COMMUNITY MENTAL HEALTH PEAKS

Submission to the Australian Senate Community Affairs Committee's Inquiry into Mental Health Services in Australia

August 2007

Mental Health Council of Tasmania Inc

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Acknowledgements

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1. Executive Summary

The Australian Community Mental Health sector comprises of over 800 not for profit community organisations and psychiatric disability support services across Australia that provide essential services to thousands of mental health consumers and their families to help ease the burden of mental illness in Australia. This submission is informed by 14 consultation meetings conducted across Australia during July 2007 and includes input from over 250 individuals representing the community sector who attended forums or provided input by phone and email.

The community mental health sector leads the delivery of recovery focused mental health care in Australia. All state and territory peak bodies have expressed a readiness and desire to participate and bring their extensive experience to program and policy development. Due to the important role required of the sector within the CoAG National Action Plan and increasingly by all Australian governments, it is essential that the sector be recognised as a key partner in the Plan's implementation and review.

2(a) The extent to which the National Action Plan assists in achieving the aims and objectives of the National Mental Health Strategy

Importantly, the National Action Plan recognises the need to redirect resources to the community, the place where recovery from mental illness occurs. Accordingly, the National Action Plan provides significant additional funding to community-based mental health services, which will in turn further the aims of the National Mental Health Strategy (NMHS). In doing so, the National Action Plan accelerates the process began by the National Mental Health Strategy.

At present it is difficult to assess the impact of both the National Action Plan and the National Mental Health Strategy for three main reasons. Firstly, the National Strategy needs to articulate measurable outcomes and a process independent of governments for reporting on progress. Secondly, some services have only just begun to be rolled out under the National Action Plan although some did commence in July 2006. Thirdly, the Action Plan is yet to establish independent accountability processes and review mechanisms. As the community mental health sector is a key service provider under the National Action Plan it is essential that the sector is involved in assisting to review and shape accountability processes.

2(b) The overall contribution of the action plan to the development of a coordinated infrastructure to support community-based care

There are a number of factors impacting on the overall contribution of the National Action Plan to the development of a coordinated infrastructure to support community-based care. These factors include the following:

- The National Action Plan fails to commit resources to "implementing a national care coordination framework to ensure consistency in approach". Consultations revealed that while the NAP includes many valuable service measures it does not include resources for care coordination projects to assist states and territories operationalise a consistent national framework.
- The National Action Plan provides significant additional funding to community-based services, notably the PHaM Program, Respite initiatives and the new MBS items but needs to support these new services to contribute to improved service linkages, collaboration and intersectorial coordination.

- The National Action Plan needs to demonstrate leadership by insisting Federal and State jurisdictions overcome a "silo" mentality and drastically improve coordination, consultation and joint planning.
- The purchasing of non-government services under the National Action Plan and under new state-based initiatives should examine new procurement models and not rely exclusively on open tender, which has increased competition between agencies operating in the same regional areas. Some respondents have argued that creation of a competitive market reduces capacity to cooperate and coordinate services.
- The role of the new community based programs such as PHaM are still not well understood by state-funded and private services.
- Coordination and linkages between service sectors remains variable and attention needs to be given to the quality and importance of the pathways linking services and care options, irrespective of whether they are government, non-government, private, mental-health specific or based in other service sectors.

2(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*

Consultations revealed the difficulty in assessing the extent to which progress has been made with the implementation of recommendations made by the Select Committee on Mental Health. This difficulty is evidenced by:

- The National Action Plan making no specific reference to recommendations of the Senate Select Committee's 2006 findings;
- Participants at all consultations being unable to identify many examples of where the Senate Report's recommendations had been implemented; and
- The lack of national data and information about the extent and detail of new service development in recent years.

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

The following gaps, shortfalls and priorities for action were identified consistently throughout the consultations and need to be given greater consideration in the National Action Plan.

- Ensuring a range of suitable housing and support options for people with mental illness including those with serious long term conditions and those with complex needs
- Addressing the social disadvantage factors impacting on many people with mental illness;
- Ensuring that people with mental illness have access to affordable primary health care;
- Developing and implementing a National Employment Strategy for people with mental illness;
- Implementing a national structural reform program that will result in resources shifting from crises driven clinical acute settings to community-based service areas.

- Further investment in early intervention and prevention services such as Step up step down models and Prevention and Recovery Centres
- Addressing the lack of parity between the non-government community mental health sector and other mental health sectors around Australia;
- Resourcing a workforce development and organisational capacity building strategy to enable the community mental health sector to provide the services that are needed to support recovery and to improve mental health outcomes;
- Developing models of service delivery and care that are culturally safe and appropriate for Indigenous Australians;
- Addressing unmet need and barriers to service use in culturally and linguistically diverse communities;
- Developing a funded, national strategy for locally based care coordination programs and systems to ensure consistency in approach;
- Increase resources towards consumer and carer-run organisations to provide independent advocacy, peer support, information, training and a voice for members;
- Establishing a national community-based and independent process for the annual reporting on progress to Australian governments which ensures that the measurement and reporting of service outcomes is based on the direct experiences of consumers, carers and communities;
- Hastening the integration of mental health services and drug and alcohol services, not just in name, but in practice; and
- More closely monitoring the impact on special needs groups such as CALD, Indigenous, youth and aged.

In conclusion, The National Action Plan has provided significant resources that in time will result in better community access and support options for consumers and carers. However, a view consistently argued during the consultations is that both the National Mental Health Strategy and the National Action Plan will fail if the social disadvantage experienced by people with mental illness and their families is not addressed. The community mental health sector welcomes the Senate Committee's review of the National Action Plan. All state and territory peaks are committed to working with the Federal Government to improve the mental health system for the benefit of all Australians.

2. Introduction

The Community Mental Health Peaks from each State and Territory, known informally as the National Peaks, collaborated to conduct consultations during July 2007 with a view to preparing a combined national submission to the Australian Senate Community Affairs Committee's Inquiry into Mental Health Services. These organisations include:

- Mental Health Community Coalition ACT
- Mental Health Coordinating Council of New South Wales
- Northern Territory Mental Health Coalition
- Queensland Alliance Mental Illness and Disability Groups
- Mental Health Community Coalition of South Australia
- Mental Health Council of Tasmania
- Psychiatric Disability Services of Victoria (VICSERV)
- Western Australian Association for Mental Health

A set of consultation questions, based on the Inquiry's terms of reference, were developed and used by the peaks to aid consultation and reporting. In each of the states and territories, individuals and organisations were able to contribute in person, via email or by phone and fax. Each peak's response is presented in this joint submission along with a summary of key issues and findings. Please note MHCC NSW embarked on a complimentary process with the NSW Council of Social Service and have forwarded their submission independently. This submission is also attached for the committee's benefit.

Structure of the National Submission

The national submission commences with a summary of findings that were consistently reported in each state and territory. Submissions from each of the states and territories are then provided in alphabetical order. At the end of each individual submission a list of member organisations are provided.

Overview of Consultation Findings

1. The extent to which the Council of Australian Governments (CoAG) National Action Plan (NAP) assists in achieving the aims and objectives of the National Mental Health Strategy

CoAG has delivered some much needed and welcome Federal funding into the area of mental health; however, given that it is only in the early stages it is difficult to ascertain the impact for consumers. Though it is quite possible that the NAP is having positive effects, the consultations in every state and territory expressed the concern that gains are being undermined by the negative effects of certain social trends and other policy initiatives, including:

- limited housing and support options;
- rising living costs;
- low incomes;
- the lack of service coordination; and
- welfare to work reforms.

Lack of independent reporting on the outcome of mental health services, treatment and care – Australia lacks a mechanism for governments to obtain independent information from communities, consumers and carers about whether their mental health plans and initiatives are having any effect on preventing mental disorders and on reducing the impact of mental illness on individuals and families. The annual reporting that occurs is prepared 'in-house' by state and territory health departments and does not include information directly from consumers and carers nor does it include information from communities. Concern was expressed about the lack of accountability that results from not having transparent, comprehensive and nationally agreed outcome measurement strategies for assessing and reporting the impact of service delivery and new initiatives. Lack of accountability is also evidenced by consumers, carers and communities not having access to the information that would assist them to make an informed assessment of the impact of national mental health plans and strategies.

Limited access to primary health care and expanded options for access to mental health care under Medicare – The new Medicare arrangements appear to have been embraced nationally. Though it is early days, there is excitement about the potential of this program to improve mental health outcomes. Some difficulties identified to date include:

- low numbers of bulk-billing GPs and psychologists nationally, hence there is still a cost barrier to many people;
- concern that people with severe mental illness and complex needs may not be able to access the expanded services of psychology and allied mental health professionals;
- 'regional' differences nationally and within states and territories; and
- group-based therapies, psycho-education and symptom management that have not commenced under the new scheme.

Groups apparently untouched by CoAG developments – Consultations consistently identified groups who appear to be largely 'untouched' by national mental health initiatives or who are falling out of eligibility for mental health services. The groups identified included:

- people with dual disorders, particularly mental illness and drug and alcohol disorders;
- people having experienced sexual abuse and family trauma;
- Indigenous communities;
- people from CALD backgrounds, particularly those whose first language is other than English;
- people with mental disorder subject to the criminal justice system; and
- people in the early stages of a psychotic illness.

Issues of rights – There is a strong view that assurance of the rights of people with mental illness and their families remains at the level of rhetoric. For example, neither the CoAG National Action Plan nor the National Mental Health Strategy commits funding to independent consumer and carer-run advocacy and peer support services. Advocacy services for people with mental illness appear to be falling into no man's land – somewhere between the Disability Agreement and somewhere between State/Territory responsibility and Federal responsibility.

The lack of attention to the rights of people with mental illness and their families is evident in the way that consumers and carers are not systematically and routinely

involved in assisting governments to assess the quality, effectiveness and outcomes of services and care. Unfortunately, personal experience of service delivery as well as their knowledge and expertise about what is needed is not routinely drawn upon for the purposes of outcome measurement, accountability and reporting. The lack of attention to the rights of people with mental illness is also evidenced by many remaining excluded from the necessities of life including:

- day-to-day goods;
- utilities and services;
- affordable housing;
- primary health care; and
- education, training and employment.

Assuring the rights of people with mental illness, require that governments address these basic and quality of life limiting infringements of human rights.

2. CoAG roll out difficulties and issues

Key issues concerning the sector with the roll out include the following:

- One size fits all models.
- The expectation to service the whole population cohort – rather than specialist cohorts.
- The haste and rush involved with the roll-out process.
- Apparent duplication of services which already exist in some areas under a different name and through a different funding program.
- Difficulty in understanding the selection of sites that would receive services.
- The requirement of existing on-site organisational infrastructure of the initial Commonwealth tenders which ruled out many non-government mental health services.
- That evaluation and outcome measurement were not integrated into the roll out process or funding allocations

3. The overall contribution of the CoAG National Action Plan to the development of a coordinated infrastructure to support community-based care

The danger feared throughout the community mental health sector is that gaps will emerge between the state and federal systems and linkages and movement of consumers between the two systems will not be coordinated.

The need for CoAG to take the lead – The lack of consumer input was a concern not only in the NAP but also in how effectively jurisdictions exercise what is widely regarded as a core principle of service development and delivery (e.g. under the National Standards for Mental Health Services). CoAG is in a position to set an example for all jurisdictions by modelling good consultation processes and linking the requirement to demonstrate consumer and carer input as a requirement of funding.

Care coordination is not cost neutral – Consultations consistently highlighted that consumer and carer organisations as well as peak bodies need to be resourced so that they can play an active and strategic role in designing, overseeing, implementing and

reviewing the care coordination model and arrangements. There is an expectation that consumer and carer involvement in this does not require funds and is cost neutral and can be done on a voluntary or as needed basis. Existing consumer and carer organisations do not have the capacity to fulfil this additional role within existing resources without jeopardising the health and wellbeing of staff and members. But consumers and carers are vital to the development of effective care coordination arrangements because of their intimate knowledge of what works, what doesn't work, why coordination breaks down and of their capacity to identify at an early stage problems that are emerging.

Acknowledgement and resourcing of the community mental health sector's role – The linkages across programs and service sectors is variable throughout Australia. Attention needs to be given to the quality and importance of the pathways linking services and care options irrespective of whether the options are government, community, public, private, mental health specific or based in different service sectors. There was consensus that the NAP must commit resources to care coordination and that the community mental health sector must have access to any additional resources given the critical nature of the sector's role in service delivery. Given the role required of the community mental health sector in the roll out of the CoAG National Action Plan it is important that the sector and each state's peak is involved with the NAP roll out and decision making processes.

Might different tendering processes lead to enhanced arrangements for care coordination – Some participants questioned whether care coordination arrangements might have been enhanced had a different procurement model been explored.

4. Progress towards implementing the recommendations of the Senate Select Committee on Mental Health

Recommendations where progress has occurred

Some progress has been made with the following recommendations.

- Recurrent Medicare funding for teams of psychiatrists, psychologists, GP's, psychiatric nurses and social workers, providing expert, integrated, primary health care in mental health centres;
- Greater emphasis on prevention and early intervention and the particular needs of children, youth, the aged and Indigenous Australians (varies greatly across Australia and is largely unimplemented in Indigenous and CALD communities);
- The Mental Health Council of Australia to be charged with reporting on progress under the NMHS;
- More respite and 'step up/step down' facilities and more long term supported accommodation all linked to mental health centres for clinical support (varied progress across states and territories).

At this stage Day to Day Living centres and PHaMs services are just commencing to operate across Australia and a limited number of new respite packages are beginning to be provided.

Recommendations where little progress has occurred

- A new National Mental Health Advisory Committee to advise CoAG on consumer and carer issues, advocate for wellbeing, resilience and illness prevention;

- The roll out of mental health first aid programs aiming for 6 percent of the population and starting with teachers, police, welfare workers and family carers;
- A doubling of investment in research and a new Commonwealth–State Mental Health Institute to develop prioritised research and pilot programs and to set standards;
- HREOC to investigate human rights abuses and discrimination (*our sector urges the HREOC to examine whether the human rights of people with mental illness are being infringed in the areas of income security, employment, housing and legal matters*);
- Financial incentives for medical and allied health training;
- More emphasis on training and employment support, tax incentives and wage replacement schemes to help place people in work;
- Drug and alcohol services to be integrated, better detoxification, rehabilitation and dual diagnosis-specific services (*remains an area of concern*);
- Long stay inpatient facilities focused on rehabilitation for people with severe and chronic disability and *more rehabilitation and supported accommodation options;*
- Specialised mental health and dual diagnosis spaces in emergency departments.

Another critical issue is the variability in funding of community-based services and the lack of parity between the community and government sectors. This is evidenced by non-government mental health services facing high demand, rising costs and no significant increase in funding. Poor salaries and conditions, relative to the public and private sectors, result in a struggle to recruit and retain staff with salaries on average $15,000–$20,000 below those in the private and public sectors. This under resourcing is of concern given the centrality of the non-government community mental health sector to the implementation of the CoAG National Action Plan. As a consequence an under resourced workforce limits organisational capacity and the implementation of new and innovative service models.

5. Remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness

Empowerment of mental health consumers and carers – The community mental health sector calls upon governments to utilise the significant and valuable lived experience of people with mental illness and their families by funding consumer and carer organisations to provide a suite of crucial services including peer support, information, training and advocacy for their members. Indigenous and migrant mental health consumers and carers must be supported to develop options suited to their cultures and communities.

Mental health needs of Indigenous Australians – Participants in consultations made the point that the needs of Indigenous Australians have not been given sufficient priority. Indigenous Australians remain largely alienated from mental health services and that many existing service delivery models are either inaccessible or culturally inappropriate. Contributors expressed the view that Indigenous communities need to be supported in finding their own solutions to their problems in a sustained and incremental manner. This includes more focus on early childhood and education, as education is an essential social determinant of both physical and mental health.

Mental health needs of migrant and CALD communities – it is generally thought that most of the new service developments have had little impact for CALD communities. Some of the major concerns of the community mental health sector about service development with CALD and NESB communities include the following:

- There are significant cultural and language barriers to mental health service access and these barriers are well understood and researched;
- The individual patient/clinician model of mental health practice and care may not be culturally appropriate in many instances and may deter engagement;
- There are high levels of mental health needs in these communities – this is well known and well researched;
- Difficulties still exist with the use of accredited and trained interpreters and some reluctance among mental health and other community professionals to use interpreters;
- There is still little mental health training and support for interpreters
- A shortage of bilingual mental health professionals;
- Migrant Resource Centres and other migrant organisations and groups are able to assist with mental health promotion, early intervention and with engaging CALD and NESB groups in mental health care but are rarely funded to do so.

Priority areas for action – Priority areas for action include the following:

- Ensuring a range of suitable housing and support options for people with mental illness including those with serious long term mental illness and those with complex needs;
- Addressing the poverty traps into which many people with serious mental illness are falling;
- Ensuring that people with mental illness have access to affordable primary health care;
- Developing and implementing a National Employment Strategy for people with mental illness;
- Addressing the lack of parity between the non-government community mental health sector and other mental health sectors around Australia;
- Developing an agreed national plan for structural reform to ensure that resources are moved into community settings where recovery is most supported;
- Resourcing the establishment of workforce development and organisational capacity building strategies to enable the community mental health sector to provide the services that are needed to support recovery and to improve mental health outcomes;
- Developing models of service delivery and care that are culturally safe and appropriate for Indigenous Australians;
- Addressing unmet need and barriers to service use in culturally and linguistically diverse communities;
- Developing a funded, national strategy for locally based care coordination;
- Funding and resourcing consumer and carer-run organisations to provide independent advocacy, peer support, information, training and a voice for members;

- Establishing a national community-based and independent body responsible for the annual reporting on progress to Australian governments and which is mandated with the responsibility of ensuring that the measurement and reporting of service outcomes is based on the direct experiences of consumers, carers and communities;
- Hastening the integration of mental health services and drug and alcohol services, not just in name, but in practice.

In conclusion, while the National Plan provides an opportunity to improve service systems across the country a view consistently argued during the consultations is that both the National Mental Health Strategy and the National Action Plan will fail if the social disadvantage experienced by people with mental illness and their families is not addressed.

The community sector welcomes the Senate's decision to provide a national watching brief so that new initiatives can be independently monitored and further gaps and difficulties identified and highlighted nationally.

3. Consultation Findings by State and Territory

For further information regarding individual state and territory submissions please contact:

3.1 Mental Health Community Coalition ACT
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3.2 Northern Territory Mental Health Coalition
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3.3 Queensland Alliance Mental Illness and Disability Groups
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3.4 Mental Health Community Coalition of South Australia
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3.5 Mental Health Council of Tasmania
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3.6 Psychiatric Disability Services Victoria (VICSERV)
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3.7 Western Australian Association for Mental Health
Ann White, Executive Officer
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Mental Health Coordinating Council of New South Wales
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3.1

The ACT Community Mental Health Sector

The Mental Heath Community Coalition of the ACT (MHCC ACT) is the peak body representing the community mental health sector in the Australian Capital Territory. Founded in 2004, the Coalition works with and promotes the diverse range of non-government organisations that provide community mental health services in the ACT, working inclusively with all stakeholders to enhance consumer and carer involvement and partnerships for better mental health.

The ACT community mental health sector assists consumers and carers to maximise recovery, independent living and active participation in the broader community; promotes understanding and acceptance of mental illness; reduces associated stigma and prevents mental illness within at-risk groups.

Community Consultation Forum

A community consultation forum was held on 16 July 2007, Griffin Centre Canberra at the Inaugural Quarterly Mental Health Consumer, Carer and Community Forum, a partnership between the ACT Mental Health Consumer Network, Mental Health Carers Alliance and the Mental Health Community Coalition ACT. The meeting was addressed by Senator Gary Humphries, Chairperson, Senate Community Affairs Committee and Mr David Crosbie, CEO, Mental Health Council of Australia. Fifty-three people attended the consultation, with the majority being consumers and carers.

The comments in each section below are largely those of participants but also includes, input from individual members and organisations consulted over this period.

1. The extent to which the Council of Australian Governments (CoAG) National Action Plan assists in achieving the aims and objectives of the National Mental Health Strategy

Questions

1.1 To what extent is the CoAG National Action Plan (NAP) assisting to prevent mental disorders and to reduce their impact on individuals, families and communities?

- Forum participants and community agencies argued that it was difficult to ascertain whether the NAP is assisting to prevent and reduce the impact of mental illness in the ACT community. At the time of this consultation only a few NAP initiatives had commenced with further initiatives expected to roll out over the next 12 months.

While participants reported that the new Federal Government initiatives were valuable, problems were also raised with the implementation process, funding levels and coordination.

- The ACT community mental health sector is concerned that there does not appear to be a system in place, both in the ACT and in the other states and territories, to assess the impact of the National Mental Health Strategy and the NAP. The annual reporting that occurs is prepared 'in-house' by state and territory health departments and does not include information directly from consumers and carers, nor does it include information from communities. Concern was expressed about the lack of accountability that results from not having transparent, comprehensive and nationally agreed outcome measurement strategies for assessing and reporting the impact of service delivery and new initiatives. Lack of accountability is also evidenced by consumers, carers and communities not having access to the information that would assist them to make an informed assessment of the impact of national mental health plans and strategies.
- Having made this point, the community sector welcomes the Senate's decision to provide a national watching brief so that new initiatives can be independently monitored and further gaps and difficulties identified and highlighted nationally.
- The ACT community mental health sector is also concerned that particular populations groups have had little access to services under the National Mental Health Strategy and the CoAG National Action Plan, or have benefited less than others. Groups included here are Indigenous Australians, people from culturally and linguistically diverse communities, people with dual disorders, people with personality disorders, and homeless people.

1.2 What has been the impact of expanded access to psychology and allied health services under Medicare? Have any problems or issues emerged?

- The new Medicare arrangements appear to have been embraced in the ACT. Though it is early days, there is excitement about the potential of this program to improve mental health outcomes. Some difficulties identified to date include:
  - low numbers of bulk-billing GPs and psychologists in the ACT, hence there is still a cost barrier to many people;
  - concern that people with severe mental illness or greater levels of impairment may not be able to access the expanded services of psychology and allied mental health professionals;
  - 'regional' differences throughout the ACT; and
  - group-based therapies, psycho-education and symptom management that have not commenced under the new scheme.
- Because of the low levels of bulk-billing by GPs in the ACT, access to primary health care by people with severe or long-term mental illness remains a concern. Service providers report that many people can't 'pass base one' and remain without the means of having their physical health care needs addressed and monitored.
- The MHCC ACT is seeking to consult with the Division of General Practice processes for streamlining access to psychological allied health services by clients of community mental health services. This will include discussion of access to groups and the possibility of sessions being conducted on-site at agencies.

- Anomalies under the Pharmaceutical Benefits Scheme were noted. Specifically, some people are not receiving the best medications because they do not meet the diagnostic eligibility requirements and because they cannot afford to purchase such medication.

1.3 Do you experience that mental health services, care and outcomes improved in the last one-and-a-half years?

- Those present at the forum had difficulty answering this question. Again, people expressed the view there is no adequate service accountability, particularly in relation to service quality and outcomes. There is little effort to routinely and systematically obtain information from those who require and use mental health services. Consumers, carers and communities should be involved in assisting service providers to know whether service and care is improving and to identify areas for improvement. Concern remains about access to publicly funded mental health assessment and treatment even when this is GP initiated, limited case-management and clinical follow-up, lack of discharge planning and lack of care coordination.
- Those present also emphasised that while it is possible that mental health services, care and the outcomes are improving, the progress made is being undermined by the increased level of poverty and housing instability that is being experienced by many people with mental illness, particularly those experiencing episodic illness or severe illness and their families.[1]
- Sustained mental health recovery requires meaningful life style options and access to adequate income support and affordable and stable accommodation. By national standards ACT housing and rental prices are amongst the highest, there are few rental vacancies and people with mental illness are finding it increasingly difficult to compete in the private market and to afford and maintain private accommodation. Public housing waiting lists are long and there is little supported accommodation especially for families. Many people with severe mental illness and their families who try to support them and carry the costs are facing increased levels of impoverishment, homelessness and family stress.[2] Consumers, carers and service providers in the ACT report that the Welfare to Work provisions are also seriously affecting people with mental illness and their families and must be addressed.[3]
- Those present at the consultation as well as other contributors stressed that the Senate needs to place the issue of increasing poverty and homelessness among people with mental illness on the national agenda. This increased experience of poverty and homelessness is undermining the impact of all of the national and state-based developments and initiatives.
- Another factor undermining the positive impact of the National Mental Health Strategy and the CoAG National Action Plan is the separation of mental health and drug and alcohol services. Contributors to the consultation emphasised the need for these two services to become one service given the high level of co morbidity. The separation of these two services makes little sense in the context of people with a mental illness, Indigenous communities and young people.

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[1] P. Yano, S. Barrow & S. Tsemberis (2004), 'Community integration in the early phase of housing among homeless persons diagnosed with severe mental illness: successes and challenges', *Community Mental Health Journ*al, 40 (2), pp. 133–50.

[2] For discussion of the impact of stable housing on mental health outcomes see T. E. Martinez & R. Burt (2006), *Impact of permanent supportive housing on the use of acute care health services by homeless adults,* Psychiatric Services, Vol. 57, July, pp. 992–9.

[3] For recent social disadvantage trends see ACOSS (2007), *A fair go for all Australians: International Comparisons, 2007 10 Essentials*, ACOSS Strawberry Hills, NSW, Australia.

- A further factor undermining the NAP is funding levels of community-based services and the lack of parity between mental health service sectors. This is particularly evident in the ACT with non-government community mental health services facing high demand, rising costs and no significant increase in funding. While the new CoAG initiatives provide an opportunity to build capacity in community based service settings many agencies voiced their concern with the total funding allocated towards ACT demonstration cites for the new PHaMs, Respite and Day to Day living programs.
- Forum participants and community agencies also highlighted the inadequate forensic mental health services and facilities available in the ACT region. A recent audit of Correctional Facilities by the ACT Human Rights Commission supports this view and proposes the need for an improved specialist forensic mental health service system and facilities. This is a critical issue considering the new ACT prison is scheduled for completion in 2008.
- A final limiting factor discussed during the consultations is the lack of emphasis on disability within professional undergraduate and postgraduate education and training. Newly graduating professionals, particularly in psychology and medicine appear to lack understanding of the areas of disability arising from the experience of mental illness.

1.4 To what extent is the CoAG National Action Plan assisting to assure the rights of people with mental disorder and their families?

- Though ACT Health has made significant progress through the recently launched Mental Health Consumer and Care Participation Framework, much remains to be done to progress the broader rights agenda of people with mental illness and their families. There is a strong view in the ACT that assurance of the rights of people with mental illness and their families remains at the level of rhetoric. For example, neither the CoAG National Action Plan nor the National Mental Health Strategy commits funding to independent consumer and carer-run advocacy and peer support services. Advocacy services for people with mental illness appear to be falling into no man's land – somewhere between the Disability Agreement and somewhere between State/Territory responsibility and Commonwealth responsibility.
- The lack of attention to the rights of people with mental illness and their families is evident in the way that consumers and carers are not systematically and routinely involved in assisting governments to assess the quality, effectiveness and outcomes of services and care i.e. their lived and personal experience of services as well as they knowledge and expertise about what is needed is not routinely drawn upon for the purposes of outcome measurement, accountability and reporting.
- Some participants went as far at to say that people with mental illness may well be 'rotting with their rights on' – all governments talk about the rights of people with mental illness and their families whilst many remain excluded from the necessities of life including day to day goods, utilities and services, affordable housing, primary health care, education, training and employment. Assuring the rights of people with mental illness, require that governments address these basic and quality of life limiting infringements of human rights.

- The consultation also argued that the rights of some groups are below everyone's 'radar' – including people with mental illness who are homeless people, people with dual disorders, personality disorder[4] and Indigenous Australians. Concern remains about the rights of parents with mental illness and the extent to which their rights are being further eroded by the lack of family-based approach to mental health care as well as by the impact of Welfare to Work provisions, the lack of affordable housing and increased cost of living

1.5 Have any issues or problems emerged in the roll out of Commonwealth or State funded new service initiatives under the CoAG National Action Plan?

