Submission by the Australian Association of Social Workers to the Inquiry by the Senate Community Affairs Committee into Mental Health Services in Australia

July 2007

AASW Contacts:
Dr Bob Lonne, AASW National President, Ph: 0401 960 580
Email: *b.lonne@uq.edu.au*

Mr Peter Richardson, AASW Executive Officer, Ph: 02 6273 0199
Email: *peter.richardson@aasw.asn.au*

EXECUTIVE SUMMARY

The Australian Association of Social Workers (AASW) is the key professional body representing social workers in Australia. Professional social workers are one of the five core professional disciplines which comprise the mental health workforce.

The AASW welcomes the new National Action Plan on Mental Health 2006-2011, and the extra funding it commits to mental health reform. Nonetheless, the AASW considers that the Action Plan requires expansion if it is to improve outcomes for people with a mental illness and their families in Australia. As it stands, the Action Plan limits the extent to which consumers can be assisted to become productive and engaged members of their community.

This submission first clarifies how professional social workers assist people with mental health problems. It outlines the nature of social work education, and the holistic approach used by social workers in assessment and intervention.

Using the Terms of Reference for the Inquiry, the AASW makes 14 recommendations, listed in full on page 15 at the end of this submission. The recommendations draw on the experience of its members, and reflect the profession's broad approach to understanding and responding to people with mental ill-health.

The recommendations focus on limitations in initiatives under the Action Plan. Changes are proposed about how these could be overcome, either now or in the future. Additionally, recommendations are made about how gaps and shortfalls in funding could be remedied.

The AASW considers that the new National Action Plan could be strengthened through a number of additional steps, including the following:

- Establishment of a national blueprint for a comprehensive mental health service system that would extend and strengthen existing service structures, especially links between clinical treatment services and non-government disability and rehabilitation support services. The blueprint could then be used to identify service gaps, and enable future initiatives to be appropriately targeted.

- Immediate implementation of a framework to evaluate the outcomes of new Commonwealth-funded initiatives, such as the Personal Helpers and Mentors program.

- Extension of MBS rebates under the Better Access to Mental Health Care program to enable provision of psychosocial interventions for clients with complex and multiple problems, and of interventions to engage and support families.

- Expansion of the provision of programs that increase access to paid or voluntary employment, whether full or part-time; secondary and post-secondary education; and stable, low-cost housing.

- Establishment of carer consultants in all mental health services who can advocate for recognition of the impact of mental illness on families and of their needs as carers.

- Creation of a national learning exchange network to facilitate shared learning about consumer-delivered services, and the contribution consumers can make to service delivery.

- Provision of funded places, scholarships and other incentives to ensure that the mental health workforce has adequate numbers of allied health professionals with expertise in psychosocial interventions, and that the non-government sector has workers skilled in rehabilitation and disability support.

AASW submission to the Inquiry by the Senate Community Affairs Committee into Mental Health Services in Australia

1. Introduction

The Australian Association of Social Workers (AASW) represents a profession committed to improving the mental health and wellbeing of all Australians. The current Inquiry is a welcome opportunity for the AASW to clarify the social work profession's contribution to this endeavour, and to review the state of mental health reform in Australia.

We applaud the renewed commitment to mental health reform shown in the new National Action Plan on Mental Health by all levels of government.

This submission draws on the experience of AASW members who work in mental health and related fields of practice. It begins with an overview of the social work workforce and social work education, and the nature of social work practice. It then addresses the specific terms of reference of the present Senate Inquiry and suggests ways in which the reform program could be strengthened.

In this submission, the AASW raises concerns about the restricted approach to mental health reform displayed in the National Action Plan. Research and practice experience show that to be effective, mental health reform should be based on a broad understanding of the origins and impact of mental illness, and the ways these can be ameliorated or resolved.

Mental ill-health occurs in the context of families and communities. It adversely affects people's capacity to engage in everyday living, whether as students, employees, parents or friends. Helping people overcome the impact of mental illness typically requires coordinated access to a wide range of services and resources, including clinical treatment and access to supported employment and quality housing. This approach is fundamental to social work practice in mental health, and is well-supported by research. However, the AASW considers that it has yet to be fully adopted in the mental health reforms currently being implemented. The submission identifies how gaps in the current reform program could be overcome.

2. Social Work's Contribution to Mental Health

2.1 The Social Work Workforce

According to ABS Labour Force figures, 13,500 professional social workers were practising in Australia in November 2006. In May 2007, 6,222 or nearly half of the social work workforce were members of the AASW, the national professional social work body.

In addition to the mental health field, social workers are employed in a wide range of other human services. They include general child and family welfare, child protection, acute health, rehabilitation, income support, corrections and juvenile justice, housing support and homeless services, and aged care. Not surprisingly, a number of social work clients in these settings are experiencing mental ill-health. As a result, social workers working outside designated mental health settings also draw on knowledge and skills in helping people with mental health problems.

