Chapter 5

Mental health

5.1 Many submitters voiced great disappointment with the COAG proposals and funding agreements in relation to mental health in terms of the level of funding, a lack of reform to mental health services, as well as a lack of integration of mental health in the planning and reform of the whole health system.[1]

Lack of funding

5.2 Of most concern was that the funding for mental health services does not reflect the burden of disease. The Royal Australian & New Zealand College of Psychiatrists (RANZCP) noted that one in five Australians experience a mental illness in any one year, but pointed to the poor level of funding:

> Current funding for mental health is inadequate. Funding for mental health should be reflective of the burden of the disease attributable to mental health. At least 14% of all health care funding should be directed towards mental health are, rather than the inadequate 6% it currently receives.[2]

5.3 Professor Patrick McGorry noted that whilst there were some positives for Australians with mental ill-health in that the 'agreement establishes a policy direction that emphasises the importance of providing young people with increased access to models of care', there were also negatives and uncertainties.[3] He continued:

> The principal negatives for Australians with mental ill-health are that the agreement exacerbates rather than addresses the structural under funding of mental health services and does little to advance the "historic reshaping of mental health services" that has been promised by the Prime Minister and that is urgently required.[4]

5.4 The lack of adequate funding was seen by the Mental Health Council of Australia (MHCA) as being particularly inexcusable given the funding of the reforms through a new tobacco excise:

> With 42% of all cigarettes sold in Australia being smoked by people with mental illness, the fact that the COAG health agreement is to be funded by

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1 See for example, Catholic Health Australia, *Submission 3*, p. 11; Professor D Penington, *Submission 7*, p. 9; Professor P McGorry, *Submission 8*, p. 1; Mental Health Council of Australia, *Submission 21*, p. 1; Australian Medical Association, *Submission 10*, p. 11; Royal Australian & New Zealand College of Psychiatrists, *Submission 12*, p. 2; Australian College of Mental Health Nurses, *Submission 23*, p. 1.

2 Royal Australian & New Zealand College of Psychiatrists, *Submission 12*, p. 1.

3 Professor P McGorry, *Submission 8*, p. 1.

4 Professor P McGorry, *Submission 8*, p. 1.

> the new excise on tobacco suggests that the primary role of mental health consumers is to underwrite improvements in systems that do not meet their needs.[5]

5.5 The funding of mental health was the critical issue for many other submitters. It was acknowledged that the Commonwealth's mental health package of $175.8 million includes $25.5 million over four years for new Early Psychosis Prevention and Intervention Centres (EPPIC) and $78.8 million over four years to establish up to 30 new *Headspace* sites reaching an additional 20,000 young people a year.[6] However, the MHCA submitted that the budgetary measures do 'little to address the crisis in the mental health sector in Australia' and are not a reflection of the outcomes of the consultation process undertaken prior to the COAG agreement.[7] The MHCA concluded these initiatives 'constitute vague in-principle support and incremental increases in just a few areas of urgent unmet need'.[8]

5.6 There was also concern that much of this funding was simply redirected or re-badged funding, rather than representing new resources directed at mental health. The Australian College of Mental Health Nurses (ACMHN), for example, argued that the mental health funding component included $31.4 million in new funding and $65.4 million in restored or redistributed funding.[9] Mr David Crosbie, of the MHCA also noted that the Commonwealth is providing more funding for mental health nurses but funding had been taken away from mental health nurses in the last budget.[10]

5.7 Professor John Mendoza also commented on the level of new funding:

> In mental health, the COAG package provides just $115m new funds over four years. There is a return of some of the previously reduced funding for mental health nurses (just $13m) and a further $57m of redirected funds from the Better Access program to tally up to the headline figure of $174m.[11]

5.8 The resignation of Professor John Mendoza was reported in the press on 20 June 2010. In a front page article entitled *Rudd Adviser Quits*, the Chairman of the National Advisory Council on Mental Health tendered his resignation in a letter to Minister Roxon last Friday (18 June). He is reported as stating:

> "It is now abundantly clear that there is no vision or commitment from the Rudd Government to mental health," he wrote.

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5 Mental Health Council of Australia, *Submission 21*, p. 10.

