child. Unless the 'identified patient' (i.e. the child) is present, services provided to a parent or carer are not allowable under the Better Access initiative.[88]

6.91 The APS suggested that this limitation could be overcome by including appropriate words in the MBS notes to allow for parents and significant others to be

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85 *Proof Committee Hansard*, 1 April 2008, p. 65.

86 *Proof Committee Hansard*, 27 March 2008, p. 43.

87 *Proof Committee Hansard*, 8 May 2008, p. 15.

88 Australian Psychological Society, *Submission 55,* p. 12.

eligible for inclusion under specified items, in relation to the treatment of young children.[89] The APS survey of members showed that 10 per cent of psychologists' Better Access patients were children aged 12 years and under.[90]

*Indigenous*

6.92 The APS also reported outcomes from the first ever meeting of Indigenous psychologists in Australia. The following issues were raised in relation to the Better Access initiative for Indigenous consumers:

- The need for a referral from a GP to access treatment from a psychologist should be removed to allow referral from other professionals, self-referral and referrals from third parties (e.g., relatives).
- Longer time should be allocated to assess an Indigenous person and more valid forms of assessment are required as many assessment tools are culturally inappropriate.
- Indigenous clients need longer appointment times and will usually need more than 12 sessions.
- All Indigenous clients should be bulk billed and the bulk billing rebate for Indigenous clients should be increased.
- All psychologists should have Indigenous cultural competence as part of a requirement of registration, as is the case in New Zealand and the USA. Cultural competence should therefore be included in university training programs and ongoing professional development.[91]

*Culturally and linguistically diverse communities*

6.93 Multicultural Mental Health Australia (MMHA) submitted that there are limits as to how much the Better Access initiative can improve access to mental healthcare for people from culturally and linguistically diverse (CALD) backgrounds. Professor Malak, Executive Director, explained that for some consumers there are no accredited professionals who speak their language. The available professionals are also already busy and there are disincentives to taking on more CALD clients:

> …health professionals with different languages are somewhat overbusy. They do a lot of work and they are not really interested in doing more. If they have the energy, the psychologists offer help. In addition, if you are overworked you can get what you call an easy client. For people with different cultures, the only clients you get to see usually are the difficult ones. If you can do the easy ones as quickly as you can and get the same payment and you can do more clients in the day, you do that.[92]

89 Australian Psychological Society, *Submission 55,* p. 12.

90 Australian Psychological Society, *Submission 55,* p. 4.

91 Australian Psychological Society, *Submission 55,* p. 16.

92 *Proof Committee Hansard*, 27 March 2008, p. 29.

6.94 MMHA submitted that a range of mechanisms are needed to develop cultural competency and increase the number of bilingual and bicultural mental health staff.[93] They also submitted that direct funding to specialist services is required. Multicultural Mental Health Australia would like to be able to use its own clinicians to access Medicare funds, given the limited number of transculturally trained providers in private practice.[94]

## Provider eligibility

6.95 There was discussion in the evidence to the committee about the eligibility of different providers to claim the Better Access Medicare items. Particular issues included the requirement for providers to be set up as private practitioners, and the inclusion of only certain allied health professionals. These issues are discussed below.

### *NGO providers*

6.96 Currently the Better Access initiative is structured around a private practice, fee-for-service model. Several organisations suggested that access to psychologists and other allied health professionals could be improved, particularly for those outside the current medical system, by simplifying access to Medicare rebates for NGOs who employ allied health professionals directly. Mr Calleja from Richmond Fellowship WA commented that there is currently no mechanism through which non-government agencies can access the Medicare rebate funding, other than having their social workers and psychologists obtain individual Medicare provider numbers.

6.97 Ms Carmody, Ruah Community Services, felt that a strength of the NGO sector is reaching people that do not easily access mainstream services. Being able to access Medicare rebated services directly through NGOs would assist people who are currently not getting mental health care. Mr Calleja noted a further advantage of providing allied health services through NGOs:

> …the individual counselling work that is done can then be supplemented by the referral to employment, by support with education, by links with carers and family members and so on.[95]

6.98 Mr Calleja and Ms Carmody did not see a role for NGOs in replicating mainstream primary health care, but saw opportunities for NGOs to help expand the reach of Medicare funding. They provided examples of how their respective organisations could utilise Medicare funding. Mr Calleja outlined:

> If one of my staff members were an accredited Medicare person and they did three hours a week of counselling, we would simply be charging their salary against a different line.

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93 See for example *Submission 14*, p. 4, *Submission 13*, pp. 9–11.

94 *Proof Committee Hansard*, 27 March 2008, p. 29.

95 *Proof Committee Hansard*, 7 May 2008, p. 50.

6.99 Ms Carmody commented:

> We have 60 staff in mental health. I would make only one of our registered psychologists available for this function, and she or he would be available to provide counselling to clients who would not normally go to a GP or link in there easily because of special circumstances of anxiety.[96]

6.100 Catholic Social Services Australia reported that some of its agencies have 'managed access to the MBS items as part of their overall service delivery design'. While these agencies have had to overcome 'administrative and organisational hurdles' to make use of the new MBS items, they have been more successful in filling service gaps than those trying to use Better Access through external providers.[97] Mr Quinlan described the administrative arrangement necessary to enable NGOs to access the Medicare rebates:

> In order to make use of this scheme, the agency is required to set itself up in such a way that it can access those items as a Medicare provider and then often has to contract its own workers separately, in a sense as if they were in private practice, in order for them to have access to those funds. So what we are seeing is almost two agencies set up within one. The agencies that have managed to do that have reported some success in terms of that being a model that has actually allowed them to provide greater services to their clients, but it is quite an administrative twist to set up in that way.[98]

6.101 WAAMH was looking at whether arrangements could be made to link a Medicare provider number with the non-government organisation that employs mental health providers, rather than with the specific practitioner.[99] Mr Calleja saw the need for briefing and guidance to NGOs on how to go about using the Medicare structure to provide services through their agencies.[100]

6.102 Ms Morris, First Assistant Secretary DoHA explained that currently the Health Insurance Act details the rules around how a provider needs to be set up and the conditions that need to be met in order for a patient to be able to claim the Medicare rebate. She noted that DoHA understood the issues with respect to NGO providers and would consider these issues as part of the post-implementation review of the Better Access initiative.[101]

6.103 The committee sees merit in establishing mechanisms by which NGOs that employ psychologists and allied health professionals directly are able to access relevant MBS mental health care items. These organisations are a key pathway

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96 *Proof Committee Hansard*, 7 May 2008, p. 50.

97 *Proof Committee Hansard*, 16 May 2008, p. 65.

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

99 *Proof Committee Hansard*, 7 May 2008, p. 13.

100 *Proof Committee Hansard*, 7 May 2008, p. 47.

101 *Proof Committee Hansard*, 16 May 2008, p. 83.

through which people who have been largely out of contact with the medical system can obtain clinical care.

**Recommendation 14**

**6.104 The committee recommends that as part of the post-implementation review of Better Access a working group be established to simplify arrangements by which NGO employed psychologists and other eligible allied health professionals can use Better Access Medicare items.**

**6.105 The committee further recommends that the Australian Government fund a series of information workshops for relevant NGOs, explaining the outcomes of the working group and the available mechanisms for NGOs to make use of the Better Access Medicare items.**

***Should counsellors be included among the eligible allied health professionals?***

6.106 The Better Access initiative established arrangements by which GPs, clinical psychologists, general psychologists, social workers and occupational therapists can deliver specific treatments as claimable items under the MBS. New items were also introduced for certain consultations with psychiatrists. The Mental Health Coordinating Council argued that by restricting access to these specified professionals and allied health professionals, Better Access has left further sources of mental health care underutilised.[102] The Australian Counselling Association (ACA) and the Psychotherapy and Counselling Federation of Australia (PACFA), the two peak bodies for counsellors and counselling organisations in Australia both argued that the Better Access Initiative should be extended to include counsellors. Professor Schofield, Director of Research PACFA, noted that counsellors have been integrated into primary health care in other western countries such as the UK and USA.[103]

6.107 Professor Schofield outlined a number of characteristics which set counsellors and psychotherapists apart from other providers such as psychologists and social workers. These included:

- a more consumer and client oriented model for working with people facing mental health crises, which aligns with recovery principles such as being person rather than problem centred and developing empowerment, hope, social skills and relationship skills;
- understanding problems as being largely interpersonal in nature, which can then create physical and mental symptoms;
- the importance of the client-therapist relationship as the key to resolving problems and effecting client change; and

102 *Proof Committee Hansard*, 27 March 2008, p. 43.

103 *Proof Committee Hansard,* 1 April 2008, p. 55.

- the capacity to work with client diversity and tailor responses to the specifics of particular clients and their circumstances.[104]

6.108 Mr Armstrong, Chief Executive Officer ACA presented the view that counselling services contribute strongly to prevention and early intervention, therefore extension of the MBS rebates to counsellors may be cost effective by helping to reduce the incidence of severe mental illness.[105] However, Mr Armstrong acknowledged that the existing research base presents mixed findings about the efficacy of counselling as a preventative measure.[106]

6.109 Mr Armstrong also observed that there are more counsellors available in rural and remote areas than psychologists and psychiatrists. He explained that 51 per cent of ACA members are outside general city areas. As such, the Australian Counselling Association argued that extending Medicare rebates to counsellors would help to fill current service gaps in these areas.

6.110 The Mental Health Council of Tasmania agreed that extending the initiative to counsellors was a way to address service shortages.[107] The Northern Territory Mental Health Council noted that, because of the lack of psychiatrists and psychologists in remote areas, people have to be taken out of their communities to access services, which is a traumatic experience.[108] They supported efforts to get more health professionals into remote communities, including counsellors.

*Impact on counsellors*

6.111 Mr Armstrong described the impact that exclusion from Better Access was having on counsellors due to a decline in referrals. In a survey of its members, the ACA found that of 330 respondents, 313 had experienced a decline in referrals since the introduction of Better Access, 255 had been told directly by their clients and GPs that they would no longer be used because of their inability to access Medicare rebates and 145 indicated that they would not be able to continue their practice for more than six months.[109] Similarly Professor Schofield commented:

> There has been a substantial negative impact on counsellors and psychotherapists who do not qualify for the Better Access initiative. We have had a consistent flood of distressed professionals who have found that their referrals have disappeared very rapidly following its introduction. We have had many stories of professionals who were in secure productive

104 *Proof Committee Hansard,* 1 April 2008, p. 56.

105 *Proof Committee Hansard,* 26 March 2008, pp. 40-41.

106 *Proof Committee Hansard,* 26 March 2008, p. 47.

107 *Proof Committee Hansard,* 31 March 2008, p. 5.

108 Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, p. 3.

109 *Proof Committee Hansard,* 26 March 2008, p. 41.

> relationships with seriously ill clients who were then referred to psychologists because that was cheaper for them.[110]

6.112 Professor Schofield also explained that employment outside private practice has become more difficult for counsellors:

> …many of the non-government organisations are moving to a different model, and even public sector mental health services are bringing in private Medicare funded services and favouring the employment of psychologists, social workers and so on because they can bring more money into the system.[111]

*Standards of service*

6.113 The Mental Health Council of Australia considered that any assessment about extending the Better Access initiative to counsellors should be based on the outcomes for consumers.[112] Improving access to mental health services is important, but so too is ensuring the standard of these services. One of the concerns about extending Medicare coverage to counsellors is the great variability in types of services that counsellors provide. Dr Freidin, Royal Australian New Zealand College of Psychiatrists said:

> Our concern is and has always been, preceding recent changes, that the word 'counsellor' can be used by anybody to do anything. There is no regulatory body and no standard of education, training, quality review or reporting. There is no oversight body like a medical board, so, although some counsellors have had various forms of training, anyone can use the word. We believe that in mental health, the same as in general health, patients in Australia should have access to fully trained, high-quality clinicians, who can be of many different sorts but have to be part of professional bodies. There has to be a degree of rigour in their education and training.[113]

6.114 Dr Freidin went on to say that the professional associations that the RANZCP work with 'generally have training programs of four to six years through universities and similar, followed by ongoing processes of supervision and training and accreditation by government recognised national bodies'.[114]

6.115 Similarly, the Australian Psychological Society said:

> The current push for counsellors to be included in the Better Access scheme is of grave concern. Counsellors are often minimally trained with few skills in the assessment and treatment of mental health disorders, are not required

110 *Proof Committee Hansard,* 1 April 2008, p. 55.

111 *Proof Committee Hansard,* 1 April 2008, p. 55.

112 *Proof Committee Hansard,* 20 May 2008, p. 88.

113 *Proof Committee Hansard,* 1 April 2008, p. 38.

114 *Proof Committee Hansard,* 1 April 2008, p. 38.

> to be registered to practice with a statutory authority, are not subject to disciplinary codes, and frequently do not engage in evidence-based treatment practices.[115]

6.116 Professor Schofield outlined that around 59 per cent of PACFA members have postgraduate qualifications in counselling and psychotherapy, with the majority of the rest having undergraduate qualifications.[116] She said:

> What we are arguing is that there is a large group of people out there who have often done significantly more training specifically in counselling and psychotherapy. Some of our practitioners have up to 13 years of training in psychotherapy. Many psychotherapies demand a very high level of training and ongoing professional development and supervision.[117]

6.117 The membership requirements for PACFA and the ACA are quite different. PACFA registration requires a minimum qualification of two years at postgraduate level or three years undergraduate training, plus 750 hours of supervised client contact and 75 hours of actual supervision.[118] PACFA indicated that currently 25 Australian universities offer mainly postgraduate and some undergraduate courses in counselling and psychotherapy, with a further 24 government accredited private training providers offering graduate and postgraduate courses.[119] In contrast, a diploma of counselling is currently the minimum requirement for membership of the Australian Counselling Association. Mr Armstrong acknowledged the breadth that currently exists in the types of training available for counsellors and explained that the Association has been working with the Industry Skills Council to develop a generic diploma of counselling. This is intended to provide a consistent minimum standard. This diploma would involve 800 to 1200 hours of training, which at best could be completed within a year.[120]

6.118 Professor Schofield noted that not all members of PACFA would currently meet the criterion to work as mental health professionals:

> Counsellors and psychotherapists would probably meet 90 per cent of the mental health training standards, but not all will have worked under supervision and so on. Not all will have the full diagnostic understanding of psychopathology.[121]

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115 Australian Psychological Society, *Submission 55,* p. 11.

116 *Proof Committee Hansard,* 1 April 2008, p. 55.

117 *Proof Committee Hansard,* 1 April 2008, p. 58.

118 *Proof Committee Hansard,* 1 April 2008, p. 58.

119 The Psychotherapy and Counselling Federation of Australia, *Submission 43, Additional Information*.

120 *Proof Committee Hansard,* 26 March 2008, p. 416.

121 *Proof Committee Hansard*, 1 April 2008, p. 60.

6.119 As such, PACFA is looking to provide pathways for those who want to complete their training to professional registration standards.

6.120 Counselling is currently not regulated by government. PACFA was established partly in response to the need for clear standards, monitoring and accountability and has been working over the past decade to improve self regulation. Professor Schofield indicated that the profession would welcome an externally regulated environment, however external regulation had not progressed:

> We would be very happy to be regulated by government if government wanted to do that, but they have said that they prefer the self-regulation route at this point. It is not that we are making that choice, in a sense. It is currently the only option that we are being given.[122]

6.121 Organisations which supported the extension of the Better Access initiative to counsellors were cognisant of the importance of ensuring service standards.[123] The Northern Territory Mental Health Council noted that, 'there would have to be a benchmark set as to what sort of training they have'.[124] The Mental Health Council of Tasmania saw the possibility for a national approach:

> …it may be about setting some national standards on what level of qualification or skills a person has to provide counselling.[125]

6.122 Professor Whiteford, Principal Medical Advisor DoHA, explained that while overall professional standards are critical, it is also important to understand that the Medicare rebates available through Better Access are not for general counselling services but for specific psychological therapies. He said:

> I think that the main thing to ensure, now that more people appear to be accessing mental health care, is the quality of care that is delivered. I think it is a misnomer to say that counselling is now on the MBS. What is on the MBS with this measure is evidence based psychological interventions, which are limited in number, for short-term, focused, evidence based therapies—cognitive behaviour therapy, psychoeducation, interpersonal therapy et cetera—and not general counselling. So we would want clinicians who are able to deliver evidence based interventions which we know work to treat common mental disorders. Even within the clinicians

122 *Proof Committee Hansard*, 1 April 2008, p. 58.

123 See for example Mental Health Coordinating Council, *Proof Committee Hansard*, 27 March 2008, p. 45.

124 Northern Territory Mental Health Coalition, *Proof Committee Hansard*, 1 May 2008, pp. 3 and 8.

125 *Proof Committee Hansard,* 31 March 2008, p. 5.

> who are in the current group, we need to ensure that those evidence based therapies are being applied.[126]

6.123 It is clear that many counsellors and psychotherapists have extensive training and supervision and are a well qualified source of mental health care that is being underutilised in the current system. However, it is also clear that the label 'counsellor' currently covers a broad range of providers, with little consistency in the minimum standard of qualifications and experience. Providing access to quality, evidence-based care is an important principle for government funded health services. Therefore, until counsellors and psychotherapists are consistently, and preferably externally, regulated the committee does not support the extension of the Better Access initiative to these groups.

## Evaluating the initiative

6.124 Numerous witnesses commented on the lack of publicly available data on the use of the Better Access initiative.[127] This means it is difficult to look at important aspects of the initiative such as uptake across different areas, the numbers of consultations that are used by patients and how many patients stay engaged with the process of referral between GPs and allied health professionals.

6.125 Further to this basic information, the absence of outcome measures was a primary concern in the evidence to the committee. Is the treatment provided assisting people in their recovery? Is the initiative making a difference to the lives of people with mental illness? Can changes be made to achieve better outcomes from the funding available?

6.126 Ms Henderson, Mental Health Coordinating Council, commented:

> A mechanism has not been established to obtain information from GPs as to whether mental health plans and initiatives are having an impact on mental health or providing effective early intervention. We feel that such outcomes need to be evaluated under the scheme. So, in view of the degree to which the MBS has been taken up, it would seem prudent to be able to measure its effectiveness.[128]

6.127 Mr Muller, President of the Queensland Alliance Mental Illness and Psychiatric Disability Groups commented:

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126 *Proof Committee Hansard*, 16 May 2008, pp. 82–83. Other submitters also raised the issue of ensuring standards among clinicians who are currently included in the Better Access scheme, particularly clinical psychologists. See Professor MacMillan, *Submission 59* and APS College of Clinical Psychologists Victorian Section, *Submission 60*. Also, the Australian College of Clinical Psychologists was concerned that APS eligibility criteria had excluded other experienced clinical psychologists from the Better Access initiative. See *Submission 40*.