Social workers are one of the five core professional groups working in the mental health field. One in 6 of the social workers who are AASW members identify with the mental health field by virtue of their employment and/or expertise.

In May 2007, the four largest areas of employment of AASW members in the mental health field were:
- Health, hospital and aged care (42 percent);
- Private practice (20 percent);
- State government agencies (16 percent);
- Non-government or other community-based organisations (11 percent).

Other less numerous forms of employment included education and training (three percent), Commonwealth agencies (two percent) and local government (one percent).

Social workers undertake a variety of work roles in the mental health field. In addition to social workers helping individuals and families, others are employed as team leaders and service managers. Many work in policy and service development in Commonwealth, state and non-government agencies.

The Australian Institute of Health and Welfare Report '*Mental Health Services in Australia 2004-05*' provides a snapshot of social work's contribution to inpatient mental health care across the country (Australian Institute of Health and Welfare 2007). For patients admitted for specialised psychiatric care during the period 2004-05, social work intervention was the most common mental health procedure provided. A total of 20,155 social work interventions were provided, representing 13.8 percent of all procedures (Australian Institute of Health and Welfare 2007:61). Put another way, over 2004-05, there were 20,124 admissions for specialised psychiatric care, and 17.2 percent had social work interventions (Australian Institute of Health and Welfare 2007: 61).

Social workers were also active in assisting patients with mental health-related diagnoses who were admitted to hospitals without specialised psychiatric units. Social work interventions totalled 11,597 or 12.3 percent of all procedures undertaken during these admissions (Australian Institute of Health and Welfare 2007: 66).

2.2 Professional Social Work Education

In Australia, a professional qualification in social work requires successful completion of four years of full-time bachelor degree level study, or its part-time equivalent. The qualification is currently known as a Bachelor of Social Work. The two common course structures are firstly, four-year integrated social work courses, and secondly, two-year social work courses undertaken after completion of at least two years of a first degree covering relevant social and behavioural science subjects. With one university already moving to a graduate model for most professional courses, there is also likely to be at least one qualifying social work course being offered at Masters level in the next two years.

Each social work course must be accredited by the AASW for its graduates to be eligible for AASW membership. Professional registration for social workers has yet to be introduced in Australia, and employers typically use eligibility for AASW membership as a core criterion for applications for social work-designated positions. The AASW regularly reviews social work courses across Australia, and either accredits them or not in terms of providing eligibility for membership. For social workers trained outside Australia, their eligibility is decided by the AASW through a comparative assessment of the social work program they undertook in their country of training.

There are currently 24 universities in Australia providing social work courses, with at least one in each state and territory, and three states (Victoria, NSW and Queensland) having five or more. The AASW has recently approved another social work course, at the Queensland University of Technology, which will begin admitting students in 2008.

The estimated annual number of social work graduates is 1,500 across Australia. As could be expected, the three states having the most social work courses produce the most graduates, with Victoria and NSW each averaging around 350 annually and Queensland about 250. They are followed by SA and WA with about 180 each, the ACT and Tasmania with around 45 each, and the Northern Territory with 20.

In terms of content, social work education includes firstly, knowledge for practice derived from the social and behavioural sciences, whether studied as part of an integrated social work program, or in a minimum of two years of a first degree prior to entry to a two-year social work program. Knowledge for practice covers key areas such as an understanding of societal development, the history and organisation of social welfare, and development of the individual, including personality development, life-cycle stages, and health and ill-health, including mental illness and associated disability.

Course content specific to social work focuses on practice knowledge and skills. This includes methods of social work intervention such as casework, group work, community work, social action, and social policy analysis and development. Students also learn the core practice skills of communication, assessment, negotiation and mediation. Other key areas of content are the ethical framework for professional social work practice, and the contexts of social work practice at local, national and international levels. Lastly, social work students undertake at least two field placements of supervised practice in human service agencies. This core component totals a minimum of 140 days either in full-time or part-time placements in two social work practice settings.

2.3 The Nature of Social Work Practice

Social workers are trained to use a holistic approach in assessing and helping people with a mental illness and their families. This means understanding how a client's life history, lifestyle and current social and economic circumstances may have contributed to their present mental ill-health. To obtain relevant information, social workers must establish collaborative and trusting relationships with clients and members of their social network who, depending on age and other circumstances, may include parents and other relatives, partners and friends.

Social workers seek to identify factors influencing the person's mental health problems, and also to understand the impact of mental illness on the person, their relationships, and their life chances, including educational and employment opportunities. Strengths are identified as well as limitations. The broader policy and service context is also part of this assessment, particularly the way this context may limit or expand pathways to recovery. For instance, eligibility requirements may delay payment of sickness benefit, with others having to provide income support. All these aspects are taken into account when developing a service delivery plan with the client and the significant others in their life. Social workers typically work alongside other mental health professionals in multidisciplinary teams, which requires information-sharing and collaboration.