- While the ACT community mental health sector welcomes many of the NAP initiatives especially the new community based programs by FACSIA and early intervention prevention services funded by the ACT Government several concerns were highlighted. These included:
  - The process used to determine how new Commonwealth funding programs were allocated to states and territories. Some participants were concerned that smaller states and territories like the ACT would be overlooked in future funding rounds like the Personal Helpers and Mentors (PHaMS) and Respite program. Similarly, the lack of local input within the tendering processes and the postcode service eligibility requirements were questioned.
  - While forum participants highlighted their support for the two new PHaMS demonstration sites and confidence that these services will make a difference in people's lives they argued that 10 workers is simply not enough in meeting the real need in the community. This is evidenced by people already being turned away from demonstration sites due to not living in the assigned service catchment areas. Forum participants highlighted the need for additional PHaMS sites in the Belconnen and Gungahlin regions as well cross border programs with neighbouring NSW towns like Queanbeyan. Service providers commented that when they consider their current capacity and the level of service demand, that an increase of somewhere between 30–40% of resources is required to make a difference and to begin to prevent mental illness and to reduce its impact. One respondent stated that if the "Australian government was serious about supporting people in the community they would have allocated at least 5000 personal helpers and mentors across the country not 900".
  - In light of the current service demands forum participants argued that a further two Personal Helpers and Mentors sites and two Day-to-Day Living Centres are required in the ACT. Carer representatives also highlighted the need for further respite support options and promotion of the new federal initiatives. Carers ACT the auspicing agency of the new respite care program highlighted several concerns about the initial funding allocation. The ACT was allocated just 0.29% of the new FACSIA Mental Health Respite Initiative making it extremely difficult to set up infrastructure costs that could otherwise be recouped through economies of scale with larger funding amounts. Usually the ACT is allocated 2% of federal funding programs.
  - Respondents argued a further injection of resources is still required in all existing community based care programs by both the Federal and ACT government.

[4] The UK has committed significant resources to developing services and supports for people with personality disorders. See the National Personality Disorder Website: www.personalitydisorder.org.au.

– The NAP evaluation process does not appear to be utilising the expertise of consumers and carers and appears to lack clarity. The opportunity to expand the evidence base and increase knowledge about what works could be wasted.
– There is also concern that some groups with significant needs might be missing out on service by reason of the initial roll out's generic approach e.g. people with mental illness with children, homeless people, people with dual disorders, older people, young people in early stages of a psychotic illness etc.

2. The overall contribution of the CoAG National Action Plan to the development of a coordinated infrastructure to support community-based care

Questions

2.1 To what extent has work progressed in your state or territory on the development of arrangements for care coordination?

- In the ACT a care coordination reference and working group comprising of key stakeholders has been meeting since late 2006. While these forums have provided a new platform for government and community stakeholders to share information there appears to be minimal resources assigned to implement a care coordination model or projects for the ACT region. In many ways care coordination offers a real opportunity to define the roles, inter-sectorial relationships and practice arrangements between government, community and private mental health sectors. One forum participant argued that care coordination is critical to a responsive system as it is the "glue that binds" the diverse programs and stakeholders delivering services.
- It was argued that while the NAP includes many valuable programs and individual service measures it does not include funding for care coordination projects to assist states and territories operationalise a care coordination framework.
- Forum participants highlighted that consumer and carer organisations as well as peak bodies need to be resourced so that they can play an active and strategic role in designing, overseeing, implementing and reviewing the care coordination model and arrangements. There is an expectation that consumer and carer involvement in this does not require funds and is cost neutral and can be done on a voluntary basis. Existing consumer and carer organisations do not have the capacity to fulfil this additional role within existing resources without jeopardising the health and wellbeing of staff and members. But consumers and carers are vital to the development of effective care coordination arrangements because of their intimate knowledge of what works, what doesn't work, why coordination breaks down and of their capacity to identify at an early stage problems that are emerging.
- In addition, the linkages across programs and service sectors are variable in the ACT.[5] Attention needs to be given to the quality and importance of the pathways linking services and care options irrespective of whether the options are government, non-government, public and private, mental health specific or based in other service sectors. There was consensus that the NAP must commit resources to care coordination and that the community mental health sector must have access to any additional resources given the critical nature of the sector's role in service delivery.

[5] ACTCOSS (2007), *No Wrong Door: Towards an integrated mental health service system in the ACT*, ACTCOSS, Canberra.

- Some participants questioned whether the cost effectiveness of the tendering process might have been enhanced had a different model of service purchasing been explored.
- Given the role required of the community mental healsth sector in the roll-out of the CoAG National Action Plan it is important that the sector and each state's peak is involved with NAP roll out and decision making processes.

1.2 To what extent has consumer and carer input influenced the development of coordination structures?

- As stated above, the development of care coordination structures are at an early stage in the ACT. Consumers are represented through the ACT Mental Health Consumer Network, an independent, consumer-run organisation. The Network is funded by ACT Health to represent the views of consumers. However, carers in the ACT are without a funded independent representative body. The Coalition and number of other organisations seek to help carers put forward their views. Consumers and carers alike struggle with national consultation processes that generally occur at the last moment, with little notice and without resourcing and support. It would seem that CoAG has the opportunity to set in place a model consumer and carer participation processes that can address the barriers to consultation and real partnerships faced by not only individual consumers and carers but also by their representative organisations and groups.
- In the absence of well resourced and supported consumer and carer consultation processes government services providers and administrators end up speaking on behalf of consumers and carers or interpreting their views which is not ideal.

1.3 To what extent has Indigenous Australians had input to development of coordination arrangements?

- In the ACT, Aboriginal community controlled health organisations and Aboriginal health workers are routinely invited to participate in whatever consultation is occurring. But clearly, the limited staffing and size of Aboriginal organisations, makes it difficult for Indigenous input. Given the enormity and significance of mental health needs in Indigenous communities, CoAG as well as State/Territory governments need to talk with Indigenous organisations about what they need if the views of Indigenous Australians are to be represented. There was consensus throughout the consultations that Indigenous Australians in the ACT are largely excluded from the new services under NAP and are under represented in the use of the Medicare Mental Health Care arrangements.
- There is concern that the Indigenous Australians with mental illness who are living in the ACT are seriously affected by the trends of impoverishment, homelessness and poor physical health discussed above. Indigenous Australians with mental illness are struggling to have enough money to buy enough food and to cover the cost of day to day living. They are also struggling to compete in the private rental market and are increasingly at risk of homelessness. They like other people with mental illness are being breached, losing Centrelink payments and losing their incomes.

1.4 Have any specific problems or issues emerged with attempts to progress care coordination?

- As discussed above there does not appear to be a clear focus on how the ACT is to progress implementing projects to support a care coordination model or framework. While some states like QLD, VIC and NSW are currently developing programs to support care coordination some respondents felt the ACT would struggle to allocate comparable resources. Concerns were raised that the smaller states and territories will let care coordination projects fall by the way side and not deliver anything that will address this critical issue. Several forum participants highlighted that this variable approach could have been avoided if the NAP had included a separate funding stream specifically for state based projects and national benchmarks to progress care coordination.

1.5 What needs to happen to make care coordination a reality? Is anything different needed in rural and remote communities or for particular community groups?

- As discussed above care coordination and inter-sectorial collaboration is pivotal to improving mental health service outcomes. The ACT community mental health sector would strongly recommend the Senate Committee to review this critical issue and consider options for developing an agreed national framework and funding program for this to occur.

3. Progress towards implementing the recommendations of the Senate Select Committee on Mental Health

Questions

3.1 To what extent has progress been made on implementing the recommendations of the Senate Select Committee on Mental Health?

Some progress has been made with the following recommendations. Comments indicating the extent of progress are included in brackets.

- Recurrent Medicare funding for teams of psychiatrists, psychologists, GPs, psychiatric nurses and social workers, providing expert, integrated, primary health care in mental health centres *(few psychiatric nurses and social workers are providing services and it couldn't be said that the ACT is witnessing the development of 'integrated primary health in mental health centres; problems with affordability with psychologists charging over the Medicare rebate)*;
- Extension of Medicare rebates to private clinical psychologists and allied health professions *(again, few allied health professionals are providing services)*;
- Greater emphasis on prevention and early intervention and the particular needs of children, youth, the aged and Indigenous Australians *(some early intervention and prevention is occurring but possibly not with Indigenous Australians)*;
- The Mental Health Council of Australia to be charged with reporting on progress under the NMHS *(unsure about progress to date*);
- More respite and 'step up/step down' facilities and more long term supported accommodation, all linked to mental health centres for clinical support *(ACT Health has began to fund step-up-step down facilities)*.

3.2 Have any recommendations not been progressed?

- A new National Mental Health Advisory Committee to advise CoAG on consumer and carer issues, advocate for wellbeing, resilience and illness prevention (*unaware of any such body having been formed*);
- The roll out of mental health first aid programs aiming for 6 percent of the population and starting with teachers, police, welfare workers and family carers (*this target has not been met in the ACT and the community mental health sector is unaware of any plan existing to achieve these targets*);
- A doubling of investment in research and a new Commonwealth–State Mental Health Institute to develop prioritised research and pilot programs and to set standards (*evaluation, research and development remain under funded with the community mental health sector receiving none or little of any such funds*);
- HREOC to investigate human rights abuses and discrimination Mental health (*our sector urges the HREOC to examine whether the human rights of people with mental illness are being infringed in the areas of income security, employment, housing and legal matters)*);
- Drug and alcohol services to be integrated (*little progress occurring in the ACT except for initiatives about to commence under HeadSpace; ACT Mental Health and ACT Alcohol and Drugs remain two separate service systems with reports that people with dual disorders are still being passed between services)*;
- A national emergency 1800 telephone help line, staffed by mental health workers 24 hours a day (*some developments have occurred here with Lifeline, Mensline for example receiving funding for specific projects)*;
- Financial incentives for medical and allied health training (*there remains a shortage of mental health professionals in the ACT, particularly with experience; the ACT mental health workforce continues to age*);
- More emphasis on training and employment support, tax incentives and wage replacement schemes to help place people in work (*very little progress here for people with mental illness if anything greater disadvantage as a result of Welfare to Work provisions and unaffordable housing; little progress with increasing employment)*;
- Better detox, rehabilitation and dual diagnosis-specific services (*remains an area of concern*);
- Long stay inpatient facilities focused on rehabilitation for people with severe and chronic disability (*more rehabilitation and supported accommodation options are required in the community; need options regionally rather than the current concentration of services at Brian Hennessy House*);
- Specialised mental health and dual diagnosis spaces in emergency departments (*remains an area of concern as agencies report that people with dual disorder presenting to emergency are generally sent away without assistance*);

3.3 Have consumers and carers had improved Medicare funded access to private clinical psychologists and allied health professionals?

- Consumers and carers do appear to be using the Medicare funded access to private clinical psychologists. It remains difficult for people to find out which GPs are participating and who will do mental health care plans. This depends on GPs facilitating this process, and some GPs are less likely to participate and be aware of the changes.

- As discussed above, it remains unclear as to whether, people with more serous mental illnesses are missing out due to clinical psychologists charging above the Medicare rebate.

3.4 Have consumers and carers had improved access to support and advocacy independent of public mental health services?

- ACT Health has just appointed a second, part-time mental health consumer advocate. The Carer Peer Support program remains minimally funded but manages to deliver valuable support.
- There is consensus that there is a lack of independent advocacy services for consumers and carers and that this is due to a reluctance of both State/Territory and Commonwealth governments to view advocacy as being a pre-requite to improving services as well as improving outcomes.
- Consumers and carers are hoping that the Senate Inquiry will place advocacy on the national agenda so that the question of responsibility for funding advocacy services is resolved and a better approach to advocacy including new service models is developed and implemented nationally.

3.5 Have any problems or issues emerged with the implementation of any of the Committee's recommendations?

- Responses to the recommendations to assist people with mental illness to become employed and to participate in training and education do not appear well progressed. Few new funding programs have been specifically targeted at vocational support and employment support programs for people with mental illness.
- The siloing of funding programs for mental health, housing, drug and alcohol, clinical and community mental health programs remains segmented. Collaboration and coordination remains spasmodic and difficult to sustain.
- Lack of attention to the increased levels of poverty experienced by people with mental illness and their families is undermining the effectiveness of progress where it is occurring.
- Research and capacity building are key components of achieving the Committee's recommendations.

4. Remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness

- The responses to the following questions have to some extent been answered in previous questions. It is important to note that the Senate Reports and the CoAG National Action Plan have contributed to a rethinking about the type of services required and how funds need to be allocated to enhance community based support options. The NAP has emphasised the need for community-based services and the role of the non-government community mental health sector in providing those services. However, despite recent government investment, the bulk of Australia's mental health spending (approximately 90% of total mental health budget) remains in

clinical acute service areas.[6] This impedes necessary mental health reforms and also poses significant challenges for community mental health sectors throughout Australia that are seeking to improve current services while also expanding to include new targeted and highly specialised recovery programs.

- The consultations in the ACT called on the Senate Inquiry to investigate the barriers that limit the growth of community mental health services around Australia and to examine the disparity between the community, private and public sectors and to look at how Australian governments can work together to increase the capacity of the sector that is so well placed through its close links to consumers, carers and communities to provide psychosocial rehabilitation, recovery support, as well as prevention, promotion and early intervention services.[7]

Questions

4.1 Have consumer and carer organisations been empowered to establish a broader range of support, information, training and advocacy for their members?

- The ACT recently launched a framework for consumer and carer participation for which there is wide support. However, concerns were raised by forum participants that this framework requires ongoing funding for independent advocacy, training of consumers and carers and support for representatives and volunteers.
- As discussed above, mental health carers in the ACT are without a funded representative body. The Carer's Alliance, which meets monthly to progress the views of carers does so without funding.
- The Carers Network, a grass roots, mutual support group which has been meeting for approximately 4 years, seeks to reach out to families who are experiencing mental illness for the first time or to families who have become isolated due to a member's mental illness. This group is also without funding although the Mental Health Foundation contributes funds towards the organisation and running of the group's meetings. Consultations reported greater awareness and networking with agencies relevant to support, information, training and advocacy which helps service providers to help consumers and carers to access these types of assistance.

4.2 To what extent have the needs of Indigenous Australians been given priority? What needs to be done as a matter of priority?

- Contributors to the consultation processes argued that current mental health service systems are not well suited to responding appropriately, flexibly and in a timely manner to the mental health needs of Indigenous Australians. The current structures of individual-based assessment, treatment, clinical follow up and rehabilitation results in many Indigenous Australians not wishing to stay engaged with services. The ACT community mental health sector encourages the Senate to place this issue high on the national reform and service development agenda.[8]

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[6] Mental Health Council of Australia (2006), *Time for Service: Solving Australia's Mental Health Crisis,* MHCA, Canberra.

[7] ACT Council of Social Service (2006), *Towards a Sustainable Community Services Sector in the ACT*, ACTCOSS, Canberra.

[8] For discussion of possible alternatives see Jeffrey D Fuller, Lee Martinez, Kuda Muyambi, Kathy Verran, Bronwyn Ryan and Ruth Klee (2005), 'Sustaining an Aboriginal mental health service partnership'*, Medical Journal Australia*, 183 (10): S69-S72; C. Salisbury (1998), 'A health service and Aboriginal and Torres Strait Islander partnership to develop and plan mental health services', *Aust J Prim Health Interchange*, 4: 18-30; C. de Crespigny, I. Kowanko, H. Murray, S. Wilson & J. Ah Kit (2006), 'A nursing partnership for better

4.3 To what extent have the mental health needs of people living in rural and remote areas been given priority? What needs to be done as a matter of priority?

- The ACT community mental health sector is aware of the dearth of clinical, rehabilitation and recovery services available to people living in towns surrounding the ACT – so close to the nation's capital but so under-resourced. For example, there are towns between an hour and two hours away from the ACT, where the Area Health Service struggles to retain enough clinical staff to ensure that clinical services can simply remain open and operate safely.
- Forum participants suggested that ACT Health needs to pilot and develop innovative shared-care service models with NSW to support these communities.

4.4 To what extent have service developments assisted people from culturally and linguistically diverse communities?

- This remains an area of concern in the ACT. Attempts by the sector to lobby for establishment funds for the fledging Transcultural Mental Health Network have been unsuccessful. There has been debate as to whether such an organisation should be stand alone, in the community sector or based in the public mental health sector, Clearly a partnership approach is required. Despite a growing consensus about this, a process for establishing and resourcing such a body remains elusive and the fledging network struggles on.
- Contributors to the consultation processes argued that the Senate could assist by placing on its agenda the question of the extent to which the mental health needs of CALD communities are being met throughout Australia. The community mental health sector is of the view that each state and territory requires a funded and resourced organising body to progress multicultural and transcultural mental health issues, to improve knowledge and practice and to identify and address barriers to service access. This body should be part of the National Mental Health Strategy funded, Multicultural Mental Health Australia. Currently, there are multicultural mental centres or networks in NSW, QLD, WA and Victoria. The Australian Capital Territory, South Australia, Northern Territory and Tasmania are without such bodies.

4.5 What gaps or shortfalls in funding still exist?

- Many gaps and shortfalls in funding were identified during the consultation processes conducted in the ACT. The community mental health sector agrees with the estimation of other state peaks that 3 or 4 fold increase in resources is required to more adequately address need and demand for services.
- As discussed above, though 99% of recovery occurs in the community and in people's homes, the bulk of Australia's mental health service investment remains in clinical acute service areas.[9]
- Due to the multi-dimensional needs of people with mental illness in their families, jurisdictions need to shift from silo funding to cross-program funding so that mental

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outcomes in Aboriginal alcohol, other drugs and mental health', *Contemporary Nurse*, vol. 22, no. 2, p. 275; C. Prideaux, J. Ah Kit, L. Ordasi, I. Kowanko, H. Murray & C. de Crespigny (2006), 'Rural and remote Aboriginal mental health – Meeting the challenges', 16th annual The MHS conference 'Reach Out, Connect', Townsville, 30 August – 1 September (invited presentation);I. Kowanko (2005), 'Coordinated Aboriginal mental health care – A model for best practice', *Indigenous Health Matters*, vol. 12 (June), p. 8.

[9] Mental Health Council of Australia (2006), *Smart Services: Innovative Models of Mental Health Care in Australia and Overseas*, MHCA, Canberra.

health services, primary health care, drug and alcohol services, housing services, employment services are encouraged to work together.

- In the ACT and in some other jurisdictions, people with mental illness and resulting psychiatric disability, are largely locked out of receiving services or funds under the State/Commonwealth Disability Services. Further, people with mental illness are often excluded from HACC-based services even though their needs fall within the program's eligibility criteria.

4.6 What gaps in services still exist and what still needs to be done as a matter of urgency or priority?

- Numerous gaps were identified. However, the community mental health sector calls on the Senate Inquiry to draw attention of governments to the following urgent gaps:
  - Appropriate, affordable and stable accommodation and support to help people remain accommodated;
  - Income security for people with mental illness evidenced by increased poverty;
  - Access to affordable primary health care;
  - Mental health services that are inclusive of and relevant to the needs of Indigenous Australians;
  - Appropriate services for homeless people with mental disorders;
  - Specialised responses for people with dual disorders and high and complex needs;
  - Sufficient early intervention services that are targeted to the specific needs of different population groups;
  - Employment support and vocational training support programs;
  - Employment opportunities e.g. innovative approaches like Social Firms;
  - Resourced care coordination;
  - Mental health services that can operate on a family/extended family model rather than solely individualised approach;
  - A more comprehensive range of mental health services for children and young people;
  - Sufficient step-up/step-down facilities for different age groups;
  - Outreach and information services for people from CALD communities;
  - Consumer and carer advocacy and peer support;
  - Evaluation, research and development funding;
  - Continued funding for promotion, prevention and stigma reducing initiatives in acknowledgement that the battle has just begun.

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3.2

NT Mental Health Coalition

Working as a part of the National Community Mental Health Peaks

The Northern Territory Mental Health Coalition is the state peak body recognised by the Minister for Health and Community services representing non-government organisations that provide services to people with mental health needs. It operates as a sub-committee of NTCOSS and was established recently. The Coalition also holds a seat on the Mental Health Council of Australia (MHCA). Consultations were held with NT service providers, consumers and carers during July 2007 and a summary of responses is included in this section.

1. The extent to which the Council of Australian Governments (CoAG) National Action Plan assists in achieving the aims and objectives of the National Mental Health Strategy

Questions

1.1 To what extent is the CoAG National Action Plan assisting to prevent mental disorders and to reduce their impact of individuals, families and communities?

We think the initiatives will be very good but they are still in the roll out stage in the NT and outcomes are not apparent at this stage. It is still too early to tell. The plan is looking to be very effective if the implementation is carried out in the way that is it said to be done. Within the urban environment the plan is having a positive impact. The further one travels from an urban centre the less the impact. In remote parts of Australia the impact is minimal.

In principle the CoAG national action plan has an excellent focus on preventing disorder and reducing impact. However, the implementation is confused. In particular FACSIA's implementation of the Personal Helpers and Mentors Program is confused in several ways. One of the biggest difficulties is that it was supposed to be designed to assist people who were not already accessing the system and people who are falling through the gaps in the system. However, advertising materials are clearly seeking referrals from people who are "…affected by mental illness". Engagement of the target groups is clearly a problem. Commonly, people who do not access the system do not recognise that they have a mental illness, or do not want this known due to issues associated with stigma or have had such poor experiences with the system that they will not access this service. Assessment, referral and other documented information are also confused. It appears that PHaM staff and organisations recruited so far do not have the experience and qualifications to support people with a mental illness.

1.2 What has been the impact of expanded access to psychology and allied health services under Medicare? Have any problems or issues emerged?

When reading the Report of the First Six Months of the program there are a lopsided usage of the new or expanded services. In the NT the Program is still in roll out stage. Capacity needs to be built to allow for expanded access in regional areas. Even in the major population centres in the NT, there are very few allied health professionals who have undertaken to register as a Medicare Provider. The groups of people who are getting counselling and psychological services through Medicare appear to not be the ones that need it most, seem a bit lopsided, and I worry that it is not an effective service this way. I refer to Professor Ian Hickie's comments regarding this matter. However, those accessing the services report positive outcomes. Agencies also report a greater capacity for individuals to access services and a greater willingness among health professionals to make referrals for clients.

Within the remote environment the impact of access to psychological and allied health services has not yet happened. Aboriginal health workers are undergoing training and time will tell if the impact will be positive.

Other comments provided include:

An excellent impact!! – We have a concern about how evaluation as there is a need to evaluate and monitor the quality and consistency of services provided to clients given that they are operating as sole practitioners.

Again, good in principle, problems in implementation.

1.3 Do you experience that mental health services, care and outcomes have improved in the last one-and-a-half years

There appears to have been an increase in service options because of increased awareness and funding, however to say that this has translated to quality services or improved outcomes is hard to say clearly. The million-dollar question is how to evaluate and measure whether there is an improvement or movement for client outcomes?

Other comments provided included:

With territory and state funded services this is definitely the case but the National Action Plan outcomes are still not apparent yet and won't be for some time

There have been improvements in the provision of mental health services in the non-government sector in the last one and half years. At this stage the National Initiatives are not in place.

Not in the remote setting. No change is evident.

No noticeable impact has been observed over the past 1 1/2 years (aside from the greater access to psychologists highlighted above).

1.4 To what extent is the CoAG National Action Plan assisting to assure the rights of people with mental disorder and their families?

There is a view that the assurance of rights of people with mental illness and their families is not resource neutral and that greater resourcing of independent advocacy is required particularly given difficulties around service access in the NT. Comments provided include the following:

I am not sure this is helping at all yet, I think more work is to be done, and people are still not getting the services they need

The CoAG National Action Plan may act to assure the rights of people with mental disorder and their families through enhanced service provision and improved relationships in coordination of care. There appears little evidence that the Plan attempts to directly address issues directly related to the civil rights of people with mental disorder.

This plan has the potential to assist greatly in assuring the rights of people with mental disorder and their families but I am not sure that the assistance is getting to the people that really need it.

The impact in remote areas is not evident. In regional centres there has been significant change.

In my opinion the rights of people with a mental illness and their families have always been recognised throughout the system. The presence of advocacy groups is an important part of the systems safety net for clients

All services should be operating within the National Mental Standards and the Mental Health Strategy. This contains the Rights and Responsibilities policy document and the standard relating to this. Therefore the action plan would have had minimal impact unless they providing funding on capacity projects around rights.

1.5 Have any issues or problems emerged in the roll out of Commonwealth or State funded new service initiatives under the CoAG National Action Plan?

There are problems but they will become more apparent as the roll out continues, it is in the very early stages at this point. There is concern about is whether the PHaM organisations are actually targeting the correct people, it looks like they are targeting the people already in services and counting on referrals; when there is an expectation that people who are not in services already were to be targeted.

There is some concern that gaps in services may still remain given the “rules” governing the operation of PHaM. For example, ex prisoners with an existing court order are not eligible for support, people with drug and alcohol issues who have not committed to addressing this issue are not eligible for support. This is particularly problematic as this is an area where the gap in service is consistently identified. There is evidence of interventions with people with drug and alcohol issues prior to a decision to implement change that may in effect contribute to the decision for change. Opportunities may be lost with the way the system is excluding consumers from a service. Rules in place for access to PHaM may ensure that the gaps in service delivery are just replicated. There may also be issues with the referral system. People with mental health issues who are not receiving a service may be in this position because they are unable to recognise the

existence of mental illness. We need to put in place a system that relies on referral and then assessment prior to admission to the service means that those people most at risk of isolation in the community are less likely to voluntarily continue with the process. It needs to be more consumers friendly.

> *The first round of the PHaM program in the Northern Territory was a bit confused in implementation, the services that got the funding really lack first hand experience in mental health service delivery, it almost looks like the government handed the money to the largest organisations because their infrastructure was already in place, some of the smaller more specialised organisations had the expertise in the fields required but were overlooked because their size.*

There has been a problem with the inclusion of Aboriginal Health Workers in the scheme. Assumptions were made that the workers would have had mental health training but this is often not the case. Organisations now have to train workers in the use of mental health care plans.

Another concern identified at this stage is an apparent lack of coordination between the State & Territory governments and the Commonwealth. Some of the initiatives appear to be hurriedly thought through especially related to workforce development.

> *There are many problems with the roll of services in Darwin/Top End. For example, there is a lack of knowledge/experience of the client group and of the service sector, Darwin services have no base and no phone other than a mobile (end July – supposed to be established May 2007). New services also appears to duplicate existing services (according to advertising materials) so it is difficult to know who and when to refer*

2. The overall contribution of the CoAG National Action Plan to the development of a coordinated infrastructure to support community-based care

Questions

2.1 To what extent has work progressed in your state or territory on the development of arrangements for care coordination?

A Reference Group made up of stakeholders have been meeting and it will take time to work through a process for operation. The initial process was separated into two areas being; people with complex needs and access to the primary health care. The Group has been working steadily through the concepts of care coordination and how that could be implemented using a system based approach. The Reference Group is in the process of drafting a protocol around the philosophy and principles of care coordination and an agreement for a **one-care plan** to improve communication and a GP care plan template that all services contribute to. Comments received about the progress of care coordination include the following:

> *NT care coordination meeting is held regularly. Poor attendance by consumer and carer community representatives from existing (non-CoAG) services. Otherwise is sharing information about services is going well. NT government chairs the meeting and has invited all relevant stakeholders.*

Current PHaM services are not networking well with other community-based and social services that are most likely to see clients who may have a mental illness but are not accessing mental health services e.g. emergency assistance, emergency housing providers. Also not networking well with existing mental health services other than through the care coordination meetings.

Generally doesn't seem to be an understanding that it is important to work with other service providers to access clients – Good work done on coordinated planning by Top End Division of General Practice and other services. The care coordination in the Northern Territory is a bit confusing at the moment, the Territory Government are chairing the meetings and are working towards positive outcomes but there seems to be a lack of participation from a lot of groups that should be involved at this stage, particularly from the larger indigenous groups in Darwin and Central Australia.