127 See for example, Dr Gurr, *Proof Committee Hansard*, 27 March 2008, p. 73.

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

> It pushed sideways a program called the Better Outcomes in Mental Health Care Initiative, which was a very measurable program. People were measured on entry and exit from the project and it was particularly styled for a certain category of people. In this one the categories are broader, but there does not seem to be any measurable outcomes. In mental health we do have outcome tools that could have been utilised. That has not happened.[129]

6.128 Dr Freidin, Royal Australian and New Zealand College of Psychiatry commented:

> The exact clinical outcomes…as with other Medicare changes that have affected psychiatrists, are very difficult to quantify, because there has not been a rigorous system of review and study of clinical outcomes…Anecdotally, we know from our fellows that it has been very helpful to be able to refer people to psychologists for specific cognitive behavioural therapy—and we also hear that from the general practitioners—so our overall impression is that this has been a useful initiative, but we would very much like to see properly-funded clinical research to study the outcomes of these new initiatives.[130]

6.129 Dr Johnson, Royal Australian College of General Practitioners, noted that there 'is really extremely limited information on the impact of the work that GPs are doing for patients with regard to mental health concerns'. She asked some pertinent questions: 'Are we targeting the people most in need of the services and do the current systems allow GPs to be effective gatekeepers? Is the initiative really encouraging GPs to take a larger interest in mental health care?'[131]

6.130 While the Department of Health and Ageing intends to undertake a post-implementation review of the initiative, Mr Crosbie, Chief Executive Officer, Mental Health Council of Australia was concerned that what was originally going to be an in-depth review has been 'scaled back':

> We were incredibly disappointed that there is to be no in-depth review of the impact of the MBS items. We had previously been led to believe that, at the end of 12 months, there would be an in-depth review and we would start looking at what was happening to people who were using these items—real consumers, their families and their providers.[132]

6.131 On the basis of correspondence with the department, Mr Crosbie concluded that the Better Access post-implementation review was focussed only on short-term affordable changes to the Medicare items. He said:

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

130 *Proof Committee Hansard,* 1 April 2008, p. 37.

131 *Proof Committee Hansard,* 1 April 2008, p. 64.

132 *Proof Committee Hansard*, 20 May 2008, pp. 82 and 86.

> From my perspective, the kind of review that we are now doing in the MBS items is, at best, a review of what the professional groups think about the program that they are running rather than us actually asking consumers and, in some cases, carers, 'How has this worked or not worked for you?'

6.132 The committee is pleased that a post-implementation review will be conducted to assess the Better Access initiative so far. However it is also concerned about the scope of the review. An initiative which has been assessed as arguable the 'most important and practical reform in Australian mental health care in the past 15 years' with a budget in excess of $770 million should be soundly evaluated.[133] Evidence to this inquiry points to some particular areas for consideration, including:

- low uptake of referrals to social workers and occupational therapists;
- low uptake of group therapy items and out-of-room consultations;
- whether the initiative is filling gaps by providing services to those who were previously missing out on mental health care;
- different access across the states and territories and metropolitan, rural and remote areas;
- barriers to access including patient out-of-pocket expenses and how these are changing over time;
- the impact of the initiative on other service sectors;
- the kinds of illnesses for which people are receiving treatment under Better Access;
- whether the initiative can be better utilised to provide services to those with the most severe illnesses;
- whether the initiative can be better utilised to provide services to specific population groups;
- how well care is being coordinated among the different providers involved in the initiative and whether there is scope to improve collaboration; and most importantly,
- whether the initiative is improving mental health outcomes and advancing the recovery process for those that access eligible services.

**Recommendation 15**

**6.133 The committee recommends that the post-implementation review of the Better Access initiative consider the concerns and issues about the initiative listed in this report (paragraph 6.132). In particular, the committee considers that assessment of the outcomes for consumers using the initiative is paramount. The committee further recommends that the findings of the post-implementation review be made publicly available.**

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133 Ian B Hickie and Patrick D McGorry, 'Increased access to evidence-based primary mental health care: will the implementation match the rhetoric?', *Medical Journal of Australia*, Vol 187 No 2, 16 July 2007, p. 101.

# CHAPTER 7

# MENTAL HEALTH NURSES

7.1 New funding for mental health nurses was another of the COAG Plan major initiatives designed to improve access to clinical care. Funding of $191.6 million was allocated for mental health nurses to work in a range of clinical teams, including with private psychiatrists and in general practices. The aim was for mental health nurses to assist in coordinating care, managing medication and making links to other health professionals.[1]

7.2 The Australian College of Mental Health Nurses outlined the credentials that mental health nurses must have in order to be eligible for the program:

> …the college has an established credentialing program, renewable every three years, which requires the mental health nurse to provide evidence of postgraduate qualifications in mental health, recency of practice and evidence of contemporary professional development in order to receive the credential. This credential is also a requirement for mental health nurses wishing to participate in the Commonwealth government's Mental Health Nurse Incentive Program.[2]

7.3 Two and a half years into the COAG Plan, the budget for the mental health nurses initiative has been reduced. The committee received evidence about the benefits of the program and factors contributing to the budget cut.

## Support for the initiative

7.4 The Australian College of Mental Health Nurses outlined that the aim of the Mental Health Nurses Incentive Program was 'really to get mental health nurses supporting GPs and psychiatrists in the primary healthcare sector particularly with that cohort of clients with severe and enduring illness'. The College observed that resources have tended in the past to be devoted to the hospital sector, due to the long waiting times for treatment, lack of capacity in in-patient services and the difficulty and complexity of the situations of acutely unwell people that present at emergency departments. There has been little attention to addressing the causes of repeat admission. The Mental Health Nurses Initiative was an attempt to redress, at least partly, this imbalance. Mr Santangelo, College President, explained:

> …the provision of mental health support to the primary healthcare sector and ongoing maintenance of care is going to be absolutely crucial in making sure that people stay well.[3]

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1 COAG Plan, p. 10.

2 *Committee Hansard*, 20 May 2008, p. 47.

3 *Proof Committee Hansard*, 20 May 2008, p. 50.

7.5 In Professor Hickie's view, the mental health nurses initiative was one of the more innovative initiatives coming out of the COAG Plan as it was aimed at a clinic level, rather than reimbursing individual providers.[4]

7.6 The Australian General Practice Network (AGPN) was also positive, commenting that the initiative aimed to facilitate 'whole of person' care. Dr McAuliffe, AGPN Mental Health Advisor, outlined some of the service linkages that the mental health nurses initiative had helped to facilitate in her area:

> In our local division, the division has been very active in working with a broad range of providers—including NGOs, disadvantaged schools, those serving Indigenous people—to look at how we can cobble together the links that enable us to best meet the needs of the community in a way that relates to the needs of our community. You need that level of local flexibility and support.[5]

7.7 The committee notes the support for the mental health nurses initiative and commends the effort to use the valuable skills of mental health nurses in primary care settings. The committee also notes that the introduction of this initiative was an acknowledgement of the need to devote resources to coordinating mental health care at a practical level.

## Budget cut

7.8 Funding for the initiative was markedly reduced in the 2008–09 Federal Budget, such that it will now have $49.5 million over four years to 2011–12.[6] Professor Calder, First Assistant Secretary DoHA, explained that the initiative had a very slow uptake due to issues of workforce availability.[7] In the same budget, $35 million was allocated to a Mental Health Nurses Training Subsidy, to help increase the number of mental health nurses available.

7.9 Dr Gurr, Comprehensive Area Service Psychiatrists Network NSW, suggested that the initiative had been destined for underspend, as it was set up in a way that did not fit with private sector organisations' priorities. He commented:

> The GPs themselves found it too difficult to organise the infrastructure to arrange for the nurses. The GP divisions in my area did not see any value to them in trying to organise it; it was just another hassle.[8]

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

5 *Proof Committee Hansard*, 16 May 2008, p. 4.

6 *Proof Committee Hansard*, 16 May 2008, p. 97; see also Community Affairs Committee, Budget Estimates, *Committee Hansard*, 5 June 2008, pp. 152 and 154.

7 *Proof Committee Hansard*, 16 May 2008, p. 97.

8 *Proof Committee Hansard*, 27 March 2008, pp. 62 and 76.

7.10 In contrast, the AGPN commended the initiative and had found that it worked well within the division structure:

> …there is certainly a cohort of divisions who have accessed funding to employ a nurse through that measure. That works very well, particularly when it is not viable for a single practice to employ a nurse, with a division employing the nurse and the nurse working sessionally across a number of practices. So we have been very active in supporting it and promoting it, and it has been welcomed by GPs.[9]

7.11 The AGPN considered that it was because of the shortage of mental health nurses that the initiative had not been taken up as much as expected. Dr McAuliffe commented on closer links being forged between private practice and the public sector to make the most of the limited number of mental health nurses:

> One of the things that is happening in a number of divisions is collaboration with the state funded mental health service, looking at how we can work with them to perhaps link what the mental health nurse initiative might do with the services they are trying to provide the community. That has been well received.[10]

7.12 Other witnesses, in raising concerns about the initiative, also pointed to the need for greater public-private collaboration.

### *Concerns about the operation of the initiative*

7.13 Several witnesses considered that specific constraints in the design of the program had limited its uptake. For example, AMSANT explained that there were no options for partial uptake:

> At the moment there is no way you would get pro rate funding. You might employ a full-time mental health nurse and take the risk on Medicare being able to generate the $150,000, which is the amount of money you can get. If you do not get 20 patients a week on average—say you see 10 patients a week on average—you get no money. You have got to meet the full requirement to get the full amount of money.[11]

7.14 AMSANT gave an example of a large Aboriginal health service which had considered taking on a well-qualified mental nurse who was available and interested, but found the financial risk too high. AMSANT noted that a pro rata option would lower the risks associated with taking up the mental health nurse initiative and also allow time for the new service to be fully developed and used. Representatives commented that it might take 12 months or more to get up to a regular schedule of 20 patients a week.[12] The Australian College of Mental Health Nurses also indicated that

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9 *Proof Committee Hansard*, 16 May 2008, pp. 2–4.

10 *Proof Committee Hansard,* 16 May 2008, p. 3.

11 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 30.

12 AMSANT, *Proof Committee Hansard*, 1 May 2008, p. 31.

it was a challenge to sustain a practice at the levels required to maintain income through the initiative.

7.15 Mr Thorn, from the Government of Western Australia expressed the state government's concerns that the mental health nurses initiative might result in nurses leaving the government sector to work with GPs or NGOs. He also noted that the state government wanted to ensure that through the initiative mental health nurses would be able to tap into the 'vast experience of the state system' and not be left working in isolation.[13] Mr Thorn considered that discussions with the Commonwealth around this issue had been positive.[14]

7.16 Professor Calder explained that the initiative has been revised to allow 'a flexible funding arrangement whereby we will now accept that the program can pay for public sector nurses to be available to work in the private sector'. She noted that to a large extent and particularly in rural and remote areas, public sector nurses are the only mental health nurses available.[15]

7.17 The Northern Territory Government welcomed changes to the Mental Health Nurse Incentive Program which facilitate shared arrangements between public sector services, private practices and Aboriginal community controlled health services.[16] At the time of the committee's hearing only two organisations in the Northern Territory had sought to employ a mental health nurse under the initiative. The NT Government considered that the small size of organisations in the Territory and lack of available workforce contributed to the low uptake of the initiative.[17] It considered that further improvements to the initiative would include the use of pro rata payments, reviewing the credentialing requirements needed for qualified nurses to be eligible for the program and allowing a broader range of organisations, such as NT Government run primary health care services in rural and remote areas to participate in the initiative.[18]

7.18 The Northern Territory Government also provided the perspective that general nurses are a resource that has been overlooked in the COAG Plan initiatives. The NT Government considered that while specialist services are needed, the prevalence of mental illness is so high that sustainable services can only be achieved by making mental health a core health service. They advocated increasing the mental health skills of the whole primary health sector.[19]

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

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

15 *Proof Committee Hansard,* 16 May 2008, p. 97.

16 *Proof Committee Hansard*, 1 May 2008, p. 50.

17 *Proof Committee Hansard*, 1 May 2008, p. 50.

18 *Proof Committee Hansard*, 1 May 2008, p. 54.

19 *Proof Committee Hansard*, 1 May 2008, p. 59.

7.19 The mental health nurses initiative shows the limitations to good initiatives when there is insufficient workforce to implement them. In the context of the budget cuts to this initiative the committee emphasises that the need which originally underpinned the initiative, that is better coordination of clinical treatment and other care for people with severe mental illness, remains real and must be addressed.

7.20 The committee is pleased to note that some modifications have been introduced to enable greater use of mental health nurses across the private and public sectors. It suggests that consideration be given to introducing further flexibility into the initiative, for example pro-rata funding to clinics where full service targets cannot be met.

# 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

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.

# 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

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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

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

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

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 videconferencing, 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

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

# APPENDIX 1

## LIST OF PUBLIC SUBMISSIONS, TABLED DOCUMENTS AND ADDITIONAL INFORMATION AUTHORISED FOR PUBLICATION BY THE COMMITTEE

1 SANE Australia (VIC)

*Supplementary information*

Provided at hearing 1.4.08

- Research Bulletin 6 *Physical health care and mental illness*, February 2007*;*
- *Smoking and mental illness: Costs,* a report by Access Economics for SANE Australia, Executive summary and recommendations, December 2007

Provided following hearing

- Additional information concerning smoking and mental illness and physical health and mental illness received 8.4.08
- Supplementary submission dated 3.6.08
- A letter supporting the submission of the Coalition of Australian Mental Health national Consumer and Carer Advocacy Peak Bodies, dated 3.6.08

2 ARAFMI Hunter

3 Siblings Australia Inc (SA)

4 Network for Carers of people with a mental illness (VIC)

*Supplementary information*

- Response to questions raised at hearing 1.4.08, received 22.5.08

5 MHS Consumer and Carer Council Members (VIC)

6 Peer Support Foundation Limited (NSW)

7 NSW Mental Health Review Tribunal (NSW)

*Supplementary information*

Provided at hearing 27.3.08

- Mental Health Review Tribunal, *2006 Annual Report*; and
- NSW Health, Consultation Paper, Review of the forensic provisions of the *Mental Health Act 1990* and the *Mental Health (Criminal Procedure) Act 1990*

Provided following hearing dated 11.4.08

- Excerpts from a paper by Fleur Beaupart
- NSW Health Department Privacy Manual (Version 2) 2005
- MHRT submission to the NSW Law Reform Commission: Review of Privacy Legislation
- Copy of article 'First steps in new approach to mental health law' M. Bisogni, Law Society Journal, April 2008

8 Australian Association of Social Workers (ACT)

9 Royal Australasian College of Physicians (NSW)

10 National Research Centre for the Prevention of Child Abuse (VIC)

11 Carers Australia (ACT)

*Supplementary information*

Provided at hearing 20.5.08

- Report by Cummins, R., Hughes, J. and Tomyn, A., 2007, *The Wellbeing of Australians – Carer Health and Wellbeing*
- Summary of the above report

12 Australian Mental Health Consumer Network (QLD)

13 Transcultural Mental Health Centre (NSW)

*Supplementary information*

Provided following hearing 27.3.08, received 4.4.08

- Clinical Group Supervision Program Report
- Psychology Intern Program Report

14 Multicultural Mental Health Australia (MMHA) (NSW)

15 NSW Consumer Advisory Group – Mental Health Inc (NSW)

*Supplementary information*

- Response to questions raised at hearing 27.3.08, dated 4.6.08

16 McPhedran, Dr Samara (NSW)

17 Police Federation of Australia (ACT)

18 Public Health Association of Australia (ACT)

19 Royal Women's Hospital (VIC)

*Supplementary information*

- Additional information about the Centre for Women's Mental Health provided following hearing 1.4.08, dated 29.4.08

20 Gippsland Advocates for Mental Health Inc (VIC)

21 Royal Australian and New Zealand College of Psychiatrists (VIC)

*Supplementary information*

Following hearing 31.3.08, received 15.4.08

- Briefing paper on Homelessness and Mental Health 26 February 2008
- Briefing paper on Mental health interventions for the Northern Territory 28 February 2008
- Submission to Commonwealth Audit of the health worforce shortage in rural and regional Australia
- A letter supporting the submission of the Coalition of Australian Mental Health national Consumer and Carer Advocacy Peak Bodies, dated 13.6.08

22 Mental Health Council of Australia (ACT)

*Supplementary information*

- Mentally Healthy WA Campaign 24 Month Report, April 2005 – April 2007
- Copy of article 'The impact on mental health in others of those in a position of authority: a perspective of parents, teachers, trainers and supervisors' R. Donovan, N. Henley, G. Jalleh, S. Silburn, S. Zubrick and A. Williams, received 13.8.07

23 Mental Health Coordinating Council (MHCC) & Council of Social Services of NSW (NCOSS) (NSW)

*Supplementary submission*

Provided at hearing 27.3.08

- Copy of statement made regarding improved access through the Medical Benefits Schedule (MBS);
- *View from the Peak*, A quarterly publication from the Mental Health Co-ordinating Council, Summer 2008; and
- *Social Inclusion, Its importance to mental health*, Mental Health Coordinating Council, June 2007

Provided following hearing

- Supplementary submission received 7.5.08
- A letter supporting the submission of the Coalition of Australian Mental Health national Consumer and Carer Advocacy Peak Bodies, dated 16.7.08
- *Reframing Responses:* Improving Services Provision to Women Survivors of Child Sexual Abuse who experience Mental Health Problems, Mental Health Coordinating Council, August 2006
- Supplementary submission received 28.8.08
- *Working Together for NSW: Good funding Policy and Practice,* NCOSS 2006

24 Students' Representative Council – University of Sydney (NSW)

25 Catholic Social Services Australia (ACT)

26 Australian Counselling Association (QLD)

*Supplementary information*

- ACA Medicare Rebate Survey Executive Summary following hearing 27.3.08, received 1.4.08

27 National Mental Health Consumer and Carer Forum (ACT)

28 Department of Families, Community Services and Indigenous Affairs (ACT)

29 Northern Territory Government (NT)

30 Victorian Mental Illness Awareness Council (VIC)

31 Women's Centre for Health Matters (ACT)

32 Service for the Treatment & Rehabilitation of Torture and Trauma Survivors (STARTTS) (NSW)

33 Women's Healthworks (WA)

*Supplementary information*

- Additional information following hearing 7.5.08, dated 10.6.08

34 South Australian Government (SA)

*Supplementary information*

- Copy of presentation at hearing 8.5.08

35 Western Australian Government (WA)

*Supplementary information*

- Briefing note outlining the *National Action Plan on Mental Health 2006-2011* key achievements in WA, dated 9.6.08

36 Asten, Mr David (TAS)

*Supplementary information*

- Article by Graham Thornicroft and Michele Tansella, 'Components of a modern mental health service: a pragmatic balance of community and hospital care', *British Journal of Psychiatry*, 2004, No. 185, pp 283–290 provided at hearing 31.3.08