Social workers often work with clients in a particular phase of the life span, such as childhood or adolescence. This necessitates paying attention to developmental needs, and liaising closely with relevant institutions such as kindergartens and schools, and health agencies like maternal and child health centres. Racial, cultural and ethnic differences may also be present. For instance, working with Indigenous Australians requires an appreciation of the impact of transgenerational trauma, and the effects of living in communities without basic resources. Social work with refugees and other recent migrants requires understanding the experience of trauma and resettlement, and sensitivity to cultural differences.

Social work interventions are typically multi-level and multi-layered. Depending on the nature of the person's psychosocial situation, interventions may include individual counselling, education and support for family carers, family therapy involving client and family, and work with groups of clients and/or families. A recovery orientation is integral to this work, with an emphasis on building on strengths and augmenting social supports (Tew 2005). Social workers also give priority to knowing about relevant community resources, and advocating for client access and expanded resources. For instance, helping adult clients may include organising better housing, locating vocational training programs or paid employment opportunities, and finding social and recreational activities.

2.4 Social Workers and the Better Access to Mental Health Care Program

In November 2006, the Medicare Rebates for Allied Health Professionals were introduced under the Better Access to Mental Health Care initiative. To be registered as Medicare Providers under this program, social workers have to be accredited by the AASW as mental health social workers. To achieve this accreditation, social workers in part or full-time private practice must be able to demonstrate substantial experience in mental health social work. It is evident that social workers have been keen to take up this new opportunity to respond to client need. From November 2006 to mid-July 2007, AASW records show that an additional 282 social workers in private practice have been accredited by the AASW as mental health social workers, bringing the total of accredited workers to 565. Over a third (38 percent) practise outside the metropolitan area.

According to Medicare Australia data (Medicare Australia 2007), from November 2006 to May 2007, AASW accredited mental health social workers have provided 5,897 Medicare-rebated sessions of focused psychological strategies to clients with mental health problems, individually or in groups. This represents 3.3 percent of the total of Medicare-rebated sessions for this type of intervention, the bulk of which are provided by registered psychologists (94.6 percent). The participation of mental health social workers in this program has increased steadily. For example, in December 2006, mental health social workers provided 613 Medicare-rebatable sessions comprising more than 50 minutes. Five months later, in May 2007, this had grown to 3,749 sessions, a sixfold increase.

3. The AASW Response to the Terms of Reference of the Senate Inquiry

3.1 The extent to which the action plan assists in achieving the aims and objectives of the National Mental Health Strategy.

The AASW notes that at its inception, the National Mental Health Strategy gave priority to replacing separate psychiatric institutions with a community-oriented system of care. This included not only expanding treatment in the community, but also providing 'mainstreamed' psychiatric inpatient care through general hospitals. Inpatient care would be integrated with community-based treatment services. It is evident that whilst some states have already met this goal, others are still struggling to achieve this fundamental change. Where states continue to run psychiatric institutions, this constrains the funds available for community-based treatment and rehabilitation programs, let alone for providing inpatient care through the general health system.

In the case of Victoria, which replaced all its 14 separate institutions by the end of 1999, Commonwealth funding played a major role. This funding was used to build modern replacement facilities, and to establish more community-based treatment teams before the institutions closed. Funding saved by shutting the institutions was quarantined for re-investment in the new replacement services. The AASW considers that it would be timely for the Commonwealth to provide those states still running institutions with additional one-off funds for their replacement. This would release funding which could be earmarked for expanding community-based services.

However, there is another step needed before such a direction could be pursued. As yet there is no agreed national blueprint about what constitutes a comprehensive mental health service system. Such a system would be responsive to the treatment and rehabilitation needs of people across the life span, with mental health problems of differing levels of symptomatic distress and associated disability. The result is that there is an unacceptable variation in what services are available for people with mental health problems and their families. Too often this depends on the state or territory in which they live, and whether their place of residence is in inner or outer metropolitan areas, large provincial towns or more remote rural locations. The AASW considers that establishment of a national blueprint is an urgent priority, requiring collaboration from all levels of government.

- ♦ **Recommendation 1:** That the federal government, in conjunction with the states and territories, produce a national blueprint for a comprehensive mental health service system.

3.2 The overall contribution of the action plan to the development of a coordinated infrastructure to support community-based care.

3.2.1 General Comments

The AASW has the following general concerns about the Action Plan:

- The lack of a baseline is a major difficulty in assessing the overall contribution of the Action Plan to developing a coordinated infrastructure to support community-based care. In other words, the Action Plan does not make clear what gaps currently exist and how initiatives in the plan will overcome them. For instance, when examining the state and territory commitments, one can only assess their significance by knowing what is already in place and how well the needs of consumers and their carers are currently being met.