The NT Government has organised consultation meetings on the subject of care coordination and though I have not been involved in the process I believe there are some positive outcomes to be seen in the future

Beginning stages, but there is evidence that there may be excellent outcomes from care coordination.

There is very little progress to date in our area or in relation to the people we see.

2.2 To what extent has consumer and carer input influenced the development of coordination structures?

There has been a little involvement from consumer and carer groups but there needs to be much more for it to be truly representative. Consumers and carers have been represented through Peak bodies. There is no direct input. The Northern Territory Community Advisory Group has advised the Minister in relation to this matter but is awaiting a reply.

2.3 To what extent have Indigenous Australians had input to development of coordination arrangements?

This is problematic as there has been very limited involvement from the major indigenous groups in the Territory to this point. Neither are individual Indigenous consumers and carers involved. The Aboriginal Congress attends the Care Coordination meeting but the major indigenous mental health service provider – Danila Dilba – has not been involved with the Care Coordination Reference Group meetings.

2.4 Have any specific problems or issues emerged with attempts to progress care coordination?

Specific problems include:

- The requirement of existing infrastructure and service capacity which has worked against non-government community mental health services in the NT being able to successfully compete in the new tendering processes;
- Lack of access to the new services by people outside of the existing service system;
- Too few services;
- Lack of access by people with complex needs;
- Lack of service access in rural and remote areas;

- Lack of formal involvement of consumers and carers;
- Lack of formal involvement of Indigenous stakeholders;
- Lack of formal involvement of CALD stakeholders;
- As mentioned earlier, lack of training;
- There are very few allied health staff in the Territory and therefore a shortage of qualified staff to be involved in the care coordination;
- Recruitment and retention issues for rural and regional areas;
- Lack of service options for accessing psychological services through Medicare in regional and remote areas;
- Lack of access to GPs who bulk-bill, which limits and acts as a barrier to accessing a GP Care Plan;
- Initial issues around sharing information and protocols for communication.

2.5 What needs to happen to make care coordination a reality? Is anything different needed in rural and remote communities or for particular community groups?

- Cooperation from all parties and a commitment to getting things done from all;
- Involvement of consumers and carers;
- Involvement of Indigenous stakeholders;
- We need specific feedback from the correct groups to get that information and there seems to be resistance from the orgs involved for some reason
- Culturally appropriate training is required in remote indigenous areas.
- There needs to be significant effort placed upon the recruitment and retention of suitably qualified staff including attention to issues of accommodation and travel.
- Improved communication between services and clients;
- More service options for psychological services in regional and remote areas;
- A long term workforce development strategy
- PHaM providers should work better with existing services.

3. Progress towards implementing the recommendations of the Senate Select Committee on Mental Health

Questions

3.1 To what extent has progress been made on implementing the recommendations of the Senate Select Committee on Mental Health?

Respondents felt that they did not have enough information to answer this set of questions. Respondents generally were of the view that as far as they are aware very little progress has been made in remote areas of the Northern Territory and it is still early days with developments that are occurring in the major urban centres.

I have some concerns with some recommendations of the Senate Select Committee because it refers to National structures when there are local structures, which are more in touch, and have more knowledge of how systems operate. For example, the recommendation that HREOC investigate discrimination – the process is far easier for a consumer to lodge a complaint with the local Anti Discrimination Commission – where an attempt to resolve by conciliates will be made in the early stages of the complaint. Similarly, most jurisdictions already provide a 24-hour counselling service through Crisis Intervention Services. In the NT, there is no formal 24-hour mental health service counselling line, although Lifeline has been funded to provide a counselling service.

Some of the programs are already up and running and some others are very close, it is too early to know what the outcomes will be but we watch with high hopes

I am not sure what the recommendations were but there has been an improvement in capacity, how effective and the quality of that is still yet to be determined.

3.2 Have any recommendations not been progressed?

Respondents stressed the need for national recommendations and implementation processes to acknowledge and factor is difficulties faced by remoteness and the range of issues presenting in the NT including significant logistical and cultural issues. The size of the Territory means that provision of service for specific groups of people is unrealistic because there is no capacity for "economy of scale" savings. For example, economies of scale issues result in a long stay rehab facility not being feasible. Recommendations such as this will not be progressed in the NT unless the logistical issues are addressed.

3.3 Have consumers and carers had improved Medicare funded access to private clinical psychologists and allied health professionals?

There was a mixed range of responses to this question, which reflects the scheme's different accessibility for different groups.

Not yet but I believe this is one of the initiatives

I have seen no evidence of this as yet.

The service has improved slightly but is very lopsided in the groups that are accessing the service

Not in the bush.

Yes access to private clinical psychologists has been of great benefit. It has expanded the referral network possibilities for people of a lower income

Not in this region because we have recently lost 2 out of 4 psychological support services for this region.

3.4 Have consumers and carers had improved access to support and advocacy independent of public mental health services?

Again there were mixed views about this. There remains concern about the level of resourcing for independent advocacy and support services.

Not through the implementation of the CoAG initiatives

Consumers and carers have access to support and advocacy, through peak organisations as well as organisations such as the Community Visitor Program, Disability Advocacy Service and the Health and Community Services Complaints Commission.

Consumers and carers have always had the non government sector through which to access services and advocacy, there are some very effective non government organisations that deal with the hard issues every day and these are very independent of the public mental health services

Not in the bush.

No noticeable difference has been observed

I cannot comment if there has been an improvement to access.

No evidence of this.

3.5 Have any problems or issues emerged with the implementation of any of the Committee's recommendations?

Respondents felt limited in their responses by the early stage of implementation of most new developments and by limited information about the developments.

It is too early to tell yet

I have no specific answer to this as yet, there needs to be more time to see the outcomes.

The new CoAG initiatives on prevention and early intervention with families and young people are only just being made available. I am not too sure whether the PHaM programs already on the ground are targeting prevention and early intervention very well.

Access in the bush is always an issue.

4. Remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness

Questions

4.1 Have consumer and carer organisations been empowered to establish a broader range of support, information, training and advocacy for their members?

There remains concern throughout the Territory about the limited resourcing for consumer and care-based initiatives.

Not through the CoAG initiatives

Only the ones that have received extra funding through the roll out of PHaM and Day2Day Living programs, the rest have been left high and dry.

Yes they have with the implementation of the Day2Day living programs

In some situations but again this has been in urban or regional areas and not in the remote areas.

4.2 To what extent have the needs of Indigenous Australians been given priority? What needs to be done as a matter of priority?

This area is also a major concern of our service sector. Comments provided illustrate the level and nature of this concern.

Priority has been given bit it is once again not being done correctly, we need to research what the communities want for themselves not what we think they should have, treat the problem not just throw money at the problem and hope it goes away.

They have been given priority on paper but the government does not seem to understand the difficulties in getting these services into rural and remote areas, just providing the places to employ more staff is not the answer, in the NT we have vacancies for workers now that we cannot fill so what is extra places going to give us, we need to offer greater incentives to people working in these areas and build infrastructure to keep the people out there. Not everyone is Mother Theresa.

Really too early to tell if this has improved, giving extra places in remote communities is only effective if you can staff the positions adequately, we can't get staff in the areas we have available now in the Territory, and I am not sure how extra places will be effective.

Indigenous people in the bush continue to be neglected or ignored. The issue of children in the bush is a key example where extreme measures have been mobilised to try to provide basic safety and care.

No noticeable changes in this area, may be too early to tell

Limited support provided through new programs.

None. CoAG initiatives too early to tell.

4.3 To what extent have the mental health needs of people living in rural and remote areas been given priority? What needs to be done as a matter of priority?

There is a general view that new service and funding programs might have tried to meet the needs of a number of selected rural and remote areas but the effectiveness of the programs are hindered by lack of attention to how the programs need to be varied to successfully factor in rural and remote factors and contingencies. Rather, there is a one-model-fits-all approach irrespective of whether the new service is being set up in Melbourne or in Alice Springs.

Yes these communities have been given priority but funding bodies don't understand the financial implications of providing service in these areas – costs of recruiting staff, cost of communication etc. and whether in fact there is infrastructure for the staff to inhabit these areas etc.

Priority has not been a result of this program.

Can't see any priority status as yet, may be too early to tell

Need must be addressed related to specific target groups and geographical areas with funding.

Yes – given priority but funding bodies don't understand the financial implications of providing service in these areas – costs of recruiting staff, cost of communication etc.

4.4 To what extent have service developments assisted people from culturally and linguistically diverse communities?

It is a view throughout our sector that people from linguistically diverse communities still experience disadvantage in accessing services. Although available services exist many CALD people still have difficulty accessing them, which makes them under utilised. Given the increasing diversity of the NT population and the mental health needs of people from small and emerging population groups it is important that barriers to service access be addressed and where necessary that new resources be allocated for this purpose.

4.5 What gaps or shortfalls in funding still exist?

A general concern is inadequate recognition of the fact that to provide effective non-government mental health services requires skilled experienced staff and that staff need to be remunerated adequately. A further component of this, is inadequate recognition by funding programs of the costliness of providing services in remote communities where everything is more expensive including organisational and office infrastructure, equipment, rent, food & cost of living for staff and clients, transport, communication, relocation expenses, educational and training needs etc. A number of gaps or shortfalls in funding were identified as the following responses indicate.

Youth services, effective indigenous services, housing focus

Effective rural and remote services, Housing/accommodation is still a big problem long and short term

I don't feel that adequate recognition is given to the difficulties of providing non-government mental health services to the population. This requires skilled experienced staff and they need to be remunerated adequately, the SACS award is not attractive to most people. There is also inadequate recognition of providing service in remote communities and the fact that it is more costly in transport, communication and training needs.

Not servicing clients at an early intervention level well. Major gap in funding to the bush for the most disadvantaged people in the country.

Housing still a problem – in the NT there are huge problems with obtaining affordable private housing and long waiting lists for public and community housing.

Access for CALD groups, appropriate youth services, housing, remote infrastructure for service providers and clinical services

Workforce development strategies developed including relevant and affordable education and training for community support workers and volunteers.

Not servicing clients at an early intervention level well.

4.6 What gaps in services still exist and what still needs to be done as a matter of urgency or priority?

- *Sector development and acknowledgement*
  It would be positive if we could have some better recognition of the services provided by NGOs, and have the funding to these organisations raised so that we can attract the kind of workers that will stay in the job and in the territory to achieve the outcomes we need. One of the biggest problems facing the Territory is getting and keeping staff on a long-term basis. It is no use having the service and not being able to staff it and run it effectively we need to pay people appropriately to get the best possible staff for these services and run them properly and long term – '*there are to many cobwebs hanging on doors of very good services that cannot be staffed adequately and then the consumer suffers from lack of support'*.
- *Housing and accommodation*
  There needs to be a range of accommodation types with funding for varying levels of support to assist in attaining independence and the promotion of recovery. These need to be developed in consultation with consumers and consumer groups.
- *Youth inpatient services*
  There are no inpatient services specifically for young people.
- *Complex care needs*
  Territorians with complex needs, who require a secure setting or extremely high levels of support, may be placed in the psychiatric inpatient facility even when not experiencing psychosis because there is no alternate setting. This has implications for the therapeutic treatment of people with psychosis because acute inpatient facilities may be over full and because noise and behaviour impact on them. This is an issue of urgent importance in the NT.
- *People with Axis 2 Diagnosis*
  The Mental Health Act still defines mental illness as excluding personality disorders which excludes many from involuntary treatment. There are also few or no specific programs in the NT for people who suffer from severe and disabling conditions other than from a 'major mental illness'.
- *More service entry points required*
  There are still a huge number of people that have no access to services whether they be remote, homeless or whatever, we need to address this issue urgently and create places where these people can access the services they need without having the stigma created by traditional services. The Day-to-Day Living programs should address some of these issues as we will be able to get more traditional clinical services involved with non-government services and that will be a good mix for the client.
- *Rural and remote services*
  Major gap in funding to the bush for the most disadvantaged people in the country. This needs to be addressed as a matter of urgency.

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3.3

The Queensland Alliance represents non-government, non-profit organisations who meet the needs of people with mental illness or psychiatric disability, including consumer groups, family and carer groups and non-government community-based service providers across Queensland. It strives to promote, strengthen and develop the growth of non-government, community-based, recovery-oriented responses to the needs of people with mental illness and psychiatric disability in Queensland. Consultations were held with members during July 2007 and include survey responses from individuals and organisations from across Queensland.

1. The extent to which the Council of Australian Governments (CoAG) National Action Plan assists in achieving the aims and objectives of the National Mental Health Strategy

Questions

1.1 To what extent is the CoAG National Action Plan (NAP) assisting to prevent mental disorders and to reduce their impact of individuals, families and communities?

There was agreement during the consultations that this is a difficult question to answer for four main reasons.

Firstly, the roll out of new initiatives and services under the CoAG National Action Plan on Mental Health is just commencing.

Secondly, Australia lacks a mechanism for governments to obtain independent information from communities, consumers and carers about whether their mental health plans and initiatives are having any effect on preventing mental disorders and on reducing the impact of mental illness on individuals and families.

The *third* reason provided is that it is unclear as to whether mental health and related services are collecting information that can actually shed light on these questions.

The *fourth* reason is that it is quite possible that the NAP is having positive effects but whether these gains outweigh the negative effects of certain social trends and other policy initiatives is uncertain, and most probably, doubtful. People referred here to the negative effects on the lives of people with mental illness of:

- housing problems;
- rising living costs;
- low incomes; and
- lack of service coordination.

1.2 What has been the impact of expanded access to psychology and allied health services under Medicare? Have any problems or issues emerged?

Though the expanded arrangements were welcome the following problems were identified.

- People are having to pay large up front, out-of-pocket expenses for care from psychologists and psychiatrists.
- Many people lack GPs, this is particularly the case for people with serious and long-term mental illness.
- Locating GPs who can provide the required mental health assessments and mental health care plans.
- Some populations group who could be assisted through some of the Medicare items to transit out of homelessness are missing out e.g. young people, people having experienced sexual abuse, family violence or other trauma.
- Group therapies for psycho-education, anxiety management, depression management or living with psychoses have not commenced.
- Some of the Medicare items need to be expanded to other professionals.
- There are significant regional differences with fewer bulkbilling GPs and fewer affordable private psychologists and other allied health professionals.

  In rural and regional areas e.g. Cairns, it is thought that the uptake of the expanded Medicare items is even more skewed i.e. being predominantly used by middle class, fairly well educated people who have relatively good strategies for coping and for getting their needs met. People with low incomes and few options are missing out.

1.3 Do you experience that mental health services, care and outcomes have improved in the last one-and-a-half years

Some contributors reported that they do have experience of mental health services improving in recent times, with some clinical teams now having more staff and trying to implement a greater recovery focus. There was general agreement though that the following factors or trends were more likely than not impacting adversely on mental health service and care outcomes.

'*Siloing' of funds and programs* – Despite the complexity and inter-relatedness of the needs of many people with mental illness, services and funding programs still operate in silos. This results in people rarely receiving all the right services and help at the right time and place.

Entry points for mental health service and care act as a barrier to service – The assessment processes of clinical mental health services' and other government services can involve the completion of questionnaire and forms in excess of 4–50 pages and the requesting of information about traumatising experiences. This results in many people reliving trauma and being re-traumatised. For reasons like these, many people with serious and long-term mental illness avoid seeking or refuse mental health assistance. Further, many do not identify as being in need of mental health services but seek help for a range of needs including housing, sexual abuse, family violence, income support, emergency relief, legal problems, child protection matters etc. It may be some time before a person will agree to seek help from the mental health system. More collaborative assessment processes that are based in or linked to agencies that people trust and use are required.

Pressure on clinical public mental health services to withdraw as soon as possible – In view of the demand for assessment and treatment and the crisis-based approach that many public mental health services are locked into, there is pressure on clinical case mangers to discharge a person from inpatient care or from ongoing clinical follow-up as quickly as possible.

> *This can amount to people being abandoned or at least feeling abandoned just as they are beginning to regain their feet. People are being abandoned fair too early in the recovery process and their families are left unsupported.*

Groups missing out on service or care or being excluded – A number of groups are missing out on mental health treatment, care and services including families, homeless people, people who also have a substance abuse problem, people who have experienced trauma and abuse, people with complex needs who require help from a number of government departments and people considered to have personality disorder.

> *These are the people who turn to community agencies for support and who communities see all the time. They rarely get past the front door with mental health services or they avoid seeking help from them – willingly.*

Stigma high among new mental health graduates – Contributors to the consultation reported that agencies are increasingly seeing young graduates who are scared of their clients with mental illness and who have come out of university with stigmatising views and attitudes toward people with mental illness. New graduates are also tending to arrive at agencies without an understanding of practice in the community.

> *Professional education and training seems to be narrowing rather than widening.*

Indigenous people caught between services and policies –

> *'We are caught between services and policies. We are being pushed into mainstream services but we fear them because we have been traumatised by government services. We feel safer with or own services but our own services are overwhelmed. The mainstream mental health services push us to hard and fast. We get traumatised by all the forms and questions. We do better in recovery groups and learning circles in our local communities and through camps and retreats that help us to reconnect to others. We need time to heal, healing takes time not six weeks.'*

Lack of access to psychological therapies and group-based therapies – Many clients of NGO mental health services are missing out on psychological therapies and group-based therapies. They can't afford those that are provided privately and public mental health services aren't in a position to routinely and consistently provide them.

New service landscape 'itsy bitsy', fragmented and perpetually competing – Apprehension was reported about the shape that the new service landscape is taking locally and how this will impact on outcomes and quality of service delivery.

> *Everyone has tried to apply for something if not everything that is going. At times it has been difficult to understand what the tender programs are actually asking for. Sometimes they appear to be asking for an old service that is just called something different. At other times they seem to be asking for a service that already exists and is already funded by a Queensland government program. It is difficult to understand how the new services will fit in or on the other hand, even make an indent on the level of need because in some instances they are not targeted at the greatest areas of need.*

Agencies have just tendered for what they think they could do and what might work locally. It's all rather piecemeal and it is anyone's guess which agencies will get funded for what. Under these circumstances it is difficult to see how a rational outcome based on local need could possibly eventuate. The ethic and practice of competition has been so deeply reinforced during all of this, that it is also difficult to see how services will be able to work collaboratively or cooperatively.

Workforce issues in the NGO mental health sector – Most of the Commonwealth and State-based service developments have involved a greater role for NGO mental health agencies. However, there is significant disparity between salaries and conditions in the community compared with the public and private sector. A range of further issues compounds the impact of the disparity, including:

- An influx of money into the sector all at once thereby resulting in a large number of new positions;
- Given the low unemployment rate in Queensland and given the sector's relatively poor wages and conditions, the NGO mental health sector is not able to compete;
- Skill shortage in the sector;
- Vacant positions and difficulty in recruiting;
- Difficulty in backfilling and recruiting and retaining a casual pool of staff to relieve;
- Insufficient training resources for the sector.

Struggle for daily survival – NGO mental health agencies see and work with people on low incomes or with little cash that are just struggling to afford each day's expenses.

1.4 To what extent is the CoAG National Action Plan assisting to assure the rights of people with mental disorder and their families?

Queensland Health has a policy of employing consumer consultants to work alongside and within public mental health services. There is still however limited access to independent advocacy throughout Queensland. NGO mental health agencies are concerned that increasingly the rights of people with mental illness are not being assured in a number of key areas including housing, safety, employment, primary health care, income support, volunteering and legal issues. The sector is not aware of any particularly CoAG initiatives that are targeted directly at assuring the rights of people with mental illness and their families.

The NGO mental health sector in Queensland is concerned that the human rights of people with mental illness are not being assured during Welfare to Work-based assessment and decision-making processes undertaken. NGO mental health agencies are reporting that clients who volunteer are placing themselves at risk of being deemed ineligible for a Disability Support Pension.

Tenancy rights also appear to be an area where rights are increasingly being infringed. This is occurring in the private rental market, private bed sits, boarding houses, caravan parks etc.

Even being a public housing tenant doesn't guarantee tenure and assurance of rights anymore. There's simply to many people waiting and ready to move in and accept whatever conditions are demanded.

1.5 Have any issues or problems emerged in the roll out of Commonwealth or State funded new service initiatives under the CoAG National Action Plan?

It's been a nightmare. The ink is not long dry on one tender or proposal and then we are faced with yet another. We have difficulty consulting with our own staff. On top of all that we are all having trouble filling existing jobs let alone the new positions that are beginning to come on line.

The NGO mental health sector welcomes CoAG's and the Queensland government to increasing community based mental health services and to increasing access to treatment and psychological therapies and mental health care through allied health professionals. Key issues concerning the sector with the roll out include the following:

- The haste and rush involved with the roll-out process.
- Apparent duplication of services that already exist in some areas under a different name and through a different funding program.
- Difficulty in understanding the selection of sites that would receive service and concern that recent QLD government service developments in an area ruled that area out of consideration for a Commonwealth-based service.
- The requirement of existing on-site organisational infrastructure of the initial Commonwealth tenders which ruled out many non-government mental health services.
- The postcode requirements of the initial Commonwealth tenders that are ruling out people from services even though there are no services where they live.
- Though the consultative and phased nature of the Headspace tendering process has been good and most welcomed, there is concern about how readily the selected model can be translated into regional, rural and remote Queensland where there is varying degrees of service and community infrastructure and in many instances few mental health and drug and alcohol professionals i.e. possible tension between national consistency and local relevance and sustainability.
- Some long standing innovative Commonwealth programs now being appearing to be abandoned despite the extensive service networks established including for example, the Innovative Health Services for Homeless Young People (IHSHY).
- Cost of high rents in rural, remote and regional areas not factored into budgets. Neither are transport costs.

The Headspace small grants to enable a consortium approach in a particular area is a good model that could be built upon, particularly to enable a more rational, coordinated and collaborative approach within a local area.

2. The overall contribution of the CoAG National Action Plan to the development of a coordinated infrastructure to support community-based care

Questions

2.1 To what extent has work progressed in your state or territory on the development of arrangements for care coordination?

The QLD Alliance sits on a CoAG Mental Health Group that is being coordinated by Premiers and Cabinet. This group is charged with developing and rolling out processes for care coordination. Given the timeframes of this group, the Alliance has had little opportunity and time to consult with the sector. Even if there had been time to consult, it is doubtful whether the sector could have responded given the demands on their time resulting from tendering processes and new service developments or service expansions.

Whilst the NGO mental health sector welcomes the Queensland Government acknowledgement that positions and funds are required, there is concern that these positions would be better situated in the community where there is significant experience and expertise in coordinating responses to a wide range of needs.

> *There is concern that if care coordination positions and resources are concentrated in public mental health services an overly clinical and narrow approach will be employed. There are also concerns that some clients will not cooperate if their care has to go through mental health services.*

2.2 To what extent has consumer and carer input influenced the development of coordination structures?

Though the process is just beginning, consumer and carer input has been coopted from a small number of individual consumers and carers. There has not been coordinated, consultative and representative process to inform consumers and carers and to obtain their views and ideas.

The NGO mental health sector in Queensland is concerned that consumers and carers do not appear to have been significantly involved in decision-making concerning recent tendering processes.

> *'The only input from consumers and carers seems to have been one or two individuals being contacted at the last minuted to provide input to selection processes. An important opportunity has been lost to draw on the lived experience of consumers and carers. They know what works. They also know what services people want and will use.'*

2.3 To what extent has Indigenous Australians had input to development of coordination arrangements?

The sector is concerned about the lack of input from Indigenous Australians and Indigenous organisations into the development of care coordination arrangements.

> *'We don't even have public mental health services that most Indigenous people will use. We are still marginalised and reluctant to use these services – too much trauma involved, too much reliving of trauma involved. As we get better we feel a strong*

responsibility to help make things better for our communities. So we spend a lot of time in meetings. We are always in there volunteering, could sit around meeting tables most days of the week but if we do we need to know that it is all worth while. We want to know we are helping to get better services for our people. It is difficult though because we always have to pay for our own expenses – petrol, buses, parking etc. '

2.4 Have any specific problems or issues emerged with attempts to progress care coordination?

- *Inclusion of CALD communities*
  The Queensland Transcultural Mental Health Centre tries hard to ensure consumer and carer participation in consultations. Like other NGO mental health services, the deluge of developments has overwhelmed the Centre. The QLD Alliance also endeavours to continually raise awareness and discussion of the need for care coordination processes to address barriers to service use and engagement faced by migrant and CALD communities.
- *Bringing together Commonwealth and State initiatives and processes*
  There was concern throughout the consultations, that it appears that Commonwealth processes are operating on their own and largely independent of state and local processes.
- *Too much haste and not enough consultation*
  There has been little consultation in QLD about possible models for care coordination and about what might work. For example, it is possible that a one size fits all model of care coordination might not work across Queensland. Regional, rural and remote centres lacking mental health service and community infrastructure might require a different model. Different approaches or strategies might also be required for different community and population groups.

2.5 What needs to happen to make care coordination a reality? Is anything different needed in rural and remote communities or for particular community groups?

People are still being stuffed around even before they get any service at all let alone a coordinated response from a number of services at the same time.

- *Learn from and build on Project 300*
  The view as expressed that there have been some excellent examples in recent in times of how care coordination might work. Project 300 is one example. A lesson learned during this project was the importance to coordinate care of brokerage funds being available for set up or start up costs. Each Project 300 client received an allocation of $5,000 on entry to the program. This acknowledged the costs involved with moving into housing e.g. bond, furniture, furnishings, fridge, curtains, food etc. it also enabled the purchasing of specialised services or assistance. A similar allocation per client might be needed in order to purchase goods, transport, services or assistance essential to either a service's engagement or a client's continuing engagement.
- *Care coordination is not cost neutral*
  There was agreement that there must be governmental acknowledgement that an agency's involvement in care coordination is not cost neutral. Care coordination needs to be a funded program.

- *Address weariness*
  There is certain weariness in relation to care coordination.

  Ten years ago the sector worked hard across Queensland to contribute to both the State and Commonwealth government's interagency and intersectoral linkages initiatives. The sector worked hard to build relationships and networks, to establish better information, referral and communication processes and to link with everyone and everything. Then the emphasis shifted to partnerships and collaboration and so the sector once again worked hard for the sake of clients to participate in these somewhat differently oriented initiatives. Now it is 'care coordination'. There is, however, concern that this will just end up like the other initiatives – a passing fad.

  Intersectoral linkages, collaboration, partnerships and care coordination all mean the same thing for community agencies. It means we must continue to be the people who try to drag government services to the table. At the end of the day it will probably mean community agencies continuing to do the bulk of the work with clients despite the fact that they are resourced far less than everyone else around that table.

Need for consultation about possible models and what might work, where and with whom – As discussed above, the NGO mental health sector think it is important that care coordination arrangements be built from the ground up, even if this involves different models for different locations and groups.

The community sector has a lot of experience and knowledge to offer concerning what hinders and what helps coordination. So too do local managers and administrators as we have all been in this together for many years now. There must be local-area based consultation so that this knowledge can be drawn out, shared, discussed and drawn upon. Solutions to making care coordination work exist but they are in the community and governments must go to communities if they are serious about all of this.

Professional training and culture change – Care coordination is going to require different professionals and different service providers to understand, acknowledge and practice respect for the importance of each other's roles. Resourcing of training and collaborative practice forums and networks will be required to provide an ongoing vehicle for culture change.

3. Progress towards implementing the recommendations of the Senate Select Committee on Mental Health

A difficulty discussed throughout the consultations is the apparent 'context-free' nature of much of the recent national-based mental health service developments. For example, the FACSIA AND DOHA initiatives have rolled out a 'one size fits all' model and tendering process. This is despite the fact that Queensland as well as other parts of Australia have had to cope with the differential impact of social changes, drought and natural disasters. The drought combined with Cyclone Larry has seen a number of large-scale problems that have affected whole communities as well as made life increasingly difficult for people with mental illness and their families. These changes and problems include:

- Massive relocation of people from drought and cyclone towns to larger regional centres in QLD as well as to urban centres;
- An urgent and chronic housing crisis resulting in a shortage of housing, high rent and no or few vacancies;

- Huge hike in food prices and other costs of living;
- Increase in fuel and transport prices;
- Few employment opportunities for people with mental illness;
- People moving away from their home towns, families and networks; and
- Increased isolation and dislocation.