37 ACT Government (ACT)

*Supplementay information*

- Brochure *Consumer Participation and Carer Participation across Mental Health ACT: A Framework for Action* provided at hearing 16.5.08

38 Department of Employment and Workplace Relations (ACT)

*Supplementary information*

- Responses to questions on notice araising from hearing 16.5.08, received 19.9.08

39 Community Mental Health Peaks

*Supplementary information*

- Responses to survey conducted by Community Mental Health Peaks, received 26.7.07
- Mental Health Council of Tasmania: additional information provided following hearing 31.3.08, received 21.4.08

  *Provided at hearing 1.5.08*

  Northern Territory Mental Health Coalition

  - opening summary provided at hearing 1.5.08

  *Provided at hearing 7.5.08*

  Western Australian Association for Mental Health

  - August 2007 submission update
  - Welfare to Work, submission to Minister for Employment Participation, dated 13 February 2008
  - Survey results – Sector comparisons
  - Annual report 2007

  *Provided at hearing 16.5.08*

  Mental Health Community Coalition ACT

- Briefing paper by Communiaty Mental Health Australia National Leadership Committee, 'Working together for mental health in the community a national industry alliance'

*Provided following hearing, received 19.5.08*

- Copy of presentation at hearing
- Social Policy Reseach Centre: Housing and Accommocation Support Initiative Evaluation Report III Summary, Report 1/07
- Gavin Andrews, Nick Titov and Rick Hudson, 'Tolkien II: A Summary', May 2006
- Copy of Financial Case Studies
- Leanne Craze, Glenn Jarvis and Barry Petrovski, 'On the Scrounge: Welfare to Work and People with a Mental Illness, October 2006
- National Survey of Mental Health and Wellbeing Bulletin 2, *Costs of psychosis in urban Australia*, June 2002
- National Survey of Mental Health and Wellbeing Bulletin 3, *Employment and psychosis,* October 2002
- Associate Professor Chris Chamberlain and David MacKenzie, *Counting the Homeless 200:1 New South Wales*, January 2004
- Additional information concerning the Personal Helpers and Mentors Program, received 20.5.08

- A letter from Mental Health Council from Tasmania supporting the submission of the Coalition of Australian Mental Health national Consumer and Carer Advocacy Peak Bodies, dated 25.8.08

40 Australian College of Clinical Psychologists (QLD)

41 Victorian Government (VIC)

42 Tasmanian Government (TAS)

*Supplementary information*

- Department of Health and Human Services - Mental Health Services Strategic Plan 2006–2011 provided at hearing 31.3.08

43 Psychotherapy and Counselling Federation of Australia (VIC)

*Supplementary information*

Received 29.7.08

- Supplementary submission, July 2008
- List of University Courses in Counselling and Psychotherapy 2008
- List of Government Accredited Higher Education Training Providers of Counselling and Psychotherapy

44 Conlan MLA, Mr Matt (NT)

45 Department of Health and Ageing (ACT)

*Supplementary information*

- Opening statement to Committee to briefing on 17.3.08

Received 2.4.08

- Membership list of Policy Revision Steering Committee

- Mental Health Standing Committee membership list
- Care coordination principles document
- Summary of State and Territory progress in implementing care coordination
- Autism Clinical Stakeholder Reference Group membership list
- New Zealand Government contact details
- Brochure Guidelines for Early Intervention for children with Autism Spectrum Disorders
- A Review of the Research to Identify the Most Effective Models of Practice in Early Intervention for Children with Autism Spectrum Disorders

46 Health Consumers' Council WA Inc (WA)

47 Bayley, Ms Patricia (NSW)

48 Top End Association for Mental Health (NT)

*Supplementary information*

- Clarification of evidence given at hearing 1.5.08, dated 23.5.08

49 Queensland Government (QLD)

*Supplementary information*

- Brochure *The Queensland Framework for Primary Mental Health Care, Local Implementation Tool and State Wide Reform Guide* provided at hearing 16.5.08
- Response to questions raised at hearing 16.5.08, dated 4.9.08

50 Ruah Community Services (WA)

51 Richmond Fellowship of WA (WA)

*Supplementary information*

Provided at hearing 20.5.08

- Information folder including Richmond Fellowship Annual Report 2006-2007; Business news article; Joint position paper *A common purpose: Recovery in future mental health services;* Hearing Voices information booklet and poster; PHaMs career opportunities; Submission on Employment of Persons Living with mental illness and copy of presentation to WACOSS Conference 2008

52 Centre for Mental Health Research, Australian National University (ACT)

*Supplementary information*

Provided at hearing 20.5.08

- 'Mental health profile of callers to a telephone counselling service', *Journal of Telemedicine and Telecare,* 2008; 14: 42-47
- 'Comparative randomised trial of online cognitive-behavioural therapy and an information website for depression: 12-month outcomes', *The British Journal of Psychiatry* (2008)
- 'Computerised therapy for psychiatric disorders', *The Lancet*, Vol 370, July 14 2007
- 'Depression in primary health care: from evidence to policy', *Medical Journal of Australia*, Vol. 188 No. 8, 21 April 2008
- Summary of Linkage and Exchange Fellowship

- 'Models in the delivery of depression care: A systematic review of randomised and controlled intervention trials', *BMC Family Practice*, 2008
- 'Internet-based mental health programs: A powerful tool in the rural medical kit', *Australian Journal of Rural Health*, 2007, 15, 81-87

Provided following hearing received 21.5.08

- Abstracts of various articles concerning case management

53 Coalition of Australian Mental Health National Consumer and Carer Advocacy Peak Bodies (SA)

*Supplementary information*

- Additional information reaffirming key issues and actions recommended by clinicians at meeting 28.8.08, dated 5.9.08
- Additional comments from Dr Martha Kent following meeting 28.8.08, dated 5.9.08
- Additional comments concerning early childhood intervention and prevention from Professor Louise Newman, dated 5.9.08

54 Laird, Dr Philip (NSW)

55 Australian Psychological Society (VIC)

*Supplementary information*

- A letter supporting the submission of the Coalition of Australian Mental Health National Consumer and Carer Advocacy Peak Bodies, dated 11.7.08

56 Origins Inc

57 Chamley, Dr Wayne

58 Alliance for Forgotten Australians (ACT)

59 Macmillan, Professor Malcolm (VIC)

60 Australian Psychological Society - College of Clinical Psychologists Victorian Section (VIC)

61 Australian Psychological Society – National College of Clinical Psychologists (VIC)

*Supplementary information*

- Supplementary submission received 31.7.08

62 Jackson, Professor Henry and Rudd, Mr Raymond (VIC)

*Supplementary information*

- A letter supporting the submission of the Coalition of Australian Mental Health National Consumer and Carer Advocacy Peak Bodies, dated 14.8.08

## Additional information

### Information provided to the committee during the Australia/New Zealand Parliamentary Committee Exchange

- New Zealand Health Commission – Issues and Background
- Mental Health Commission documents: *Te Hononga 2015 Connecting for greater well-being*;*Te Haererenga mo te Whakaōranga 1996–2006, The Journey of Recovery for the New Zealand Mental Health Sector; Te Kaitātaki Oranga, Statement of Intent 2007–2010; Te Tāhuhu, Improving Mental Health 2005–2015; Te Kōkiri, The Mental Health and Addiction Action Plan 2006–2015*.

**NSW Government, The Hon Reba Meagher, Minister for Health,** correspondence explaining lack of contribution to the inquiry, received 26.3.08

### The Brook Receovery, Empowerment and Development (RED) Centre

- *Nine Lives, Personal Stories of Mental Illness*, edited by Lesley Singh;
- Statement to Committee on areas of concern

### Sisters Inside

- *Women in Prison*, A report by the Anti-Discrimination Commission Queensland, March 2006;
- Understanding the Queensland *Women in Prison* Report: A detailed Analysis, Sisters Inside, March 2006;
- Correspondence from Ms Anne Warner, Chairperson Sisters Inside Inc, to Ms Christine Clements, Deputy State Coroner, 12 June 2007; and
- Evaluation report, *A Place to Call Home Pilot Project*, Sisters Inside October 2007.

### Open Minds

Copy of opening statement made at the hearing

### Ms Evelyn Pettigrew

Copy of submission to the NSW Special Commission of inquiry regarding the interface between community mental health services, the emergency department and the acute admission ward

### Comprehensive Area Service Psychiatrists Network of NSW:

- Article by Eagar, K., Pirkis, J., Owen, A., Burgess, P., Posner, N. and Perkins, D., 'Lessons from the National Mental Health Integration Program', *Australian Health Review*, May 2005, Vol. 29, No. 2;
- Copy of the submission to the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals; and
- Anne Twomey and Glenn Withers, *Federalist Paper 1, Australia's Federal Future*, A report for the Council for the Australian Federation, April 2007

Provided following hearing 27.3.08, received 21.4.08

- Article by Rosen, A, Mueser, K and Teesson, M, 'Assertive Community Treatment – Issues from scientific and clinical literature with implications for practice', *Journal of Rehabilitation Research & Development,* Vol. 44 No.6, 2007
- Article by Rosen, A, McGorry, P, Groom, G, Hickie, I, Gurr, R, Hocking, B, Leggatt, M, Deveson, A, Wilson, K, Holmes, D, Miller, V, Dunbar, L, and Stanley, F, 'Australia needs a mental health commission, *Australasian Psychiatry,* Vol.12, No.3, September 2004
- Rosen, A, Teesson, M, 'Does case management work? The evidence and the abuse of evidence-based medicine'
- Article by Rosen, A, Callaly, T, 'Interdisciplinary teamwork and leadership: issues for psychiatrists', *Australasian Psychiatry,* Vol.13, No.3, September 2005
- Continuum of Care Service Components, received 27.4.08

**Community Services and Health Industry Skills Council**

Briefing for the Inquiry into mental health services in Australia

**Australian Psychological Society**

Australian Maps indicating the locations of psychologists

**Advocacy Tasmania**

Annual Report for the Mental Health Advocacy Program of Advocacy Tasmania 2006/07

**AMSANT**

Information folder including fact sheets; a letter on needs based collaborative planning; and papers on a model for integrating alcohol and other drug, community mental health and primary health care in aboriginal Medical services in the NT; and Indigenous access to core PHC services in the NT

**Council of Official Visitors WA**

Council of Official Visitors Annual Report 2006-2007 provided at hearing 7.5.08

**South Australian Network of Drug and Alcohol Services**

Copy of summary of presentation made at the hearing

**UnitingCare Wesley Port Adelaide**

Copy of Adelaide PhaMS Program Sites

**Headspace National Youth Mental Health Foundation**

Information folder including copy of presentation; fact sheet; Early Intervention in Youth Mental Health supplement to the Medical Journal of Australia October 2007; headspace Establishment Report 2007 provided at hearing 20.5.08

**The Australian College of Mental Health Nurses Inc**

Copy of opening statement made at the hearing 20.5.08

***Letters supporting the submission of the Coalition of Australian Mental Health National Consumer and Carer Advocacy Peak Bodies (Sub 53)***

**Australian Private Hospitals Association** – dated 6.6.08

**Australian Health Insurance Association** – dated 16.6.08

**Advocates for Survivors of Child Abuse** – received 3.7.08 and dated 8.7.08

**Inanna Inc** – dated 16.7.08

**Australian Medical Association** – dated 8.7.08

**Orygen Research Centre** – dated 16.7.08

**Australian Society for Psychiatric Research** – dated 14.8.08

**Bravehearts Inc** – dated 16.7.08

**Headspace National Youth Mental Health Foundation** – dated 21.8.08

**Dr Alan Rosen** – 12.9.08

**Ms Janne McMahon**

Provided at briefing on 28.8.08

SANE Factsheets – Borderline Personality Disorder and Suicidal behaviour and self-harm

Headspace Factsheet – Self-harm

# APPENDIX 2

## WITNESSES WHO APPEARED BEFORE THE COMMITTEE AT PUBLIC HEARINGS

***Friday, 10 August 2007***
***Parliament House, Canberra***

**Committee Members in attendance**

Senator Gary Humphries (Chair)
Senator Claire Moore (Deputy Chair)
Senator Lyn Allison
Senator the Hon Kay Patterson
Senator Ruth Webber

The Committee held a public hearing in the form of a Roundtable discussion. Participants at the Roundtable were:

**Professor Helen Christiansen,** Director, Centre for Mental Health Research

**Mr David Crosbie,** Chief Executive Officer, Mental Health Council of Australia

**Professor Lyndel Kay Littlefield**, Executive Director, Australian Psychological Society

**Mr Harry Lovelock**, Director of Policy, Royal Australian and New Zealand College of Psychiatrists

**Ms Janne Christine McMahon**, Independent Chair, Private Mental Health Consumer Carer Network (Australia)

**Professor Alan Rosen**, Secretary, Comprehensive Area Service Psychiatrists Network

**Mr Sebastian Rosenberg**, Deputy Chief Executive Officer, Mental Health Council of Australia

**Ms Jennifer Anne Speed**, Deputy Director, Australian Mental Health Consumer Network

**Ms Margaret Springgay**, Executive Director, Mental Illness Fellowship of Australia

**Ms Leanne Wells**, Manager, Policy and Development, Australian General Practice Network

### *Wednesday, 26 March 2008*
### *Undumbi Room, Parliament House, Brisbane*

**Committee Members in attendance**

Senator Claire Moore (Chair)
Senator Gary Humphries (Deputy Chair)
Senator Lyn Allison
Senator Kate Lundy
Senator Ruth Webber

**Witnesses**

**Queensland Alliance Mental Illness and Disability Groups**
Mr Jeff Cheverton, Executive Director
Mr Noel Muller, President Queensland Alliance State Council
Ms Melody Edwardson, Queensland Alliance State Councillor

**Australian Mental Health Consumer Network**
Ms Helen Connor, Executive Director
Ms Jennifer Speed, Deputy Director

**Australian Counselling Association**
Mr Philip Armstrong, Chief Executive Officer

**Open Minds**
Mr Bernard Wilson, Chief Executive Officer
Ms Suzanne Desailly, Personal Helpers and Mentors Program Coordinator

**Sisters Inside**
Ms Debbie Kilroy, Director

**The Brook Recovery, Empowerment and Development Centre**
Ms Jude Bugeja, Manager
Ms Brenda McLaren, Peer Support Worker

### *Thursday, 27 March 2008*
### *Jubilee Room, Parliament House, Sydney*

**Committee Members in attendance**

Senator Claire Moore (Chair)
Senator Gary Humphries (Deputy Chair)
Senator Lyn Allison
Senator Kate Lundy
Senator Ruth Webber

**Witnesses**

**Service for the Treatment & Rehabilitation of Torture and Trauma Survivors**
Mr Lachlan Murdoch, Deputy Director
Ms Debbie Gould, Clinical Supervisor and General Services Counsellor

**Multicultural Mental Health Australia**
Associate Professor Abd Malak AM, MMHA Chair

**Transcultural Mental Health Centre**
Ms Maria Cassaniti, NSW TMHC Coordinator
Mr Phil Sandford, TMHC

**Mental Health Coordinating Council**
Ms Jenna Bateman, Chief Executive Officer
Ms Corinne Henderson, Senior Policy Officer

**NSW Consumer Advisory Group – Mental Health Inc**
Ms Karen Oakley, Acting Executive Officer

**Comprehensive Area Service Psychiatrists' Network of NSW**
Dr Alan Rosen, Secretary
Dr Roger Gurr, Policy Committee Chair

**NSW Mental Health Review Tribunal**
The Hon Greg James QC, President

**Community Services and Health Industry Skills Council**
Ms Di Lawson, Chief Executive Officer
Mr Robin Flynn, Research and Policy Manager
Ms Donna Bestic, Project Coordinator

### *Monday, 31 March 2008*
### *Churchill Room, Salamanca Inn, Hobart*

**Committee Members in attendance**

Senator Claire Moore (Chair)
Senator Gary Humphries (Deputy Chair)
Senator Lyn Allison
Senator Sue Boyce
Senator Carol Brown
Senator Helen Polley

**Witnesses**

**Mental Health Council of Tasmania**
Ms Michelle Swallow, Executive Officer
Mr David Asten

**Department of Health and Human Services**
Ms Mary Bent, Deputy Secretary, Community Health Services
Dr John Crawshaw, Manager, Mental Health Services

**Anglicare - Tasmania**
Ms Jane Carlson, Manager, Mental Health Services
Mr Daryl Lamb, Manager, Community Services

**Advocacy Tasmania**
Ms Valerie Williams, Mental Health Advocate

**Tasmanian Community Advisory Group on Mental Health (TasCAG)**
Ms Dot Boxhall, Executive Member

***Tuesday, 1 April 2008***
***St James Court Conference Centre, Melbourne***

**Committee Members in attendance**

Senator Claire Moore (Chair)
Senator Gary Humphries (Deputy Chair)
Senator Judith Adams
Senator Lyn Allison
Senator Sue Boyce

**Witnesses**

**SANE Australia**
Ms Barbara Hocking, Executive Director

**Network for Carers of people with a mental Illness**
Ms Sandra Genovesi, Project Co-ordinator

**Victorian Mental Illness Awareness Council**
Ms Isabell Collins, Director

**Royal Women's Hospital**
Dr Dennis Handrinis, Psychiatrist
Dr Chris Bayly, Associate Director

**Royal Australian and New Zealand College of Psychiatrists**
Dr Julian Freidin, Former President
Ms Sarah Gafforini, Manager of Policy and Practice Standards

**Australian Psychological Society**
Professor Lyn Littlefield, Executive Director

**Psychotherapy and Counselling Federation of Australia**
Professor Margot Schofield, Director of Research

**Royal Australian College of General Practitioners**
Dr Caroline Johnson, College Member
Ms Jane, London, Project Officer, Quality Care

### *Thursday, 1 May 2008*
### *Signatures Room, Crowne Plaza, Darwin*

**Committee Members in attendance**

Senator Claire Moore (Chair)
Senator Judith Adams
Senator Lyn Allison
Senator Sue Boyce
Senator Ruth Webber

**Witnesses**

**Northern Territory Mental Health Coalition**
Mr Phil Dempster, Project Officer

**Aboriginal Medical Services Alliance Northern Territory (AMSANT)**
Ms Stephanie Bell, Acting Chair, Board of Directors
Dr John Boffa, Public Health Medical Adviser

**Top End Association for Mental Health Inc**
Ms Melissa Heywood, Services Manager and Acting Chief Executive Officer
Ms Lorraine Davies, Respite Team Leader
Ms Erin Evans, Family and Youth Services Team Leader
Mr Anthony Willits, Personal Helpers and Mentors Team Leader and Acting Services Manager

**Department of Health and Community Services, Northern Territory**
Dr David Ashbridge, Chief Executive Officer
Ms Penny Fielding, Acting Assistant Secretary
Ms Bronwyn Hendry, Director Mental Health