- As already noted above, another important gap is a national blueprint for a comprehensive system of mental health care. The AASW considers that provision of such a blueprint would provide the direction for future reform efforts which is currently lacking in the Action Plan.

- The new programs are being added to an already complex network of services, rather than being explicitly designed to build on existing structures. This is likely to lead to more fragmentation, with increased demands for coordination of service delivery to clients due to the expanded number of services, ultimately resulting in a less coordinated infrastructure for community-based care.

  For example, in NSW, the new Commonwealth-funded PHaMS and Day to Day Living programs are being funded in communities where the state Housing and Accommodation Support Initiative (HASI) is either established or being established, and where NSW Health is already tendering for NGOs to provided services under the new state Resource and Recovery Service program. The PHaMS and Day to Day Living programs provide much needed services, but their implementation in the same communities will potentially lead to confusion in service provision. Extensive coordination will be required to ensure that consumers, carers and other service providers are not baffled by the even more complex set of services.

- A further problem arises in non-government organisations being targeted as the preferred service providers. This means community-based clinical mental health services have been by-passed. This is both puzzling and short-sighted as many of the latter are already engaged in providing rehabilitation and recovery programs, often on an outreach basis. In this instance, tender briefs could at least have required that submissions identify the links to be established with clinical mental health services.

- ♦ **Recommendation 2:** That future reform efforts extend and strengthen existing service structures, and foster the link between clinical mental health services, whether public or private, and non-government disability and rehabilitation support services.

3.2.2 Comments on Specific Programs

The AASW notes that a number of Commonwealth initiatives under the Action Plan appear to lack a clear rationale and have high overhead costs, including an extra layer of bureaucracy. Three particular programs which raise questions about their rationale are the Mental Health Respite Care program of $224m, the Personal Helpers and Mentors (PHaMS) initiative of $284m, and the Mental Health in Communities program of $45.2m. The funds identified here are the totals for each program across five years.

Mental Health Respite Care
Respite care is a key component of a community-oriented system of care as it can provide a break for both consumers and carers from the demands of caring, which often involves conjoint living. However, the AASW identifies several problems with the new Commonwealth-funded Mental Health Respite Care program:

- Priority access is to be given to 'elderly' carers of adult offspring with either a psychiatric or an intellectual disability, yet no rationale is provided for giving preference to this age group. This is particularly unfortunate given the increased evidence of the number of younger people caring for parents, including older parents, with a mental illness.

- The inclusion of respite care for people with an intellectual disability within a mental health action plan is regrettable at many levels. It perpetuates public misunderstanding about differences between the two types of disability, and also fails to acknowledge that respite care for each group should be distinct and disability-specific. However, this may be less of an issue following the recent release of the new federal government Disability Assistance package. This includes funding of $270m over 5 years for additional in-home and centre-based respite for older parent carers with adult children receiving a Disability Support Pension.

- That the initial allocation of funds under this program went to Commonwealth Carer Respite Centres for brokerage is also of concern. It would appear this was not preceded by consultation with carers of people with a mental illness about their familiarity with these Centres. Further, the level of familiarity of these Centres with respite care services for people with a psychiatric disability is not clear.

Lastly, it is welcome news that the next tranche of funding is designed to enhance the capacity of the non-government sector to provide respite for people with psychiatric disability and their carers. Respite care for this group has been established for over ten years in some parts of the country. For instance, in Victoria, expansion of respite care for carers of people with a mental illness was a major component of the 1996 state government carer strategy.

- ♦ **Recommendation 3:** That the Commonwealth ensure the newer entrants to delivering respite care be required to demonstrate experience in responding to the particular requirements of people with psychiatric disability.

Personal Helpers and Mentors (PHaMS)
The PHaMS initiative raises a number of questions. On the positive side, its implementation across Australia means this type of support may be available in some jurisdictions for the first time. Nevertheless, the AASW has the following concerns with this program:

- The PHaMS represents yet another program with its own separate goals and reporting framework being added to an already complex service system. In several jurisdictions, home-based outreach services providing support and rehabilitation are by now a feature of service provision. Given the relatively small amounts of funding for each PHaMS provider, this could have been allocated directly to the states and territories for implementation. This could have minimised the costly bureaucratic overheads already incurred, and the imminent demands of extra coordination and clarification of service boundaries for consumers, carers and service providers.

- The number of extra staff (five) for each successful PHaMS tender is few compared to the likely demand, yet the rationale for arriving at this number is not given. What is also puzzling is that services can decide whether or not these staff would work on an outreach basis or not. Provision of services in the recipient's own environment should be a *necessary* rather than optional component of this type of service.