6 Australian Government, *Budget Paper No. 2, 2010–11*, pp 234–235.

7 Mental Health Council of Australia, *Submission 21*, p. 1.

8 Mental Health Council of Australia, *Submission 21*, p. 2.

9 Australian College of Mental Health Nurses, *Submission 23*, p. 1.

10 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 103.

11 John Mendoza quoted in 'Senior advisor attacks "mad" health reform for its neglect of mental health', *Croakey*, 3 May 2010.

> "The Rudd government is publicly claiming credit for the increased investment in mental health when almost all of this is a consequence of the work of the Howard government."[12]

5.9 Professor Mendoza's letter of resignation dated 18 June 2010, and effective immediately, includes this scathing assessment of the Rudd Government's efforts:

> Two years ago when we first met to develop the work plan for the Council you requested we develop a vision for mental health, a framework for accountability, proposals to improve the Commonwealth's current mental health investments and specific proposals for new investments based on evidence and (with emphasis) consumer and carer views. The Council has also responded to the requests for advice on the revised National Mental Health Policy, the 4th National Mental Health Plan, the revised National Mental Health Service Standards, the Better Access Program and the ATAPS program. All those requests were met.
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> However, it is now abundantly clear that there is no vision or commitment from the Rudd Government to mental health. While significant improvements have been made in disability employment policy and to a lesser extent in housing and community services, there is no evidence of a change in policy or investment in mental health. The Rudd Government is publicly claiming credit for the increased investment in mental health when almost all of this is a consequence of the work of the Howard Government.[13]

5.10 The RANZCP argued that over five years, the additional funding allocated to mental health amounts to $120 million compared to $7.3 billion for health in general. The RANZCP concluded that:

> Quality and integrated mental health services cannot be achieved through such a piecemeal approach to funding. These funding differentials will only serve to widen the gap further between mental health and other health services.[14]

5.11 This concern was shared by Professor Patrick McGorry who argued that $57 million of the $58.5 million flexible care packages is pre-existing funding and that $47.5 million of the $78.8 million in *Headspace* funding represents a continuation of the existing level of funding for *Headspace*. He argued that, on this basis, the allocation to mental health care represented a widening gap between mental health care and physical health care funding.[15] Professor McGorry continued:

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12 'Prime Minister Rudd's top mental health advisor John Mendoza quits', *The Sun Herald*, 20 June 2010, p. 1. http://www.heraldsun.com.au/news/breaking-news/prime-minister-kevin-rudds-top-mental-health-adviser-john-mendoza-quits/story-e6frf7jx-1225881829753

13 http://www.theage.com.au/pdf/resignation.pdf

14 The Royal Australian & New Zealand College of Psychiatrists, *Submission 12*, p. 2.

15 Professor P McGorry, *Submission 8*, p. 2.

> The 2% of additional health funding allocated to mental health under this agreement is alarmingly small. It is one fifth of the proportion of health funding that mental health currently receives (6%) and about one tenth of the proportion of health spend recommended by the 2006 Senate Select Committee on Mental Health (up to 12%). It is less than a tenth of the share of Australia's health burden attributable to mental ill-health (13%). Such minimal growth is simply nowhere near enough to achieve any meaningful reform and better outcomes in mental health care.[16]

Unmet need for mental health services

5.12 Witnesses provided the committee with an overview of the level of unmet need for mental health services. Professor McGorry commented that there is a hidden waiting list in mental health of several million Australians including 750,000 young Australians. Lack of services for people with mental illness leads to more unnecessary and premature deaths and unnecessary disability.[17]

5.13 Mr Crosbie, MHCAH, illustrated the level of unmet need through the experience of those presenting with a mental health crisis at hospital emergency departments:

> Of the 76,000 presentations in 2006 in New South Wales emergency departments, 21,000 gained admission and 55,000 did not.[18]

5.14 Emergency departments are a first point of contact for persons seeking after hours care and those seeking assistance for the first time. However, 63 per cent were not admitted or provided with referral to another hospital. The MHRC quoted a 21 April 2010 newspaper report in *The Australian* to highlight the state that many people with mental illness would be in when they reached a hospital emergency department:

> For three days, Vittoria Tonin took a cocktail of drugs she expected would kill her, then wen it did not, she presented herself to the emergency department of the Royal Melbourne Hospital asking for help. She was 17 and in the final year of school. Although she had "some quite developed suicidal plans", the psychiatrist who saw her only offered her a late school pass.[19]

5.15 The MHCA noted that two-thirds of people with mental illness report that they didn't receive mental health care in 2006–07 whilst one in four people who made a suicide attempt did not access services for mental health problems in the previous twelve months.[20] It also highlighted the need for recovery support systems for

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16 Professor P McGorry, *Submission 8*, p. 3.