### *Wednesday, 7 May 2008*
### *Emerald Hotel, Perth*

**Committee Members in attendance**

Senator Claire Moore (Chair)
Senator Gary Humphries (Deputy Chair)
Senator Lyn Allison
Senator Helen Polley
Senator Ruth Webber

**Witnesses**

**Western Australian Association for Mental Health**
Ms Ann White, Executive Officer
Mrs Pamela Gardner, Chairperson, Bay of Isles Community Outreach Inc
Ms Sandra Vidot, Executive Director, Mental Illness Fellowship of WA

**Women's Healthworks**
Ms Mandy Stringer, Manager
Ms Madeleine Sewell, Coordinator, Body Esteem Program

**Ruah Community Services**
Ms Sheryl Carmody, Executive Manager Ruah Mental Health
Ms Simone Hosgood, Team Coordinator Ruah Armadale Personal Helpers and Mentors

**Richmond Fellowship**
Mr Joe Calleja, Chief Executive Officer
Mr Alastair Miller, Mental Health Consumer

**Western Australian Mental Illness Awareness Council**
Ms Lorraine Powell, Secretary

**Council of Official Visitors**
Ms Debora Colvin, Head of Council
Ms Val O'Toole, Deputy Head of Council

**Health Consumers' Council**
Ms Maxine Drake, Deputy Director

**Western Australian Government**
Dr Steve Patchett, Executive Director, Mental Health, Department of Health
Mr Michael Thorn, Director, Crime and Justice, Policy Division, Department of the Premier and Cabinet

***Thursday, 8 May 2008***
***Stamford Grand, Glenelg, Adelaide***

**Committee Members in attendance**

Senator Claire Moore (Chair)
Senator Gary Humphries (Deputy Chair)
Senator Lyn Allison
Senator Helen Polley
Senator Ruth Webber
Senator Dana Wortley

**Witnesses**

**Mental Health Coalition of South Australia (MHCSA)**
Mr Paul Senior, Acting President
Mr Geoff Harris, Executive Director

**South Australian Network of Drug and Alcohol Services**
Mr Trevor Bignell, Chairperson
Ms Lesley Edwards, Executive Officer
Mr Andris Banders, Comorbidity Project

**Mental Illness Fellowship of Australia**
Ms Margaret Springgay, Executive Director
Ms Natasha Miliotis, Executive Director

**Private Mental Health Consumer Carer Network (Australia)**
Ms Janne McMahon, Independent Chair

***Mental Health Coalition of South Australia panel***

**Survivors of Torture and Trauma Assistance and Rehabilitation Service (STTARS)**
Ms Bernadette McGrath , Director

**UnitingCare Wesley Port Adelaide**
Mr Peter Warner, Manager, Community Mental Health Programs
Ms Karen Bradbury, Acting PhAM Manager

**Carers SA**
Ms Karen Richardson, Manager, Community Services
Ms Jan Wallent, Board President

**Health Consumer's Alliance**
Ms Emma Willoughby, Project Officer, Mental Health

**South Australian Government**
Mr Derek Wright, Director Mental Health Operations
Mr Mark Leggett, Deputy Director, Mental Health

## *Friday, 16 May 2008*
## *Parliament House, Canberra*

**Committee Members in attendance**

Senator Claire Moore (Chair)
Senator Gary Humphries (Deputy Chair)
Senator Judith Adams
Senator Lyn Allison

**Witnesses**

**Australian General Practice Network**
Ms Leanne Wells, Manager, Policy and Development
Dr Chris McAuliffe, Mental Health Advisor

**Mental Health Community Coalition ACT**
Dr Leanne Craze, Consultant, Policy and Pojects
Mr David Plant, Senior Policy Consultant

**ACT Government**
Dr Peggy Brown, Director of Mental Health, ACT Mental Health
Mr Richard Bromhead, Manager, Mental Health Policy Unit, ACT Mental Health

**Government of Queensland**

Dr Aaron Groves, Director of Mental Health, Queensland Health

**Catholic Social Services Australia**

Mr Frank Quinlan, Executive Director

Mrs Jackie Brady, Manager of Strategic and Network Communications

**Department of Families, Housing, Community Services and Indigenous Affairs**

Mr Evan Lewis, Group Manager, Mental Health, Autism and Community Support Group

Mr Ian Boyson, Acting Branch Manager, Mental Health Branch

**Department of Health and Ageing**

Professor Rosemary Calder, First Assistant Secretary, Mental Health and Workforce Division

Ms Megan Morris, First Assistant Secretary, Primary and Ambulatory Care Division

Ms Colleen Krestensen, Assistant Secretary, Mental Health & Suicide Prevention Program Branch

Professor Harvey Whiteford, Principal Medical Advisor, Mental Health and Workforce Division

Mr Nathan Smyth, Assistant Secretary, Mental Health Reform Branch

Ms Lana Racic, A/g Assistant Secretary, Mental Health Reform Branch

**Department of Education, Employment and Workplace Relations**

Ms Sharon Rose, Branch Manager, Disability and Mature Age Policy Branch

Ms Gaylene Smith, Team Leader, Policy and Future Development Team

## *Tuesday, 20 May 2008*
## *Parliament House, Canberra*

**Committee Members in attendance**

Senator Claire Moore (Chair)
Senator Gary Humphries (Deputy Chair)
Senator Judith Adams
Senator Lyn Allison
Senator Sue Boyce
Senator Barnaby Joyce
Senator Ruth Webber

**Witnesses**

**Headspace National Youth Mental Health Foundation**

Mr Chris Tanti, Chief Executive Officer

Mr Peter Orchard, Director Service Reform and Policy, Deputy Chief Executive Officer

Mr Nathan Frick, Chairperson, Headspace Youth National Reference Group

Professor Patrick McGorry, Chair, Executive Committee

**Centre for Mental Health Research**
Professor Helen Christensen, Director, Centre for Mental Health Research
Professor Ian Hickie, Director, Brain and Mind Research Institute

**Australian Association of Social Workers**
Ms Liz Sommerville, Mental Health Policy Officer
Dr Valerie Gerrand, Member

**Australian College of Mental Health Nurses**
Mr Peter Santangelo, President
Ms Sharon Olsson, SA Branch President

**Carers Australia**
Ms Joan Hughes, Chief Executive Officer
Ms Susan Aiesi, Polcy and Research Manager

**National Mental Health Consumer and Carer Forum**
Mr David Lovegrove, Deputy Consumer Co-Chair
Ms Kate Shipway, Carer Co-Chair
Ms Liz Ruck, Executive Officer

**Mental Health Council of Australia**
Mr David Crosbie, Chief Executive Officer

### *Thursday, 28 August 2008*
### *Parliament House, Canberra*

**Committee Members in attendance**

Senator Claire Moore (Chair)
Senator Rachel Siewert (Deputy Chair)
Senator Judith Adams
Senator Catryna Bilyk
Senator Sue Boyce
Senator Mark Furner
Senator Gary Humphries

The Committee held a meeting with clinicians to discuss issues concerning Borderline Personality Disorder.

Clinicians in attendance were Dr Andrew Chanen, Professor Pat McGorry, Dr Martha Kent, Dr Maria Tomasic, Dr Choong-Siew Yong and also Ms J McMahon, Spokesperson for the Coalition of Australian Mental Health National Consumer and Carer Advocacy Peak Bodies.

# APPENDIX 3

Council of Australian Governments (COAG)

# National Action Plan on Mental Health 2006 – 2011

***14 July 2006***

## Leaders' Foreword

The effects of mental illness are felt across our nation. Recent reports from Parliamentary inquiries and independent reviews have presented strong evidence for change in the way governments respond to mental illness. In February 2006, Australian leaders recognised that mental health is a major problem for the Australian community and committed to reform the mental health system in Australia.

The Council of Australian Governments (COAG) has agreed to a National Action Plan on Mental Health. The Plan provides a strategic framework that emphasises coordination and collaboration between government, private and non-government providers in order to deliver a more seamless and connected care system, so that people with mental illness are able to participate in the community.

All governments have invested significantly in mental health services in recent years, with the National Mental Health Report 2005 finding that Australian governments spent a total of $3.2 billion in 2002-03. However we all acknowledge that more needs to be done.

This National Action Plan presents a unique opportunity to support people to manage their mental illness and make best use of services that will work for them, their families and carers in a more integrated way. This will require collaboration between Commonwealth, State, and Territory governments, and between the government and non-government sectors. Governments have committed to a new model of community care for people with severe mental illness and complex needs, who are most at risk of falling through the gaps in the system.

COAG recognises that it will take time to strengthen the capacity of our mental health services. This National Action Plan outlines a series of initiatives that will be implemented over the five-year period, comprising a significant investment from all governments. The value of measures covered in the Individual Implementation Plans totals approximately $4 billion over five years. All governments have agreed to continued investment in the area after this time.

The Plan aims to improve mental health and facilitate recovery from illness through a greater focus on promotion, prevention and early intervention; improved access to mental health services, including in Indigenous and rural communities; more stable accommodation and support; and meaningful participation in recreational, social, employment and other activities in the community. Improving the care system will involve a focus on better coordinated care and building workforce capacity.

The success of the Plan will require continuing effort by all governments. COAG has therefore agreed to new arrangements for the Commonwealth and States and Territories to work together to implement our commitments in the most effective way.

The Plan is an historic step towards governments working together to achieve better outcomes for people with mental illness. Together these reforms will significantly contribute to the wellbeing of people with mental illness, and their families and communities.

## Contents

## Introduction

Mental illness is a term used to describe a number of diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities. These include depression, bipolar disorder and schizophrenia.

Mental illness can impair a person's development, education and career and diminish quality of life. Nearly one in five, or more than three million Australians are affected by a mental illness in any one year. Severe mental illnesses are less prevalent and affect around two and a half per cent of the population at any one time.

It is estimated that the annual cost of mental illness in Australia is approximately $20 billion, which includes the costs from loss of productivity and participation in the workforce. It follows that improving mental health can lead to social and economic benefits to the Australian community (Victorian Government, 2006).

### *Outcomes of this Plan*

The National Action Plan is directed at achieving four outcomes:

1. reducing the prevalence and severity of mental illness in Australia;

2. reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery;

3. increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention; and

4. increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation.

Governments are committed to actions that are directed at achieving these outcomes, and have identified indicators of progress against each of these that will be measured and reported on over the life of the Plan.

### *Roles and Responsibility for Action*

Both the Commonwealth and State and Territory governments, the private sector and non-government organisations provide care and support for people with mental illness. Governments have made significant investments in services over the past years, however from a consumer perspective, the responsibilities for action are not always clear, services can overlap and result in fragmentation and poor connections between them. This has a detrimental impact on individuals who need to access services and is costly and inefficient.

The Plan outlines where Commonwealth, State and Territory governments will significantly expand and improve their mental health services, and access to them. It also defines opportunities where better connections will be made between services provided by different governments, and where greater collaboration and joint action will occur between governments, so that people with a mental illness are better supported to participate in the community.

The Commonwealth Government will significantly expand its funding in key areas of responsibility, such as:

- services delivered by private psychiatrists in the community, general practitioners (GPs), psychologists, mental health nurses and other allied health professionals;
- labour market programmes associated with assisting people with mental illness find and stay in employment; and
- tertiary education including funding training places and scholarships, and enhancements to course content.

States and Territories will be enhancing services in their key areas of responsibility including the provision of emergency and crisis responses; mental health treatment services by public hospitals and community-based teams; mental health services for people in contact with the justice system; and supported accommodation.

In addition, the Commonwealth, States and Territories are investing in areas of common action, along with a strong commitment to work together more closely to ensure that investment is coordinated, efficient and effective. These areas of common action include:

- promotion and prevention programmes including suicide prevention;
- school-based early intervention programmes targeting children and young people;
- community-based mental health treatment services particularly for people with mental illness and drug and alcohol issues;
- mental health services in rural and remote areas;
- support for people with more severe mental illness to gain living skills and work-readiness;
- clinical rehabilitation services;
- telephone counselling and advisory services, including through the National Health Call Centre Network; and
- support for families and carers including respite care.

In light of the range of services for people with mental illness delivered by all governments, COAG has committed to two flagship initiatives to better integrate and connect services on the ground. The first is joint action to coordinate the provision of health and community support services for people with severe mental illness and complex needs across Australia. The second is to establish institutional arrangements to ensure that new investment under this Plan by each level of government is delivered in the most effective way within each State and Territory. These initiatives are outlined in the section titled *Coordinating Care*.

### *Structure of this Plan*

This Plan comprises two major parts. The first part describes the overarching outcomes, indicators, and five areas for action with specific policy directions agreed between governments.

The second part of the Plan contains Individual Implementation Plans that have been prepared by each government. These set out the additional investment that each government will be making to achieve the outcomes and policy directions that are agreed at the national level and set out in the first part of this Plan.

This framework complements the approach being taken by COAG in developing a National Reform Agenda that is aimed at enhancing productivity and participation and the wellbeing of all Australians.

## Promotion, Prevention and Early Intervention

COAG agrees that promotion, prevention and early intervention are critical to enabling the community to better recognise the risk factors and early signs of mental illness and to find appropriate treatment. Growing evidence suggests that when identified and treated early, mental illnesses are less severe and of shorter duration, and are less likely to recur. Early intervention is therefore critical to promote recovery and reduce the incidence in the community and chronic disability. In this Plan, recovery means people reach their optimal capacity to live independent and fulfilling lives.

This Plan identifies several specific policy directions necessary to achieve effective promotion, prevention and early intervention, specifically: building resilience and coping skills of children, young people and families; raising community awareness; improving capacity for early identification and referral to appropriate services; improving treatment services to better respond to the early onset of mental illness, particularly for children and young people; and investing in mental health research to better understand the onset and treatment of mental illnesses.

Consistent with these policy directions, governments will be investing extra funds on top of their existing programmes and services to support promotion, prevention and early intervention. Each government is undertaking different actions as part of their Individual Implementation Plan. This diversity reflects the differences in the range and scale of services that are already in place in each State and Territory. Some examples of the types of actions that are included in the Individual Implementation Plans include:

- expanding suicide prevention programmes under the National Suicide Prevention Strategy;
- public information and education activities that improve community awareness of mental health risk factors and promote social inclusion and support;
- investing in support groups for children of parents with mental illness;
- investing in health services for young people that focus on early intervention;
- investing in health services that focus on early intervention, including counselling services, primary care and maternal and child health;
- expanding mental health research through research centres or bodies, universities and various initiatives, including *beyondblue*;
- specialist youth mental health services such as early psychosis programmes and conduct disorder programmes;
- specialist mental health services for older people; and
- statewide 24-hour 7 days a week mental health service access by telephone, which would be linked to the National Health Call Centre Network.

In each of these areas, the needs of Aboriginal and Torres Strait Islander people will be subject to particular attention.

Details on the actions being funded in each jurisdiction are set out in each government's Individual Implementation Plan.

## Integrating and Improving the Care System

People with mental illness often require access to a range of human services provided by Commonwealth, State and Territory governments and the private and non-government sector. Better coordination of all these services can help to prevent people who are experiencing acute mental illness from slipping through the care 'net' and reduce their chances of readmission to hospital, homelessness, incarceration or suicide. Better coordinated services will also mean that people can better manage their own recovery.

An effective care system will provide timely and high-quality health and community services to people with a mental illness that assists them to live, work and participate in the community. An effective, integrated care system has several parts working well together:

- psychiatrists in the community and a primary health care sector of GPs, psychologists, mental health nurses, and other allied health workers that provide clinical services to people with mild, moderate and severe mental illness, including early identification, assessment, continuous care and case management;
- emergency, acute and community-based mental health services assisting people who are experiencing acute episodes of mental illness to prevent crisis and promote rehabilitation and recovery;
- community support services such as accommodation, personal support, vocational education and training, and employment services that enable people with mental illness to live stable and productive lives in the community; and
- effective assessment and triage within all parts of the system to ensure care needs are properly identified early, and that people with mental illness are referred to the services from which they will benefit most.

Achieving such an integrated care system requires governments to focus on two specific policy directions: to resource adequately health and community support services to meet the level of need; and to develop ways of coordinating and linking the range of care that is provided across the

continuum of primary, acute and community services by public, non-government and private sector providers.

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

- implementing new Medical Benefits Schedule items for psychology and other allied health providers, psychiatry and GPs;
- improving access to acute and community-based clinical services through enhancing emergency departments, providing additional acute and non-acute beds and expanding community treatment services across the lifespan;
- providing additional step-up and step-down community-based treatment facilities;
- more services in rural and remote areas and providing a more flexible approach to service delivery in these areas;
- providing additional care coordination services through the public, private and non-government sector;
- improving services for people with mental illness in the criminal justice system, including community-based forensic mental health services;
- integrating mental health and drug and alcohol services, including in Indigenous communities; and
- improving mental health clinical information and accountability.

Additional investment is also being made to expand capacity in community support services for people with mental illness, as outlined in the section titled *Participation in the Community and Employment*.

Importantly, as part of the Plan, governments have committed to two flagship initiatives consistent with the specific policy strategic direction of coordinating and linking the range of care that is provided across the continuum of primary, acute and community services by public, non-government and private sector providers. These are described in the section entitled *Coordinating Care.*

## Participation in the Community and Employment, including Accommodation

People with mental illness are amongst the most socially disadvantaged and economically marginalised in our communities. Three quarters of the 360,000 people of working age in Australia diagnosed with a severe mental illness are not in the labour force.

COAG recognises the importance of ensuring that people experiencing severe mental illness are better connected with services and supports that will allow them to live independently in the community and lead productive and satisfying lives. For the majority of people with mental illness, effective community-based support will reduce their need for acute hospital services, leading to improved health outcomes and reduced costs of care. Carers also provide a vital role in the recovery process for people with mental illness, and supporting carers is an essential component of this Plan.

Governments have agreed to a number of specific policy directions to achieve positive change in this area, including: enhancing support services for people with mental illness to participate in the community, education and employment; enabling people with mental illness to have stable housing by linking them with other personal support services; improving referral pathways and links between clinical, accommodation, personal and vocational support programmes; and expanding support for families and carers including respite care.

Each jurisdiction is undertaking different actions as part of their Individual Implementation Plan. This diversity reflects the range and scale of services that are already in place in each State and Territory. Some examples of the types of actions within governments' Individual Implementation Plans include:

- increasing the number of places in programmes that assist people with severe mental illness with daily living including additional home-based outreach, day programmes and residential rehabilitation services;
- providing more one-on-one assistance to young people to help them stay in education, such as programmes delivered in partnership with schools;
- additional places in support programmes to help people with a mental illness obtain and stay in employment;
- supporting families and carers of people with mental illness to continue to care for people with a severe mental illness, including peer support, and respite programmes through the non-government sector; and
- increasing housing options and support in accommodation for people with a mental illness.