- Further, the AASW is aware from members' anecdotal reports that the competitive tendering process has created difficulties for many smaller non-government organisations, and been disruptive of formerly collaborative relationships between services. Additionally, there is reportedly a general lack of confidence in an open competitive tendering process necessarily delivering the best quality services for clients and their families. Nonetheless, some new partnerships have emerged from the tender process.

- As yet, it appears that no evaluation program is in place, which is a major concern as much baseline data is already lost. The lack of a comprehensive evaluation contrasts with the NSW Housing and Accommodation Support Initiative (HASI), where the evaluation was built into its roll-out (Morris, Muir et al. 2005). The AASW considers this gap should be rectified as soon as possible.

♦ **Recommendation 4:** That an evaluation framework for the PHaMS program be implemented in the immediate future, incorporating recovery of the maximum amount of baseline data possible.

Mental Health Community-Based Program Initiative
This initiative was originally described as involving the funding of local community-based projects to support families, children and young people affected by mental illness (Council of Australian Governments 2006: 9). The initiative's purpose clearly has merit, although it could be said that the track record of project-based funding is not good, unless it can build on existing structures. For instance, there is arguably little evidence of lasting benefits from the one-off National Mental Health projects funded by the Commonwealth under the First National Mental Health Plan. In the present case, it would appear that the boundaries being set for the project are very broad.

In addition, the Hansard record of the Senate Estimates hearing on 29 May 2007 shows that the first allocation of funding for three years was made by FaCSIA directly to seven 'family relationship centres', based on recommendations from departmental officers (Australian Senate Community Affairs Committee 2007: 60-64). Not only did this transgress the rule applied elsewhere for new services or programs to be competitively tendered, but it also targeted services which appear to have had no history in working with families with a member with a mental illness.

Evidently FaCSIA was under time pressure to commit the first allocation of funds. Further, providing this to generalist family services may mean they pay attention to the needs of families with a mentally ill member, possibly for the first time. However, there are many organisations throughout the country which already provide support and education to families with a mentally ill relative. Often these organisations have limited funding. The first tranche of funds available under the Mental Health Community-Based Program could have enabled these organisations to provide additional services which are currently beyond their means.

It is noted that the remaining funds for this initiative have now been tendered. However, the parameters remain surprisingly loose. It would be unfortunate if the outcome were to be a hotchpotch of discrete projects with little connection to services already in place. The alternative could have been an extended and strengthened service infrastructure, had this been given priority.

Better Access to Mental Health Care
The take-up rates for the Better Access to Mental Health Care program indicate that it is meeting a need in the community. The AASW initially welcomed this program as it appeared to enable access to allied health services for the first time to people with mental health problems whose access had previously been limited due to cost considerations and/or geographical inaccessibility. However, to this point it is not clear to what extent the program is improving access to allied health services for these groups.

Improved access means firstly, the availability of bulk-billing to avoid out-of-pocket costs beyond the reach of people with low disposable incomes, and secondly, the accessibility of allied health services outside the inner metropolitan areas, including outer suburban fringes and rural and remote locations.

It would appear however, that to date, targets have not been set for an increase in either form of accessibility through the Better Access program. Furthermore, publicly-available data on service use make it impossible to identify how many instances of focused psychological strategies are being bulk-billed (Medicare Australia 2007). It is also not possible to determine how many sessions are being provided in different geographical locations, such as inner and outer metropolitan, and rural and remote areas. Only a breakdown in terms of state and territory is available at this stage (Medicare Australia 2007).

Limiting allied health service provision to 'focused psychological strategies' also presents difficulties. Mental health social workers typically provide a range of services in helping clients with mental health problems. This is consistent with social workers' training in a holistic approach to assessment and intervention, and also a response to the array of difficulties which clients may be facing. For instance, clients may have multiple and complex problems, including illicit drug abuse as well as mental illness, poor health, and difficulties with housing and income support.

The readiness of mental health social workers to identify these problems and assist clients with their resolution is valued by other practitioners, especially GPs, who may themselves lack the time or knowledge to take action. In this regard, the Better Access to Mental Health Care should be extended to acknowledge the complexity of problems faced by some clients and the capacity of social workers to help in resolving them.

- **Recommendation 5:** That the Better Access to Mental Health Care program be extended to include an MBS item for provision of psychosocial interventions by mental health social workers to clients with complex and multiple problems referred by a GP.

The AASW is also concerned that the current list of 'focused psychological strategies' does not include family therapy. The mental health problems of an individual affect those with whom they live, who are often family members. Mental health social workers typically draw on family therapy to ameliorate the impact of mental health problems for the client and their family. This type of intervention is also fundamental to working with children and adolescents with mental health problems especially conduct disorders.

- **Recommendation 6:** That the range of focused psychological strategies be widened to include Medicare-rebatable sessions of family therapy.

3.3 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*.

It is understood that the recommendations of the Senate Select Committee on Mental Health have never been formally endorsed for action by government, so their status is unclear.