All of these factors increase the demand for counselling and community based NGO mental health support services and also increase the costs and difficulty of providing services. Service initiatives under CoAG NAP and the National Mental Health Strategy appear not to have made allowance for this.

Questions

3.1 To what extent has progress been made on implementing the recommendations of the Senate Select Committee on Mental Health?

- Very recently the Queensland Government allocated resources to assist smaller NGOs to respond to Federal Government tender processes. Unfortunately these funds have been allocated after the deadlines for Commonwealth tender processes have closed.
- The Queensland Alliance has developed a strategic plan for the growth of the NGO sector (Attachment 1) in consultation with the membership, which highlights the need for sector development work.
- Neither the Federal Government nor the Queensland Government is yet to allocate any new resources to sector development initiatives in support of CoAG funding opportunities – either Federal or State. The amount of funding to the NGO sector in Queensland will quadruple in this financial year, but there has yet been no funds allocated to build the capacity of the sector, develop new services or respond to workforce challenges. This a significant concern, especially when there has been funds reserved for sector development for two years but not yet allocated to an NGO.
- As part of a broader strengthening NGOs project by the Queensland Government, psychiatric disability support services are receiving additional support to meet the requirements of the Disability Sector Quality System. The Quality Project, is being conducted with the aim to ensure that NGO psychiatric disability services funded by Disability Services Queensland have a high level of ownership of the Disability Services Quality System(DSQS). This project is working collaboratively with the NDS (formerly ACROD) Quality Team and is seeking to provide additional support to NGO psychiatric disability service providers to achieve accreditation to the DSQS and explore the unique contributions that NGO psychiatric disability services make to the DSQS.

Initial information and findings emerging from these projects are pointing to:

- The significant under-resourcing of non-government organisations in Queensland
- The need for government support to the sector to address service development, sector development, workforce development and organisational infrastructure challenges.

Without this support, the new funds may not be allocated to best effect.

3.2 Have any recommendations not been progressed?

A number of recommendations do not appear to be addressed or have only been addressed in a limited or an initial way.

- *Better mental health services and care for Indigenous Australians*
  Queensland has a large and diverse Indigenous population. It is time for governments to support Indigenous communities to work with community agencies and mental health service providers to develop services and processes that Indigenous people will trust and use.
- *Integrated drug and alcohol and mental health services work*
  These two services still largely work as two separate service systems. The consultations reported on how it is non-government mental health sector that is left with trying to help a client get a response from either or both of these services. It is thought that this separate universe approach of these two key services will place a significant stumbling block in the path of care coordination.
- *Employment for people with mental illness*
  The consultations reported that there are limited employment opportunities for people with mental illness and are often confined to the 3 'f's:
  - Food (e.g. stacking shelves, kitchen work);
  - Filth (e.g. cleaning)
  - Filing (e.g. menial administration tasks like photocopying, filing, shuffling paper etc.).

  'We have a client who has a PhD who is stacking shelves even though he is capable of doing far more.'

  'The casual nature of much of the available work can often be undermining of a person's recovery, particularly given that so much of it this work is shift work, irregular, uncertain and unguaranteed, involves difficult or long hours. These conditions act as disincentives and barriers to people with mental illness being employed.'

  'The employment agencies by and large try hard but we need to look at different schemes. We need to build on the expertise and knowledge-base that has been developing over the years in specialist vocational support programs.'

- *Housing and supported accommodation*
  The Queensland Government has allocated $80M to mental health housing initiatives over four years and this is linked to new funds for support services. However this allocation will only meet the needs of approximately 80 people, and there are many, many more people in need of housing and support services. Additionally, the last budget allocated an additional $500M to new social housing in Queensland.
  There is simply not enough affordable, appropriate and accessible housing in Queensland. Neither are there sufficient programs to provide accommodation support if people could be housed.

3.3 Have consumers and carers had improved Medicare funded access to private clinical psychologists and allied health professionals?

As discussed above there has been improved access to private clinical psychologists and allied health professionals but that this access has been skewed and that people with low incomes and higher levels of impairment and trauma are missing out.

The consultations discussed a not 'so obvious' gap group – being people who are considered to be clients of the clinical mental health service. Many of this group are discharged from clinical follow-up long before they have been able to consolidate symptom management techniques or worked through trauma associated with or preceding their illness. This is despite research indicating that people with more serious mental illnesses, including psychotic disorders, benefit significantly from psychological therapies.

3.4 Have consumers and carers had improved access to support and advocacy independent of public mental health services?

Queensland has a small number of well-regarded independent advocacy services that consumers and carers can access. However, these services are all stretched if not 'swamped' and cannot service the whole state, or even respond to all the calls they receive for assistance.

3.5 Have any problems or issues emerged with the implementation of any of the Committee's recommendations?

This question has been also discussed in other sections above. Further issues or problems emerging with the implementation of service developments include the following:

- *Carers respite initiatives*
  There have been a number of difficulties with these initiatives including the limited number of programs funded across Queensland. A further difficulty has been with the model itself that has largely been pulled over from aged care and seems largely directed at older carers.

  In the mental health context, it is difficult to see how carer respite programs cannot be integrated with psychosocial rehabilitation and recovery programs.

- *Divide between clinical and non-clinical*
  Contributors to the consultation argued that the recent Commonwealth based service developments appear to have reinforced the divide between services referred to as clinical and others referred to as non-clinical. Contributors discussed the need for there to be more in-situ or on-site collaboration. One agency gave the example of an NT Team Health initiative where community trainers and peer support workers were trained in CBT by mental health clinicians with a view to them then helping their clients to develop CBT-based techniques for managing their illnesses and for general day to day problem solving. Other agencies discussed the IHSHY services where GPs, nurses and other health workers conduct clinics, sessions and interviews at youth agencies accessed and trusted by homeless young people.

- *Areas and centres missing out*
  Contributors to the consultation questioned the process by which sites were selected for funding.
- *Need to not drop or abandon other important work*
  Contributors to the consultation pointed to evidence that suggests that important service areas including promotion, prevention, early intervention advocacy and peer support are having difficulty maintaining their resource base and competing for new and further funds.

4. Remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness

Questions

4.1 Have consumer and carer organisations been empowered to establish a broader range of support, information, training and advocacy for their members?

The NGO mental health sector in Queensland is committed to the invaluable perspectives of consumers and carers on the mental health service system and the treatment Queenslanders receive being heard. The Consumer Voice Project at the Queensland Alliance works with consumer and carer groups across Queensland to design a mechanism that will provide policy advice to government from a consumer perspective. The Consumer Voice Project will:

- Audit existing Consumer Advisory Groups and consumer participation mechanisms across Queensland Health and the non-Government sector;
- Consult with a broad range of consumer and carer groups about the development of state-wide voice for consumers;
- Produce three area forums to strengthen or initiate cross-district networks, identify key issues for consumers and discuss the various proposed models of an accountable, state-wide consumer voice or network.

The Final Report of the Consumer Voice Project recomends the Queensland Government fund the development of an independent consumer and carer organisation to provide advice to government.

Mental health consumers and carers in Queensland need the ongoing support of both the Commonwealth and Queensland governments because of the enormous difficulty and logistical problems they face in putting forward their views and perspectives. Difficulties arise from:

- The small funding base of consumer and carer-run activities in Queensland;
- The embryonic nature of many peer and mutual support-based consumer and carer initiatives in Queensland;
- The size and demographics of Queensland;
- The isolation and social circumstances faced by many consumers and carers.

The costs involved with travel and with the logistics of trying to conduct consultations, training and development with consumers and carers throughout Queensland.

4.2 To what extent have the needs of Indigenous Australians been given priority? What needs to be done as a matter of priority?

The consultations made the point that needs of Indigenous Australians have not been given sufficient priority. Contributors expressed the view that Indigenous communities need to be supported in finding their own solutions to their problems in a sustained and incremental manner. This includes more focus on early childhood and education, as education is an essential social determinant of both general and mental health.

Queensland has models showing promise of cultural appropriateness and of assisting to meet mental health needs of Indigenous Australians. One example is the Cultural Healing program is based on the Sunshine Coast. The team consists of both Indigenous Health Workers and Clinical positions. The Sunshine Coast Area Health Service covers an area of approximately 3,000 sq. km with a current Indigenous population of approximately 4,000. The Cultural Healing Program has developed strong links within the local and surrounding communities. The program has a strong focus on culturally appropriate engagement, assessment and case management. The criteria for service provision are very broad, encompassing not only those with serious mental illness but also addresses widespread depression, anxiety PTSD and substance abuse. Over the past 18 months the Child and Youth component of the team has expanded and a major focus has been to link with other services including Child and Youth Mental Health Services. The team has been involved with identifying and developing programs for Youth at Risk. This innovative model is based on the 1996 Aboriginal and Torres Strait Islander People Queensland Mental Health Policy Statement. It seeks to provide a holistic model of care that encompasses the social emotional cultural physical and mental wellbeing of the individual, and their family, and the whole community. It also seeks to reflect and respect on current historical and spiritual values.

Attempts have been made to draw on the lived experience of Indigenous consumers. An example is the Toowoomba District Mental Health Service Indigenous Mental Health Symposium held in late 2004. Indigenous consumers and Indigenous Mental health workers came from across Queensland and other Australian states to discuss the challenges of improving the delivery of culturally safe mental health services to Indigenous people accessing the service. The theme of the symposium was ‘Service Capacity Building’. Speakers and a workshop focused on a wide range of topics with the aim of sharing knowledge and strategies for improving the mental health service delivery to Indigenous consumers. Recommendations included:

- Greater involvement of Indigenous people. For example, including family or community members in the treatment and care of Indigenous mental health patients.
- Dedicated Indigenous health care facilities staffed by both Indigenous and non-Indigenous health care workers and clinicians who are culturally aware.
- Research into improved methods of achieving and maintaining better communication between patients and carers.
- Expanding and updating current cultural awareness programs in hospitals and training programs for medical students, health workers, clinicians and consultants.
- Merging these cultural awareness programs with community programs to promote increased understanding and respect on the community level as well as the individual level.
- Specific research to address the best ways to improve communication between mental health workers/clinicians and their patients. This might involve development of appropriate tools. For example, development of culturally appropriate

questionnaires and survey tools in a language and delivered in a manner that Indigenous mental health patients understand. It is suggested that this will help reduce misdiagnosis of patients' symptoms. The involvement of Indigenous people was seen as paramount to this process and to achieve success and credibility.

- A clear pathway to progress to higher skills and training for Indigenous mental health workers.
- More opportunities for achieving higher qualifications and support from management to allow time off to pursue these opportunities.
- More education of the early warning signs of mental health problems within Indigenous communities.
- Involvement and education of family members and significant others in these signs.
- Positive role models, particularly for young people, to discourage drug and alcohol abuse.
- The formation of Indigenous support groups in areas of the most need.
- The formation of a forum for the development and subsequent supervision of a structured pathway to higher qualifications. This forum could be led by both Indigenous and non-Indigenous experts in the field of mental health.
- A peer group support structure for those workers undergoing training and higher qualifications.
- Mentoring schemes for junior staff members by more senior Indigenous and non-Indigenous staff.

The consultations urged the Senate Inquiry to inquire into and promote examples of culturally sensitive and safe mental health programs and recommendations like the ones above. The consultations also urged the Senate Inquiry to recommend funding programs that empower Indigenous communities to develop partnerships suited to meeting local need.

4.3 To what extent have the mental health needs of people living in rural and remote areas been given priority? What needs to be done as a matter of priority?

Rural and remote areas in Queensland are characterised by large distances between communities and low but growing population densities, impacting on the sustainability of health services and subsequent accessibility. There are also a large number of remote Indigenous communities, homelands and outstations. The vast area of the state makes delivering comparable mental health services to those already provided in the metropolitan area more difficult. Added to this, are the difficulties attracting, retaining and developing skill levels of staff in rural and remote services. Problems include:

- Small, dispersed centres without population size or economies of scale required to maintain a highly skilled professional and representative workforce;
- Distance to the nearest inpatient services;
- Transport problems and cost;
- Staffing problems exist, ad hoc arrangements for trying to attract, retain and support staff;
- Few professional development opportunities;

- Shortages in all health professional groups in rural, regional and remote Queensland;
- Affordable housing for staff; and
- Few community-based psychosocial rehabilitation and recovery programs.

The consultations called on the Senate Inquiry to give priority to recommending solutions to increasing mental health services in rural and remote areas.

4.4 To what extent have service developments assisted people from culturally and linguistically diverse communities?

The consultations called on the Senate Committee to inquire into the service e development that is required to improve mental health service access in CALD communities. Despite innovative work undertaken throughout Queensland by organisations including the Transcultural Mental Health Centre, considerable further work is needed. Barriers to service access still exist though being well known –

- Cross-cultural language barriers and jargon of service sectors and government;
- Institutional barriers including complexity of government systems, lack of information about procedures and processes of government, attitudes of professionals, lack of resources for appropriate forms of engagement, lack of
- Access and technological barriers;
- Mistrust including fear of authority, lack of relationship building, different perceptions about the role of government, mistrust of government, perceptions of tokenism, disillusionment based on past experience and the attitude that it is futile to be engaged with Government;
- Barriers to engagement including both consultation fatigue and lack of consultation, lack of capacity and resources for engagement, discomfort of formal processes, problems with techniques of engagement (e.g. meetings, small groups, large groups) cross cultural issues of engagement, timeframes for engagement and role of gatekeepers; and
- Lack of Information: including multi-lingual material, problems with dissemination, cultural issues in information, language and literacy issues, use of jargon and timeliness of material.

Further developments required include:

- Language services;
- Designing culturally sensitive service delivery;
- Ensuring more inclusive processes for consultation, engagement and participation;
- Training for mental health professionals to understand and work with cultural difference and to look at practice models more suited to CALD communities; and
- Developing relationships and partnerships with multicultural agencies that have the trust of CALD communities.

4.5 What gaps or shortfalls in funding still exist? & What gaps in services still exist and what still needs to be done as a matter of urgency or priority?

A number of gaps were identified during the consultations. Attention was drawn to the urgent need for action in the following areas:

- Lack of housing for people with mental illness;
- Increased levels of poverty being experienced;
- Lack of employments options and programs;
- A continuing imbalance in resources with still far too few community-based psychosocial rehabilitation and recovery services as well as promotion, prevention and early intervention;
- Limited resources to support ongoing workforce development in the NGO mental health sector;
- Research and development funding programs to explore new models for providing integrated or one-stop shop models for people with complex needs; and
- Funding to resource local level care coordination.

The following extract is taken from the our recent "Ten Year Plan for the Growth of the Mental Health NGO Sector" 2006 and highlights key priorities to progress sector development and growth.

Financial target

For an effective, recovery oriented mental health system, 30% of the mental health budget should be allocated to the NGO sector.

Value of NGOs

- The NGO mental health sector leads the way in developing and implementing the recovery model.[10]
- The NGO mental health sector is able to deliver on recovery.[11]
- The NGO mental health sector is a more efficient use of funds.[12]
- The NGO sector uses an evidence-based approach.[13]
- The NGO mental health sector belongs to and is managed by the community.
- The NGO mental health sector consistently receives high consumer satisfaction, and is the service system of choice for many consumers.

NGO services to be funded

- Health promotion
- Early intervention/prevention
- Long term services/psychosocial rehabilitation services

[10] Anthony, 1993; Australian Health Ministers, 2003; Queensland Health, 2005.
[11] Mental Health Council of Australia, 2005, p. 49; Anthony, 1993.
[12] Morris et al., 2006; Meehan 2004.
[13] Harding et al., 1987; Campbell & Schraiber, 1989; Anthony et al 2002; Dumont & Jones 2002; Ralph 2000.

- Innovative models of clinical service delivery.
- Peer support services
- Family/carer support
- Services for specific populations groups

Service system supports needed

- Consumer participation
- Carer participation
- Workforce development
- Consumer development
- Research & evaluation
- Service development and innovation

Government supports needed

- Establishment of a Queensland Mental Health Commission
- Evaluation of tender process
- Realistic funding indexation
- Genuine partnerships
- Effective liaison and collaboration with other service departments

For further information regarding this submission please contact:

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3.4

The non-government community mental health service sector plays an important role in delivering services that support mental health reforms that help people with mental illness to live well and stay well in the community.[14]

The MHCSA welcomes the commitment of the South Australian Government to a range of reforms outlined in the Social Inclusion Board's plan for mental health called 'Stepping Up'. This commitment includes announcement by the SA Government of allocation of $116.9m over 4 years to reforms that will support the effectiveness of the CoAG National Action Plan (NAP) on Mental Health 2006–2011 (CoAG NAP).

The consultation highlighted that although the state and Commonwealth contributions under the CoAG NAP are significant, they do not represent a panacea for the complex problems in mental health. The Mental Health Council of Australia figures were quoted in the consultation that the mental illness burden in Australia is around 13% of all illness but the increased spending under the CoAG NAP will still not bring the spending on mental health beyond around 7 or 8%.

The timing of this call for feedback on the CoAG NAP is not ideal, as many of the services identified are not yet being delivered. Our consultation strongly advised the need for thorough monitoring, accountability and evaluation processes to be put in place to inform ongoing adjustments and development of CoAG–NAP funded services. If this is done well, we can go forward with more confidence about the outcomes of the various parts of the reform and the Medicare rebates were identified as one area where this is very important to gauge success or otherwise. It was stressed in the consultation that this work needs to focus on outcomes that are relevant to consumers and their recovery, and it was noted that usual processes have tended to be more narrowly illness and symptom focused. Again the work of the Mental Health Council of Australia was referenced in suggesting appropriate goals for the broader mental health system such as reduction in illness burden, reduction in disability, increased employment and measures that report the consumer experience. The MHCSA has discussed measurement and reporting of outcomes in detail with our sector as well as with our interstate colleagues. The non-government community mental health service sector has years of experience in this area and MHCSA (and other state peaks) is well positioned to contribute to the development of appropriate outcomes measurement and reporting.

[14] MHCSA (2005), Mental Health – Let's Make it Work, www.mhcsa.org.au; MHCSA (2006), *Industry Development Paper 1: The Role, Strengths and Functions of the Community Mental Health Service Sector* (non-government), www.mhcsa.org.au; MHCSA (2006), *Industry Development Paper 2: The Current Profile of the Community Mental Health Service Sector* (non-government), www.mhcsa.org.au.

The consultation highlighted that there are a number of risks to the success of CoAG NAP including the lack of access to appropriate affordable housing. The need for improved collaboration across all Commonwealth and State portfolios was stressed, especially in relation to the provision of housing programs, coordination and continuity of care and workforce development.

Workforce training and development was raised in the consultations as a significant issue that could compromise the potential success of the CoAG NAP. The MHCSA has done considerable work with our sector on this important issue and mapped out a strategic direction for workforce development and training with the SA non-government community mental service sector[15]. Our equivalent peak bodies in other states are doing similar work and could effectively work with the states and Commonwealth to progress this important agenda.

Overall, our consultation highlighted that there are many areas where increased collaboration would help to build Commonwealth and state initiatives into a more coordinated system. As identified in the Mental Health Council of Australia system, there is a need for more coordination in the planning and delivery of services. The non-government community mental health service sector is currently not well-engaged in the structures and processes of the CoAG NAP, however, if opportunities were established the MHCSA is well-placed to put the views of this important sector in SA to inform system development and coordination that would enhance the potential outcomes for people affected by mental illness.

Introduction

In February 2006 CoAG issued its communiqué on its Human Capital Stream of Reform aiming to achieve a "healthy, skilled and motivated population" [16] A key component of this was mental health. The CoAG Reform Council immediately called for a mental health action plan to be prepared by June 2006.

In July 2006 CoAG released the National Action Plan (NAP) on Mental Health 2006–2011. The NAP aims to implement a strategic framework for collaboration between government, private and non-government providers to deliver a "more seamless and connected care system."[17]

The NAP consists of five main areas:

- Promotion, Prevention and Early Intervention
- Integrating and Improving the Care System
- Participating in the Community and Employment, including Accommodation
- Coordinating Care
- Increasing Workforce Capacity

The various state mental health peaks agreed that given the scope and size of the NAP, a joint submission would be more effective means and provide more useful content to support the work of the inquiry.

[15] MHCSA (2006), *Industry Development Paper 3: Ensuring a Skilled, Motivated and Effective Workforce in the Community Mental Health Service Sector* (non-government), www.mhcsa.org.au.
[16] Council Of Australian Governments Communiqué February 2006.
[17] National Action Plan on Mental health 2006–11, CoAG July 2006.

The Mental Health Coalition of South Australia (MHCSA) provided its members with the opportunity to participate in a consultation workshop or to submit their views in writing.

The short time that the NAP has been in place has made it difficult to gather extensive detail on the impact and effectiveness of specific program and services effectiveness to date. Many of the elements of the plan have yet to become operational.

While the sector welcomes the commitment of all jurisdictions to address mental health needs, certain themes have emerged from our consultations that can be summarised as follows.

- *Promotion, Prevention and Early Intervention (PPEI)*
  This has received some long overdue attention but the range of issues and complexities on the continuum from PPEI to crisis care is very diverse, however, the emphasis in the broader system remains on the crisis end of the continuum.
- *Integrating and Improving the Care System*
  The CoAG initiatives will fill some significant gaps and improve access pathways into mental health system supports, however, gaps and barriers to entry will remain. The system will continue to be difficult to navigate, especially for consumers or family members, and mitigate against early intervention and self-management.
- *Participating in the Community and Employment, including Accommodation*
  Access to affordable, appropriate, secure and stable housing is central and critical to the effectiveness of any program providing mental health services. The evidence of housing stress for people with mental illness is currently is compelling and poses the greatest risk to the effectiveness of CoAG. The statistical snapshot below has been presented to the Prime Minister and Leader of the Opposition in a letter from the MHCSA.
  - A snapshot survey of inpatients in mental health beds across the country showed that around 50% of patients were still in hospital because they had no suitable place to be discharged to.
  - Our survey of waiting lists in three of our major SA metropolitan non-government community housing providers reveals around 500 people with mental illness on their waiting lists.
  - There are 24,016 people on the waiting list (as at 30 June 2006) to get access to public housing in SA (a state with a proud history of investing in public housing) and of those 2,026 have self-reported mental illness.
  - During 2005/2006, according to the most recent data published, 7716 people applied for public housing in SA alone. Approximately 10% had self-reported mental illness with less than half (331 people) being allocated housing during that period.
  - There are over 500 people in Supported Residential Facilities who have mental illness and it is likely that there is a similar number in boarding house type accommodation.
- **Coordination and Continuity of Care**
  The need for coordination and continuity of care is reinforced across the sector but many of the problems existed before CoAG. Discussions about how best to achieve this need to be acknowledge that, even with the investment associated with CoAG, under-investment in the mental health system remains a major reason for not meeting consumer and carer expectations for the system. There are already positions within the system to ‘coordinate’ care but if services do not exist or are unable to accept referrals more such positions will be ineffective.

- **Increasing Workforce Capacity**
  The workforce is one aspect of sector capacity and it shortages in the clinical workforce are well documented, especially in rural and remote areas. The non-government Community Mental Health Service Sector will benefit from investment in ongoing workforce development via the peak bodies in each state.[18]

Through the South Australian consultations several groups commented that the CoAG NAP had increased the range of services that their clients could access and this was a welcome improvement.

The Consultation

The comments in each section below are largely as given by participants in order to reflect an unfiltered view. A list of organisations invited to contribute is attached.

1. The extent to which the Council of Australian Governments (CoAG) National Action Plan assists in achieving the aims and objectives of the National Mental Health Strategy

Questions

1.1 To what extent is the CoAG National Action Plan (NAP) assisting to prevent mental disorders and to reduce their impact of individuals, families and communities?

- Too early to judge and the broad initiatives will take 2–3 years before impact can be assessed. However resources allocated to plan represent an estimated 25–50% of what could be invested to make a significant difference.
- *The timing of the inquiry was an issue for all members however, most acknowledged the need to keep the visibility of mental health as high as possible in front of all jurisdictions as even with the significant investment via CoAG mental health problems will not be 'fixed'.*
- CoAG has delivered some much needed Commonwealth funding into the area of mental health, however, given that it is only in the early stages it is too early to assess the impact for consumers. The danger is that gaps will emerge between the state and Commonwealth systems and linkages and movement of consumers between the two systems will not be smooth.
- *A focus on improved coordination to deliver the National Action Plan needs to include more robust consultation and willingness to modify program design across government and non-government/ state and Commonwealth to generate a more 'joined-up' system.*
- More consumers and their carers are seeking psychology services in the private sector knowing they can now receive major Medicare rebates. This was particularly noted as beneficial by people affected by disorders such as panic, anxiety and obsessive-compulsive disorders. Some GPs have been reluctant to register and or produce relevant metal health care plans.

[18] Workforce Development MHCSA (2007), www.mhcsa.org.au.

- *Care needs to be taken in how the effectiveness of Medicare rebates on mental health is assessed. There is danger that strong take-up of rebates may be too quickly judged as being a successful outcome. Analytical attention should focus on issues such as whether the payment gaps are precluding low-income households, whether the interventions provided are effective. Other issues include access by indigenous people, young people, people in rural and remote areas, people from CALD backgrounds. GP reluctance to register was noted as an issue and should also be considered further as the GP is a central plank of this initiative.*
- Concern was expressed regarding Community Nurses who play a critical role in delivering services and
- Increased number of carer consultants and peer workers employed within the SA mental health system was noted as an important addition to the workforce and system capacity.
- *Community Nurses and Aboriginal Heath Workers were noted as valuable, especially for special needs groups and populations such as indigenous communities. Maintaining and expanding this work force capacity was identified during the consultation as an issue that would benefit from the NAP establishing targeted recruitment and retention programs.*

1.2 What has been the impact of expanded access to psychology and allied health services under Medicare? Have any problems or issues emerged?

- Consensus was impact is too early to tell. Increased access to psychology services was noted by people affected by high prevalence disorders such as anxiety, panic, obsessive-compulsive disorders.
- Some GPs and Psychologists were reportedly slow to take up this option and it was noted that these services have not been widely understood or publicised in the general community. Lack of 'top up' option disadvantages low-income households.
- *Consultation feedback suggested that it might be time to target promotional campaigns to low-income households rather than across the board, to improve up take by disadvantaged households. The facilitation of more bulk-billing would help support successful access by this target group.*
- *Comments about lack of understanding by people affected by mental illness of basic elements of the system were common.*

1.3 Do you experience that mental health services, care and outcomes have improved in the last one-and-a-half years

- SA Government has released a plan ('Stepping Up') which outlines a comprehensive program of major change in the SA mental health system
- The MHCSA critique of this noted that two important steps in the transition from a medical/clinical dominated system to a whole of community responsibility for care are missing:
  - *Missing Step 1 'Support in the Home'*
    This step includes increased NGO capacity to deliver services and develop partnerships to provide pathways out of the bed-based steps in the 'Stepped Care' model. Emphasis is on supporting people to achieve sustained recovery in their own homes and ongoing reduction in demand for acute care. Requires a system of flexible, high quality packages of care and increased involvement, training and support for carers and peer workers. Allocation still based on need,

but more equitable access is required – e.g. self or family referral, referral by GP, etc. – not just access for people who are frequent users of the public mental health system.

  - *Missing Step 2 'Citizenship and community capacity'*
    This step includes supporting communities to become more resilient. Emphasis is on enhancing community options to reduce stigma, promote mental health and prevent illness including strengthening peer support, carer support, networks and information and local government involvement.