This Plan also includes an initiative to ensure that people with severe mental illness and complex needs receive community support services that are better connected with their clinical care. This initiative is outlined in the following section.

## Coordinating Care

This Plan contains two flagship national initiatives directed at providing more seamless and coordinated health and community services for people with a mental illness.

### *Coordinating Care*

COAG is committed to ensuring coordinated care for people with severe mental illness and complex needs who are most at risk of falling through the gaps in the system. This will have an initial focus on those people with serious illness who are most likely to benefit. This group of people have persistent symptoms and significant disability, have lost social or family support networks and rely extensively on multiple health and community services for assistance to maintain their lives within the community.

Governments have agreed to introduce a new system of linking care. People within the target group will be offered a clinical provider and a community coordinator from Commonwealth and/or State and Territory government funded services.

The clinical provider, who may be a GP, a mental health nurse, a treating doctor in hospital, or where appropriate an Aboriginal Health Worker, will be responsible for the clinical management of the person.

The community coordinators could be Commonwealth-funded personal helpers and mentors or coordinators from State and Territory government funded services. The community coordinator will be responsible for ensuring the person is connected to the non-clinical services they need, for example accommodation, employment, education, or rehabilitation.

This new way of linking services for people with a mental illness is aimed at giving them the ability to better manage their recovery by giving them clear information on who is providing their care, including information on how to access 24-hour support, and who can help link them into the range of services they need. Regular communication will also empower professionals to work across Commonwealth and State and Territory boundaries, and across clinical and non-clinical services. Clinicians and community coordinators would ensure continuity of care is maintained when they are relinquishing their role to a new clinician or community coordinator.

This new system will build on any existing coordination arrangements. This system will be progressively developed over the next six months in consultation with key stakeholders.

### *Governments Working Together*

To ensure the full effectiveness of the Plan, COAG has agreed that the Premier or Chief Minister's department in each State and Territory will convene a COAG Mental Health Group. These groups will involve Commonwealth and State and Territory representatives and engage with non-government organisations, the private sector and consumer and carer representatives.

These groups will provide a forum for oversight and collaboration on how the different initiatives from the Commonwealth and State and Territory governments will be coordinated and delivered in a seamless way. The groups represent a commitment to collaborate on improving the responsiveness of the mental health system for the benefit of individuals with a mental illness, their families and carers, and the wider community.

These groups will ensure that all relevant Commonwealth, State or Territory government agencies work with each other at a State and Territory level, and consult with the non-government and private sectors as well as consumer and carer representatives, in order to deliver the best possible system of care. The groups should comprise representatives with responsibility for, and expertise in, mental health policy and service delivery.

The first task of these groups will be to consider how the new community coordinators for severely mentally ill people will be implemented in each jurisdiction. Implementation in each jurisdiction needs to be flexible reflecting local systems and their capacity.

Each of these groups will report back to COAG Senior Officials on their progress after six months and then at regular intervals.

## Increasing Workforce Capacity

There are serious workforce shortages across all mental health professional groups, including mental health nurses and psychiatrists. This shortage hinders the ability of government and non-government providers to meet the increasing demand for services. A major focus of the Plan is to build the capacity of the public, private and non-government workforce to deliver services.

The Plan includes the specific policy directions to: increase the mental health workforce; improve its ability to meet patient needs across Australia, particularly in rural and regional areas and for Aboriginal and Torres Strait Islander people; and support the non-government and private sector to provide quality services to people with mental illness.

Each government is undertaking different actions as part of their Individual Implementation Plan. This reflects the differences in the range and scale of services that are already in place in each State and Territory. Some examples of the types of actions include:

- increasing the number of training places for mental health nurses and clinical psychologists;
- improving mental health tertiary training in health-related university courses;
- training front-line workers to better respond to mental illness;
- providing education and employment support programmes that target Aboriginal and Torres Strait Islander workers; and
- workforce development, including education, training and support for new and more experienced staff, recruitment and retention initiatives, and piloting new/expanded roles.

Details on the actions being funded in each jurisdiction are set out in each government's Individual Implementation Plan.

## Measuring the Progress of the National Action Plan

All governments are committed to working together to achieve the four defined outcomes over the life of the Plan and beyond. A series of measures have been identified to track progress against the outcomes. Australian Health Ministers will report annually to COAG on implementation of the Plan, and on progress against the agreed outcomes. Governments have also agreed to an independent evaluation and review of the Plan after five years.

| Outcome | Progress Measures[1] |
|---|---|
| Reducing the prevalence and severity of mental illness in Australia | The prevalence of mental illness in the community[2] |
| | The rate of suicide in the community |
| Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent longer term recovery | Rates of use of illicit drugs that contribute to mental illness in young people |
| | Rates of substance abuse |
| Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time, with a particular focus on early intervention | Percentage of people with a mental illness who receive mental health care |
| | Mental health outcomes of people who receive treatment from State and Territory services and the private hospital system |
| | The rates of community follow up for people within the first seven days of discharge from hospital |
| | Readmissions to hospital within 28 days of discharge |
| Increasing the ability of people with a mental illness to participate in the community, employment, education and training, including through an increase in access to stable accommodation | Participation rates by people with mental illness of working age in employment |
| | Participation rates by young people aged 16-30 with mental illness in education and employment |
| | Prevalence of mental illness among people who are remanded or newly sentenced to adult and juvenile correctional facilities |
| | Prevalence of mental illness among homeless populations |

[1] These progress measures may be enhanced through work under way in the Australian Health Ministers' Conference, Productivity Commission and other entities.

[2] The prevalence of mental illness in the community may in fact appear to increase at first, if the Plan is successful in helping to identify a greater number of people with mental health issues who should be treated. The increase in people seeking treatment is a positive first step towards reducing the real prevalence throughout society. There should be a similar trend identified in the percentage of people with a mental illness who receive mental health care.

# Individual Implementation Plans

# INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

# COMMONWEALTH

The Prime Minister announced new Commonwealth funding of $1.9 billion over five years as part of the COAG package on 5 April 2006. These funds were included in the Commonwealth Budget for 2006-07. These new funds are in addition to existing Commonwealth funding and measures previously announced.

## ***Promotion, Prevention and Early Intervention ($158.3 million)***

**Expanding Suicide Prevention Programmes ($62.4 million)**

Funding will be provided to expand and enhance national and community-based projects under the National Suicide Prevention Strategy. National research and development projects to increase understanding of suicide and how to prevent it will also be funded. *Implementation arrangements:* through the National Suicide Prevention Strategy. *Implementation commencement date:* July 2006

**Alerting the Community to Links between Illicit Drugs and Mental Illness ($21.6 million)**

Funding will be provided to help people better understand the links between drug use and the development of mental illness, and to encourage individuals and families to seek help or treatment. *Implementation arrangements:* through public information and education activities targeting the general population. *Implementation commencement date:* July 2006

**New Early Intervention Services for Parents, Children and Young People ($28.1 million)**

Assistance will be provided to parents and schools to allow them to identify better children at risk of mental illness and to offer early referral for appropriate treatment. Resources, information and training for parents and schools will be provided to promote the availability of new mental health services for children and young people with complex mental health conditions. *Implementation arrangements:* through programmes such as the MindMatters programme, and through funding to education providers and other relevant organisations. *Implementation commencement date:* September 2006

**Community Based Programmes to help Families Coping with Mental Illness ($45.2 million)**

Local, community-based projects will be funded to support families, children and young people affected by mental illness. Projects will target prevention and early intervention, with a particular focus on Indigenous families and those from a culturally and linguistically diverse background. *Implementation arrangements:* through non-government organisations (NGOs) and community-based organisations. *Implementation commencement date:* July 2006

**Increased Funding for the Mental Health Council of Australia ($1.0 million)**

The Mental Health Council of Australia secretariat will receive additional funding to assist the Council to respond to an increased focus on mental health issues in the broader community. *Implementation arrangements:* funding will be provided under the Department of Health and Ageing's Community Sector Support Scheme. *Implementation commencement date:* July 2006

## ***Integrating and Improving the Care System ($1,196.9 million)***

**Better Access to Psychiatrists, Psychologists and General Practitioners (GPs) through the Medical Benefits Schedule (MBS) ($538.0 million)**

Reforms to the MBS will improve access to, and better teamwork between, psychiatrists, clinical psychologists, GPs and other allied health professionals. Reforms will allow private psychiatrists to refer patients to psychologists and GPs, encourage early assessment and management of people with

a mental illness by GPs, and allow GPs to refer patients to psychologists and allied health professionals. *Implementation arrangements:* through changes to the MBS and training delivered through organisations such as Divisions of General Practice. *Implementation commencement date:* November 2006

**New Funding for Mental Health Nurses ($191.6 million)**

New mental health nurses in private psychiatry practice, general practice and other appropriate organisations will assist people with serious mental illness to receive better coordinated treatment and care. They will work closely with the patient's psychiatrist or GP and provide services such as home visiting, medication management, and improving links to other health professionals. *Implementation arrangements*: through a range of payment mechanisms. *Implementation commencement date:* July 2007

**Mental Health Services in Rural and Remote Areas ($51.7 million)**

Access to mental health services for people in rural and remote areas will be improved through funding for treatment services provided by appropriately trained allied mental health professionals such as psychologists, social workers, occupational therapists, and mental health nurses. *Implementation arrangements:* through flexible funding to a Division of General Practice or alternative organisations such as an Aboriginal and Torres Strait Islander primary health care service. *Implementation commencement date:* November 2006

**Improved Services for People with Drug and Alcohol Problems and Mental Illness ($73.9 million)**

The non-government drug and alcohol sector will be funded to provide treatment for clients who also have a mental health problem. Best-practice models for intervention for clients with substance use and mental health co-morbidities will be identified and training will be provided for the drug and alcohol workforce. *Implementation arrangements:* through Non-Government Organisations (NGOs), and through the National Comorbidity Initiative and National Illicit Drug Strategy. *Implementation commencement date:* July 2006

**Funding for Telephone Counselling, Self-Help and Web-based Support Programmes ($56.9 million)**

Non-government organisations currently providing telephone counselling services will be provided with more funding to further enhance the services they currently provide. New web-based counselling services will also be developed. *Implementation arrangements:* through NGOs currently funded to provide similar services. *Implementation commencement date:* July 2006

**New Personal Helpers and Mentors ($284.8 million)**

Funding will be provided to the non-government sector to engage 900 personal helpers and mentors to assist people with a mental illness who are living in the community to better manage their daily activities. People with a severe mental illness will be assisted in accessing the range of treatment, income support, employment and accommodation services they need. *Implementation arrangements:* through NGOs. *Implementation commencement date:* July 2006

### ***Participation in the Community and Employment, including Accommodation ($370.0 million)***

**Helping People with a Mental Illness enter and remain in Employment ($39.8 million)**

Funding will provide 2,500 additional places in the Personal Support Programme to help people with a mental illness who are not yet ready to benefit from the Job Network. Funding will also support people with a mental illness at risk of losing or leaving their jobs, and help evaluate and disseminate information on effective ways of providing employment assistance for people with mental illness. *Implementation arrangements:* through the Department of Employment and Workplace Relations. *Implementation commencement date:* July 2006.

**Support for Day-to-Day living in the Community ($46.0 million)**

7,000 additional places will be created in programmes that assist people with severe mental illness to provide access to structured activities such as cooking, shopping and social outings, and help improve social participation through independent living skills and social rehabilitation activities. *Implementation arrangements:* through NGOs. *Implementation commencement date:* July 2007

**Helping Young People stay in Education ($59.5 million)**

The Youth Pathways programme will be increased to help young people who are experiencing a mental health problem and who are at risk of dropping out of school, including the provision of one-on-one assistance to identify services and professional support to help individual young people with their specific needs (for example, counselling, support to find housing or remain at home). This initiative, in conjunction with the Partnership Outreach Education Model, will assist an estimated 6,000 young people who are experiencing mental health issues. *Implementation arrangements:* through Youth Pathways providers. *Implementation commencement date:* January 2007

**More Respite Care Places to help Families and Carers ($224.7 million)**

Funding will be provided for approximately 650 new respite care places to help families and carers of people with a mental illness or an intellectual disability. Overnight respite and day respite services will be provided for up to 15,000 families a year, and priority access will be given to elderly parents who live with, and care for, a son and daughter with a severe mental illness or an intellectual disability. *Implementation arrangements:* through NGOs. *Implementation commencement date:* July 2006

## ***Increasing Workforce Capacity ($129.9 million)***

**Additional Education Places, Scholarships and Clinical Training in Mental Health ($103.5 million)**

Funding will be provided to increase the supply and quality of the mental health workforce. An additional 420 mental health nursing places and 200 post-graduate psychology places each year will be provided, as well as 25 full-time and 50 part-time post-graduate scholarships to nurses and psychologists. Mental health competencies and mental health clinical training will be increased across the health workforce, including medicine, psychiatry, nursing, psychology, occupational therapy and social work. *Implementation arrangements:* universities will provide student places and scholarships. *Implementation commencement date:* components of this initiative will start from November 2006

**Mental Health in Tertiary Curricula ($5.6 million)**

Funding will be provided to increase the mental health content in tertiary curricula through the development of mental health training modules for registered nurses, including the culturally appropriate management of Indigenous patients, and will provide students with clinical training in multi-disciplinary teams that include allied health, medical and nursing students. *Implementation arrangements:* through funding to education service providers, such as universities. *Implementation commencement date:* July 2006

**Improving the Capacity of Health Workers in Indigenous Communities ($20.8 million)**

Five new scholarships will be provided for Indigenous students undertaking studies in a mental health discipline, and 10 additional mental health worker positions will be created in Indigenous communities. A range of mental health training programmes and resources will be provided for the existing Indigenous health workforce to enable them to identify better mental illness and assist people to access appropriate treatment. *Implementation arrangements:* scholarships will be provided through the Puggy Hunter Memorial Scholarship Scheme. *Implementation commencement date:* July 2006.

# INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

# NEW SOUTH WALES

The New South Wales Government will deliver a $938.9 million programme of additional expenditure in mental health services over the next five years, commencing with $148.8 million in the 2006-07 financial year. This five-year programme comprises:

- $337.7 million in new additional recurrent funding commencing in the 2006-07 Budget;
- $263.3 million in additional recurrent funding for the expansion of programmes and services which has been previously announced; and
- $337.9 million in capital works, including additional funding for new capital works, works-in-progress, and privately-financed projects.

## ***Promotion, Prevention and Early Intervention ($102.2 million)***

**Expanding University Based Research ($10.0 million)**

Funding of $6.0 million will be provided to the Brain and Mind Research Institute to conduct research and clinical outreach services and $4.0 million to the University of New South Wales to further its research into schizophrenia, depression and anxiety disorders. *Implementation arrangements:* through the university sector. *Implementation commencement date:* May 2006

**Expanding Early Intervention Services for Youth ($28.6 million)**

Tertiary mental health treatment services will be expanded for young people 14-24 years of age. These services will focus on intervention at the early stages of their serious mental illness and effective evidence-based treatment, bringing together specialist youth mental health treatment services, general practitioners (GPs), drug and alcohol workers and other relevant services in a one-stop shop. *Implementation arrangements:* through Area Health Services in collaboration with the non-government and primary care sector. *Implementation commencement date:* July 2006

**Specialist Assessment of the Needs of Older People ($37.3 million)**

Funding will be provided to expand specialist community mental health teams to provide assessment and treatment for older people with mental illness and age-related mental health problems. This programme will build on 2005-06 Budget enhancements for older peoples' mental health community teams and community-based programmes. *Implementation arrangements:* through Area Health Services in partnership with aged care services. *Implementation commencement date:* July 2006

**Statewide 24-hour Mental Health Access by Telephone ($26.3 million)**

Funding will be provided for a New South Wales mental health telephone advice, triage and referral service, staffed by mental health clinicians. This will link into the National Health Call Centre agreed to by the COAG. *Implementation arrangements:* through the roll-out of a statewide 1800 number linked to Area Health Services. *Implementation commencement date:* July 2006

## ***Integrating and Improving the Care System ($699.7 million)***

**Enhancing Community Mental Health Emergency Care ($51.4 million)**

An additional 65 specially-trained professionals will be funded to respond to out of hours emergency and acute community responses across the State by 2007-08, and doubling by 2009-10. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006.

**Expansion of Community Forensic Mental Health Services ($6.5 million)**

Specialist community forensic mental health services will provide assessment, support court diversion, discharge planning from custody and case management of difficult adults and adolescents with a mental illness in contact with the criminal justice system. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

**Better Integration of Mental Health Services with Drug and Alcohol Services ($17.6 million)**

This includes specialist support for offenders and young people, and the trial of methamphetamine treatments. In 2006-07, 20 new graduates will be placed with drug and alcohol and mental health services to strengthen the workforce and build relationships across the two areas. Funding will support new positions that provide specialist drug and alcohol advice and assistance to mental health services and emergency departments. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

**Supporting People with Mental Illness in the Prison System ($5.0 million)**

Enhancement funding will be provided for programmes to assist people with mental illness in correctional centres who are exhibiting challenging behaviours, including through stronger case management. *Implementation arrangements:* through Department of Corrective Services. *Implementation commencement date:* July 2006

**Further increasing the Number of Acute and Non-acute Mental Health Beds ($151.7 million)**

An additional 300 mental health beds in public hospitals have been planned and will be opened over the next three years. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

**Building and Operating New Forensic Facility at Long Bay Prison ($171.6 million)**

*Implementation arrangements:* through public/private partnership. *Implementation commencement date:* July 2006

**Expansion of Community-based Professional Mental Health Services including Child and Adolescent Services ($14.3 million)**

*Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

**Specialist Mental Health Services for Older People ($10.8 million)**

Funding is being provided to reconfigure seven 16-bed units across New South Wales to operate as short-medium stay specialist assessment and treatment facilities for older people with severely and persistently challenging behaviours associated with dementia and/or mental illness. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

**Improving Mental Health Clinical Information and Accountability ($7.6 million)**

*Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

**Building New Facilities to Accommodate New Mental Health Beds including Works at Lismore, Illawarra and Bloomfield Hospital ($117.0 million)**

*Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006.