The AASW broadly supports the 91 recommendations outlined in the Final Report of the Select Committee. Two recommendations considered to be particularly worthy of immediate implementation are:

- that the Mental Health Council of Australia, as an independent national body, be funded to monitor and report on progress in implementation of the National Mental Health Strategy (Senate Select Committee on Mental Health 2006: 7), and

- that the allocation to mental health be increased from 9 to 12 percent of the health budget by 2012 (Senate Select Committee on Mental Health 2006: 5).

The AASW is generally supportive of the recommended nationwide establishment of new community-based mental health centres, with the centres to employ salaried and apparently also fee-for-service practitioners rebatable through Medicare (Senate Select Committee on Mental Health 2006: 5). However, we have the following reservations:

- It is not made clear whether or how these centres would be integrated with inpatient and residential services for the area. Examples of integrative measures at the service level could include a single point of management, staff rotation and common orientation and in-service training programs, and acceptance of joint responsibility for clients. Integrating these service components is critical for continuity of client care and the coordination of service provision.

- The apparent inclusion of practitioners providing Medicare-rebated treatment sessions does not necessarily mean they would be affordable to people on low incomes.

- Service provision could be constrained by Medicare-related service definitions, resulting in overly narrow service response based on centralised bureaucratic design rather than clinically assessed client need.

3.4 Identifying any possible remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness.

Social workers are concerned for the whole person, not just their symptoms. What is critical is that consumers have access to the full range of services known to aid recovery, such as access to psychosocial rehabilitation and meaningful daily activity, including voluntary or paid work, as well as stable low-cost housing with flexible support.

The AASW strongly endorses the concept of 'social inclusion' as a guide to identifying service gaps and their resolution, and evaluating the outcomes. The British Professor of Social Work, Peter Huxley, pioneered application of this concept in the mental health field. Together with his British psychiatric colleague, Professor Graham Thornicroft, Huxley has recently identified how psychiatrists could use this approach in their practice (Huxley and Thornicroft 2003). The use of social inclusion in service development has been recently elaborated by Dr Julian Leff from the UK, and Dr Richard Warner from the United States, two senior psychiatrists with established reform credentials (Leff and Warner 2006).

Put simply, recovery for people with mental health problems is made harder by being excluded from participation in valued social and economic roles in the community. Social inclusion means providing access to employment, education, housing, recreation and social activities. Through their holistic approach to assessment and intervention, social workers are well-placed to assist clients in accessing these services.

The AASW considers that the concept of social inclusion highlights major gaps which are not addressed by the Action Plan:

Employment and Income Support

The importance of employment to recovery is now well-established (King, Waghorn et al. 2006). Employment can mean paid or voluntary work, whether full or part-time. There is already considerable evidence of Australia's low rates of employment for people with psychiatric disability compared to other developed countries (Waghorn and Lloyd 2005). Unfortunately, federal government policy initiatives currently being pursued in relation to 'Welfare to Work' are making it harder for people with psychiatric disability to get into the paid workforce, whether on a casual, part or full-time basis. These initiatives are also putting at risk client access to the income support provided by the Disability Support Pension (DSP) and other Centrelink payments.

The application of the principle of 'mutual obligation' is particularly problematic for people with psychiatric disability, as it makes little allowance for the fluctuations in everyday functioning typical of mental illness (Bland 2006). For instance, behaviour considered to breach job participation rules does not take account of people who, due to their mental illness, may have difficulty in organising their time and keeping appointments.

Assessing the job capacity of someone with psychiatric disability requires that the assessor has a sound grasp of mental ill-health and associated disability. The use of job capacity assessments also assumes firstly, that the right range of employment and training opportunities are available, with the additional on-the-job support often required by people with psychiatric disability, and secondly, that the staff member making the assessment is familiar with what is available. However, a number of mental health social workers already report that job capacity assessments, and therefore life-influencing decisions, are being made by under-qualified and inexperienced staff (many of them newly-qualified professionals or semi-professionals), often with little additional information to guide them.

In addition, the person previously on a DSP for primary or secondary psychiatric disability who loses their paid work through a recurrence of mental illness will now face a reduced set of benefits if they are assessed as eligible to return to the DSP. Lastly, the AASW has anecdotal reports from its members that people with psychiatric disability are withdrawing from contact with Centrelink due to the seemingly punitive application of the new policies. This can lead to individual impoverishment and greater financial strain on families.

- **Recommendation 7:** That when applying the new Welfare to Work regulations, Centrelink staff be given specific training about the impact of psychiatric disability on everyday functioning and how to recognise the associated behaviours, and that they be supported in making allowance for the impact of psychiatric disability on an applicant or recipient, and in seeking to avoid worsening the person's situation.