17 Professor P McGorry, *Committee Hansard*, 8.6.10, p. 17.

18 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 99.

19 Mental Health Council of Australia, *Submission 21*, p. 4.

20 Mental Health Council of Australia, *Submission 21*, p. 4.

consumers discharged from hospital without adequate assistance including that of accommodation, employment options and other support. It argued for a more integrated model for mental health services, which:

> …acknowledges the whole of life needs of consumers and which effectively links treatment to ongoing recovery outside the hospital based acute setting, would improve treatment effectiveness and long term health outcomes.[21]

5.16 The RANZCP argued that there was an 'inherent unmet need' within the population that must be considered which was:

> …approximately 60% of those with mental disorders receive no specific mental health care. Concurrent to this projections suggest that mental health related disease burden will grow markedly as a proportion of overall disease burden, and community expectation of mental health care is increasing as specific campaigns raise awareness and expectation of treatment.
>
> Substantial additional investment in the prevention, diagnosis and treatment of mental illness will achieve both health benefits for individuals and families affected by mental illness in the short and longer term, but also bring broader community benefits such as increased productivity and workforce participation.[22]

5.17 The unmet need for mental health services is not restricted to only one part of the health care system with the AMA noting that:

> There is significant unmet need in the mental health system across the service spectrum, for prevention and early intervention, to sub-acute and acute care and specialist follow-up in both community and hospital settings.[23]

Community based services

5.18 Many submitters argued that the lack of community services is the major issue underlying unmet need for mental health services. Mr Crosbie, for example, stated that over the last 15 years, the number of community treatment beds halved, not withstanding the development of the National Mental Health Strategy.[24] The level of community based residential care for people with mental illness ranges from two beds per 100,000 in two states to 24 in another.[25] Mr Crosbie went on to comment:

> We need the community programs in place that we have really run down, if anything, since we closed all the institutions. We had 30,000 acute beds for

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21 Mental Health Council of Australia, *Submission 21*, p. 6.

22 Royal Australian & New Zealand College of Psychiatrists, *Submission 12*, p. 2.

23 Australian Medical Association, *Submission 10*, p. 11.

24 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 99.

25 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 101.

> eight million people in the sixties. Many of them were beds that we would never want to recreate, of course. We are down to 8,000 acute beds for double that population and we have halved the number of community beds. If I am a frontline service provider, a GP or anyone, who do I send someone to if they present, are starting to lose touch with reality and need some time out, maybe some medication and maybe some containment? What are the options at a community level? I go to countries like New Zealand and they have community run options. They do not have to go to a hospital.[26]

5.19 The MHRC's submission highlighted the ramifications for the health system as a whole when community services are not available:

> It is the case that many people with mental illness have little access to appropriate mental and other support in their local community and increasingly become unwell. This results in a vicious cycle that leads them back to the need for acute hospital based care, which could have been averted with adequate access to treatment options and community supports.
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> Lack of strategic alternatives for many mental health consumers to adequately manage their illness in the community means that hospital emergency departments are a significant first point of contact in the mental health system.[27]

5.20 Mr Crosbie concluded:

> Everyone agrees, from the Prime Minister's statements to some of the senators sitting around this table, about the need for a greater investment at a community level, and yet I do not see that investment.[28]

5.21 SARRAH emphasised that people with chronic and severe mental health needs would be better cared for in the community if funding for community based mental health services were channelled through the PHCOs arguing that:

> To achieve better health outcomes for those with mental health problems, reforms must empower local structures in rural and remote communities to use funds flexibly and make decisions about the most appropriate packages of care.[29]

5.22 Concerns were raised regarding the $58.5 million funding directed at individual care packages which are to support up to 25,000 people. According to the Minister for Health and Ageing, the individual care packages will support clinical and

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26 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 105.