**Redevelop and Integrate Mental Health Services with Drug and Alcohol Services at St Vincent's Hospital ($23.0 million)**

*Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

**Refurbishing and relocating Mental Health Facilities at Concord, Gosford, Newcastle and Orange hospitals ($117.4 million)**

*Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

**Establishing Psychiatric Emergency Care Centres ($5.8 million)**

Funding is to be provided for continuing the roll-out of Psychiatric Emergency Care Centres at Major Metropolitan Hospitals such as Blacktown, Liverpool, Nepean, Campbelltown, Wollongong, Hornsby, Wyong, St. George and St Vincent's. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

***Participation in the Community and Employment, including Accommodation ($113.8 million)***

**Housing Accommodation and Support Initiative ($58.8 million)**

This initiative is in partnership with the Department of Housing and the non-government sector. This funding will provide an additional 234 support packages to the 736 already funded. A significant proportion of this funding will be for individualised support packages for people requiring ongoing monitoring after in-patient care. In partnership with the NGO sector, this will help people re-settle in the community and prevent re-admission. In 2006-07, 100 of these support packages will be available. The Department of Housing will spend $5.0 million of these funds on the leasing of properties to accommodate people participating in the Housing Accommodation and Support Initiative. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

**Community Rehabilitation Services ($41.5 million)**

This initiative includes extra clinical rehabilitation specialists that will provide assessments and options for people at the earliest stages of their disorder. This includes individualised plans for intervention, transition to community care and specialist psychosocial rehabilitation in the community. This initiative will introduce Vocational Education Training and Employment (VETE) clinicians to provide individual assessments and intervention; preparation and support of VETE plans; linkages and advice on mental health issues for the client as required to Vocational Rehabilitation providers (CRS), employment services and educational providers; and development of local service networks to facilitate referral and management options. It will also include the introduction of Recovery and Resource Services to increase the capacity of NGOs to provide quality social and leisure opportunities for people with a mental illness, based on best practices. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

**Enhance New South Wales Family and Carer Mental Health Programme ($13.5 million)**

Funding will be made available to provide: specialist clinical advice and a comprehensive range of support services for families and carers education and training for families and carers; information for new carers about their rights and responsibilities; involvement of families and carers in assessment, care planning and discharge planning of a loved one; and better access and referrals for families and carers to other community support services. *Implementation arrangements:* through Area Health Services and NGOs. *Implementation commencement date:* July 2006.

## ***Increasing Workforce Capacity ($23.2 million)***

**Mental Health Workforce Programme ($11.0 million)**

This programme comprises a variety of initiatives to improve the capacity of the health workforce to deliver mental health services. These include training of extra doctors in psychiatry, new graduate and transition training programmes for nurses and allied health, 600 undergraduate and postgraduate scholarships for mental health nurses, guaranteed employment for up to 50 New South Wales psychologists while undertaking the Clinical Masters course, and expanding uptake of GPs in the GP Procedural Training Programme in Mental Health. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

**Aboriginal Mental Health Workforce Programme ($12.2 million)**

This initiative will place local Aboriginal mental health trainees in mainstream community mental health teams to address the high and complex needs of Aboriginal people, and for Aboriginal people to engage better with mental health services. This programme is being expanded following a pilot in the Greater Western Area Health Service, which won the Premier's Public Service Award in 2005. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2006

# INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

# VICTORIA

The Victorian Government will deliver at least $472.4 million under the five-year COAG Plan, as part of an ongoing comprehensive strategy for significant and sustained growth and reform.

This five-year programme comprises:

- $222.7 million in new initiatives announced since February 2006, including $178.8 million announced in the 2006-07 State budget. Of this, $20.5 million is to fund capital works at three sites;
- $161.9 million in additional recurrent funding from 2006-07 to 2010-11 announced as part of the landmark investment in mental health services in April 2005; and
- $87.8 million to provide for cost growth in existing services over the same period.

Victoria will carry through reforms begun in previous years and make new investments that are aimed at:

- strengthening our prevention and early intervention efforts;
- expanding the available range of community based treatment and support options;
- improving hospital based mental health services and providing alternatives to inpatient care; and
- providing for the wider support needs of people with a serious psychiatric disability, particularly for supported accommodation.

## ***Promotion, Prevention and Early Intervention ($80.4 million)***

Victoria's commitment to promotion, prevention and early intervention in mental health has been progressed over the past several years. Victoria is a leader in early psychosis programmes, including ORYGEN Youth Health and the Early Psychosis Prevention and Intervention Centre (EPPIC). Victoria has been involved in the establishment of *beyondblue*, including the Victorian Centre for Excellence in Depression.

Other initiatives include Vic Health's Mental Health Promotion Strategy, the employment of Mental Health Promotion Officers in child and adolescent mental health services; and the establishment of Primary Mental Health Teams to support general practitioners (GPs) and other primary care providers across the State.

### Expanding Early Psychosis Programmes ($16.9 million)

Funding will be provided to expand further early psychosis programmes for young people 16 to 25 years as part of a progressive statewide rollout of these services. Early psychosis programmes target young people who are experiencing a first episode of psychosis, with a view to reducing the impact of the illness and improving engagement with the health and education systems. Two early psychosis programmes were funded in 2005 and three more will be funded in 2006. It is anticipated that by the end of 2006-07 approximately 70 per cent of the State will have access to these services. *Implementation arrangements*: through adult clinical community services. *Implementation commencement date:* progressively from July 2005

### Expanding Conduct Disorder Programmes ($8.4 million)

Funding will be provided to further expand conduct disorder programmes for primary school children as part of a progressive statewide rollout of these services. Two conduct disorder programmes were funded in 2005 and two more will be funded in 2006. These programmes are delivered in partnership with schools and target children with severe behavioural and emerging conduct disorder problems with a view to improving behaviour and educational engagement. *Implementation arrangements:* through child and adolescent clinical community services. *Implementation commencement date:* progressively from July 2005,

**Support for Children of Parents with a Mental Illness ($2.4 million)**

Funding will be provided to support families with children where a parent has a mental illness. Family support for children in these circumstances will help improve their educational attainment, and reduces their likelihood of long-term mental illness and contact with the protective and criminal justice systems. This initiative will be coordinated between seven area mental health services to maximise access to the programme. *Implementation arrangements:* through area mental health services. *Implementation commencement date:* July 2006

**Postnatal Depression Support Services ($4.9 million)**

Funding will be provided for additional treatment and support for women with mental illness in the post-partum period and their babies, as well as training, advice and support to primary health and adult mental health services. These services will be funded through the three specialist mother/baby units and will promote attachment and bonding known to be associated with better health and wellbeing outcomes for mothers and babies. *Implementation arrangements:* through specialist mother/baby services. *Implementation commencement date:* July 2005

**New Centre for Women's Mental Health ($1.1 million)**

New funding will be provided to the Royal Women's Hospital (RWH) in 2006 to strengthen the hospital's capacity to identify better, diagnose and treat mental illness. This funding will also help establish a telephone-based secondary consultation service on women's mental health for specialist and generalist clinicians. *Implementation arrangements:* through the hospital. *Implementation commencement date:* October 2006

**Expanding Counselling in Community Health Services ($2.6 million)**

Funding will be provided for up to five additional counselling positions in community health centres to support people with primary mental health problems. *Implementation arrangements:* through community health centres. *Implementation commencement date:* October 2006

**Expanding Primary Prevention and Promotion Programmes ($36.0 million)**

Vic Health will provide a focus on mental health primary prevention and promotion through its mental health strategy and research programme. *Implementation arrangements:* through Vic Health. *Implementation commencement date:* from July 2006

**Mental Health Research ($8.0 million)**

Funding will be provided to relocate the Mental Health Research Institute (MHRI) to the Australian Centre for Neuroscience and Mental Health Research. This will strengthen Victoria's medical research into the causes and treatment of mental illness. *Implementation arrangements:* through the new Centre. *Implementation commencement date:* from July 2005

## ***Integrating and Improving the Care System ($284.9 million)***

Victoria's early investment in mainstreaming hospital-based services and providing community-based care, has meant that it now provides the highest number of total beds (acute and community) per capita nationally. In recent years, Victoria has built on this reform and diversified through, for example, Prevention and Recovery Care (PARC) services to provide new options for step-up/step-down care.

Victoria has also responded to the needs of key target groups through, for example, Dual Diagnosis Services, the Victorian Centre for Excellence in Eating Disorders and the Victorian Institute for Forensic Mental Health Care.

Additional funding includes $79.6 million allowed for cost growth in forward estimates over the five years of the Plan.

## Expand community mental health services

### Expanding Child and Adolescent, Adult and Aged Specialist Community Services ($47.3 million)

Funding will be provided to expand the intensive community treatment capacity of adult, aged and child and adolescent clinical mental health services. In 2005, 57 additional positions were funded and 24 more positions will be funded in 2006. This funding forms part of an ongoing statewide strategy to strengthen the core capacity of clinical ambulatory services to reduce demand for bed-based services and more assertively manage and treat consumers with complex needs. *Implementation arrangements:* through adult, aged and child and adolescent clinical community services. *Implementation commencement date:* progressively from July 2005

In addition a new specialised eating disorder day programme will be established for young people up to 24 years of age with eating disorders who do not require hospitalisation but require a higher level of care than can be provided in the community by specialist mental health services. *Implementation arrangements:* through an area mental health service in partnership with the Butterfly Foundation. *Implementation commencement date:* October 2006

### Expanding Dual Diagnosis Services ($8.9 million)

Funding will be provided for a range of workforce initiatives that will improve the quality of services provided to people experiencing both mental health and drug and alcohol problems, and encourage greater collaboration between mental health and drug and alcohol treatment services. *Implementation arrangements:* through adult clinical community services in collaboration with alcohol and drug treatment services. *Implementation commencement date:* July 2005

## Improve hospital care and alternatives

### Expansion of Mental Health Teams in Hospital Emergency Departments ($15.6 million)

Funding will be provided for an enhanced mental health response at hospital emergency departments (EDs) to assist staff in addressing demand pressures within the ED. Five hospitals received funding in 2005 and nine more hospitals will receive funding in 2006. This initiative is part of an ongoing strategy to reduce waiting times in EDs and improve outcomes for consumers, and builds on existing crisis assessment and treatment capacity to enable 24-hour, seven day a week coverage. *Implementation arrangements:* through hospitals. *Implementation commencement date:* progressively from July 2005

### Supporting Transition to the Community for Long-term Residents of Extended Care Facilities ($6.6 million)

Funding will be provided for a new initiative to support the transition of long stay residents from bed-based extended clinical care services to the community. The 12 intensive psychosocial support packages will be augmented by intensive clinical outreach support. *Implementation arrangements*: through selected Psychiatric Disability Rehabilitation and Support Services (PDRSS), in partnership with adult clinical community services. *Implementation commencement date:* October 2006

### Expanding Capacity in Bed-based Forensic Mental Health Services ($21.1 million)

Funding will be provided for an additional 18 interim forensic mental health beds at Thomas Embling Hospital. This investment will provide the service system with greater capacity in the immediate term to manage the complex mental health problems of the prison and forensic population while the long-term expansion of forensic mental health capacity is planned. *Implementation arrangements*: through Forensicare. *Implementation commencement date:* late 2006

### Additional Step-up/Step-down PARC Sub-acute Places ($25.1 million)

Funding will be provided for additional Prevention and Recovery Care (PARC) places for people who need short-term sub-acute care. In 2005, two new PARC services were funded and in 2006 another full service and one extended service will be funded. These services will avert inpatient admissions for consumers who would otherwise require acute inpatient care and provide post-acute treatment and

support to facilitate discharge from this serive setting. *Implementation arrangements:* through PDRSS, in partnership with adult clinical community services. *Implementation commencement date*: progressively from July 2005

**Hospital Demand Management ($17.4 million)**

Funding will be provided to support hospitals to manage mental health ED presentations, increase the capacity of community-based services to reduce avoidable admissions by consumers with chronic and complex needs (HARP), and provide additional acute inpatient beds and diversionary services. *Implementation arrangements*: through hospitals and area mental health services. *Implementation commencement date*: July 2005

**Increasing the Acute Mental Health Bed Capacity ($39.9 million)**

Funding will be provided to support the expansion of adult acute inpatient capacity. This includes full year funding for 26 new beds and the purchase of private beds on an interim basis, while new/replacement beds are constructed in the future. *Implementation arrangements*: through hospitals. *Implementation commencement date*: July 2005

### Improve information flow

**Improving Triage Practice ($2.8 million)**

Funding has been provided to improve service information and effective triage and intake assessment, especially for people in crisis, to improve client flow through the service system. These are linked to broader developments across key service interfaces with acute hospitals, primary care and community health. *Implementation arrangements*: through hospitals and adult clinical community services. *Implementation commencement date*: July 2005

**Building Better Mental Health Facilities ($20.5 million)**

Funding will be provided to support the efficient use of acute inpatient beds and provide alternative discharge options and diversion from inpatient services. The initiatives include:

- **Heidelberg Repatriation Hospital Mental Health ($9.0 million)** Developmental works for a secure extended care beds facility on the Heidelberg Repatriation Hospital site will be advanced. This funding will also enable the construction of the Kokoda gymnasium and pool for the Heidelberg Repatriation Hospital site;
- **Shepparton Mental Health – Ambermere ($6.5 million)** Facilities in the former Ambermere psychiatric hospital will be redeveloped for mental health services that will provide opportunities for both recovery and rehabilitation for 20 patients. This development includes facilities for the Centre for Older Person's Health, which operates from the Ambermere site; and
- **Brunswick Human Services Precinct: Bouverie Centre Relocation ($5.0 million)** The Bouverie Centre will be relocated to the new Brunswick Human Services precinct. The move to Brunswick will co-locate the Bouverie Centre with the Victorian Foundation for Survivors of Torture to provide an accessible location for family intervention services.

*Implementation arrangements*: through the hospitals and Bouverie Centre. *Implementation commencement date*: from October 2006

### ***Participation in the Community and Employment, including Accommodation ($102.7 million)***

Over the past several years, Victoria has invested in a comprehensive network of clinical and non-clinical community-based services. This has seen the growth of a robust PDRSS sector to promote recovery, primarily delivered through non-government agencies. These services include housing support, day programmes, residential rehabilitation services, and respite care.

Victoria's investment in clinical and non-clinical mental health services has increased the capacity to provide a range of supported accommodation options for people with a mental illness and their carers

living in the community. In addition, the Victorian Homelessness Strategy has provided new pathways out of homelessness for people with mental illness.

Additional funding includes $8.2 million allowed for cost growth in forward estimates over the five years of the Plan.

**Growing Psychiatric Disability Rehabilitation Support Services ($38.6 million)**

Funding will be provided for the progressive statewide expansion of PDRSS living support services for people with a psychiatric disability, and to improve service sustainability by addressing cost pressures. In 2005 services received a nine per cent increase in funding with further growth funding provided in 2006. This funding will also improve links between homelessness support services and the mental health system. *Implementation arrangements*: through the PDRSS sector. *Implementation commencement date*: progressively from July 2005

**Expanding Community Care Units ($7.5 million)**

Funding will be provided to expand community care unit capacity for people who need extended clinical care by the equivalent of 14 additional beds. *Implementation arrangements*: through metropolitan and rural health services. *Implementation commencement date*: October 2006

**Supported Accommodation for Vulnerable People ($40.4 million)**

Funding will be provided to assist pension-level Supported Residential Services to improve accommodation and personal support for residents with psychiatric and other disabilities. *Implementation arrangements*: through pension-level Supported Residential Services. *Implementation commencement date*: July 2006

**Homelessness and Mental Health Initiatives ($8.0 million)**

Funding will be provided to create stable and affordable housing pathways for people with a mental illness post their discharge from adult acute inpatient and extended care facilities through the provision of proactive tenancy support. *Implementation arrangements*: through homelessness support agencies. *Implementation commencement date*: July 2006

## ***Increasing Workforce Capacity ($4.4 million)***

Victoria's commitment to delivering high-quality services has been paralleled by a focus on workforce development.

Victoria will continue to invest in clinical training and a range of graduate and postgraduate supports for students, as well as ongoing education and training for mental health professionals. This will be complemented by additional training for frontline workers in health and non-health sectors to improve early recognition and intervention of mental health problems, and facilitate integrated service responses.

Victoria will continue to fund Consumer and Carer Consultants within mental health services who provide a range of peer support services and contribute to service development.

As part of a broader health workforce strategy, Victoria will pilot new or expanded roles and service/workforce models to improve the quality and safety of care.

**Enhancing Workforce Capacity ($4.4 million)**

Funding is being provided for specialist graduate nurse positions and post graduate nursing scholarships. In 2005, 81 post graduate scholarships and 10 graduate positions were funded. In 2006, another 37 post graduate scholarships and six graduate positions will be funded. These initiatives form part of a strategy to provide new starters and early career staff with a structured package of peer supports and professional opportunities, and to support the implementation of education and training initiatives to improve workforce quality in the specialist mental health sector. *Implementation arrangements*: through area mental health services. *Implementation commencement date*: progressively from July 2005

# INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

# QUEENSLAND

From 2006-07 the Queensland Government is committing new funding of $366.2 million over five years to improve the quality of, and access to, mental health services. This includes:

- $189.0 million announced in the October 2005 Special Fiscal and Economic Statement, with the first full year of funding to commence in 2006-07;
- $109.6 million additional recurrent funding for the expansion of initiatives previously announced;
- $35.7 million in new additional recurrent funding commencing in the 2006-07 State Budget; and
- $32.0 million for capital works, including additional funding for new capital works and works-in-progress.

In addition to the above initiatives, more than $250.0 million has been provided to address wages growth over the next three years to attract and retain skilled mental health staff. Initiatives have been split between the four below areas, where appropriate.

## ***Promotion, Prevention and Early Intervention ($6.9 million)***

To complement existing investment targeting depression, suicide, resilience in school children and wellness in rural and remote communities, Queensland has funded the following initiatives.

**Early Years Service Centres ($4.9 million)**

Queensland is establishing four early years service centres to improve services and support for families with children from 0–8 years of age. The services will integrate universal child care and family support with early childhood education and health services and provide targeted support to vulnerable families in a non-stigmatising way. Mental health-related prevention and early intervention strategies will include parenting resources and programmes, emotional well-being and developmental programmes, a range of play therapy and counselling initiatives, health screening and assessment and mental health promotion. Specialist early childhood teams will provide home visits for high need families, outreach services to early childhood settings and broker specialist support as required. *Implementation arrangements:* through the Department of Communities. *Implementation commencement date:* the centres will be phased in from 2006 to 2009

**Prevention Strategies in Schools**

New strategies are also being developed to assist schools in supporting students with a mental illness. Strategies will include: regional contact officers; a statewide senior guidance officer; on-line materials; and staff professional development. *Implementation arrangements:* through the Department of Education and the Arts. *Implementation commencement date:* Queensland is reprioritising its existing budget commitments to allow for these to be developed as soon as possible.

**Dual Diagnosis Positions ($0.8 million)**

Thirteen new dual diagnosis positions will be created across Queensland to respond to people showing early symptoms of mental health and/or drug and alcohol problems. The positions will enhance service capacity in both the mental health and drug and alcohol sectors by: integrating assessment, intervention and care processes; implementing workforce development and training initiatives; and formalising collaboration and leadership development. The positions will have a strong early intervention focus. Part of the funding package is to improve the care system and is represented in that section. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2006

**Transcultural Mental Health Workforce ($1.2 million)**

Eleven transcultural mental health workers will be employed across thirteen District Health Services to support mental health services working with people from culturally and linguistically diverse backgrounds. Staff will dedicate a proportion of their time to work with local multicultural groups to initiate mental health promotion, illness prevention and early intervention strategies. The Queensland Transcultural Mental Health Centre will engage a range of bilingual mental health promoters, who will implement community activities that promote mental wellness. Part of the funding package is to improve the care system and is represented in that section. *Implementation arrangements:* through District Mental Health Services*. Implementation commencement date:* from 1 July 2006

## ***Integrating and Improving the Care System ($289.0 million)***

Queensland will enhance mental health service delivery across a range of sectors. It will target both the general population and specific population sub-groups, including children and young people in care; Indigenous people; people from culturally and linguistically diverse backgrounds; the homeless; people who come into contact with police and the criminal justice system; and those in correctional facilities. Queensland will supplement its existing investment through the following initiatives.