- *The cultural divide between clinical and non-clinical approaches to mental health was noted as requiring attention. Both were seen as valuable and putting effort into building stronger partnerships would enhance the overall outcomes for people affected by mental illness.*
- A strong view was presented during the consultation that the NGO sector has supported significant cultural change in the sector, which has supported increasing numbers of consumers and carers to 'live well' in the community. It was noted however that a huge gap exists in the system in SA in terms of both access and capacity. The bulk of non-government provided services (funded by the state) are available only via referral from government provided services.
- Accessibility of some private sector services (e.g. psychological and allied health services) has improved dramatically via pathway of GP referral and more recent changes to Medicare.
- Consultation reported however that demand for government-provided mental health teams seems to have increased over recent years leading to less intensive follow up, absence of care plans and referral for primary care back onto GPs (who are already over-subscribed).
- *Many NGOs believe their value is not acknowledged by the clinical sector.*
- *This would indicate the broader system is still under considerable pressure but may also point to structural issues such as the GPs not being able to refer clients directly to non-government services for support and treatment. This results in extending the waiting time for clients before they can access services that may well be preventative.*
- A strong view from people consulted was that despite CoAG investment there is still a long way to go to 'fix' the mental health system
- *While participants stated it was very early in the life of the NAP there was some concern about how the signposts of progress would be determined and when. This would allow all parts of the system to build a capacity to measure and contribute to a meaningful evaluation of CoAG's broader aims. Non-government service providers expressed interest in contributing their input into how to measure the success of non-clinical supports.*
- It was noted that discharge from acute care is often delayed by lack of appropriate accommodation. An example quoted was 12 people in a one ward at Glenside currently ready to be released but for 9 of them no suitable housing has been identified.
- *Lack of accommodation was cited as a common problem that requires urgent attention, especially in the area of supporting social housing programs and systems to be more effective. There was a lack of capacity to meet mental health accommodation needs for people across a range of government portfolios and settings – e.g. health, mental health and corrections.*

- A national snapshot survey of people in inpatient care showed that around 50% of people could be discharged but have no suitable housing and/or supports.
- *Such bottlenecks not only put pressure on the all parts of the system but also put in jeopardy the treatment progress of the client as well as any established support linkages they may have.*

1.4 To what extent is the CoAG National Action Plan assisting to assure the rights of people with mental disorder and their families?

- Rights require acknowledgement, systems change, and recovery and service provision. CoAG NAP is making a genuine effort in this regard.
- *While rights have been increasingly acknowledged, their protection is more accurately reflected in legislation and policies at state level. South Australia is currently reviewing its mental health act and the MHCSA believes that in addition to stating rights, they must be policed through independent mechanisms such as Community Visitor schemes and independent advocacy. Some participants commented that the NAP did not adequately allow for a consumer and carer perspective, which is fundamental to any set of principles underpinning rights.*
- A strong view emerging from the consultation was the need to maintain the dignity of the carer and the patient.

1.5 Have any issues or problems emerged in the roll out of Commonwealth or State funded new service initiatives under the CoAG National Action Plan?

- The major problem with the models developed within the CoAG roll out – has been the expectation to service the whole population cohort – rather than specialist cohorts. In particular there is no recognition that services to older people require any particular expertise – which they clearly do. This puts agencies who see their core business as servicing one particular cohort at a disadvantage as, to successfully tender, they need to be delivering services across the full lifespan specified.
- *The NAP may be too general in terms of addressing the needs of specific target groups. There is a need to build the capacity of the non government organisations via the state peak body to continually improve evaluation including a focus on effectiveness of interventions, valuing consumer and carer experiences and ensuring proportionate provision to specific population groups.*
- Services may have difficulty in starting up new services, due to workforce capacity issues.
- *The South Australian Community Mental Health Services Sector has undertaken significant research on workforce issues, which highlights a range of capacity related issues.[19] While there is a need strengthen workforce development, there is an antecedent need to improve the capacity of non government organisations to make higher quality feasibility assessments for service development and strengthen their negotiation capacity in relation to setting up new services. An issue raised during the consultation potential difficulties relating to workforce issues for new services.*
- Consultation raised concern that even with CoAG investment, the system will continue to move too slowly to prevent serious illness or provide early intervention as a regular feature of the system.

[19] Careers at the Coalface, Community Services in South Australia. Carson, Meagher and King 2007.

2. The overall contribution of the CoAG National Action Plan to the development of a coordinated infrastructure to support community-based care

Questions

2.1 To what extent has work progressed in your state or territory on the development of arrangements for care coordination?

- Most of this work has been at the strategic level, and we are yet to see how it will work on the ground. It was noted that 'gate keeping' too tightly was a feature of the current system that restricted access to support when needed resulting in deeper cycles of illness and consequent impact on individual, family and friends.
- A belief was expressed that in SA attempts at care coordination were being hampered by privacy laws and under capacity in the system was noted as compounding factor.
- Need for more capacity (especially for state peak) to deliver sufficient training.
- It was noted that there are very poor linkages across programs and no clear or easily understandable map, especially for consumers and carers. Large part of the problem was seen as lack of capacity and service diversity to provide service when and where needed, even when CoAG investment comes on stream. Mental illness provides around 12–13% of the disease burden and even with CoAG funding nationally only 8% of need will be met. [20]
- *This was a constant theme across the consultation to the extent that shortfall in investment (compared with illness burden) and inadequate linkages in the system presents a risk to meeting the aims of the NAP. Part of the problem is seen as lack of funding for a 'joined up' system of services – particularly in SA the low level of funding for non-government services. It was acknowledge that the state government has made significant improvements in investment in the non-government sector over recent years. Consultation highlighted that not enough attention was being given to the quality and importance of the pathways connecting services and care options between government and non-government, public and private and cross portfolio services (especially accommodation).*
- A general view was put that the consumer and carer viewpoint is not adequately reflected in the CoAG Plan.
- View was expressed that it is not clear what demand or need indicators are used to determine what services go where. Consultation around service planning and development appears was seen to be too limited.
- *Some participants commented that the tender process did not lead to efficiencies. In SA it was noted that some country towns could have up to three organisations delivering services with duplication of infrastructure. While states generate planning support tools like social and health atlases, the view was put that more effort is required to develop an effective and efficient framework for delivery. This would require some loosening of the competitive tendering model to encourage reduced duplication of infrastructure and in some areas to encourage establishment in areas where a lack of potential providers exists.*

[20] Media Release (2007), CoAG Mental Health Action Plan Applauded, Mental Health Coalition of Australia.

- *Consultation highlighted the need for CoAG to guarantee greater representation of the non-government sector in the NAP roll out, evaluation and future amendment.*
- A strong view was put that coordination of care is often dependent on the knowledge and ability of particular treating person, local availability and timing of availability rather than the system itself.
- *Such comments reflected long-standing problems with the system. More work and investment is required by the states and Commonwealth to avoid reinforcing a "pot luck" approach to outcomes for people with mental illness. This may also reflect poorly implemented standards and quality improvement in the sector as a whole. MHCSA recently undertook a quality improvement project that promoted a high level of awareness of quality in the non-government sector but, formalising adoption of systems of quality, particularly in smaller organisations, is an unfunded cost and therefore may not be sustainable.*[21]

2.2 To what extent has consumer and carer input influenced the development of coordination structures?

- Carers and consumers are often consulted at the last point – however given the wording of several of the funding rounds it was clear that CoAG had focused on clear articulation of the model in the plainest language possible.
- A strong view from the consultation was that more collaboration with consumers and carers needs to occur.
- It was pointed out that there is no clear consultation model or policy that specifies such input.
- *The lack of consumer input was a concern not only in the NAP but also in how effectively jurisdictions exercise what is widely regarded as a core principle of service development and delivery (e.g. under the National Standards for Mental Health Services). CoAG is in a position to set an example for all jurisdictions either by way modelling good consultation processes and linking the requirement to demonstrate consumer and carer input as a requirement of funding.*
- New Zealand model for consumer and carer involvement and higher investment in non-government provided supports was cited as superior to ours with around 30% of mental health budget funding non-government services.
- Current system is dominated by government-provided services and much of the non-government service system receives clients only by referral from government services. Given the pressures on the government system and reported difficulties accessing government services, this raises a significant concern about access for consumers and carers. Concerns were also raised that if this is not acknowledged, the problem of care coordination and appropriate linkages will be misplaced in solutions such as care coordination positions placed in government services. Such responses were seen as largely ineffective without solving the problem of service structure and, in particular, non-government service capacity to support clients to live well in the community and reduce dependence on unplanned use of acute care.

[21] Service Excellence Project, Mental Health Coalition of SA and Department of Families and Communities, May 2007.

2.3 To what extent has Indigenous Australians had input to development of coordination arrangements?

- More encouragement and collaboration for input needed plus more extensive training programs.
- *The response to this issue does not appear to have been well developed. There is a need to identify an acceptable meaning of mental health and treatment approaches for indigenous people. Comments elsewhere point to a lack of appropriate research across the board and more specific areas such as indigenous mental health.*

2.4 Have any specific problems or issues emerged with attempts to progress care coordination?

- Blockages emerge in transitioning consumers between systems with different eligibility criteria, financial contributions – this has been overcome where the transition maintains established staff and is within the organisation.
- *The movement of people within the system is hampered often by low resource levels but also by poor definition and promotion of the system and its components. There is a need to review the role of keepers of the "correct gateways" and move to a position that reinforces to the public and people in need that it is one system with intent and capacity to help and support. In particular the restrictive practices of GPs not being able to refer directly to much of the non government services system is a serious limitation to enabling people to access the services they need to manage their own illness.*
- A strong view was that services, even with the CoAG investment, would not be able to keep up with demand.

2.5 What needs to happen to make care coordination a reality? Is anything different needed in rural and remote communities or for particular community groups?

- This was acknowledged as a complex issue
- An example was provided for older people where consistency of staff is important in maintaining positive benefits of services. A period of consultancy between the outgoing and incoming service coordinators has been beneficial in promoting appropriate responses during periods of higher need.
- *South Australia has recently undertaken the step of redefining regional boundaries as a step in planning and delivering services in rural and remote areas. Potentially, this makes the population needs assessment and allocation process more effective. However, it will still require properly represented care coordination bodies.*

3. Progress towards implementing the recommendations of the Senate Select Committee on Mental Health

Questions

3.1 To what extent has progress been made on implementing the recommendations of the Senate Select Committee on Mental Health?

- Too many recommendations were made to accomplish in such a short period– perhaps should have had fewer and put more into each.
- Need a doubling of investment in research, especially into effective treatments beyond drug-based research.

3.2 Have any recommendations not been progressed?

- Philosophy of care within state long stay facilities is currently based on the medical model (maintenance), rather than rehabilitation – cultural change is a long term goal in this area as outlined in the SA state mental health plan 'Stepping Up'.)
- *There appear to be ongoing tensions between medical/clinical service providers and rehabilitation / recovery service models as service development and delivery is underpinned by the different sets of values. The handling of this debate risks becoming a preoccupation in itself rather than moving towards a wholly coordinated, respected and effective system that aims for wellness.*

3.3 Have consumers and carers had improved Medicare funded access to private clinical psychologists and allied health professionals?

- This depends on GPs facilitating this process, and some GPs are less likely to participate and be aware of the changes.
- *This requires some urgent investigation and has been the subject of recent public statements. There is a risk that a response based on a quick or poor evaluation resulting in simply increasing the number of participating professionals may do little to achieve the aims of the NAP.*
- Increased use of psychological services was reported during the consultation and seen as potentially beneficial for people affected by panic, anxiety and/or obsessive compulsive disorders

3.4 Have consumers and carers had improved access to support and advocacy independent of public mental health services?

- Definite increase in SA state government investment has provided significant increase in access to support services in the last 18 months, provided by the non-government Community Mental Health Service Sector. A major feature of the psychosocial services in this is a strengths-based and consumer-oriented focus
- *Several organisations stated there was an improvement in individual advocacy as a result of increased service provision particularly by non-government agencies. It was noted that systems advocacy faced resistance from government service providers/planners/funders due to an unwillingness to see such advocacy as a healthy part of improving services to people with mental health issues. CoAG can play a role in encouraging and enabling a bolder approach across the system as a whole.*

3.5 Have any problems or issues emerged with the implementation of any of the Committee's recommendations?

- No clear plan on research in community mental health.
- Metal health system too compartmentalised and lack of parity/equity between clinical and community based services. Generally poor links across other portfolios and significant problems in timely availability of critical services such as suitable accommodation and alcohol and other drugs services.
- *Research and capacity building are key components of achieving the Committee's recommendations.*

4. Remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness

The responses to the following questions have to some extent been referred to or included in the sections above. Given the scope and diversity of the mental health system the pursuit of gaps is likely to throw up an endless stream of specific and general items. The MHCSA believes that in practicing what it preaches it has a need to also look at its own gaps and consider its own role and ability to contribute to the area of mental health.

From an historic viewpoint the non-government sector is a relatively new provider of mental health services and naturally its own capacity to meet demand and provide value is the subject of ongoing examination. However, if it is genuinely valued by all jurisdictions it must also be provided for equitably in order to examine and build that capacity, which in itself is critical to filling gaps.

The MHCSA has produced a series of papers that reflect the SA non-government Community Mental Health Service Sector on these issues. Papers 1–4 are available on www.mhcsa.org.au.

Questions

4.1 Have consumer and carer organisations been empowered to establish a broader range of support, information, training and advocacy for their members?

- Recent CoAG and state government funding has allowed consumer and carer organisations to increase service options, and a wider range of staff have been included, including peers, volunteers, those with a lived experience and carers. This emerged as a major step forward in SA, though not directly resulting from CoAG.
- Consultation reported greater awareness and networking with agencies relevant to support, information, training and advocacy which helps service providers to help consumers and carers to access these types of assistance
- This was seen as a work in progress and if supported properly would potentially have great value.
- Consultation recognised the significant work that has been done in this area by the state peak body.

4.2 To what extent have the needs of Indigenous Australians been given priority? What needs to be done as a matter of priority?

- Need a shared conception of what Indigenous Mental Health means and addressing the access barriers to non government mental health services especially the need for direct access and not through the clinical services system
- Indigenous Australians have been targeted as special needs groups.
- Overall feedback was that this group is not being catered for very well. Needs identified included a 'listening ear' approach, training and emphasis on providing supports in remote/rural areas.
- Impact of CoAG too early to assess.

4.3 To what extent have the mental health needs of people living in rural and remote areas been given priority? What needs to be done as a matter of priority?

- Roll out needs to continue, as the level of need is extreme. Some areas getting there but other dramatically short of clinical and NGO mental health services. Currently patchy but should improve as CoAG rolls out
- Need more local specialist mental health staff

4.4 To what extent have service developments assisted people from culturally and linguistically diverse communities?

- This is an area of big concern, especially in rural communities and still needs attention. Metro based services appear to be better equipped to address this need.
- Need more carer support groups.

4.5 What gaps or shortfalls in funding still exist?

- Several in the consultation estimated that it would require around a 3 or 4 fold increase in resources to more adequately address need.
- Focus remains on severe mental illness/functional limitations and this makes it difficult to take early intervention approach when still dealing with crises and urgent cases. Full CoAG roll out would not shift this focus enough.

4.6 What gaps in services still exist and what still needs to be done as a matter of urgency or priority?

- Appropriate, affordable and stable accommodation was strongly seen as a critical factor to all aspects of the plan succeeding. It is clear that public and community housing stock does not match the need. Recognition required that housing stress can occur across the full range of tenures – e.g. public housing, community housing, private rental, owner-occupied, homeless, in Supported Residential Facilities, boarding house type accommodation etc. This means that effective policy responses must be broad based to meet people's housing and support across the full range of tenures.
- Not clear on how well state is performing in addressing metal health from a housing point of view in terms of the time lag between approval for housing and allocation. Data clearly shows that timely access is a problem

- Homelessness still not adequately addressed and numerous and contemporary studies show the relationship between homelessness and mental illness.
- Supported Residential Facilities are of variable quality and are not necessarily appropriate, particularly for people with acute conditions.
- Mental health and lack of housing in many country areas is an acute problem.
- Need to develop a continued and genuine partnership approach between government and non-government sectors and a steady and continued build up of resource levels.
- More appropriate and effective early intervention programs that reduce the need for police intervention.
- Need to put more resources into discharge planning that is effective in supporting people to recover in the community.
- Referral processes and rules i.e. not being able to refer directly to NGO agencies puts some customers at risk. NGO services can play a critical role in avoiding crisis, as often it's the first point of contact.
- Lack of supports for refugees is a problem especially where go to settle in country and rural areas.
- Poor information availability for NESB was identified as a problem
- Youth and special needs groups were identified as needing more specialised one on one services.
- The role of advocacy by the NGO sector is an unfunded expectation of service provision and problem made worse by complicated systems and pathways. Limited individual advocacy is possible but systemic is poorly resourced
- Services are generally under-funded in rural and remote areas and struggle to attract qualified staff. Failure to attract basic clinicians can lead to a very low level psychiatric servicing.
- GP's have limited capacity to refer directly to NGO's and the need for further education of GPs in mental health and raises a curriculum issue
- The shared care program struggles to provide the required quota of GP's in some areas.
- Telephone support services are a good opportunity for NGOs.
- Advocacy services have not been given a clear signal that it is acceptable to undertake systems advocacy in the interests of improving mental health services. Some concern that funding agreements act as gags.

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3.5

Mental Health Council of Tasmania Inc.

The Mental Health Council of Tasmania (MHCT) is the peak body representing the interests of consumers, carers and non-government mental health service organisations. MHCT provides a public voice for people living with a mental illness and the community mental health service sector in Tasmania. Consultations were held members during July 2007. This section also includes a summary of issues raised by the Australian Counsellors Association, whose members participated in an online survey.

1. The extent to which the Council of Australian Governments (CoAG) National Action Plan assists in achieving the aims and objectives of the National Mental Health Strategy

Questions

1.1 To what extent is the CoAG National Action Plan assisting to prevent mental disorders and to reduce their impact on individuals, families and communities?

Too early to tell but the availability of funds through the CoAG-based tendering processes has the potential of either fragmenting services or creating large semi bureaucratic services. Information about which agencies have been funded is not readily forthcoming. The peak is not kept in the information loop, nor are individual agencies.

Comments provided included:

I believe stigma within the community still plays an important part in preventing persons and their families seeking help. I would hope the CoAG National Plan is addressing the impact of Mental Health's impact upon individuals, their families, work colleagues and the general community.

I believe that the National Action Plan is failing to assist in the prevention of mental disorders, and to reduce their impact on individuals, families and communities. The Action Plan still remains reactive rather than proactive. People experiencing difficulties continue to avoid GP and Psychology contact due to denial of their part in the difficulties being experienced and due to the stigma and adverse effects with work, friends, family and community of being labelled with a diagnosis. People are saying they want to be listened to not diagnosed and medicated.

1.2 What has been the impact of expanded access to psychology and allied health services under Medicare? Have any problems or issues emerged?

It appears that the service is being used by those with least need. Other groups such as rural young men are not being serviced. However, some people are at least getting some talk therapy for which there is huge need as is prevention, early intervention and actual treatment. It would be god if some of the psychological techniques could be simplified versions and taught in primary schools as US studies found that it prevented all sorts of troubles years later.

Impacts observed and reported recently in Tasmania include the following.

- The waiting lists for access to a Medicare psychologist has lengthened. Also the number of Psychologist willing to undertake this work. Not sure of impact with other counselling services.
- Massive increases in waiting lists to receive psychology
- People not receiving counselling help needed immediately in order to wait for the cheaper option of Medicare Psychology at the expense of their relationships and the expense of their personal health and wellbeing
- Psychologists are seeking professional development in the field of relationship counselling as a large percentage of clients being referred by GPs for relationship issues, anger management issues, mild depression or mild anxiety. Psychologists are not trained to work in these emotional areas.
- Mental health consumers are now waiting on long waiting lists for urgently needed help while psychologists are wading through the relationship and related issues referees.
- Psychologists are leaving critical positions in Mental Health Services for the now more financially lucrative Medicare Market.
- Mental Health Services struggle with reduced service capacity due to clinicians going into private practice, while not recognising the skills of registered counsellors to contribute in this field.
- A high majority (95%) of Counsellors surveyed by the Australian Counsellors Association (ACA) in 2007 have experienced a reduction in client turnover since the introduction of Medicare Psychology.
- 77% of those counsellors surveyed stated that they had been told by GPs that they would no longer be used for referral due to the availability of Medicare Psychology. I am one of these counsellors and as coordinator of the ACA (Tasmania) hear complaints of this nature on a daily basis.
- 64% of counsellors surveyed indicated that they would not be able to continue in practice for more than 6 months unless the current situation changed. 1% have already closed their doors!
- 63% of student counsellors surveyed are considering ceasing studies due to the drop in viability of counselling as a financially sustainable means of work.
- There is concern that when the Medicare-based Psychology services fail due to an inability to maintain services due to unsustainable waiting lists that there may be insufficient newly trained and registered counsellors to pick up the pieces.
- There is alarm in Tasmania at the number of families that are ‘stuck’ in adverse conditions while their loved ones wait on lists for service and help.

Please see the attached submission forwarded to the Council by the Australia Counsellors Association.

1.3 Do you experience that mental health services, care and outcomes have improved in the last one-and-a-half years

Most people are of the view that it is too early to tell and that information to assist with assessing this question is not readily available. Some people report that the care and outcomes of mental health services have improved in the last one-and-a-half years but we still have a long way to go. Partnerships between government and non-government

organisations have strengthened however many people continue to fall through the gaps. For the lucky few who receive help there is hope, while others struggle on increasing waiting lists, or struggle while their loved one refuses to see the doctor as a diagnosis of mental illness is out of the question, and they either cannot afford counselling, or refuse to use counselling when free services are available under Medicare.

Apart from those that have sought and are receiving medical help, there are still a number of people who are not picked up in the system. As always those living with a person who has mental health issues struggle to access help

1.4 To what extent is the CoAG National Action Plan assisting to assure the rights of people with mental disorder and their families?

This remains a concern in Tasmania. Comments received included the following.

The Action Plan is not ensuring the rights of carers. It is my experience that people experiencing difficulty due to trauma in their lives resulting in symptoms of mental illness are still not all receiving the help they need while carers still remain out of the loop and powerless to effect change.

Some of the services that are receiving these funds are using them constructively to benefit carers and consumers, while others seem to fritter away at the funds employing more staff and providing limited benefits to their target population. ARAFMI Hobart continues to roll out increased services to an increasing carer population with no increase in financial support. They have been considering cutting staff hours in order to sustain financial survival.

1.5 Have any issues or problems emerged in the roll out of Commonwealth or State funded new service initiatives under the CoAG National Action Plan?

As the roll out of new services is only just beginning, most respondents felt that is too early to comment on this.

2. The overall contribution of the CoAG National Action Plan to the development of a coordinated infrastructure to support community-based care

Questions

2.1 To what extent has work progressed in your state or territory on the development of arrangements for care coordination?

Most respondents had not heard of the National Plan's emphasis on coordination of care and were unaware that anything to improve the coordination of care was happening locally as evidenced by the following comments.

No evidence as yet.

Never heard of it.

However, other respondents reported that the Mental Health Helpline 24 hour state line seems to be offering a well-integrated service now. As a result of this, it is thought that state-based mental health case management services are becoming more integrated and that links with NGOs are strengthening. There are still some areas of difficulty around effective referral of consumers to case management by GPs on discharge from secure mental health units such as the Department of Psychological Medicine. Therefore people taken in to the services are getting better more integrated services, unfortunately there still remains the many who are waiting for counselling and cannot afford it, remaining on waiting lists for government funded help. A huge proportion of counselling services previously well utilised is now under used and at risk of becoming completely lost to their communities.

2.2 To what extent has consumer and carer input influenced the development of coordination structures?

Some respondents reported that as far as they are aware that consumers and carers have not had input into the implementation of this particular initiative.

Not at all

No idea & I have volunteered in the carer sector for 10 years!

Though the opportunity has been there for consumers and carers to have input into various consultations, the time for input has been generally rushed, allowing little time for preparation, careful contemplation and well-considered input. Forums and reviews have been launched with little notice and no time for effective final analysis

It was disappointing that at the 'Discussion on FACSIA Mental Health Initiatives' held on 26 September 2006 in Hobart there appeared to be a strong indication given by the facilitator for the Community Based Programmes stream of funding that the funding for innovative projects would not just be restricted to the four categories nominated, but that Consumer Organisations would also be eligible to apply for funding. It was extremely *disappointing to learn, a number of months subsequent to this consultation, that this was not to be the case.*

Consumers do not just present in the mental health sector looking for 'support'. An increasing number of consumers are looking for socially useful, worthwhile, challenging work that accords with their intelligence, abilities and valuable experience of the positives and deficiencies of the mental health system. Mental Health Consumer Education Projects – to work towards improving community attitudes); Mental Health Consumer Representative Projects – to skill people up into working as effective advocates at the service delivery level, and at the broader policy development level; are just two types of ***very*** *worthy projects that consumers in the 'capable' as opposed to the 'dysfunctional' role are crying out for.*

I would hope that future CoAG funding initiatives would cater for the diversity that exists in the mental health consumer community – both for consumer's 'support' needs – as this funding round is endeavouring to meet; and, just as importantly (and for many of us more importantly) that COAC caters for our need to develop our strengths – so that we may become effective advocates to improve services, community attitudes and the quality of life of mental health consumers (and those close to us – carers/family members and workers).

2.3 To what extent have Indigenous Australians had input to development of coordination arrangements?

Unknown. Some report that Indigenous Australians have been well encouraged to participate in the development of coordination arrangements, but that they are not aware of the details and the extent that participation has occurred.

2.4 Have any specific problems or issues emerged with attempts to progress care coordination?

Specific problems reported included the following.

- Appears to be little co-operation between State and Federal Government.
- No involvement by State service Case Managers.
- The effective referral of consumers from secure wards to effective case management seems to be of poor quality and in some cases is not happening.
- Referrals to previously well-used and very effective counsellors are now **not** being followed through with as there is a cheaper option available and consumers can use this option plus the existence of waiting lists to further avoid working with their underlying issues.
- The burden of this is falling on the carers, as they now have to hold the fort while waiting longer for counselling or psychology.
- Consumers are stating that their emotional needs are not being heard by psychologists and that they would rather receive counselling but cannot afford it.
- 93% of general public surveyed by the ACA responded that they would use counselling if it were available on Medicare.

2.5 What needs to happen to make care coordination a reality? Is anything different needed in rural and remote communities or for particular community groups?

It is thought that the exclusion of so many counsellors from providing a service under Medicare needs to be sorted out and addressed.

Creating an environment where counselling is available to the public on Medicare would truly open up care coordination. Effective case management is the realm of the counsellor, as is working with relationship issues, stress reduction, and mild depression. The utilisation of counselling for these and other areas of emotional support and validation for people would supply early intervention before medication and diagnosis is a requirement. This will in turn reduce waiting lists for people experiencing clinical depression, post-traumatic stress and other diagnosable mental illness symptoms. Reduced waiting lists will mean faster help for those who are in real strife, reduced stress on mental health services and a dramatic saving on the public purse. The cost of using GPs to gate keep Medicare psychology is huge and has been dramatically underestimated. The cost of seeing a patient through the cycle, of GP – Care Plan – Referral to first psychology session, would fund from 6 to 10 sessions with a counsellor with a greater reduction in waiting lists. This in turn equates to a reduction in family stress and relationship breakdown, and reduction in lost revenue through increased employment participation and reduced sick days.

There are a greater number of counsellors in rural and remote areas than there are psychologists and counsellors are more likely to offer after hours services, mobile services and in home services to the public.

Counsellors are highly trained in counselling and are registered, receiving regular supervision and professional development. Registered counsellors are trained in when to refer to a GP, psychologist or psychiatrist, and work to a strict code of ethics.

3. Progress towards implementing the recommendations of the Senate Select Committee on Mental Health

Questions

3.1 To what extent has progress been made on implementing the recommendations of the Senate Select Committee on Mental Health?

As far as is evident in Tasmania, only the following two recommendations have been implemented locally:

- Recurrent Medicare funding for teams of psychiatrists, psychologists, GP's, psychiatric nurses and social workers, providing expert, integrated, primary health care in mental health centres.
- Extension of Medicare rebates to private clinical psychologists and allied health professions.

Comments received included:

Not able to comment on following questions.

First 2 points only have been observed by myself.

I am a MH First Aid presenter & I haven't noticed any changes.

Recurrent Medicare funding for teams of psychiatrists, psychologists, GP's, psychiatric nurses and social workers, providing expert, integrated, primary health care in mental health centres and the extension of Medicare rebates to private clinical psychologists and allied health professions have been implemented.