Education

Another gap is access to educational opportunities to overcome learning deficits due to periods of illness. An example of how this can be tackled is the Certificate in General Education for Adults (CGEA), a nationally-accredited educational program being run by the Mental Illness Fellowship in Victoria. This provides a flexible and supportive learning environment to enable consumers whose schooling may have been disrupted through illness to finish secondary level education. The program is reportedly very successful in assisting people to complete their secondary education and go on to enrol in post-secondary courses.

- **Recommendation 8:** That information about the Victorian Mental Illness Fellowship's CGEA program be circulated to the education departments of state and territory governments, and that they be requested to initiate funding of comparable programs.

Housing

The lack of adequate housing options is a major problem for people with a mental illness. Recent research shows that homelessness can contribute to the emergence of mental health problems (Chamberlain, Johnson et al. 2007). A key finding was that 30 percent of the research population of 4,252 homeless people had mental health issues, and of the group, just over half (53 percent) developed mental health problems *after* becoming homeless (Chamberlain, Johnson et al. 2007). This finding challenges the common assumption that people become homeless *because* they have a mental illness.

For people with a mental illness, housing options should cover the continuum from independent low-cost stable housing with off-site flexible support (like Victoria's Housing & Support Program and NSW's Housing and Accommodation Support Initiatives), to housing with on-site 24 hour practical support.

The Action Plan refers several times to the importance of stable accommodation and the need to increase access. However, no commitment of Commonwealth funding is made to expand the options available. Instead this responsibility is left solely to the states and territories, despite funding for public housing at least nominally still being a shared responsibility between the two levels of government.

- **Recommendation 9:** That both federal and state and territory governments provide additional targeted funding to ensure increased access by people with a mental illness to stable low-cost housing. A proportion of the funding from the Commonwealth/State and Territory Disability Agreement (CSTDA) should also be earmarked to ensure adequate provision of accommodation support.

Treatment Services

There are also gaps in the range of treatment services available in different parts of Australia. A particular example is access to step-up/step-down care as an alternative to acute admission or for a transition following discharge, and to residential rehabilitation. Again this highlights the need for a national blueprint for a comprehensive system of mental health care. It would then be possible to identify areas still lacking those services designated as core components, and target new funding accordingly.

- **Recommendation 10:** That once established, the national blueprint be used to identify gaps in services, and that meeting these gaps become a priority for future mental health reform efforts.

Family and Social Support

There is now good evidence that supportive family and social networks play a vital role in assisting people with a mental illness (Webber 2005). However, few families know what to do when their family member experiences mental illness. Ready access to information, education and support are important for sustaining families in their caring role, yet still cannot be guaranteed. This should be a core component of a comprehensive mental health service system.

- **Recommendation 11:** That all public mental health services be funded to employ paid carer consultants or advocates to ensure that carer needs are an integral part of service responsiveness and individual care planning.

Consumer-Delivered Services

Consumers are now being employed in a number of services to provide advocacy and/or direct service to others consumers. This includes examples such as the employment of consumers as consumer consultants or peer specialists in clinical services, and of consumers as peer support workers or recovery guides in non-government rehabilitation services.

A nationally-supported learning network for services delivered by consumers for consumers would enable shared learning and consolidation of a range of initiatives across the states and territories. In addition, a TAFE-level national curriculum for interested consumers should also be initiated by the federal government, and supported through incentives such as funded places and scholarships.

- **Recommendation 12:** That the federal government establish and support a national learning exchange network for consumer-delivered services. A national TAFE-level curriculum should also be established and a package of incentives funded to encourage consumers to undertake the training.

Workforce

Delivering services based on a holistic approach requires a workforce with the right balance of knowledge and skills. This means ensuring sufficient training places and other incentives for mental health professionals skilled in this approach.

The Action Plan largely focuses on expanding training opportunities for mental health nurses and clinical psychologists. There has been minimal attention to ways of increasing the numbers of social workers and occupational therapists in the mental health workforce. This is despite these two professional groups having the skills to provide a more comprehensive approach to people with mental health problems, and evidence of their existing contribution.

There is a known shortage of social workers and occupational therapists in the mental health workforce due to the lack of designated mental health training places in university courses, and competition from other fields of practice for the limited output of graduates. Of particular concern is lack of support in the Action Plan for the development of occupational therapy, a profession with specific knowledge and skills in mental health rehabilitation.

- **Recommendation 13:** That the federal government fund initiatives to support an increased numbers of graduates for the mental health workforce from social work and occupational therapy courses.

In addition, the Action Plan did not make allowance for the need to provide relevant training opportunities for non-government workers, in spite of the number of new Commonwealth programs making use of these workers. To date, not all states and territories have instituted TAFE-level vocational courses in psychiatric disability. It would be timely for the Commonwealth to initiative negotiations with the states and territories to ensure this gap is overcome in the immediate future. Provision of scholarships or other incentives would also assist in providing a more skilled workforce in the non-government sector.