**Blueprint for the Bush Service Delivery Hubs ($1.8 million)**

Under the auspices of Blueprint for the Bush, Queensland will establish three multi-tenant service hubs in rural and remote areas. The hubs will co-locate a range of services including family support workers; support services to vulnerable families with children from 10 to 14 years of age; and suicide prevention initiatives for older men at risk of suicide and self-harming behaviour and to promote social inclusion for isolated older people. *Implementation arrangements:* through the non-government sector. *Implementation commencement date:* from July 2007

**Indigenous Domestic and Family Violence Counselling ($1.2 million)**

Domestic and family violence counselling services will be piloted in three rural communities (the Torres Strait, Cooktown and Cherbourg) to provide support to Indigenous victims and child witnesses of domestic and family violence. The services will also provide outreach support to surrounding Indigenous communities. These counselling services can assist clients to overcome anxiety and depression, often associated with being a victim of violence, and reduce the likelihood of more serious mental illness developing. *Implementation arrangements:* through the non-government sector. *Implementation commencement date:* from March 2007

**Child Safety Therapeutic and Behaviour Support Services ($17.6 million)**

Queensland will provide capital and operational funding to establish two new therapeutic residential facilities in South East Queensland. The facilities will each provide placement options for four to six children and young people with complex to extreme needs at any point in time. It is part of a statewide roll-out of therapeutic services established to provide professional treatment for complex emotional, mental and behavioural problems in children. *Implementation arrangements:* to be operated under service agreements by the non-government sector*. Implementation commencement date:* July 2007

**Health Action Plan - Existing Service Pressures ($58.1 million)**

The pressure on acute mental health inpatient services and emergency departments has increased over the years as a result of approximately twice the national average population growth and increases in the level of acuity in people presenting with mental health problems. Additional funding will be targeted specifically at these services components to deal with high levels of bed occupancy and the high volume of mental health presentations in Emergency Departments. *Implementation arrangements:* through District Health Services. *Implementation commencement date:* from January 2006

**Community Mental Health Services – Enhancement ($114.5 million)**

Queensland will improve specialist community mental health services to provide acute care, crisis assessment, mobile intensive treatment, continuing care and intake and assessment services in

community settings. More people with mental illness will be able to access services and receive treatment in the community and in settings closer to their natural support networks. *Implementation arrangements:* through District Community Mental Health Services*. Implementation commencement date:* from 1 July 2006

**Dual Diagnosis Positions ($4.7 million)**

Thirteen new dual diagnosis positions will be created across Queensland to respond to people showing early symptoms of mental health and/or drug and alcohol problems. The positions will enhance service capacity in both the mental health and drug and alcohol sectors by: integrating assessment, intervention and care processes; implementing workforce development and training initiatives; and formalising collaboration and leadership development. Part of the funding package is for promotion and prevention activities and is represented in that section. *Implementation arrangements:* through District Mental Health Services*. Implementation commencement date:* from 1 July 2006

**Mental Health Intervention Teams ($4.1 million)**

Funding will be provided to improve responses to mental health incidents that require police or ambulance officers. This initiative aims to prevent and resolve mental health crisis situations by establishing collaborative responses between Queensland Health, the Queensland Police Service and the Queensland Ambulance Service. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* 1 January 2006

**Forensic Mental Health Services ($14.8 million)**

Additional funding will be provided to enhance service responses to high-risk forensic patients in Queensland. This will include the provision of support services to people with mental illness transitioning through the criminal justice system and the provision of support, advice and education to district mental health staff to manage high-risk patients. *Implementation arrangements:* through Community Forensic Mental Health Services*. Implementation commencement date:* from 1 July 2006

**Transcultural Mental Health Positions ($6.8 million)**

Eleven transcultural mental health workers will be employed across 13 District Health Services to support mental health services working with people from culturally and linguistically diverse backgrounds. Staff will dedicate a proportion of their time to work with local multicultural groups to initiate mental health promotion, illness prevention and early intervention strategies. At the statewide level, the Queensland Transcultural Mental Health Centre will engage a range of bilingual mental health promoters who will implement community activities that promote mental wellness. Part of the funding package is for promotion and prevention activities and is represented in that section. *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2006

**Area Clinical Mental Health Networks ($7.7 million)**

In recognition of ongoing pressures on mental health services, Queensland will allocate funding to Area Mental Health Clinical Networks to address priority service capacity issues and to initiate innovative responses to area-wide service delivery issues. *Implementation arrangements:* through Area Mental Health Clinical Networks. *Implementation commencement date:* from 1 July 2006

**Alternatives to Admission ($17.5 million)**

Nine District Health Services have been funded to develop and implement a range of alternatives to acute admission, in collaboration with the non-government sector, consumers and carers. *Implementation arrangements:* through District Mental Health Services*. Implementation commencement date:* from 1 July 2007

**Responding to Homelessness ($19.7 million)**

As part of the Responding to Homelessness Strategy 2005-2009, Queensland will establish homeless outreach teams in Brisbane, the Gold Coast, Townsville, Cairns, and Mount Isa as part of a commitment to address homelessness and public intoxication. In addition, 36 transitional housing places will be established in Brisbane and Townsville. This will assertively tackle the high prevalence of mental illness amongst homeless people in high-need areas and reduce the number of people with mental illness being discharged into homelessness. *Implementation arrangements:* through District Mental Health Services; Department of Housing and the non-government sector. *Implementation commencement date:* this project has been underway since 1 July 2005

**Mental Health Services in Prisons ($8.6 million)**

Queensland will enhance clinical mental health services to people in correctional facilities across the state, including in-reach assessment and treatment services. *Implementation arrangements:* through Community Forensic Mental Health Services and District Mental Health Services. *Implementation commencement date:* from 1 July 2006

**Mental Health Capital ($12.0 million)**

Queensland has committed capital funding of $5.8 million over five years for the construction and redevelopment of designated mental health facilities to support enhanced access to services. In 2006-07, the Cairns Mental Health Community Rehabilitation and Recovery Service and the Rockhampton Child and Youth Mental Health community clinic will be completed. An investment of $41.0 million over five years in a number of community health and primary health care centres including Gladstone, Nundah, and Yarrabah will also result in enhanced access to community-based health and mental health services. This $41.0 million investment includes $6.1 million which will be specifically for access to community mental health services. *Implementation arrangements:* through District Health Services. *Implementation commencement date:* from 1 July 2006

***Participation in the Community and Employment, including Accommodation ($64.3 million)***

Queensland will supplement its existing investment through the following initiatives.

**Housing Capital ($20.0 million)**

A mix of accommodation to best meet the needs of individual clients will be procured for adults with a mental illness and moderate to high support needs (clinical and non-clinical) who are currently housed inappropriately, and who are assessed as being able to live independently in the community, with appropriate support. Housing for about 80 people will be provided in 2006-07 in accordance with social housing eligibility guidelines. Planning is currently under way with Queensland Health and Disability Services Queensland to link identified clients with support arrangements who are ready to live independently with suitable accommodation arrangements. *Implementation arrangements:* through the Department of Housing. *Implementation commencement date:* from 1 July 2006

**Health Action Plan Non-Government Organisation Funding ($25.0 million)**

Funding will be provided to Queensland non-government organisations to support people with a mental illness living in the community, including people living in housing provided by the $20.0 million capital investment identified above. This will ensure that people living in the community have access to adequate clinical and non-clinical support to assist them in their recovery process. *Implementation arrangements:* through the non-government sector. *Implementation commencement date:* 1 July 2006

To further complement the $20.0 million housing capital, the Queensland Government will support clients through the Special Fiscal and Economic Statement funding announced in October 2005, specifically the Mental Health Community Organisation Funding Programme; and growth funding to Disability Services Queensland for accommodation support services. The housing capital investment will also enable some acceleration of Project 300 clients to access appropriate accommodation.

**Disability Services Respite and Sector Capacity Building ($12.0 million)**

Additional funding will be provided for the establishment of new, and enhancement of existing, respite and day services. Additional services under the Resident Support Programme will be funded to assist people living in private residential facilities, while people inappropriately housed in hostels and boarding houses will be supported to relocate to alternative accommodation through Hostels Response funding. Funding through both the Family Support and Adult Lifestyle Support Programmes will enable people with a psychiatric disability to maintain their community living either independently or with their families. *Implementation arrangements:* mostly through the non-government sector. *Implementation commencement date:* from August 2006

**Employment and Training ($5.0 million)**

Financial assistance will be provided to the non-government sector as part of the 'Breaking the Unemployment Cycle' initiative, to provide job and training opportunities to people with a mental illness who experience disadvantage in the labour market. Funding will initially be provided under the Community Jobs Programme to community and public sector organisations to provide job search assistance and training to people with a mental illness and/or employment for three to six months on projects that will enhance skills development and future employment prospects. It is proposed that approximately $1.0 million will be directed towards projects during 2006-07 to assist 130 people with a mental illness. From 2007-08 onwards, it is proposed that about 100 people with a mental illness will be assisted each year for the following four years. *Implementation arrangements:* predominantly through the non-government sector. *Implementation commencement date:* from August 2006

**Mental Health Services in Prisons ($2.3 million)**

Funding will be provided to the non-government sector to support the enhanced prison mental health services, particularly to provide post-release support to people with mental illness returning to the community. *Implementation arrangements:* through the non-government sector. *Implementation commencement date:* 1 July 2006

## ***Increasing Workforce Capacity ($6.1 million)***

Queensland is the most decentralised state in Australia, and as such, needs a workforce for the large, urban specialist inpatient and community mental health services, and a workforce for its small rural and remote communities. This requires a range of different skill sets to meet differing needs and appropriate remuneration and conditions of employment to ensure that Queenslanders have access to high-quality health care. Queensland will supplement its existing investment through the initiatives outlined below.

**Increased Workforce Remuneration ($5.8 million)**

As a result of this overall increased investment in mental health, remuneration and conditions of employment have improved for all mental health staff which will assist in attracting and retaining the required workforce. This will particularly assist in the areas of community mental health services ($3.6 million), community forensic mental health services ($1.0 million), services to correctional facilities ($1.0 million) and services designed to assist situations where the first response is by police or ambulance officers ($0.2 million). *Implementation arrangements:* through District Mental Health Services. *Implementation commencement date:* from 1 July 2006

**Mental Health Transition to Practice Nurse Education Programme ($0.3 million)**

Queensland Health will establish a Mental Health Transition to Practice Nurse Educator Programme to provide adequate practical clinical experience for inexperienced nurses before they enter the mental health sector. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* 1 July 2008.

# INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

# WESTERN AUSTRALIA

In September 2004 the Western Australian Government announced the *Mental Health Strategy 2004-07*. The strategy is targeted to:

- expand statewide mental health emergency services within emergency departments;
- increase access to adult in-patient beds for people with severe mental illness;
- promote recovery for people with mental illness through provision of accessible community services, which encourage early identification, intervention and rehabilitation, and to enhance service coverage and accountability and provide a whole of service/government approach to promote mental health and recovery from mental illness for young people; and
- expand the range and amount of community supported accommodation services for people with severe and persistent mental illness.

The strategy contains increases in both capital and operating funding and covers expenditures within the Department of Health and other agencies, including the Department of Housing and Works.

The table below provides summary information on the budgeted increases in funding for mental health initiatives provided since the commencement of the strategy.

| | 2004-05 | 2005-06 | 2006-07 | 2007-08 | 2008-09 | 2009-10 | |
|---|---|---|---|---|---|---|---|
| | Actual $'000 | Estimated Actual $'000 | Budget $'000 | Budget $'000 | Budget $'000 | Budget $'000 | Total $'000 |
| **Operating** | 11,000 | 32,484 | 47,268 | 30,000 | 30,000 | 30,000 | **180,752** |
| **Capital** | 516 | 4,200 | 20,584 | 19,000 | 15,500 | 12,000 | **71,800** |
| **Total** | 11,516 | 36,684 | 67,852 | 49,000 | 45,500 | 42,000 | **252,552** |

Western Australia's contribution to the National Action Plan is therefore not a one-off effort, but rather a continuation of the State's deliberate *Mental Health Strategy* of growth and reform. In total, this lifts overall spending on mental health funding by the Western Australian Government to more than $300 million a year. Further information on the additional funding allocated under the *Mental Health Strategy* is provided below.

## ***Promotion, Prevention and Early Intervention ($60.7 million over six years)***

**Multi-systemic Therapy for Adolescents ($10.5 million)**

This initiative will provide two Multi-systemic Therapy (MST) Teams for young people aged 12 - 16 years at risk of developing mental illness in the south and north metropolitan areas. *Implementation arrangements:* establishment of clinical teams through Area Mental Health Services. *Implementation commencement date:* September 2005

**Post-natal Depression Services ($2.0 million)**

Statewide Post-natal Depression (PND) Service for mothers with babies will be expanded through non-government community services, including areas with a high growth of young families. Research will be undertaken to develop PND services for culturally and linguistically diverse and Aboriginal groups. *Implementation arrangements:* statewide service provision through a non-government service. *Implementation commencement date*: July 2006

**Assertive Case Management Systems (including Increased Access to In-patient Care) ($45.2 million)**

Based on national benchmarks to meet the increase in population, community mental health team staffing levels will be increased to introduce the Assertive Community Care (ACC) model. This model will be embedded within existing community mental health services to provide intensive intervention to people with severe and persistent mental illness. *Implementation arrangements:* through Area Mental Health Services to existing community mental health services. *Implementation commencement date:* July 2006

**Homeless Clinical Services ($1.0 million)**

This service will provide transitional supported accommodation services in the metropolitan area for homeless adults and young people with a mental illness, including 24-hour on site supported residential accommodation, access on site to specialist mental health, substance abuse and psychosocial support services and access on site to employment, income support and educational services. *Implementation arrangements:* through non-government services. *Implementation commencement date:* May 2008

**Intensive Community Youth Services ($2.0 million)**

This service will provide intensive counselling, access to stable accommodation, education and employment access for homeless youth at risk of mental illness, with little family or guardian support, in the south metropolitan area. *Implementation arrangements:* establishment of a clinical community service through the South Metropolitan Area Mental Health Service. *Implementation commencement date:* services operational with permanent offices to be completed by November 2007

***Integrating and Improving the Care System ($53.6 million over six years)***

**Emergency Department Mental Health Liaison Nurses and On-duty Registrars ($24.5 million)**

Additional mental health nurses will provide 24-hour 7-day a week specialised mental health triaging and clinical support within Emergency Departments across the metropolitan area. The number of On-Duty Psychiatric Registrars for after hours cover across the metropolitan area will also be increased to provide psychiatric assessment, treatment and support for mental health patients in the Emergency Department. *Implementation arrangements:* through Area Mental Health Services. *Implementation commencement date:* July 2006

**Acute Observation Emergency Department Beds ($20.1 million)**

Observation mental health beds will be established three main metropolitan hospitals (Joondalup, Fremantle Hospital and Royal Perth Hospital) and a four-bed admissions unit will be established at the main psychiatric hospital, Graylands. These units will provide a safe and secure environment for both patients and staff during assessment and triage. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* March 2007

**Rural and Remote Medical Cover ($9.0 million)**

Additional psychiatrist and medical officer cover in rural and regional Western Australia. *Implementation arrangements:* recruitment through Area Health Services. *Implementation commencement date:* September 2006

***Participation in the Community and Employment, including Accommodation ($129.4 million over six years)***

**Intermediate Care Units ($25.0 million)**

These units will be established in the metropolitan and regional areas to provide a central role in the progressive move towards more community based rehabilitation and recovery services. The units will be available for consumers who are no longer in the most acute phase of their illness, but who are not

yet ready for discharge to supported accommodation or independent living. Consumers will be engaged in a multi-disciplinary therapeutic programme, tailored to their individual needs and strengths, to prepare them for entry into either independent living or supported community accommodation. *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* July 2008

**Day Treatment Programme ($29.0 million)**

This initiative will establish Day Therapy services in metropolitan locations. Art Therapy Services will also be established in Joondalup and Northbridge and an adult transition unit at Sir Charles Gairdner Hospital. Day Therapy Units will be intermediate level services based on a recovery model, using multi-disciplinary teams, and including a range of rehabilitative interventions following inpatient care, intensive therapy for individuals with long-term severe mental disorders following a relapse and ensure rehabilitation and maintenance, early intensive treatment options for those severely affected by the high prevalence disorders (anxiety, panic disorder and depression) and for some services, low prevalence disorders (eating disorders, and obsessive compulsive disorders). *Implementation arrangements:* through Area Health Services. *Implementation commencement date:* November 2006

**Supported Community Residential Units ($27.2 million)**

Community Supported Residential Units will be established in key metropolitan and rural locations. This cluster style accommodation will provide 24-hour non-clinical support in permanent, home-like accommodation to support community integration and participation including access to generic mainstream services, facilities and recreational pursuits, along with access to a mix of services including clinical, case management, GP and non-clinical community support. *Implementation arrangements:* through non-government services, in collaboration with Area Mental Health Services. *Implementation commencement date:* August 2007

**Licensed Psychiatric Support Expansion ($10.0 million)**

Psychosocial support services to people with severe and persistent mental illness living in psychiatric hostels will be expanded, including an increase in the Personal Care Subsidy payment. *Implementation arrangements:* increased service delivery through psychiatric hostels. *Implementation commencement date:* July 2006

**NGO Psychosocial Support Expansion ($10.0 million)**

This initiative will expand non-clinical psychosocial support services to assist people to live in their own homes, including purchasing personal care services to provide assistance for each resident with activities for daily living and communal living. It will also establish 60 housing units for the Independent Living Programme per year. *Implementation arrangements:* increased service delivery through non-government services. *Implementation commencement date:* July 2006

**Clinical Rehabilitation Teams ($28.2 million)**

This service will establish two Mobile Clinical Rehabilitation Teams (CRT) to maintain people with chronic mental illness and disability, who have been long-term inpatients, in supported community-based residential environments. These multidisciplinary teams will provide ongoing clinical and rehabilitation services to residents. The model will be one of intensive and assertive case management where each team is responsible for all aspects of clinical mental health care and rehabilitation. The CRTs will develop strong partnerships and will collaborate with the non-government accommodation provider on the best way to relocate individuals and provide the ongoing clinical, rehabilitation and disability support. *Implementation arrangements:* through Area Mental Health Services in collaboration with a non-government service provider. *Implementation commencement date:* December 2008

## ***Increasing Workforce Capacity ($8.8 million over six years)***

**Workforce and Safety Initiatives ($2.3 million)**

A statewide mental health safety group has been convened to provide a sector-wide response to major safety issues for staff and patients in mental health services. The safety group will produce guidelines on areas such as design of mental health facilities, training and safe transportation of patients, the use and availability of duress alarms, communication (including mobile telephones) and safe flexible working environments. In addition to the work of this group, guidelines on the management of inpatient violence are also being developed, in collaboration with clinicians and consumers. *Implementation arrangements:* statewide in collaboration with Area Mental Health Services. *Implementation commencement date:* October 2006

**Workforce Development and Expansion ($5.5 million)**

The Department of Health will embark on a major recruitment drive in Australia and overseas to recruit and retain staff. The Department will also work in collaboration with Western Australian universities to attract graduates and post-graduates to mental health nursing. *Implementation arrangements:* through Area Mental Health Services and in collaboration with universities. *Implementation commencement date*: July 2006

**Standards and Implementation Monitoring ($1.0 million)**

The following programmes will be delivered to implement the National Practice Standards:

- a statewide orientation programme for all staff new to Western Australia;
- the development and implementation of a framework and training package for clinical supervision, along with a supervision database;
- the facilitation of a Mental Health Management and Leadership programme for senior mental health staff;
- the development of a cultural competency training package that includes cultural competency standards and a self-assessment audit tool for mental health services;
- the transfer of $2.0 million to Health Services to procure duress systems across the State;
- the progressive implementation of the Mental Health Clinical Information System (PSOLIS);
- a project to develop a policy and clinical practice framework in Clinical Risk Assessment and Management, including the implementation of these standards in Health Services, through training; and
- development of training programmes for nursing professions and NGO sector development.