Greater emphasis on prevention and early intervention and the particular needs of children, youth, the aged and Indigenous Australians has not been achieved, in fact due to the increased waiting lists for Medicare funded services and the loss of psychologists from mental health services to private practice early intervention has been further delayed and in some cases eradicated.

Respite funding is now just starting to be rolled out and as yet there has been a confused and very cautious response by funded services to providing respite options for carers.

3.2 Have any recommendations not been progressed?

Most of the Senate Committee's recommendations have not been progressed in Tasmania as far as anyone is able to report or determine.

Greater emphasis on prevention and early intervention and the particular needs of children, youth, the aged and Indigenous Australians has regressed

The availability of Mental Health First Aid training for carers remains expensive and financially unavailable and the ability to attend training in this area is further hampered due to the unavailability of support for their charges.

3.3 Have consumers and carers had improved Medicare funded access to private clinical psychologists and allied health professionals?

The answer to this in Tasmania is yes and no for al of the reasons discussed above.

Not yet as the carer body I am involved with doesn't get any Commonwealth funding & until just very recently, there was no real alternative

Waiting lists are a problem and some concern re psychologists available/willing to undertake this work.

There is an improvement from a financial perspective, however from a service prospective, waiting lists have increased by up to one month in length and clinical psychologists have been lost from mental health services teams into private practice. This compiled with a high rate of clinician retirement and an international shortage of clinicians is a recipe for looming disaster.

And due to the creation of an unlevel playing field through Medicare funded psychology access to services has been eroded increasing the pressure on psychology while abandoning counselling, thus abandoning early intervention.

3.4 Have consumers and carers had improved access to support and advocacy independent of public mental health services?

No. There still is only one Mental Health Advocate for the state!

3.5 Have any problems or issues emerged with the implementation of any of the Committee's recommendations?

The loss of psychologists from mental health services has decreased response times for some consumers and their families. Consumers are still saying they are not feeling heard or understood, services are still understaffed resulting in no time to listen effectively to consumer's emotional needs.

4. Remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness

Questions

4.1 Have consumer and carer organisations been empowered to establish a broader range of support, information, training and advocacy for their members?

This has not resulted.

Additional training being established for our volunteers to provide info for our callers.

Yes, I believe a broader range of support, information and training for our members has slowly become apparent, however ARAFMI still remains financially handcuffed to utilise these potential benefits for the empowerment of their carers.

The development of Mental Health Consumer (systemic) advocacy in Tasmanian is severely hampered by a lack of funds. Admittedly the current situation is better than prior to October 2005 when there was no funded mental health consumer advocacy organisation in Tasmania.

Mental health consumer advocacy is viewed many as a 'luxury' the mental health sector cannot afford / as an optional 'add on'. There appears to be a strong cultural understandings in the Tasmanian mental health sector that mental health consumer advocacy work is not really 'work' but is really a form of psychosocial rehabilitation/therapy that a consumer performs voluntarily because they are not really performing 'work' but are receiving a therapy service….

Because mental health consumer advocacy deals with the enthusiasm, strengths, dedication, skills, experience, knowledge, expertise, intelligence, creativity, goodwill etc., etc. of mental health consumers – and not with the 'rectification of dysfunction', its relevance to the mental health sector is often not comprehended.

The Tasmanian Mental Health Consumer Network exists to improve mental health services, community attitudes and the quality of life of mental health consumers. We do this through the following main activities:

- *Advocacy for improved community attitudes*
- *Advocacy for system improvement*
- *Working to strengthen the mental health consumer community.*

Our vision is for a vibrant and effective advocacy and leadership, by and with Tasmania's mental heath consumers. All the dynamism of the Tasmanian Mental Health Consumer Network (TMHCN) will not translate into the types of service provision delivered by, for example, the Victorian Mental Illness Awareness Council (VMIAC) – Victoria's peak mental health consumer organisation; without:

- *A recognition by Tasmanian MHS and other 'key players' in the mental health sector of the **true** worth and potential benefits of mental health consumer advocacy (systemic) to the mental health consumers, carers/family members, services, the mental health sector, the community sector, and the general community; and*

- *Adequate resourcing to enable the TMHCN to develop in a healthy, sustainable and effective way so that we can actualise our Mission and Vision.*

4.2 To what extent have the needs of Indigenous Australians been given priority? What needs to be done as a matter of priority?

Better community identification of Indigenous populations and more integrated and resourced connections between indigenous services and NGOs.

4.3 To what extent have the mental health needs of people living in rural and remote areas been given priority? What needs to be done as a matter of priority?

Mental Health Services have been increased to consumers in more rural and remote areas through the establishment widening of the cluster teams under mental health services, however carer support still remains unavailable to most carers outside the metro areas.

4.4 To what extent have service developments assisted people from culturally and linguistically diverse communities?

The recent tendering of one FACSIA-based funding programs, the Community-based funding program, strongly focused on CALD communities. Though there was support for this, there was also some concern about whether there were sufficient resources irrespective of a person's background.

4.5 What gaps or shortfalls in funding still exist?

A number of gaps were reported including the following:

- Funding for psychosocial rehabilitation and community support programs is still inadequate.
- Annual funding restrictions by state funding bodies – "Projectitis" funding schedules
- Tasmania's peak community mental health body is under funded and is unable on the funding provided to perform all the responsibilities required, requested and expected of a peak.
- Likewise Tasmania's mental health consumer advocacy (systemic) organisation (The Tasmanian Mental Health Consumer Network) is unable on the funding provided to perform all the responsibilities required and requested of a (prospective) peak mental health consumer advocacy organisation.
- As far as we can deduce, carer support is still under funded.
- An inclusion of counselling into the national Medicare mental health care access scheme would have the effect of providing a low cost early intervention service for the population and thus help keep many people out of the mental health system and reduce pressure on GP services, many of whom are now closing their books to new clientele. Further the use of counsellors for effective case management would free up clinical professionals to pursue their areas of expertise.

4.6 What gaps in services still exist and what still needs to be done as a matter of urgency or priority?

- Adolescent inpatient unit
- Real prevention at primary school level
- Appropriate treatment services for people with multiple disorders e.g. anxiety/depression personality disorder & substance abuse.
- Place registered counsellors onto the National Health Scheme as is the case in other countries such as Britain. This will reduce the alarming 1 in 5 mental health statistic created as a result of delays in accessing early help with difficulties in relationships before they escalate into major avoidant symptoms.
- Increase funding to Mental Health carer Organisations such as ARAFMI.
- Increased funding for consumer run initiatives, peer support and advocacy.

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Submission provided to Mental Health Council of Tasmania by the Australian Counsellors Association

Executive Summary

ACA Medicare Rebate Survey

This survey was distributed to ACA members including their networks. Many non-ACA counsellors also completed the survey after being made aware of it through their own networks. The survey was conducted from 18th of May 2007 to 24th of May 2007. This summary does not include surveys received after 24th of May 2007; a further updating of this summary will be made available on 30th of May 2007. To ensure the integrity of the survey it was noted in the survey that the term 'counsellor' referred to a non-psychologist or social work counsellor.

Aim: The aim of the survey was to ascertain what impact, if any, have the new Medicare Benefits Schedule (Better Access initiative) had on the counselling industry as a whole. The survey was aimed at gathering information from six areas within the industry:

1. Private Practice
2. Students undertaking counsellor training
3. Non-Government Agencies

4. Training Providers from VET and HE sectors.
5. Employers of Counsellors and employed counsellors
6. Member of the public who is not a counsellor

ACA felt it was important to ensure the survey incorporated all aspects of the industry to capture any general patterns as well as any specific patterns in the responses. The results of the survey do indicate that the introduction of the new legislation opening up NHB exclusively to psychologists and social workers to the exclusion of counsellors has had a negative global impact on the counselling industry.

Not all questions in each category were answered. Some returned surveys showed partial responses in multiple areas. Due to this totals are inconsistent with the number of responses in some cases.

Private Practice: 330 responses were received from Private Practitioners. Of these 313 indicated that they had experienced a decline in referrals since the introduction of the new legislation and 17 indicating no decline. Several of those who indicated 'no' clarified this with notations that they had only just started in practice therefore were not able to identify any patterns. 309 of the 330 respondents who identified a decline indicated that they believed the decline was attributable to potential clients being referred to similar services with Medicare rebates. 255 of the 313 respondents indicated that they had been told directly by clients/GPs that they will no longer use the counsellor's service because of a lack of access to Medicare services. 213 respondents indicated that they had lost current clients who stated the reason they were changing services was to access Medicare rebates. 145 respondents indicated that would not be able to continue in practice for more than 6 months unless the current situation changed. Of these 44 were already looking for alternative employment and 3 had already closed their doors. 297 claimed that they believed the down turn in business was directly attributable to the new legislation and 303 stated that their vote at the 2007 Federal election would be influenced by the government's response to this issue. 289 felt this issue was an election issue.

Students undertaking a Graduate or qualification course in counselling: 137 students responded to the survey. 84 indicated they had reconsidered completing there studies as a direct result of exclusion of counsellors to Medicare rebates. 56 indicated they had actually ceased or were seriously considering changing their courses from counselling to social work, 74 indicated they had actually ceased or were seriously considering changing their courses from counselling to psychology and 2 were unsure. 141 believed that exclusion to Medicare rebates would have a direct negative impact on their qualification. 14 respondents had ceased studying as a direct result due to the exclusion of counsellors from Medicare rebates. Of the 14 respondents 12 indicated that they had been studying – 1 x PhD, 6 x Masters, 1 x Graduate Diploma, 2 x Advanced Diploma and 2 x Diploma. 123 indicated this was an election issue for them and the outcome would influence how they voted.

Non-Government Agencies: Most respondents disclosed the agency that they worked in, with all the major agencies being named. For confidentiality purposes individual agencies have not been named. 134 surveys were returned from various agencies. 98 of these indicated that they had experienced a significant decrease in client numbers since the introduction of the rebates. 96 of the 98 respondents indicated they attributed the decline to clients being referred to similar private services that offered rebates. 90 respondents indicated that the future of their counselling service was now in danger. 130 of the respondents indicated that the exclusion of counselling services from Medicare rebates was not in the interest of those from low-income families.

Training Providers, both VET/HE sectors: 18 providers responded to the survey. 7 indicated that the exclusion of counselling for rebates had a negative impact on enrolments. 15 indicated that they have had students cancel their enrolment as a direct consequence of exclusion from the rebates. 15 indicated that students had shown significant concern about counsellors being excluded from Medicare rebates. All respondents indicated that this was an election issue for them. 12 respondents indicated their training courses would not be commercially viable if counsellors were not given access to rebates. 10 indicated that they believed counsellor training would not be in demand if rebates were not made available to counsellors.

Employed/Employers of Counsellors: 136 responded to this section of the survey. 103 indicated that the introduction of rebates threatened their job security. 110 indicated that it was not viable to hire counsellors because they cannot offer rebates. 105 indicated that there was no future for counselling as an employer/employee without access to Medicare rebates. 102 indicated that there was no future in the counselling industry without immediate access to Medicare rebates.

Members of the public (non counsellors): 303 members of the public responded to this section. 282 indicated they believed that counselling services by counsellors should be made available through Medicare. 300 indicated they would use a counsellor if Medicare rebates were made available.

3.6

Psychiatric Disability Services
of Victoria (VICSERV)

Psychiatric Disability Services of Victoria (VICSERV) Inc. is the peak body for Psychiatric Disability Rehabilitation and Support Services (PDRSS) in Victoria. Our member agencies in Victoria provide housing support, home-based outreach, psychosocial and pre-vocational day programs, residential rehabilitation, mutual support and self help, employment, training and support, carer education, respite and advocacy. VICSERV provides a range of services to member agencies which include: Sector Coordination, Support and Advocacy; Training and Professional Development; Policy Development; and Information Services. We are committed to honouring consumer and carer experience, embracing diversity, promoting a sense of belonging and inclusiveness, and encouraging innovation.

1. The extent to which the Council of Australian Governments (CoAG) National Action Plan assists in achieving the aims and objectives of the National Mental Health Strategy

Question

1.1 To what extent is the CoAG National Action Plan assisting to prevent mental disorders and to reduce their impact of individuals, families and communities?

- It may be too early to assess how the CoAG NAP has assisted in the prevention mental disorders.
- If this question were to be answered, how would it be measured? Are the necessary structures and tools in place to do this?
- Reduction of the impact of mental disorders may be happening due to the extension of the Medicare rebate.
- Respite funding has come into the Region and plans are being developed as to where, who and how this should be utilized.
- As the Personal Helpers and Mentors (PHaM's) and the Mental Health Community Based Program funds are rolled out we may identify change.

1.2 What has been the impact of expanded access to psychology and allied health services under Medicare? Have any problems or issues emerged?

People who have never accessed the services of a Psychologist are now able to do so. However, psychologists and GPs are found in greater numbers in wealthy inner city suburbs, whereas people with psychosis and profound psychiatric disability are over represented in other areas. In rural areas there are limited practitioners available and the good ones are overloaded.

There are also concerns that very junior psychologists are practising in small GP clinics with minimal supervision. In small operations, one psychologist will need to cover all specialities of psychology such as early childhood, compulsive behaviours and psychiatric illness etc., a task beyond that of any one individual. There is also the risk that unscrupulous practitioners will be able to offer very short consultations and still be renumerated at the same level with little clinical efficacy.

There is more work to be done to ensure that these services are integrated into the existing service system so that people with psychiatric disability can access these services in useful ways. There is a need for further studies and/or research dissemination into the value of psychological services and counselling for this group. Otherwise, there is a danger that these resources will only go to people with high prevalence disorders. There is also a need to develop models of how GPs and community mental health services can work together to help people with psychiatric disability access these resources.

1.3 Do you experience that mental health services, care and outcomes have improved in the last one-and-a-half years

Not in general. There are pockets of really good practice and programs from agencies delivering evidence-based models of service and care but this is not the norm. Outcome measurement systems for clients using the mental health system do not exist. Current tools tend to measure service-specific outcomes that are not always the same thing as measuring the effectiveness of the system. There need to be incentives for good practice.

1.4 To what extent is the CoAG National Action Plan assisting to assure the rights of people with mental disorder and their families?

I am not sure if the CoAG NAP has assisted with this. The assurance of the rights of people with a mental disorder and their families is imbedded in the values and principles of individual services. Mental Health promotion can contribute to this but for mental health services, the rights of people with a Mental disorder and their families is integral to the National Mental Health Standards and PDRSS standards that services are assessed on and accredited.

1.5 Have any issues or problems emerged in the roll out of Commonwealth or State funded new service initiatives under the CoAG National Action Plan?

The NAP gives considerable emphasis and resources to community supports outside of the mental health clinical system and also attempts to employ a more holistic approach to the needs of people with mental health problems. This is to be welcomed and encouraged.

There are also real concerns being expressed in regard to service coordination and the interface between the existing mental health service system (State) and new Commonwealth funded providers. What level of integrated planning has gone on between the State (Victoria) and the Commonwealth? There are also concerns that, in the long term, States will provide fewer resources to the mental health system because the Commonwealth is also involved now.

Specific issues:

- Concerns that PHaMs funding will go to organisations with no previous expertise in supporting the recovery of people with psychiatric disability.
- Some bemusement about the selection of postcodes and sites for both PHaMs and Support for Day-to-Day Living programs.
- Some frustration that funding and program guidelines for Support for Day to Day Living lead to a model which is about the maintenance of people in the community rather than recovery. Recent work in the PDRSS sector in Victoria has recommended that more funding be provided to day programs to facilitate community participation for individuals with psychiatric disability.

2. The overall contribution of the CoAG National Action Plan to the development of a coordinated infrastructure to support community-based care

Questions

2.1 To what extent has work progressed in your state or territory on the development of arrangements for care coordination?

VICSERV were involved in consultations with the state government and FACSIA about this until the end of last year. There has been no follow up with us as a peak body since then.

There is real concern that the CoAG spending and initiatives will create a more complex and less coherent mental health system for consumers, carers and workers to negotiate. It is imperative that CoAG builds on existing services, expertise and structures where possible.

2.2 To what extent has consumer and carer input influenced the development of coordination structures?

Consumer and Carer input has influenced the development of coordination structures in Victoria.

2.3 To what extent have Indigenous Australians had input to the development of coordination arrangements?

Cannot comment. We are not aware of this taking place

2.4 To what extent have CALD communities had input to development of coordination arrangements?

Cannot comment. We are not aware of this taking place

2.5 Have any specific problems or issues emerged with attempts to progress care coordination?

Service coordination tools (SCoTT) have been developed in Victoria. However, in some regions, clinical mental health services are not currently using these. “Confidentiality” can be used as a barrier to service coordination.

2.6 What needs to happen to make care coordination a reality? Is anything different needed in rural and remote communities or for particular community groups?

- In rural and remote communities there are few service providers; due to this care coordination is probably more effective. If services are provided out of a multi-purpose or mainstream service the stigma so often associated with mental illness is less likely to be experienced.
- Utilisation of common (electronic) referral tools that are easy and time efficient to complete.
- Rotation of staff to experience a placement in a different disciplines e.g. A&D services and PDRS services
- Assisted referrals – referees accompanying the person being referred to another service.
- Nurse practitioners based in GP’s practices.

3. Progress towards implementing the recommendations of the Senate Select Committee on Mental Health

Questions

3.1 To what extent has progress been made on implementing the recommendations of the Senate Select Committee on Mental Health?

- Mental Health First Aid has been delivered in our region for some 3 years (pre Senate Select Committee).
- Medicare rebates have been implemented.
- New funds, PHaM’s, Support for Day-to-Day Living and MHCBP have not yet been fully rolled out.

3.2 Have any recommendations not been progressed?

It is difficult to provide information about the recommendations that have not been progressed. However progress has been made on the following:

- Extension of Medicare rebates
- Greater emphasis on prevention and early intervention – children, youth, aged & Indigenous Australians via Mental Health Community Based Program – applications for submissions closed 20/07/07.
- Roll out of Mental Health First Aid. This has occurred via the Primary Mental Health Early Intervention Initiative for some years

- Training and employment support has had some progress
- More Respite
- Expansion and roll out of the step up/step down service type by the Victorian Govt. Not linked with “Mental Health Centres”
- Long stay (Community Residential Care Units) inpatient facilities focussed on rehab. Exist in most Regions in Victoria

3.3 Have consumers and carers had improved Medicare funded access to private clinical psychologists and allied health professionals?

Yes. However, in Rural areas this has created an added pressure on already overloaded psychologists and allied health professionals.

3.4 Have consumers and carers had improved access to support and advocacy independent of public mental health services?

Not that we are aware of.

3.5 Have any problems or issues emerged with the implementation of any of the Committee’s recommendations?

Employment support service system does not adequately recognise the particular support needs of people with a mental illness. In particular, it fails to recognise the episodic and ongoing nature of mental illness and the effects that stigma has on disclosure. The Job Capacity Assessment (JCA) provides systemic disincentives to people with a mental illness to look for work and this runs counter to the aims of the NAP to improve participation in the community

4. Remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness

Questions

4.1 Have consumer and carer organisations been empowered to establish a broader range of support, information, training and advocacy for their members?

- There are existing consumer and carer organisations in Victoria that have been offering support, training and advocacy for carers and consumers well before the CoAG NAP. These existing services need more funding to increase their capacity to deliver services to more people.

4.2 To what extent have the needs of Indigenous Australians been given priority? What needs to be done as a matter of priority?

- Not aware of any change. Indigenous communities need to be consulted to determine priorities. Indigenous services are very much separate to the mainstream community mental health service system in Victoria.

4.3 To what extent have the mental health needs of people living in rural and remote areas been given priority? What needs to be done as a matter of priority?

Not sure if mental health needs of people living in rural and remote areas have been given “priority”. I have not observed any evidence of this.

What needs to be done:

- Consultation and strategic planning with local communities to determine and prioritise what service types are required and where they should be located and fund them adequately, taking into consideration distances, isolation and the real cost of delivering services in rural and remote communities.
- Access by PDRS services to specialist mental health services such as “Spectrum” & “Origin”
- Access to private psychiatrists
- Address mental health workforce issues
- Sustainable employment opportunities for people with mental health problems
- Safe, secure, affordable and appropriate housing with support to assist in recovery

4.4 To what extent have service developments assisted people from culturally and linguistically diverse communities?

The focus on these communities as expressed in application guidelines for PHaMs, Support for Day-to-Day Living and MHCBP is to be very much welcomed. Some Psychiatric Disability Rehabilitation and Support services in Victoria are planning to make use of allocated CoAG funds to meet the needs of people from ethnic backgrounds. It is important that service agreements and funding models allow flexibility for services to engage with ethnic communities.

4.5 What gaps or shortfalls in funding still exist?

- Lack of funding for housing is the most glaring gap. Neither the Commonwealth nor Victoria are allocating housing for people with mental health problems. It is essential that such housing be intrinsically linked with community mental health resources to provide support.
- Sufficient funding for non-clinical services to engage experienced and well qualified staff. Additional spending through the CoAG initiatives will make it harder for all parts of the mental health system to attract appropriate staff. It is deeply concerning that workers in community services are paid much less than their clinical counterparts and it is likely that the quality of these services will suffer as a result.
- Development of a rural funding formula that recognises the real cost of delivering services in rural communities e.g. fuel, vehicle replacement costs etc.

4.6 What gaps in services still exist and what still needs to be done as a matter of urgency or priority?

People in remote rural communities have little access to mental health services, mental health funding needs to be made available to Bush Nursing services and multi purpose services to build their capacity to assist people with mental health problems within their own community. Bush Nursing services are doing mental health work already and there is a need to recognize this by funding them accordingly and appropriately.

Housing and Support from Recovery Support workers and changes to employment support system.

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3.7

WAAMH
Western Australian Association for Mental Health

The WA Association for Mental Health Inc. (WAAMH) is the peak mental health representative body in Western Australia for non-government not-for-profit agencies that operate for the benefit of people affected by mental illness. WAAMH supports and encourages the development of the non-government not-for-profit mental health sector for the benefit of people affected by mental illness. The Agency Vision is to work towards a future in which the health and well being of people affected by mental illness is promoted and supported by a range of community based mental health services, and in which there is a community acceptance of people with mental illness. During July 2007 consultations were undertaken with member agencies consumers and carers to assist with this submission.

1. The extent to which the Council of Australian Governments (CoAG) National Action Plan assists in achieving the aims and objectives of the National Mental Health Strategy

Questions

1.1 To what extent is the CoAG National Action Plan (NAP) assisting to prevent mental disorders and to reduce their impact of individuals, families and communities?

- *Difficult to know but initiatives welcomed*
  Those contributing to the consultations in WA expressed the view that it is difficult to know whether the Commonwealth plans and their initiatives are assisting to prevent mental disorders and to reduce the impact of mental illness. There was agreement on a number of fronts including the following:
  - That the consecutive National Mental Health Strategies have assisted and supported the development of more comprehensive modern mental health services in WA;
  - That the National Mental Health Strategies have assisted organisations in WA to undertake activities aimed at increasing awareness and understanding of mental illness and of available help and treatment, encouraging help seeking behaviour at an earlier point and reducing stigma;
  - That the new CoAG related initiatives of PHaMS, enhanced mental healthcare access under Medicare, Day-to-Day Living Centres, respite services etc. are most welcomed and need.

The consultations generally agreed that the capacity to assess the impact of the National mental health initiatives is clouded or impeded by the community mental health sector in WA being acutely aware of the growing number of people with mental illness who are facing crises in their immediate day-to-day living circumstances. This crisis is impacting negatively on the mental health, physical health and wellbeing of people with mental illness and may in fact be significantly impeding the national work. Aspects of this crisis are detailed below.

- *The current crisis experienced by many people living with mental illness and their families*
  The crisis is experienced on a number of fronts, key of which are unaffordable housing, reduced income security, inability to afford daily living essentials and reduced mental health and physical health.
- *Appropriate housing with secure tenure is becoming increasingly outside the reach of many people with mental illness in WA*
  The housing market is booming, interest rats are rising, rents are spiralling and people with mental illness are increasingly having difficulty obtaining or maintaining home ownership and finding affordable housing. There is neither enough supported accommodation nor a sufficient range. Rental accommodation at the lower end often lack security of tenure, is inappropriate and some distance from a person's original community. With higher housing costs comes less disposable income, a reduced capacity to afford daily essentials, increased stress, deterioration in mental health and physical health.
- *Access to GPs and primary health care*
  Access to bulkbilling or otherwise affordable GPs is difficult for people with mental illness in general. Affordability of GPs is an even bigger problem in areas outside of the Perth metropolitan areas i.e. in regional, rural and remote centres and areas. Like other Australian studies, studies in WA have consistently reported high levels of illness and injury among people with mental illness, which often remain undiagnosed and untreated for long periods. With physical health and mental health being inter-related, difficulty in accessing GPs impacts negatively on a person's mental health.
- *Loss of income security*
  Centrelink payments are generally the major income source of the majority of people with serious or long–term mental illness. The progressive implementation of changes to the Disability Pension and to employment payments under Welfare to Work provisions is resulting in people with mental illness being breached, people living with a high degree of stress and uncertainty about their payments, reduced payments and pressure on families to assist more than they already are. A growing number of people living with mental illness are giving up, dropping out of contact with Centrelink and trying to eek out an existence independently of government in an effort to avoid the stress and distress of the assessment process. It is thought that there is an increased level of minor offending as people struggle to obtain daily necessities and are forced to spend more time on the streets or in unsafe circumstances.
- *Few employment options*
  WA 'enjoys' a situation of low overall unemployment rates and high employment rates. Competition for jobs in most sectors is high. Under these labour market conditions it is difficult for people with mental illness to compete. People with mental illness do not fare well in the causal employment market due to the uncertainty, variability and terms and conditions of much casual work.

- *Dislocated from family, friends and what is familiar*
  People with mental illness are having to move away from family, friends and familiar areas in search of affordable housing and employment or training options. This often results in increased isolation and impacts
- *Inability to access inpatient mental health care unless suicidal*
  despite this increased levels of stress and crisis being experienced by people with mental illness. The non-government mental health sector is consistently observing that people with mental illness have difficulty in gaining admission to an acute inpatient service unless they are suicidal. If not admitted, waiting time for assessment by community mental health teams can be between 3–6 weeks.

Those contributing to the consultations in WA agreed that all of these factors are combining to work against some of the objectives of the excellent CoAG strategy on mental health and to increase the hardships experienced by people with mental illness and their families.

Impact of Welfare to Work on the CoAG NAP and the National Mental Health Strategy

Considerable discussion occurred during Western Australian community mental health consultations about the impact that the Welfare to Work provisions are having on the lives of people with mental illness. There is general agreement throughout the sector that these adverse impacts are working at odds with the CoAG NAP and the National Mental Health Strategy. The sector commends the Australian Government for recognising the importance of work to the well being of individuals, families and the Australian community. Work is important both in maintaining mental health and in promoting the recovery of those who experience mental health problems. Employment opportunities for people living with mental illness are an important concern of those working in mental health services, not least because they form part of the rehabilitation and reintegration work of those services. It is in this context that the community mental health sector argues for a softening or re-thinking of aspects of Welfare to Work policy – for a more facilitative approach to Welfare to Work, with a strong focus on partnership with mental health services. In doing so, the sector seeks the support of the Senate Inquiry in helping to promote governmental understanding of the need for people living with mental illness to be supported in the transition to employment because we are finding that the “one model fits all” application of the policy is harming some people who live with a mental illness and can harm many more.

The main issues have been identified through a range of earlier consultation processes that the WA Association for Mental Health, as the Mental Health peak body in Western Australia, has participated in, or facilitated. These include having held Welfare to Work Forums attended by over 400 people, extensive feedback from welfare advocacy, mental health and employment services, and consumers and carers, and participation in the Centrelink Mental Health Community Consultative Committee. Concerns raised during these earlier consultations as well s during the consultation process for the Senate Inquiry are now outlined.