- **Recommendation 14:** That the federal government support establishment of a national TAFE-level curriculum for psychiatric disability and rehabilitation support, and provide incentives such as funded places, scholarships and course materials for PDRS workers to undertake these courses.

4. Summary

In conclusion, the AASW is committed to mental health reform, and to further changes that will improve the life chances of people with mental health problems and their families across Australia. The key recommendations from this submission are listed below.

The AASW recommends that:

1. The federal government, in conjunction with the states and territories, produce a national blueprint for a comprehensive mental health service system.

2. Future reform efforts extend and strengthen existing service structures, and foster the link between clinical mental health services, whether public or private, and non-government disability and rehabilitation support services.

3. The Commonwealth ensure the newer entrants to delivering respite care be required to demonstrate experience in responding to the particular requirements of people with psychiatric disability.

4. An evaluation framework for the PHaMS program be implemented in the immediate future, incorporating recovery of the maximum amount of baseline data possible.

5. The Better Access to Mental Health Care program be extended to include an MBS item for provision of psychosocial interventions by mental health social workers to clients with complex and multiple problems referred by a GP.

6. The range of 'focused psychological strategies' be widened to include Medicare-rebatable sessions of family therapy.

7. When applying Welfare to Work regulations, Centrelink staff be given specific training about the impact of psychiatric disability on everyday functioning and how to recognise the associated behaviours, and be supported in making allowance for the impact of psychiatric disability on an applicant or recipient, and in seeking to avoid worsening the person's situation.

8. Information about the Victorian Mental Illness Fellowship's CGEA program be circulated to the education departments of state and territory governments and that they be requested to initiate funding of comparable programs.

9. Both the federal and state and territory governments provide additional targeted funding to ensure increased access by people with a mental illness to stable low-cost housing. A proportion of CSTDA funding should be earmarked to enable adequate provision of accommodation support.

10. Once established, the national mental health service blueprint be used to identify gaps in services, and meeting these gaps become a priority for future mental health reform efforts.

11. All public mental health services be funded to employ paid carer consultants or advocates to ensure that carer needs are an integral part of service responsiveness and individual care planning.

12. The federal government establish and support a national learning exchange network for consumer-delivered services. A national TAFE-level curriculum for providers of consumer-delivered services should also be established and a package of incentives funded to encourage consumers to undertake the training.

13. The federal government fund initiatives to support increased numbers of graduates for the mental health workforce from social work and occupational therapy courses.

14. The federal government support the establishment of a national TAFE-level curriculum for psychiatric disability and rehabilitation support, and provide incentives such as funded places, scholarships and course materials for PDRS workers to undertake these courses.

REFERENCES

Australian Institute of Health and Welfare (2007). Mental health services in Australia 2004-05. Mental Health Series. Canberra, Australian Institute of Health and Welfare.

Australian Senate Community Affairs Committee (2007). Senate Estimates Hearing. Canberra, Australian Government Hansard Service: CA51-CA74.

Bland, R. (2006). Poverty and Mental Illness. Thinking About Poverty. K. Serr. Sydney, Federation Press: 71-81.

Chamberlain, C., G. Johnson, et al. (2007). Homeless in Melbourne: Confronting the Challenge. Melbourne, RMIT Publishing: 47.

Council of Australian Governments (2006). National Action Plan on Mental Health 2006-2011. Canberra, Commonwealth Government of Australia: 1-38.

Huxley, P. and G. Thornicroft (2003). "Social inclusion, social quality and mental illness." British Journal of Psychiatry(182): 289-290.

King, R., G. Waghorn, et al. (2006). "Enhancing employment services for people with severe mental illness: the challenge of the Australian service environment." ANZ Journal of Psychiatry **40**: 471-477.

Leff, J. and R. Warner (2006). Social Inclusion of People with Mental Illness. Cambridge, Cambridge University Press.

Medicare Australia (2007). Requested Medicare Items processed from October 2006 to March 2007 Medicare Australia.

Morris, A., K. Muir, et al. (2005). Housing and Accommodation Support Initiative - Report 1: Summary. Sydney, Social Policy Research Centre.

Senate Select Committee on Mental Health (2006). A national approach to mental health - from crisis to community: Final report. Canberra, Senate of Australian Parliament: 1-33.

Tew, J. (2005). Social Perspectives: Towards a Framework for Practice. Social Perspectives in Mental Health: Developing Social Models to Understand and Work with Mental Distress. J. Tew. London, Jessica Kingsley Publishers: 216-227.

Waghorn, G. and C. Lloyd (2005). "The employment of people with mental illness." Australian e-Journal for the Advancement of Mental Health **4**, 2 (Supplement).

Webber, M. (2005). Social Capital and Mental Health. Social Perspectives in Mental Health: Developing Social Models to Understand and Work with Mental Distress. J. Tew. London, Jessica Kingsley Publishers: 90-111.