*Implementation arrangements:* through the Office of Mental Health, in collaboration with Area Mental Health Services. *Implementation commencement date:* January 2006

# INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

# SOUTH AUSTRALIA

Over the past four years South Australia has increased spending on mental health service programmes by 24 per cent, from a base of $145.8 million in 2001-02 to $181.0 million in 2005-06. In addition, a one off allocation of $25.0 million was made for the provision of non-government mental health services in 2005-2006 and 2006-07. Additionally, the South Australian Government has made new commitments with relevance to this Plan. Over four years South Australia will deliver a $116.2 million programme of additional expenditure in mental health services:

- $50.1 million in new additional recurrent funding commencing in the 2006-07;
- $53.1 million in recurrent funding for programmes and services which have been previously announced; and
- $13.0 million in one off funding for programmes and services which have been previously announced.

The 2006-07 South Australian Budget will be brought down on 21 September 2006. Further information on the programmes below concerning implementation arrangements, implementation dates and final funding commitments and their impact over five years will be available after the 2006 Budget.

## ***Promotion, Prevention and Early Intervention ($39.5 million over four years)***

### Promoting Mental Health ($1.1 million)

A new five year agreement with *beyondblue* commences on 1 July 2006. Funding will be provided to *beyondblue* to develop promotion and prevention strategies, enhance professional training, commission and support research and promote partnerships across health and other sectors. *Implementation commencement date*: 1 July 2006

### Preventing Mental Illness by Building Resilience ($29.6 million)

The *Every Chance Every Child* home visiting programme will be expanded with an additional $6.5 million over four years to provide families in need with up to 34 visits in the first two years of their baby's life. South Australia's network of Early Childhood Development Centres will be expanded to 20 with the establishment of a further 10 centres. They will provide education services for children and their parents, and will help children in the transition from the early years to junior primary school. Health services will include: immunisation and health checks; child and youth health; parenting networks; child and adolescent mental health; speech pathology; and health promotion ($13.0 million capital funding and $10.0 million recurrent over four years). These initiatives give increased capacity to programmes focusing on building resilience and coping skills of children, young people and families.

### Early Intervention with Young People ($8.8 million)

The *Healthy Young Minds* programme will provide 20 additional community outreach workers in Child and Adolescent Mental Health Services, plus three psychiatrists to improve and expand services in areas where there is high demand for therapy.

## ***Integrating and Improving Care Systems ($75.7 million over four years)***

### Shared Care with General Practitioners (GPs) ($10.0 million)

This initiative will provide 30 allied health professionals such as psychologists, occupational therapists, nurse practitioners and social workers to work with GPs in private practice. GPs are at the frontline in the delivery of primary health care services. This shared care initiative will increase their capacity to provide appropriate services to people with mental illness who have complex needs.

**Improving Services to People with Mental Illness and Drug and Alcohol Issues ($3.5 million)**

Through the *Healthy Young Minds* funding, two specialist mental health workers and a consulting psychiatrist will provide an outreach service for adolescents with both mental illness and substance abuse problems ($1.2 million over four years). This builds on the 2005 allocation of $578,000 per year for coordinated care between mental health and drug and alcohol services.

**24-hour Mental Health Access by Telephone ($8.0 million)**

A 1800 number service will provide South Australia with a mental health telephone advice, triage and referral service, staffed by mental health clinicians. This will link into the National Health Call Centre agreed to by COAG.

**Enhancing Emergency Department Responses ($6.7 million)**

Mental health cover in the Emergency Department of the Women's and Children's Hospital will be extended to provide 24-hour seven day a week help for children and adolescents in crisis ($480,000) through *Healthy Young Minds* funding. This builds on the annual allocation of $1.4 million for 15.4 additional, full-time mental health liaison nurses in metropolitan emergency departments to enhance patient services and the $156,000 per year to expand the Mental Health Emergency Response Service for Children and Young People, based at the Women's and Children's Hospital, announced in 2005.

**Improving Access to Acute and Community-based Clinical Services ($22.7 million)**

Acute and community-based mental health services have been given increased capacity to assist people who are experiencing acute episodes of mental illness to prevent crisis and promote rehabilitation and recovery. Ten new nurse practitioners will be placed in metropolitan and country regions, working in areas such as Glenside Hospital, emergency departments, aged care, and the child and adolescent sector ($1.1 million per year). The programme includes: 20 extra nurses or allied health professionals to enhance assertive care of those with severe and complex illnesses ($1.0 million per year); increasing mental health 'hospital at home' services ($1.2 million per year): more social workers to provide and evaluate discharge follow-up for each patient leaving hospital ($740,000 per year); the Central Northern Adelaide's Peer Support Programme will employ mental health consumers to provide support, education and advocacy for fellow consumers in our mental health system ($500,000 per year); a youth mobile outreach service focused on reducing the rate of relapse in young people through timely emergency intervention ($265,000 per year); and community support and expansion of Assessment and Crisis Intervention team capacity to improve emergency mobile response ($830,000 per year).

**Increased Services for People in Country Areas ($7.6 million)**

More services are being provided in rural and remote areas and a more flexible approach to service delivery in these areas. This has been made possible through: six additional workers in country-based Child and Adolescent Mental Health Services ($475,000 per year); enhanced treatment and support of people experiencing acute mental illness in country areas ($600,000 per year); additional psychosocial rehabilitation programmes ($496,000 per year); and expanded emergency triage and liaison services for country South Australians ($330,000 per year).

**Extra Support for Aboriginal and Torres Strait Islander People ($5.1 million)**

This is being done by enhancing the Northern Assessment and Crisis Intervention Team's emergency response for Aboriginal and Torres Strait Islanders ($180,000 per year) and development of a peer-support programme for Aboriginal and Torres Strait Islanders run by Central Northern Adelaide Health Service ($100,000 per year). A substance abuse treatment centre and outreach programme will provide assessment, referral to hospital if intensive medical support is required for detoxification, and residential rehabilitation programmes for up to three months on the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands ($1.0 million per year).

**Community Support ($12.0 million one-off)**

Community based psycho-social support services to enable consumers with mental illness to reside safely in the community with packages of support delivered through community organisations. Support packages include home-based support, social skill development, assistance with medication management, support to engage with recreation, training education and employment. Funding is also included for building capacity with General Practice to work with primary care networks and provide shared care mental health specialist services.

## ***Increasing Workforce Capacity ($1.0 million one-off)***

**Peer Support Workers ($1.0 million)**

Training and employment of peer support workers to work alongside mental health workers has been provided with one-off funding. These peer workers will provide support, education, and advocacy for fellow consumers of the mental health system.

# INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

# TASMANIA

The Tasmanian Government committed to significant reform and investment in service delivery for mental health services following the 2004 *Bridging the Gap* review. This was in recognition that Tasmanians suffering mental illness are entitled to expect high quality, professional mental health care in a safe environment.

The approach to reform will see the Mental Health Services budget increase from $55.5 million in 2003-04 to $92.5 million in 2006-07. The reforms and growth to Tasmania's mental health system will be based on the *Tasmanian Mental Health Services Strategic Plan 2006-2011*. The Strategic Plan aligns closely with the directions of the COAG Plan.

The Tasmanian Government understands that improvement of mental health services is not static and requires consistent and constant attention to ensure best practice, transparency and accountability. Following implementation of the *Bridging the Gap* reforms an evaluation of this strategy will result in recommendations for future effort for the period 2008-2011.

## ***Promotion, Prevention and Early Intervention ($2.0 million)***

**Kids in Mind Tasmania ($2.0 million)**

The Kids in Mind Tasmania (KIMT) initiative focuses on the needs of and support for children and young people in families where a parent has a mental illness. Services are delivered by non-government organisations (NGOs) funded to conduct specific interventions (Taz Kidz Clubs, Champs Camps) and by staff employed within Mental Health Services. The programme commenced as a two-year trial in 2004. This allocation of at least $400,000 per annum will build upon and extend the KIMT trial as part of ongoing mental health services.

## ***Improving and Integration the Care System ($21.1 million)***

**Improved Alcohol and Drugs Programmes ($2.0 million)**

Funding will be provided to Tasmania's Alcohol and Drug Services, including NGOs, to provide better support and further development for people with drug and alcohol problems, especially through the shared care model for pharmacotherapy.

**Secure Mental Health Unit ($12.5 million)**

The Wilfred Lopes Centre is a secure hospital, primarily for patients from the criminal justice system who are in need of psychiatric assessment and/or care and treatment. The hospital has been purpose-designed and built to further the delivery of advanced clinical programmes. An allocation of $2.5 million per year ($12.5 million over five years) has been made. Patients will be provided with modern, professional and highly specialised psychiatric care and treatment. Treatment will be based on individually tailored programmes designed to support independence and dignity, and minimise the ill effects of long-term care.

**Improved Access to Acute Psychiatric Care, including Emergency, Crisis, Acute Inpatient and Community Services ($1.5 million)**

Additional clinical positions to assist people experiencing serious mental illness to receive better coordinated treatment and care will be allocated following a review of existing positions, and the needs of the Tasmanian population. Implementation of the Tasmanian model of care will result in a statewide triage process, commencing in September 2006, to provide a standardised user-friendly access point for all consumers, carers, and supporting organisations to refer people experiencing mental illness to Mental Health Services.

**Improved Youth Health Services - Child and Adolescent Mental Health Services (CAMHS) ($5.1 million)**

Additional clinical positions will be added to CAMHS to provide assistance to young people experiencing serious mental illness, and act as a resource to services that also work with young people.

## ***Participation in the Community and Employment, including Accommodation ($11.3 million)***

**Additional Accommodation for People with Mental Illness ($6.3 million)**

A total of $5.3 million will be invested in a Launceston facility and accommodation clusters in the North West and South to provide supported accommodation for people experiencing serious mental illness. Further funding has also been allocated to provide an expansion of level one and two packages of care.

**Support to the Non-Government Sector to Provide Quality Services to People with Mental Illness ($5.0 million)**

Additional support to the non-government sector will be provided for recovery services for people experiencing serious mental illness ($2.2 million), more packages of care ($2.9 million) and the upgrading of services ($500,000).

## ***Increasing Workforce Capacity ($8.6 million)***

**Improve the Working Conditions and Remuneration for Doctors and Allied Health Professionals ($8.6 million)**

In an environment of serious workforce shortages across all disciplines within mental health services there is strong demand for professionals. Funding to improve the working conditions and remuneration for doctors and allied health professionals will assist Tasmania to successfully fill additional places in its expanded mental health workforce.

# INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

# AUSTRALIAN CAPITAL TERRITORY

Mental health service delivery and prevention activity in the Australian Capital Territory (ACT) is guided by the population mental health framework of the *ACT Mental Health Strategy* and *Action Plan*. The strategy describes the local service picture and priorities for the Territory. The prioritising of mental health by COAG has enabled a number of ACT priorities to be brought forward. The actions described in this Individual Implementation Plan emerge from the alignment of local priorities with the areas identified for action in the COAG Plan.

The ACT will work collaboratively with the Commonwealth and other jurisdictions to achieve the best outcome from the national reform of mental health, including effective interaction of government and newly-funded community services.

The ACT Government has allocated a total of $20.6 million over five years for new mental health initiatives. The specific initiatives are outlined below, with funding amounts over five years unless otherwise stated.

## ***Promotion, Prevention and Early Intervention ($3.2 million)***

Funding will be provided to begin implementation of the ACT Action Plan for Mental Health Promotion, Prevention and Early Intervention 2006 – 2008 as outlined below.

**Perinatal and Infant Mental Health Services ($0.9 million)**

This initiative will enhance mental health services capacity to participate in an integrated model of early childhood health care, and provide an early intervention approach to service delivery. This model will build on the successful *beyondblue* perinatal project previously undertaken in the ACT as part of the national project.

**Community Education ($0.4 million)**

This initiative will increase the capacity of community agencies to provide mental illness education to the ACT community through schools and other agencies. Services will be based on a ‘consumers and carers as educators’ model.

**Children of Parents with a Mental Illness ($0.3 million)**

This initiative will provide for the development and delivery of a training programme for professionals and community workers across sectors to enhance skills in working with children of parents with a mental illness (COPMI).

**Workplace Mental Health Promotion ($0.7 million)**

This initiative will facilitate the ACT working in partnership with *beyondblue* and other agencies to support the development of mental health promotion in workplaces throughout the ACT. This programme will not only help to raise awareness of mental illness but will also provide training and education about how to maintain a mentally health workplace and reduce the risk of mental illness.

**Early Recovery Support ($1.0 million)**

Additional funding will provide intensive early recovery support for people who have experienced an episode of mental illness and hospitalisation, to overcome the barriers to re-engagement with the community and rehabilitation programmes.

## ***Integrating and Improving the Care System ($11.5 million)***

**Improving the General Health of People with a Mental Illness ($0.8 million)**

This funding will embed and expand the ACT Better General Health for People with Mental Illness pilot programme. This programme improves the physical health outcomes for persons with serious mental illness through improved referral and access for clients of Mental Health ACT to GP practices. There may be future capacity to utilise this programme as a model for collaborative service delivery between specialist mental health services and GPs.

**Increase Capacity for Carer and Consumer Participation in Service Planning ($0.4 million)**

The ACT Government will allocate additional funding to provide additional part-time carer and consumer consultant positions to improve the level of consumer and carer contribution to the development of mental health services that better meet their needs.

**Mental Health Legislation Review ($0.2 million over two years)**

The ACT Government is funding a full review of the *ACT Mental Health (Treatment and Care) Act* to ensure compatibility with the *ACT Human Rights Act* and consistency with current best practice for mental health. The review will be conducted in full consultation with consumers, carers and all other key stakeholders.

**Mental Health Services Plan ($0.08 million in 2006-07)**

Funding has been allocated to develop a comprehensive Mental Health Services Plan for the ACT to guide the future development and operation of government and community agency mental health services, including redevelopment of inpatient services to meet the special needs of groups such as women and adolescents and culturally and linguistically diverse communities. The Plan will be developed in consultation with the ACT community and will consider the range of services required for good mental health including specialist clinical services, primary care, step-up/step-down services, rehabilitation, employment and accommodation. This Plan will guide future funding decisions for mental health based on those service needs identified in the Plan.

**Intensive Treatment and Support Programme for People with a Dual Disability ($10.0 million)**

Funding has been allocated for the ACT Department of Disability, Housing and Community Services to establish the Intensive Treatment and Support Initiative for People with Dual Disabilities. The service is expected to commence in July 2006 and will provide a comprehensive additional service for an identified group of clients aged 17 and over who have an intellectual disability and a mental disorder with complex behavioural problems and who are at significant risk of entering the criminal justice system. The programme includes a step-up short-term purpose-built accommodation to be used for some within this client group requiring intense support.

## ***Participation in the Community and Employment, including Accommodation ($2.8 million)***

**Youth Supported Accommodation ($2.8 million)**

This initiative will increase capacity to provide 24-hour supported accommodation and outreach services to youth with mental illnesses, which is an identified area of need in the ACT. This service will be developed in collaboration with the community sector and will provide a safe, supportive environment to facilitate early intervention and access to education and employment opportunities for this client group.

## ***Increasing Workforce Capacity ($3.1 million)***

**Additional Medical Workforce Positions ($3.1 million)**

This funding has been allocated to provide medical officer positions for the ACT public mental health system. These additional positions will help to improve access to specialist mental health services in the ACT.

# INDIVIDUAL IMPLEMENTATION PLAN ON MENTAL HEALTH

# NORTHERN TERRITORY

The following is a summary of the Northern Territory initiatives that commenced in 2006 or that are planned to commence in 2007. Funding for these initiatives is committed for the full five years of the Plan.

## ***Promotion, Prevention and Early Intervention ($1.0 million)***

### Suicide Prevention and Response ($1.0 million)

Increased suicide prevention and response activities including creation of a Suicide Prevention Coordinator position. *Implementation commencement date:* 2006

## ***Integrating and Improving the Care System ($13.0 million)***

### Sub-acute Beds ($5.5 million)

24-hour supported community based services as an alternative to hospital admission or to facilitate intensive support following discharge from hospital. *Implementation commencement date:* facilities planning underway, service expected to commence January 2007

### Rural and Remote Services ($4.0 million)

Increased services to rural and remote communities, including additional child and adolescent clinical positions for rural and remote areas, increased funding to Aboriginal Mental Health Worker Programmes and Visiting Psychiatrist Services (in addition to Medical Specialist Outreach Assistance Program funding). *Implementation commencement date:* 2006

### Prison In-reach Services ($3.5 million)

Increased forensic mental health clinical, behavioural and Aboriginal Mental Health Worker positions to provide in-reach services to people in Alice Springs and Darwin prisons who have a mental illness, intellectual disability or acquired brain injury. *Implementation commencement date:* 2006

## ***Participation in the Community and Employment, including Accommodation ($0.5 million)***

### Rehabilitation and Recovery Services ($0.5 million)

Increased funding for rehabilitation and recovery and carer support services provided by the non-government sector. *Implementation commencement date:* 2006