- *Participation Requirements for Social Capital Development and Social Inclusion*
  At present Activity Participation Requirements focus on short term vocational courses – to facilitate a rapid return to work. In the case of people living with mental illness, there needs to be a stronger focus on building a capacity for social inclusion and re-engagement with family and society in a manner that facilitates rehabilitation and recovery, as well as the development of employability skills. Short-term training can work against longer-term pathways to reintegration and social inclusion. For

people with serious mental health vulnerabilities, the latter focus should take precedence. The sector argues that, for people living with mental illness, longer-term educational courses and non-vocational engagement in education and training and parenting should be counted as activities that meet Participation Requirements.

- *Compassionate Removal for Breaching Risk*
  The current Participation Reporting (breaching) guidelines are particularly onerous for people with a mental illness, and the sector is concerned that this is placing a person living with a mental illness at higher risk than most people. The potential for breach is very stressful for people living with mental illness and puts them at greater risk of relapse. The sector is of the view that changes are required to ensure that vulnerable people living with mental illness are not put at risk in this way, or at the very least ensure that such a person who is breached has recourse back to allowance if the person modifies their behaviour.

- *Eligibility for Financial Case Management*
  During the consultations the view was put strongly that the conditions for financial case management under which people with mental illness can be considered for case management are extremely harsh and restrictive, particularly for people living with a mental illness. The guidelines state that people should be on medication in order to get access to financial case management. There will be people with psychotic conditions that are not taking medication and will be unreliable in meeting the eligibility requirements and will be breached. The consultations argued that the conditions under which people with mental illness can be considered for financial case-management needs to be revised in consultation with mental health professionals, mental health consumer and carer organisations and community mental health service providers.

- *Centrelink 'vulnerability flags'*
  The consultation for the Senate inquiry discussed the Western Australian Centrelink use of 'vulnerability flags', which is thought to be achieving a high level of success in Western Australia of ensuring a more sensitive response and consideration of the needs of people who are living with a mental illness. The community mental health sector commends Centrelink in WA for the initiative shown around vulnerability flags and the related follow up. It is hoped that this might be one initiative that can be implemented as successfully across other states.

- *Remove Deterrence to Job Seeking*
  The sector notes that a person on a Disability Support Pension (DSP) who wishes to try to obtain a job in open employment has to be put through the work assessment process. This opens them to the risk of losing their DSP, regardless of whether they are or are not successful in getting a job. Clearly, this is a major deterrent to people with mental illness who are considering trying to get into open employment. The consultations called for this approach to be revised so that people living with mental illness are able to return to the DSP at any time within a given period (up to 12 months) without any questions/assessments should their attempt to obtain and maintain employment fail. This would encourage people to try without fear of significant financial repercussions. Even if a person returns to the DSP, there are no financial repercussions for the Commonwealth. The United Kingdom has an effective policy like this, one that supports people on the DSP to try for open employment.

- *Voluntary work*
  The consultations also raised the problem of voluntary work. People living with mental illness who undertake voluntary work can be negatively impacted on by being assessed as no longer being eligible for the DSP and thereby losing the DSP. Voluntary work is often the entry point for many people back into the employment market – and for people with mental illness doing small amounts of voluntary work

activities can boost self-esteem, confidence and employability skills. However the results of being taken off DSP will negate many of the benefits – not only is it an immediate deterrent for them but it could also damage future directions into the employment job market, and could have the very detrimental effect of causing a relapse potentially resulting in costly medical intervention and hospitalisation. It will also reduce the likelihood of mental health professionals encouraging people into voluntary work even though, under normal circumstances, this would be beneficial to recovery.

- *Suitability of Job Capacity Assessors*
  Many people living with mental illness fear that they will be misrepresented by the Job Capacity Assessment process, as an assessment of their abilities is based on a one-off interview with a Job Capacity Assessor who may have neither understanding of mental health issues nor the disabling consequences of mental illnesses. This fear is shared by many mental health professionals.

  There is concern about the completion of Job Capacity Assessments by those who are not suitably qualified. Whilst people living with mental illness can have access to psychologists and social workers, there are too many occasions where people with significant mental health issues have been assessed by physiotherapists and occupational therapists who do not have the requisite professional skills to deal appropriately with these clients and to do no harm in the process. It is not just about the availability of psychologists and social workers but also about the ability of people struggling with mental illness and associated problems to be able to articulate and ask for a suitable health professional. It is also about the potential harm that can occur with an untrained practitioner conducting these assessments. An example was given of a consumer who reported that in the course of the assessment that the Job Capacity Assessor asked questions around the consumer's thoughts of suicide and then went on to talk about the JCA's own parent's suicide attempts and depression within the JCA's family. The consumer reported that the JCA was normalizing suicide and depression and had the consumer been in a more vulnerable place that the consumer may have thought that suicide was all right.

  The consultations discussed the observation that some consumers with mental health issues who do not have activity requirements will agree to participate in retraining programs just to leave the interview and are not aware of their rights to refuse or to delay agreeing to such activities until they have discussed it with their treating health professional. Potentially consumers could agree to activities recommended by Job Capacity Assessors, those with non-mental health backgrounds, which will be detrimental to the consumer's mental health. The consultations argued that JCAs should be provided with training about mental illness and about strategies that build the capacity of people living with mental illness through social capital development and social inclusion.

  The consultations expressed the view that professionals making job capacity assessments should be appropriately qualified and that they be required to actively seek information from clients and their health professionals before making any judgment about work capacity or participation. It seems unsatisfactory and unfair that this judgment should be based on a one-off test. Rather the assessment should be made following close collaboration with the person, their mental health service provider and family supports with consideration to the person's motivation to work, their work history, cognitive impairments the usually episodic and non-linear course of the person's mental illness.

- *Time allocated for assessments*
  An hour is insufficient time in which to fully assess someone with mental illness. It appears that this might be influenced by the financial incentive for 'for-profit' service providers to reduce the time for assessments. This move to see more people in a

day can cause undue pressure on their clients and on staff. There appear to be uneven standards across service providers when conducting these assessments and that some of this is driven by cost cutting, which could ultimately incur greater costs to the community in increased mental health costs.
The following questions emerged during the consultation processes:

  - What rigour is being used to ensure high standards of process across all service providers?
  - What quality assurances are used to ensure this?
  - How is consistency and thoroughness of the assessment process ensured given the high turnover among assessors that is occurring?
  - Do JCA's receive support, training and incentive to respond appropriately and sensitively to the circumstances of people with mental illness?

- *Knowledge of the mental health sector*
  There was agreement throughout the consultations that there is a widespread lack of knowledge amongst mental health professionals in WA about 'Welfare to Work' and employment and allied programmes that will support the person's return to work and vocational rehabilitation. The 'Welfare to Work' legislation and its implications for the clients of mental health services have not been promoted within the mental health sector. Most mental health professionals know very little about it, despite the major implications for their consumers and carers. The consultations drew attention to the need for an extensive awareness and partnerships program to be conducted for mental health professionals to ensure they understand Welfare to Work and what they can do to support the aspirations of consumers to return to work, including partnerships with the employment sector.

- *Training and support for job placement agencies*
  The consultations also raised the needs for training and support for job placement agencies, Centrelink and public mental health clinicians so that they are all better placed to work together with flexibility around Welfare to Work procedures to ensure effective outcomes for people with mental illness.

Groups becoming increasingly marginalised and possibly 'untouched' by national mental health initiatives

The WA consultations drew attention to groups who appear to be largely 'untouched' by national mental health initiatives or who are falling out of eligibility for mental health services. The groups identified included:

- People with dual disorders, particularly mental illness and drug and alcohol disorders;
- People having experienced sexual abuse and family trauma;
- Indigenous communities;
- People from CALD backgrounds, particularly those whose first language is other than English;
- People with mental disorder subject to the criminal justice system; and
- People in the early stages of a psychotic illness.

1.2 What has been the impact of expanded access to psychology and allied health services under Medicare? Have any problems or issues emerged?

The review of the first six months of mental health care access under Medicare suggests that in WA women aged 25–55 years of age with depressive illnesses and anxiety disorders who are able to afford gap payments are among predominant users of the scheme. Problems and issues identified with the expanded scheme included the following:

- Limited access to bulkbilling GPs;
- GPs being fully booked out and unable to accept new patients;
- Limited capacity to afford gap payments charged by psychologists among people with serious mental illness in general as well as among certain population groups including people from new and emerging communities, refugees and people under humanitarian resettlement schemes, young people and young adults;
- People being unable to afford private psychologist fees, unable to afford other private options and unable to get 'into' public mental health services resulting in time delays of people getting assessment and follow-up of any kind;
- Lack of access to group-based therapies;
- Access to other allied health professionals with some professionals being excluded from the expanded arrangements e.g. counsellors, social workers;
- Lack of information in community languages for migrants;
- GPs are having difficulty in working with public mental health services;
- The necessary links between government services, non-government mental health service providers, GPs and private psychologists and other allied health professionals.

It is hoped that once the arrangements for mental health care through mental health nurses come on board that people with more serious and long-term illness might fare better.

1.3 Do you experience that mental health services, care and outcomes have improved in the last one-and-a-half years

Those contributing to the consultations were in agreement that there are currently signs of mental health services, care and outcomes not having improved in recent times or having only improved in a patchy way. There is concern that relapse rates might be increasing. Significant concerns also exist about the poor physical health and the level of undiagnosed and/or untreated physical illnesses among people with serious and/or long-term episodic mental illness.

1.4 To what extent is the CoAG National Action Plan assisting to assure the rights of people with mental disorder and their families?

The community mental health sector in WA is concerned that many fundamental rights are not being assured for people with mental illness and their families including:

- Timely and appropriate assessment and treatment;
- Primary health care and specialist health care;
- Interpreter assisted assessment and treatment;

- Eviction from housing;
- Independent advocacy and representation;
- Procedural fairness in government-based administrative and legal processes e.g. Welfare to Work, migration matters, tenancy, administrative appeals etc.;
- Legal representation before courts and tribunals;
- Sound employment conditions etc.

WA lacks a funded, independent consumer run organisation to represent the views and interests of people experiencing mental illness and to promote their inclusion in decision-making about the services they use, require and prefer as well as in decision-making more broadly.

1.5 Have any issues or problems emerged in the roll out of Commonwealth or State funded new service initiatives under the CoAG National Action Plan?

The new services are only just being established. For example, a PHaMs service and a Day-to-Day Living Centres are currently recruiting staff. During the tendering processes and this initial establishment phase a number of issues or problems have been identified including those that are now discussed.

- *Requirement of infrastructure in targeted locations*
  The initial rounds of PHaMs and Day to Day Living Centres required tendering agencies to have existing organisational and office infrastructure in the specified locations (bounded by set postcodes). This requirement ruled out many existing community mental health service providers and gave generic and larger community, family support and welfare organisations an advantage irrespective of their experience with providing psychosocial support services for people with mental illness.
- *Postcode-based eligibility for service*
  The requirement that people live within certain postcodes is ruling out people who have significant needs for services and for whom no services exist in their local area.
- *Resources required to tender*
  Agencies have estimated that the costs of tendering are around $10,000 – includes time and input of staff, board, referees, colleagues in other agencies who are supportive of the tender etc. Agencies that cannot afford a consultant or who do not have a designated tender writer struggle to maintain the agency's workload and prepare a tender at the same time.
- *Backdrop against which the developments are occurring*
  Mental health service development in WA has been rapid in recent years. For example 3 years ago $173 million was made available to the mental health system by the State government for the purposes of amongst others providing 280 supported accommodation and residential placements. To reach these service targets, a further 150–200 additional staff will be required in the non-government community mental health sector. At the same time, the public mental health system required a further 420 plus positions to be filled at a time when there were already 380 job vacancies throughout the public mental health system. Because the public sector pays staff between $15,000–20,000 more per annum, many staff in the NGO sector went over to the public system. Meanwhile the private sector is also recruiting and many professionals are leaving both the public and NGO sector for jobs in the private sector (e.g. in the mining and exploration industry). This is occurring against a backdrop of low unemployment. Under these circumstances it is difficult for the

community mental health sector to attract and retain staff. Agencies are also reporting increased difficulty in recruiting men as the sector can only afford salaries at a rate lower than national average. These recruitment difficulties are exacerbated in mining regions and regional and remote areas of WA.

- *Lack of parity between non-government community mental health sector, public and private mental health sectors*
  As discussed above there is significant lack of parity between sectors not only in relation to salaries but also in relation to terms and conditions. NGO funding is often project-based and non-recurring and often based on unrealistic estimates. For example, the PHaMS level of funding only allows agencies to employ 'cheap' workers and those employed must tolerate conditions that aren't considered acceptable in the public sector. For example, community mental health outreach and support workers work alone and conduct home visits alone, whilst in the public sector psychiatric nurses etc. only go out in pairs. Currently there are many positions unfilled in the NGO community mental health sector. This means that existing staff have to try and cover the demands so more and more end up working many more hours than they are paid to work. It is feared that burnout will increase under these circumstances.
- *Implications of the funding levels set by funding programs*
  As discussed above the funding levels set under the new Commonwealth programs do only allow agencies to pay relatively low wages. Wage level of course limits the extent to which experienced and suitably qualified staff can be recruited. The Day-to-Day Living Centres funding formula requires that only 15% of the total grant be spent on administrative costs. In most areas of WA, this ignores the reality of the high cost of rent and office space.
- *Difficulty with roll out in rural and regional centres*
  The national initiatives and their funding programs assume a one-model-fits all approach. The funding levels are not sufficient for rural and remote areas in WA where costs are higher and where there is limited or no service infrastructure. For example in WA, there is no psychiatrist north of Geraldton, a small clinical mental health capacity exists at Karratha and the Pilbarra, and there is half a carer support position in the whole of the Kimberly. The funding programs fail to factor in increased costs of office rent, goods and services, recruitment, relocation of new staff, incentives that must be offered to recruit staff, support for the health and mental health of staff, and the costs associated with providing services in areas where there are few other services e.g. communication, travel, transport, providing intensive support whilst waiting for assessment and assistance from clinical services etc. Funding formulae for establishing and operating services for rural and remote areas in WA need to incorporate funds for staff housing, professional support, education of accompanying children, flights to and from the communities of origin of staff, travelling expense associated with annual leave etc.

  The roll out of the new national initiatives have left much of WA untouched.

2. The overall contribution of the CoAG National Action Plan to the development of a coordinated infrastructure to support community-based care

Questions

2.1 To what extent has work progressed in your state or territory on the development of arrangements for care coordination?

A statewide care-coordination group being organised by the Premiers Department has been operating since October 2006 and has had three meetings. WAAMH is represented on this group. A consultation process is currently underway throughout WA. The process to date has largely been state-government driven and based. A number of issues have come up including the following.

- The perceived need to pay GPs who participate in this coordinating group.
- The role of public mental health services case managers in care coordination.
- The assumption that care coordination is cost neutral and that Commonwealth funding programs provide sufficient funds for care coordination to be carried out as well providing the specific service.
- It remains unclear how the Commonwealth-based care coordination processes will relate to the state-based processes for care coordination – the two processes appear to be working separately or out of synch with each other.
- The responsibility for driving care coordination falling on the non-government community mental health sector and its agencies, the player with the least resources, the least power and possibly the least capacity to ensure that psychiatrists, GPs, and clinicians come to the table and cooperate with each other.
- The need for cultural change as well as a framework for care coordination.

There was agreement during the consultation that generally speaking the overall needs of an individual are rarely addressed in a coordinated and holistic fashion. Further, for care coordination to be successful with certain population groups, an individual-centred approach will not be successful. For example, in CALD communities and for Indigenous Australians a family and community-based approach might be more appropriate. Mental health service providers, GPs and allied health professionals will need to break out of individual client/clinician model and develop culturally appropriate family-based approaches

2.2 To what extent has consumer and carer input influenced the development of coordination structures?

Consumer and carer input has been minimal except where one or two individual consumers and carers have been invited to attend meetings or provide input. WA lacks a funded and resourced independent consumer voice. Organisations like the Carers Association and ARAFMI provide a voice for carers. Wherever possible WAAMH supports both consumers and carers to provide input – but this is not the core business of the organisation and is totally unfunded.

2.3 To what extent has Indigenous Australians had input to development of coordination arrangements?

Indigenous Australians have had little or no input to the development of care coordination arrangements. Indeed there was general agreement during the WA consultations that roll-out of national initiatives has proceeded on false assumptions about what works in Indigenous communities and that what works is the same for Indigenous communities as it is for the broader community. By and large, most Indigenous communities and individuals are alienated from mainstream mental health services that work separately from drug and alcohol services and primary health care services. It is not surprising that few Indigenous people will use mainstream public mental health services voluntarily when it is remembered that in some Indigenous languages there are no terms for mental health problems.

2.4 Have any specific problems or issues emerged with attempts to progress care coordination?

CALD communities appear shut out of care coordination arrangements by reason of the limited use of interpreters and bilingual workers and the lack of outreach to and community development with CALD groups, organisations and agencies to assist to raise awareness of service developments and to resource them to carry out activities that raise community awareness of mental illness and available help, to reduce stigma and to reduce other barriers to mental health service use.

Other problems identified with progressing care coordination included:

- Lack of resources and funds specifically for care coordination;
- Lack of positions dedicated to care coordination, networking, relationship building and community development;
- Lack of a local area-based model i.e. lack of 'glue' that can bring everyone together and keep services working together collaboratively and in a coordinated fashion;
- The competitive tendering processes which are dividing service providers;
- Lack of training ad information for GPs and allied health professionals about available resources and services for people and families living with mental illness;
- Disincentive to collaborate and commit to care coordination in case it is a passing fad – here today gone to tomorrow.

2.5 What needs to happen to make care coordination a reality? Is anything different needed in rural and remote communities or for particular community groups?

Care coordination in rural areas – In some ways care coordination can and does work more readily in rural areas because service providers know each other well and depend on each other. Coordination tend to fall down in rural areas where the mental health system either doesn't or is unable to assist people with mental illness early enough or when people are discharged back to their communities too soon before arrangements for follow up and support have been set in place.

As discussed above a family approach to care coordination might be more appropriate and better suited to CALD and Indigenous people.

Contributors to the WA consultations welcomed the WA state-government's commitment to establishing processes for care coordination and welcomed the consultations that are beginning to occur throughout WA. A number of different ideas including the following were suggested in response to the consultation question – what needs to happen to make care coordination a reality.

- Develop a model of care coordination that is appropriate to Indigenous Australians.
- A 'one size model fits all' might not be appropriate. It might be more appropriate to develop a number of models that are designed to meet the needs of different groups and different circumstances e.g. CALD communities, Indigenous Australians, children and young people, older people, rural and remote areas etc.
- A local area-based model might have the greatest chance of working i.e. where care coordination funds are made available at a local area for coordination expenses, service brokerage, training, conferences, evaluation and research, show casing, conferences etc. The funds might be managed by an interagency group which acts as the local care coordination reference group
- A 'community builders model' proved successful in coordinating services in the area of suicide prevention (e.g. Mandurah Suicide Prevention Project).
- As HACC services are in most communities, it might be possible for HACC-based programs to have a role in care coordination.
- A further possible model might involve all mental health service related funding program to include a set amount for care coordination so that all service providers have a responsibility for ensuring this function and role is performed at both the level of individual clients and at service level.

3. Progress towards implementing the recommendations of the Senate Select Committee on Mental Health

Questions

3.1 To what extent has progress been made on implementing the recommendations of the Senate Select Committee on Mental Health?

Those contributing to the consultation discussed the way in which the Senate Report and other national reports have helped to accelerate service development in WA. The expanded Medicare arrangements, the PHaMs services, the Day to Day Living Centres and expanded respite options for carers though in their early stages, have been exciting and welcomed initiatives. It is also thought that the National Reports have helped to accelerate state-based developments including additional supported accommodation and residential programs. One, community mental health organisation, GROW, discussed the impact of having received additional state funding:

> *GROW has operated in WA for 40 years. For 38-and-half-years this was with very little funding which largely came from fund raising. One and half years ago extra funding was received from the State government. The impact of this funding has been significant. It has enabled GROW to employ more staff and more staff for longer hours. We have also been able to employ staff in rural remote areas. The*

extra funding enabled us to significantly expand our services; mainly in the area of more grow groups and promotion of mental health. We now have 27 mutual help support groups around the metro and country areas here in WA. All of these groups are run by the members themselves with support and back up from our office. The extra funding was the turning point for our organisation and demonstrates just what can be done with proper levels of funding. The improvements and service expansion we have been able to make demonstrates just what can be done with additional funding and how it has helped our members and the community in general. (See attached recent annual survey of GROW members in WA.)

3.2 Have any recommendations not been progressed?

The consultations in WA identified a number of areas of recommendations where little progress appears to have been made.

- *Improved services for people with dual diagnoses* – the two services systems remain separately funded, are separately administered, operate separately of each other and have trouble talking to each other and working in a coordinated and collaborative fashion.
- *Employment for people with mental illness* – there remains no national or state-based policy or framework for the employment of people with mental illness despite the extent of unemployment and high levels of aspiration to work among people with mental illness.
- *Building an evidence base for psychosocial rehabilitation and for other community based mental health service delivery* – there remains no money for research and development, for showcasing effective practice and models and for sharing information from evaluation and research.
- *National framework for outcome measurement* – that draws on the direct experience of consumers – we are still without national framework of service outcome measurement that directly draws its conclusions from the experience of consumers and carers. The current Annual National Mental Health Report equates to the Commonwealth, State and Territory governments all self assessing and giving themselves a big tick or a merit award each year.

3.3 Have consumers and carers had improved Medicare funded access to private clinical psychologists and allied health professionals?

As discussed above, contributors to the consultations in WA noted that access to Medicare funded clinical psychologists and allied health professionals has increased but concern exists about affordability of the gap fees and about access to GPs in general. In many areas of WA there are not enough GPs and it can be difficult to find A GP who bulkbills.

3.4 Have consumers and carers had improved access to support and advocacy independent of public mental health services?

Access to support services has improved in some parts of metropolitan Perth and in some towns. However, may parts of WA remain without significant improvement. Access to advocacy independent of public mental health services has not increased. As stated above, WA still lacks an independent and funded consumer run voice for mental health consumers and for people who experience mental illness but who do not identify as a ‘consumer’.

3.5 Have any problems or issues emerged with the implementation of any of the Committee's recommendations?

The implementation of some of the key recommendations of the Senate Inquiry has made no or little impact on most rural and remote areas in WA. The roll out has also had little impact on Indigenous Australians and their communities. There is concern that the mental health needs of migrants from non-English speaking countries have been neglected as well.

4. Remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness

Questions

4.1 Have consumer and carer organisations been empowered to establish a broader range of support, information, training and advocacy for their members?

As stated above this remains a neglected area in WA and is an area of concern. The community mental health sector calls upon governments to utilise the significant and valuable lived experience of people with mental illness and their families by funding consumer and carer organisations to provide a suite of much need services including peer support, information, training and advocacy for their members.

Advocacy is a real problem in WA as there are few advocacy services across the board and so people with mental illness must stand in line with other groups to receive the benefit of the scarce services.

4.2 To what extent have the needs of Indigenous Australians been given priority? What needs to be done as a matter of priority?

As stated above, there remains significant concern in WA that Indigenous Australians remain largely alienated from mental health services and that many of the mental health service delivery models are unsuitable and not culturally appropriate. The WA community mental health sector argues that Indigenous mental health should be made a priority and that Indigenous communities and organisations should be consulted about service barriers and what might work.

4.3 To what extent have the mental health needs of people living in rural and remote areas been given priority? What needs to be done as a matter of priority?

As stated above, the mental health needs of people living in rural remote areas remains a significant concern and requires action as a priority. It is difficult to see how progress can be made without the commitment of significant resources.

4.4 To what extent have service developments assisted people from culturally and linguistically diverse communities?

In concise terms, it is generally thought that most of the new service developments have had little impact for CALD communities. Some of the major concerns of the community mental health sector in WA about service development with CALD and NESB communities include the following:

- There are high levels of stigma in these communities about mental illness;
- There are significant cultural and language barriers to mental health service use and these barriers are well understood and researched;
- The individual patient/clinician model of mental health practice and care may not be culturally appropriate in many instances and may deter engagement;
- There are high levels of mental health needs in these communities – this is well known and well researched;
- Too many difficulties still exist with the use of accredited and trained interpreters;
- There is still reluctance among mental health and other community professionals to use interpreters;
- There is still little mental health training and support for interpreters;
- Bilingual mental health workers and health workers are not routinely used and here is a lack of emphasis on their recruitment and retention;
- Migrant Resource Centres and other migrant organisations and groups are able to assist with mental health promotion, early intervention and with engaging CALD and NESB groups in mental health care but are rarely funded to do so.

A further concern is that there is a lot of rhetoric and many words printed on paper about the need for cross cultural and cultural awareness training for mental health and community professionals. In practice though, little training is occurring.

Finally, access to and sufficient resourcing for interpreter services remains an issue throughout Australia not just in WA. However, interpreter assistance is critical to the mental health assessment, treatment and recovery processes. The WA community mental health sector is of the view that the Senate Committee should place this matter high on its agenda and seek evidence and ideas for addressing this matter nationally.

4.5 What gaps or shortfalls in funding still exist?

This submission has already highlighted several key gaps in funding. The non-government community mental health sector in WA asks the Senate Committee to inquire into the level of under resourcing of this sector nationally and to make recommendations for bringing the community mental health sector on par with the public and private mental health sectors. Other significant funding gaps include:

- Continued funds for promotion, prevention, early intervention and peer support;
- Research, evaluation and development;
- Independent advocacy;
- Housing;
- Rural and remote mental health service development and delivery;
- Care coordination; and
- Improved mental health care and service for Indigenous Australians and people from CALD and NESB.

4.6 What gaps in services still exist and what still needs to be done as a matter of urgency or priority?

The non-government community mental health sector in WA urges that the following service gaps be addressed as a matter of urgency.

- *A national mental health housing policy and program*
  Under the next Commonwealth/State Housing Agreement there must be a new component that deals with the housing crisis being experienced by people with mental illness and their families. Housing options must continue to be linked to support.
- *A national employment policy for people with mental illness*
  It is time to address the high unemployment rates among people with mental illness and to respond to the high level of aspiration for work among people with mental illness.
- *National action empowering Indigenous communities to shape and deliver in partnership the services they require for mental health, social and emotional wellbeing.*
- *Anomalies under the Commonwealth/State Disability agreement*
  In some states and territories including WA, people with mental illness and resulting psychiatric disability are largely excluded from service under the local implementation of this agreement.
- *Disadvantage for people with mental illness under the Welfare to Work provisions*
  These disadvantages are increasing the risk of poverty and relapsed mental health for people with mental illness and their families. The disadvantaging provisions of the Welfare to Work legislation and framework must be addressed.
- *Increase the affordability of primary health* for people with mental illness
  Too many people with mental illness remain without GPs and live with undiagnosed and untreated physical illnesses.
- *Increase service access and availability for groups currently largely excluded*
  This in includes CALD and NES communities, people with dual diagnoses, people with eating disorders, people with personality disorders, people with metal disorder who are subject to the criminal justice system

For further information regarding this submission please contact:

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GROW WA
2007 MEMBER SURVEY

Questionnaires were distributed in June 2007 to members who regularly attend GROW meetings, with an invitation to complete. 125 questionnaires were completed and returned. What follows is a summary of the information received.

DEMOGRAPHIC INFORMATION

A majority of respondents (**60%**) were female. **23%** of respondents were in the 36 to 45 year age bracket, **25%** of respondents were in the 46 to 55 year age bracket, **24%** of respondents were in the 56 to 65 year age bracket, though the full range was from 22 to 85 years. **69%** of respondents were born in Australia. They had been members of GROW for periods ranging from 2 weeks to 38 years, the average length of membership being 4.4 years.

EMPLOYMENT

45% of respondents receive Centrelink benefit or pension.

42% of respondents are in paid employment.

34% of respondents are involved in volunteer work.

38% of employed Growers say that GROW has helped them to retain or regain their employment.

DIAGNOSIS

81% of respondents had received a diagnosis of mental illness.
Of those with a diagnosis:

75% were diagnosed with depression.

53% were diagnosed with anxiety.

26% were diagnosed with bi-polar affective disorder.

23% were diagnosed with panic attacks

11% were diagnosed with post natal depression

13% were diagnosed with schizophrenia

15% were diagnosed with other disorders.

USE OF PROFESSIONAL SERVICES

Professional help (medical, para-medical or counselling)
92% of respondents had received professional help at some time.

44% no longer receive professional help.

77% report that GROW helped them reduce or end their need of help.

4. Membership of State and Territory Community Mental Health Peak Organisations 2007–08

mental health
community coalition ACT

Member Organisations

ACT CISM
ACT Mental Health Consumer Network
ADFACT
Barnardos – Canberra
Belconnen Community Service
Calwell Community Centre
Canberra & Queanbeyan ADD Support Group
CANFACS
Carers ACT
Centacare Canberra
CIT Skills for Carers
Community Connections Inc.
FaBRiC
GROW ACT
Inanna & Raja Inc.
Mental Health Foundation ACT
Mental Illness Education ACT (MIEACT)
Mental Illness Fellowship ACT
Northside Community Services
OZ Help Foundation & VYNE
Respite Care ACT
Richmond Fellowship ACT
Southside Community Services Inc.
Toora Womens Inc.
Volunteering ACT
Woden Community Service Inc.
Women's Centre for Health Matters
Work-ways

Associate membership includes 58 individual members

Northern Territory Mental Health Coalition

Member Organisations

Mental Health Carers NT (NTARAFMI)
GROW NT
Top End Mental Health Consumers' Organisation (TEMHCO)
Top End Association for Mental Health (TEAM Health)
Mental Health Assoc of Central Australia (MHACA)
NT Council of Social Service (NTCOSS)

Member Organisations

A Place to Belong: An Anglicare Mental Health Network
Aboriginal and Islander Community Health Service Brisbane Limited
Access Recreation Inc.
Addiction Help Agency Cairns Inc.
Advance Employment Inc.
ALARA Association Inc.
Amparo Advocacy Inc.
Anam Cara
Anglicare
Anglicare Central Queensland Limited
Anglicare CQ Mental Health Information & Resource Service
Anxiety Self Help & Support Group Gold Coast
ARAFMI Bundaberg
ARAFMI Maryborough
ARAFMI Queensland Inc.
ARAFMI Townsville/Thuringowa Support Group
Auseinet
Australian and New Zealand College of Mental Health Nurses Inc.
Australian Huntington's Disease Association (Queensland) Inc.
Australian Red Cross
Autism Advisory Services
Awareness Learning for Excellence
Bay Support Services Group Inc.
Bayside Initiatives Group
Belmont Private Hospital Consumer Group
Bidgerdii Community Health Service
Bio-Balance Health Association
Blue Care Central West Respite Services Longreach
Boystown
Brain Injury Association of Queensland Inc.
Bridges Clubhouse Inc.
Brisbane Domestic Violence Advocacy Service
Brisbane Obsessive Compulsive Disorder Support Group
Brisbane Youth Service
Brook Recovery Empowerment & Development Centre Inc.
Bundaberg Area Youth Service
Bundaberg Community Development
Bundaberg Consumer Advisory Group Inc.
Caboolture Kilcoy Bribie Area Mental Health Support Service
Cairns Consumer Carer Advisory Group
Caloundra Community Centre
Canefields Clubhouse Beenleigh Inc.
Capricornia Respite Care Association
Carers Queensland
Caring Friends
Catholic Psychiatric Pastoral Care
Centacare
Centre for Rural & Remote Mental Health, Queensland
Centre for Social Justice
Charters Towers Consumer Advisory Group
Choice Support Service Inc.
Commonwealth Carer Respite Centre, Sunshine Coast
Communify Queensland
Community Employment Options Inc.
Community Resource Unit Inc.
Connections Inc.
Consumer Carer Advisory Group Toowoomba District

Coolibah Family Support Program
Coral Coast Employment Inc.
Dalflin Employment
depressioNet
Discovery Program
Eating Disorders Association Inc.
Endeavour Foundation
Epic Employment Service Inc.
FNQ Independent Living Support Assoc. Inc.
Fraser Coast Consumer Advisory Group
FSG Australia
Gladstone Consumer Advisory Group
Gold Coast Employment Support Service Inc.
Gold Coast Recovery Services
Graceville Centre
Group 61
GROW Queensland
Health & Community Services Workforce Council Inc.
Health Consumer Network
Hervey Bay Community Access Assoc. Inc.
Hervey Bay Consumer Advisory Group
Hervey Bay G.E.M.S.
Housing Action Group Maryborough District Inc.
Housing for Life
Impact Make your Mark
ISIS Centre for Women's Action on Eating Issues Inc.
Jacaranda Clubhouse
Jerendine Family Support Program
Karakan Hostels
Keppel Community Care
Kiah Association Inc.
Kingston East Neighbourhood Group Inc.
Kith and Kin Association Limited
Kui Lifestyle Support Agency
Kyabra
Lifeline – Brisbane, Cairns Region, North Queensland
Link In Association Sunshine Coast Inc.
Logan Consumer and Carer Action Group
Mackay Advocacy Inc.
Mackay CAG
Mainstream Community Association Inc.
Maleny Care Givers Group
Many Hats Support Group
Mareeba Information & Support Centre Incorporated
Matilda Regional Health Service
Mental Health Association (Queensland) Inc. – Cairns, Gold Coast, Bundaberg
Mental Health Consumer Advisory Group for the Sunshine Coast & Gympie
Mental Health Resource Service Centacare Cairns
Mental Illness Fellowship of North Queensland
Mental Illness Fellowship of North Queensland Mackay Branch
MICAH Projects Inc.
Migrant Resource Centre Townsville MH Project
Mount Isa Consumer Advisory Group
Multicultural Centre for Mental Health & Well Being
Multicultural Cons & Carer Network
Multilink Community Care
Myriad Support Group
National Disability Services
NEPS Centre
New Farm Community Options Inc.
Newstead Progressive Industries Inc.
North and West Queensland Primary Health Care
North Queensland Attention Deficit Disorder Support Group
Nyunda Park Cooperative Ltd
Oasis House Peer Support Group Inc.
Open Minds
Ozcare
Partners A.W.A.R.E Australia Inc.
Pindari – Salvation Army Homeless Person's Service
Post Traumatic Stress Disorder Support Group

Princess Alexandra Consumer & Carer Advisory Group

QPASTT Inc.

Queensland Disability Housing Coalition

Queensland Division of General Practice

Queensland Injectors health network ltd

Queensland Lifestyles Services Inc.

Queensland Public Interest Law Clearing House

Quest Care Incorporated

Redcliffe and Caboolture District CAG

Redcliffe Neighbourhood Centre Association Personal Enrichment Program

Redlands Bayside Disability Services inc

ReSolutions Employment

Richmond Fellowship Queensland

Rights in Action

Rockhampton Adult Consumer Advisory Group

Royal Australian Inst for Comm Justice & MH Res & Dev

Royal Flying Doctor Service (Mt Isa)

Royal Flying Doctor Service

RSL care

Rural Lifestyle Options Association Inc.

Schizophrenia Fellowship of Queensland Inc. (Gold Coast)

SHARE: TRIPLE SSS

Sisters Inside Inc.

Smith Family

South Burnett Mental Health CAG

South West Disability Support Services

Spiritus

Spiritus-Social Services Toowoomba

St John's Community Care Ltd

St Marys Community Services

Stepping Stone Clubhouse

Supported Options in Lifestyle and Access Services Inc. (SOLAS)

Tableland Community Link Ass Inc.

Tamborine Mountain Community Care Association Inc.

The Advocacy & Support Centre

The Panic Anxiety Disorder Association (Qld) Inc.

The Park – Consumer & Carer Advisory Body

The Sunshine Coast Private Hospital Consumer & Carer Group

Toowoomba Clubhouse Association Inc.

Townsville Consumer Advisory Group

TPCH & MHU Consumer and Carer Advisory Group (CCAG)

United Synergies Ltd

Valley Consumer Action Group

VICSERV

Warrina Community Coop Ltd

West End Community House

Westside Community Services Limited

Womens Health Queensland Wide

Work Solutions

Worklink Employment Support Group Inc.

Wuchopperen Health Service Ltd

YMCA of Bundaberg Inc. – Disability Service

Young Parents Program

Youth & Family Services (Logan City) Inc.

Youth Affairs Network of Queensland

Member Organisations

Anglicare SA
Baptist Community Services
Carers Association
Centacare
COMIC
Diamond Clubhouse
EDASA
GROW
Helping Hand
Life Without Barriers
MIFSA
MHRA
Neami
OCDSS
PADA
Roofs Housing Association
Royal District Nursing Service
Southern Cross Care Inc.
STTARS
The Station
Uniting Care Wesley Adelaide
Uniting Care Wesley Port Adelaide
South Australian Network of Drug and Alcohol Services
Youth Affairs Council of South Australia

Mental Health Council of Tasmania Inc.

Member Organisations

Advocacy Tasmania
Anglicare
ARAFMI Hobart
ARAFMI Tasmania
Aspire
Carers Tasmania
Caroline House
Colony 47
Family Based Care Association
GROW
The Hobart Clinic
Langford Support Services
Lifeline Hobart
Relationships Australia
Red Cross Tasmania
Richmond Fellowship Tasmania
ROPES
Tasmanian Mental Health Consumer Network

Psychiatric Disability Services
of Victoria (VICSERV)

Member Organisations

Australian Community Support Organisation (ACSO)

ADEC Psych Disability Support

AMHRU, Sunshine

Anglicare Family Support, Preston

Anxiety Recovery Centre Victoria

ARAFEMI

Aspire

Ballarat Community Health Centre (APROTCH)

Bethlehem Community

Boomerang Network Inc.

Carer Respite Southern Region

Centacare – MASC, PDSS, Planned Respite, Supported Housing

Dianella Community Health Inc.

EACH – C.A.M.H.A., CREST, Groundwork Employment (Knox, Box Hill, Lilydale and Ringwood), Halcyon, Intensive Outreach Program, Lifeworks, Rivendell Community Support Program

Eating Disorders Foundation Victoria

ERMHA – Berwick Day Program and Outreach, Leonard Centre Day Program, Outreach Program

Finchley Support Service

Fintry Bank Supported Accommodation Project

Francis Foundation Inc.

GARSS, Morwell

Geelong Mental Health Consumers Union Inc.

Golden City Support Services

Golden City Support Services, Loddon Campaspe

Grampians Community Health Centre, Balgartnie

GROW Victoria

Homeground Services

Hopesprings

IEMHSA – GlenReach, Mosaic, Terra Firma

Impact

Inner South Community Health Service – Prahran, SouthPort, St Kilda

Karingal Inc.

Latrobe Community Health Services – Creative House

Loddon Mallee Housing & Support Services

Loddon Mallee Housing Services

Macaulay Community Support Association

Mallee Family Care – PDS Program, Swan Hill Disability Support

Mental Health Legal Centre

Mental Illness Fellowship – Barwon Residential Rehabilitation, Breakaway, Bromham Place Clubhouse, Eastern Region HBO, Family MSSH Program, Geelong, Gippsland, HBO Frankston, Hume Region Respite, Mulberry House, Mutual Support & Self Help Frankston, O'Meara House, Rossdale House, Shepparton Clubhouse, Shepparton Home Based Outreach & Support, TJ's, Warragul Clubhouse, Wonthaggi Clubhouse

MHAV Hostels

Moonee Valley Psychiatric Disability Services – Boomerang Club

Moreland Community Health Service

NEAMI – Darebin, Feenix Club North East, Splash Art Studio, Whittlesea, South East Sydney

North Richmond Community Health Services – Learning Things

Norwood Association Inc.

NYCH – Yarra Community Support

Out Doors Inc.

OWPDS – Horizons, Outlooks Melton Day Program

PANDA

Pathways – Clearwater Business Services, Geelong Program, Rehabilitation & Support

Peninsula Support Services

Prahran Mission – Employment & Training, Psychosocial Rehabilitation, Home Based Outreach, JobSupply Personnel, Open House, Second Story

Ramahyuck District Aboriginal Cooperative

Reach Out Southern Mental Health – Resource Club, SAILS

Regina Coeli Community

Richmond Fellowship of Victoria – Amaroo, Apollo Program, Appleby Crescent, ARGOS (Rosa Gilbert & Outreach), Bendigo Residential Rehabilitation, Chiron Program, Denham House, Edith Pardy House, Electra Street, Jacaranda, Jeshimon House, Kamara, McPherson Community, Narana, Nette Court, Outer Eastern Residential Rehabilitation, PALS, Purro-Gunya (Warrnambool), Residential Rehabilitation Wodonga, Sandridge House, Seaford, Southern Respite Service, Trelowarren House, Victoria Street Program, Wattlebridge Residential Rehabilitation, Western Respite, Wodonga HBO, Wodonga RRR, Wunnik Gunyah, Yandina

Salvation Army – Gippscare, Kardinia Centre

Social and Emotional Well Being Project

Special Needs Access Programs Inc. – Sale, Bairnsdale, Korumburra

St Kilda Baptist Benevolent Society, Scottsdale

St Kilda Drop-In Centre

St Luke's Anglicare – Bendigo PDSS, Echuca, Southern Region

St Mary's House of Welcome – No Limits PDS at Richmond

The Compassionate Friends Victoria Inc.

Trinity Community Support Association Inc.

Upper Hume Community Health – Get Together House

Victorian Mental Illness Awareness Council

Western Region Health Centre – Rocket, Home-based outreach

Wimmera Uniting Care – Horizons Services

WISHIN

Member Organisations

55 Central Inc.
Access Housing Association, Fremantle
Access Housing Association Mandurah
Albany Outreach Support Service
Alzheimer's Australia WA Ltd.
Anglican Homes
Anxiety Self Help Association Inc.
ARAFMI
ASeTTS
Australian & New Zealand College of Mental Health Nurses, WA Branch
Australian Red Cross
Baptistcare
Bay of Isles Community Outreach Inc.
Bunbury Pathways '92 Inc.
Carers Association of WA
Casson Homes
Centrecare Goldfields
Child Abuse and Adult Mental Health Action Group
Derbarl Yerrigan Health Service
Even Keel Bi Polar Disorder Support Association
Friends of Biala Inc.
Goldfields Mental Health Action Group
GROW

Hills Community Support Group
June O'Connor Centre, Subiaco
L.A.D.S.
LAMP
Mental Health Law Centre
Mental Illness Fellowship of WA Inc.
Midland Women's Health Care Place
Perth Home Care Services
Perth Inner City Youth Service
Pilbara and Kimberley Care Inc.
Post Natal Depression Support Association Inc.
Rainbow Project, Manning Uniting Church
Ruah Inreach
Schizophrenia Fellowship (Albany & Districts) Inc.
Share & Care Community Services Group Inc.
Silver Chain Nursing Association Inc.
Soundworks
South Metro Migrant Resource Centre
Southern Cross Care WA
St Bartholomews House, East Perth
St John of God Health Care Inc.
Support In Site

Tanderra Hostel, Salvation Army
The Richmond Fellowship of WA Inc.
Vincentcare
WA Aids Council
WAGP Network
Wanslea Family Services
Wesley Housing, ILP

West Australian Mental Illness Awareness Council (inc)
Women's Health Care House
Youth Focus
Zonta House Refuge Association Inc.
Community Housing Coalition of WA
WANADA

Member Organisations

Action Foundation

Active Employment

Advocates for Survivors of Child Abuse

Anglicare

Australian College of Mental Health Nurses Inc., NSW

Australian Foundation for Disability (AFFORD)

Aftercare

AIDS Council of New South Wales Inc.

Alcohol & Drug Foundation of NSW – Cyrenian House

Alice's Cottages Incorporated

Alliance to Improve Mental Health Services (AIMHS)

Anxiety Disorders Alliance

Association of Relatives and Friends of the Mentally Ill (ARAFMI) – ARAFMI Central Coast, ARAFMI Cronulla (Sutherland), ARAFMI Illawarra, ARAFMI Newcastle, ARAFMI Wingecarribee, Auburn Cottage, Inc.

Banks House Support Group

Bankstown Women's Health Centre

Baptist Community Services

Bay Ami Accommodation Incorporated

Billabong Clubhouse

Black Dog Institute

Blackheath Area Neighbourhood Centre

Blue Mountains Food Service Inc. (Lunch Club Project)

B. Miles Women's Housing Scheme

Carers NSW

Castle Personnel Services Inc.

Catholic Healthcare

Centacare Psychiatric Rehabilitation Service (PRS)

Centacare Ageing and Disability Services

Cessnock Uni-Clinic

City Womens Hostel

Clarence Valley Community Program

Club Speranza

Coffs Harbour Employment Support Service Committee (C.H.E.S.S.)

Community Links Wollondilly

Compeer Program, Chatswood

CAN (Mental Health) Inc. (Consumer Activity Network (Mental Health) Inc.)

Community Consultative Committees (CCC) – Armidale CCC, Bankstown Mental Health CCC, Campbelltown CCC, Central Sydney CCC, Coffs Harbour CCC, Inner City CCC, Liverpool/Fairfield CCC, Macleay CCC, Manning CCC, Mid Western Area Health Service CCC, Mudgee CCC, Northern Beaches CCC, Northern Sydney Area Mental Health CCC, Port Macquarie Base Hospital CCC, St George CCC, South Eastern Consumer Network CCC, Tamworth CCC, Tenterfield CCC, Tweed Valley CCC, Wingecarribee CCC

Co.As.It (Italian Association of Assistance)

Compeer

Compeer Illawarra

Counselling and Retraining for Employment (C.A.R.E)

Counsellors & Psychotherapists Association NSW

Creative Youth Initiatives

Disability Advocacy Network (DAN)

The Disability Trust

Doña Maria Pre and Post Natal Support Network

Dympna House

Education Centre Against Violence

Echo Neighbourhood Centre

Exodus Foundation

Fair Go Health Forum

Family Drug Support

GROW

GROW North Coast Community Centre

Hope Unlimited Group

Hornsby Ku-Ring-Gai Association Action For Mental Health Inc.

Hornsby Ku-Ring-Gai Lifeline & Community Aid Inc.

The Housing Connection (NSW) Inc.

Hunter Joblink Inc.

Hunter New England Area Health Service

Hunter New England AHS, Consumer Consultative Committee

Hunter New England AHS, Manning Mental Health Service

Illawarra Mental Health Service

Independent Community Living Association (I.C.L.A)

Integrated Functional Health Worldwide P/L

Interchange Respite Care(NSW) Inc.

JewishCare

Justice Action

Justice Health

Kaiyu Enterprises, Inc.

Life Without Barriers

Lifeline – Central Coast, South Coast, Newcastle & Hunter, Western Sydney

Macarthur Disability Services

Mandala Community Counselling Service

Manly Drug Education & Counselling Centre (MDECC)

Mental Health Accommodation & Rehabilitation Services (MHARS)

Mental Health Association NSW Inc. (formerly NSW AMH)

Mental Health Carer Network Incorporated

Mental Health Reconnect

Mid North Coast Living Skills / Rehabilitation Forum

Mid Western CAG Inc.

Mind Matters Media Inc.

Moomba Accommodation Services

Mountains Community Resource Network

The Multicultural Disability Association (MDAA)

National Association for Loss and Grief (NSW) Inc.

Neami Inc.

New Horizons Enterprises Limited

Newtown Neighbourhood Centre, Boarding House Project

Northern Beaches Mental Health Support Group

North Sydney Health Area Mental Health Services

Northern Sydney Health (NSH) Area Mental Health (AMH) Consumer Network

NSW Consumer Advisory Group For Mental Health (NSWCAG)

NSW Disability Discrimination Legal Centre Inc.

NSW Rape Crisis Centre

NSW Users & Aids Association

Open Employment

On Track

Parramatta Mission

Peer Support Foundation

Personnel Employment Albury Wodonga Inc.

Physical Disability Council of NSW

Progressive Employment Personnel (PEP)

Psychiatric Rehabilitation Association (PRA)

Reconnect

Richmond Fellowship of NSW

Richmond Fellowship of NSW, Hunter

Roam Communities

Samaritans Foundation

Schizophrenia Fellowship of NSW

Support and Education for Living and Health (SELAH)

SOMA Health Association Of Australia Limited

South Eastern Sydney Illawarra Area Mental Health

Southern Community Welfare Inc.

St Louise Lodge

St Vincent's Mental Health Service

Stepping Out Housing Program

Suicide Prevention Australia Inc.

Sydney Counselling Service (STEPS)

Sydney Women's Counselling Centre

The Australian Mental Health Suicide Consumer Alliance Incorporated (Club Speranza, Suicide Prevention Education)

The Benevolent Society

The Salvation Army

The Station Limited

Transcultural Mental Health Centre

Triple Care Farm – Mission Australia

Tweed Valley Mental Health Carers Network

Uniting Care Nareen Gardens

Uniting Care Supported Living

Ways Youth Services

Wesley Mission Homeless Person's Services

Western Riverina Community Care

Westworks Incorporated

Women And Mental Health (WAMH)

Women Incest Survivors Network

Woodville Community Services Inc

5. Appendix 1: Senate Inquiry Consultation Survey 2007

National Peaks Combined Submission to the Australian Senate Community Affairs Committee's Inquiry into Mental Health Services in Australia

Introduction

The Community Mental Health Peaks from each State and Territory, known informally as the National Peaks, have agreed to collaborate to conduct consultations during July 2007 with a view to preparing a combined national submission to the Australian Senate Community Affairs Committee's Inquiry into Mental Health Services.

About the Inquiry

This National Inquiry follows on from the work of the Select Committee on Mental Health and its report, *A national approach to mental health – from crisis to community* as well as the Council of Australian Governments National Action Plan on Mental Health 2006–2011. The Inquiry's *Terms of Reference* are as follows.

On 28 March 2007 the Senate referred the following matter to the Community Affairs Committee for inquiry and report by 30 June 2008:

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.

3. That the committee have access to, and have power to make use of, the evidence and records of the Select Committee on Mental Health. http://www.aph.gov.au/Senate/committee/clac_ctte/mental_health/tor.htm

Submissions are required by 31 July 2007. Submissions become Committee documents and are made public only after a decision by the Committee. Publication of submissions includes loading them onto the internet and their being available to other interested parties including the media. Persons making submissions must not release them without the approval of the Committee. Submissions are covered by parliamentary privilege but

the unauthorised release of them is not protected. Following consideration of submissions, the Committee will hold public hearings. The Committee will consider all submissions and may invite individuals and organisations to give evidence at the public hearings.

The Inquiry provides an opportunity for Community Mental Health Peaks to highlight the views of their members about what is happening in their own state or territory as well being able to influence national developments at an early stage. It also provides the Peaks with an opportunity to highlight the views of consumers and carers from around Australia.

Consultations to be conducted in each State and Territory

As much as is possible in the brief time frame, Community Mental Health Peak's in each State and Territory will conduct consultations with members and with other community stakeholders. Following the consultations each peak will compile their state/territory's response that will then be forwarded to a project consultant, Leanne Craze, who will then compile the national submission.

Consultation on the Australian Senate Community Affairs Committee's Inquiry into Mental Health Services in Australia

Consultation Questions

1. The extent to which the Council of Australian Governments (CoAG National Action Plan assists in achieving the aims and objectives of the National Mental Health Strategy

The broad aims of the National Mental Health Strategy 2003–08 are to:

a. Promote the mental health of the Australian community;

b. Where possible, prevent the development of mental disorder;

c. Reduce the impact of mental disorder on individuals, families and community; and

d. Assure the rights of people with mental disorder.

The broad aims of the CoAG National Action Plan 2006–08 are to:

a. Improve mental health and facilitate recovery from illness through a greater focus on promotion, prevention and early intervention;

b. Improve access to mental health services, including in Indigenous and rural communities;

c. More stable accommodation and support an meaningful participation in recreational, social, employment and other activities in the community; and

d. Improve the care system with a focus on better coordinated care and building workforce capacity. (For the National Plan and each state and territory's plan see www.**coag**.gov.au/meetings/140706/docs/nap_**mental_health**.pdf.)

Questions

1.1 To what extent is the CoAG National Action Plan assisting to prevent mental disorders and to reduce their impact of individuals, families and communities?

1.2 What has been the impact of expanded access to psychology and allied health services under Medicare? Have any problems or issues emerged?

1.3 Do you experience that mental health services, care and outcomes have improved in the last one-and-a-half years

1.4 To what extent is the CoAG National Action Plan assisting to assure the rights of people with mental disorder and their families?

1.5 Have any issues or problems emerged in the roll out of Commonwealth or State funded new service initiatives under the CoAG National Action Plan?

2. The overall contribution of the CoAG National Action Plan to the development of a coordinated infrastructure to support community-based care

The CoAG Plan seeks to provide 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. The Plan states:

> *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.*

Questions

2.1 To what extent has work progressed in your state or territory on the development of arrangements for care coordination?

2.2	To what extent has consumer and carer input influenced the development of coordination structures?

2.3	To what extent have Indigenous Australians had input to development of coordination arrangements?

2.4	Have any specific problems or issues emerged with attempts to progress care coordination?

2.5	What needs to happen to make care coordination a reality? Is anything different needed in rural and remote communities or for particular community groups?

3. Progress towards implementing the recommendations of the Senate Select Committee on Mental Health

The recommendations of the Senate Select Committee on Mental Health are outlined in its report 'A national approach to mental health – from crisis to community' (see www.aph.gov.au/senate/committee/mentalhealth_ctte/report02/report.pdf). Far-reaching recommendations were made, including:

- Recurrent Medicare funding for teams of psychiatrists, psychologists, GP's, psychiatric nurses and social workers, providing expert, integrated, primary health care in mental health centres.
- Extension of Medicare rebates to private clinical psychologists and allied health professions;

- Greater emphasis on prevention and early intervention and the particular needs of children, youth, the aged and Indigenous Australians;
- The Mental Health Council of Australia to be charged with reporting on progress under the NMHS;
- A new National Mental Health Advisory Committee to advise CoAG on consumer and carer issues, advocate for wellbeing, resilience and illness prevention;
- The roll out of mental health first aid programs aiming for 6 percent of the population and starting with teachers, police, welfare workers and family carers;
- A doubling of investment in research and a new Commonwealth–State Mental Health Institute to develop prioritised research and pilot programs and to set standards;
- HREOC to investigate human rights abuses and discrimination
  Mental health and drug and alcohol services to be integrated;
- A national emergency 1800 telephone help line, staffed by mental health workers 24 hours a day;
- Financial incentives for medical and allied health training;
- More emphasis on training and employment support, tax incentives and wage replacement schemes to help place people in work;
- More respite and 'step up/step down' facilities and more long term supported accommodation, all linked to mental health centres for clinical support;
- Better detox, rehabilitation and dual diagnosis-specific services;
- Long stay inpatient facilities focused on rehabilitation for people with severe and chronic disability;
- Specialised mental health and dual diagnosis spaces in emergency departments.

Questions

3.1 To what extent has progress been made on implementing the recommendations of the Senate Select Committee on Mental Health?

3.2 Have any recommendations not been progressed?

3.3 Have consumers and carers had improved Medicare funded access to private clinical psychologists and allied health professionals?

3.4 Have consumers and carers had improved access to support and advocacy independent of public mental health services?

3.5 Have any problems or issues emerged with the implementation of any of the Committee's recommendations?

4. Remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness

The CoAG National Action Plan outlines where Commonwealth, State and Territory governments will significantly expand and improve their mental health services, and access to them. Here are some excerpts.

'The Plan 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*.'

Questions

4.1 Have consumer and carer organisations been empowered to establish a broader range of support, information, training and advocacy for their members?

4.2 To what extent have the needs of Indigenous Australians been given priority? What needs to be done as a matter of priority?

4.3	To what extent have the mental health needs of people living in rural and remote areas been given priority? What needs to be done as a matter of priority?

4.4	To what extent have service developments assisted people from culturally and linguistically diverse communities?

4.5	What gaps or shortfalls in funding still exist?

4.6	What gaps in services still exist and what still needs to be done as a matter of urgency or priority?

Many thanks for taking the time to provide the Alliance with your comments. Please send your responses to:

Leanne Craze
Phone: 02 6238 1549 Mobile: 0408 869 051 Email: lrcraze@bigpond.net.au

6. Appendix 2: MHCC and NCOSS NSW Senate Inquiry Submission