27 Mental Health Council of Australia, *Submission 21*, p. 4.

28 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 99.

29 Services for Australian Rural and Remote Allied Health, *Submission 6*, p. 5.

non-clinical care for up to 25,000 people with severe mental illness living in the community.[30] Mr Sebastian Rosenberg, for example, stated:

> The package also offered $57 million to develop tailored packages of care for 25,000 Australians with severe mental illness. Leaving aside that this amounts to $2280 per person, the exact nature of what model of care this expenditure seeks to advance eludes me.[31]

Funding for mental health services for young people

5.23 The Commonwealth has provided additional funding for *Headspace* and EPPIC. Professor McGorry stated that this was 'significant and positive in direction, but timid in scope and scale'.[32] He commented on the limited impact of the Commonwealth's proposals:

> The investment that has been announced will probably reduce by about three to four per cent the number of young Australians who are currently unable to get access to mental health care, and that is about 750,000 young Australians. So we will make some inroads, but the model that we proposed to the government earlier this year would have made a much bigger impact. Our target was to reduce the waiting list of 750,000 by about 200,000 to 250,000. Our goal was to make a much more serious inroad into that waiting list because people's lives are at stake here—young people's lives through premature suicide and death, their careers, their vocational opportunities and their families. The burden on their families is extreme…The frustrating thing is it is all preventable if we scale up these sorts of models more rapidly.[33]

5.24 Professor McGorry raised concerns regarding the practicability of the EPPIC investment model given that the 'allocated funding of $6.35m p.a. is significantly less than the cost of even one EPPIC centre (depending on scale these centres would cost between $10-20m p.a. to run)'.[34] Professor McGorry went on to comment:

> Therefore, even with co-investment by State Governments there remain significant implementation challenges to be overcome to provide young Australians with psychosis access to the most evidence based care.[35]

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30 The Hon Nicola Roxon MP, Minister for Health and Ageing, *Improving the Nation's Mental Health System*, Media Release, 20 April 2010, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/B1FD5F2BFF934FD1CA25770C0001C666/$File/nr075.pdf (accessed 21.5.10); Australian Government, *Budget Paper No. 2, 2010–11*, p. 235.

31 Sebastian Rosenberg, 'Waiting for Ruddo – mental health misses out at COAG', *Crikey*, http://www.crikey.com.au/2010/04/21/waiting-for-ruddo-mental-health-misses-out-at-coag/ (accessed 21.5.10).

32 Professor P McGorry, *Submission 8*, p. 2.

33 Professor P McGorry, *Committee Hansard*, 8.6.10, p. 14.

34 Professor P McGorry, *Submission 8*, p. 3.

35 Professor P McGorry, *Submission 8*, p. 3.

5.25 Professor McGorry argued that the recent allocation for *Headspace* and EPPIC should be increased to $200 million a year.[36] He noted that this level of funding would increase capacity to make 'sustainable inroads into a huge hidden waiting list of young Australians currently denied mental health care'.[37] Professor McGorry highlighted that the new youth mental health funding (for *Headspace* and EPPIC) translates as $13.9 million per annum over new funding to provide care to an additional 23,500 people each year. He went on to state:

> This represents just 3% of the 750,000 young Australians who experience mental ill-health each year without accessing appropriate supports.[38]

5.26 Professor McGorry also noted that:

> EPPIC is demonstrably the most evidenced based model in the spectrum of mental health care and highly cost-effective. Though it is an internationally acclaimed Australian innovation that has been implemented in hundreds of centres across the world over the past 15 years, it has not yet been made available to the Australian population, except in heavily diluted fashion in Victoria.[39]

5.27 The MHCA held a similar view arguing that the 'welcome endorsement for proven youth mental health models is not matched by appropriate funding levels'.[40] It continued that there were good practice models that informed the recommendations of the 2006 Senate Select Committee inquiry into mental health services and the report of the NHHRC. It was also noted that:

> What is urgently needed now is serious consideration of why such services are not the norm in Australia's mental health system today and the implementation changes to the funding system that support this status quo.[41]

5.28 The concern that the initiative would only reach an estimated three per cent of young people with mental ill health was shared by the Mental Health Council of Australia.[42]

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36 Professor P McGorry, *Submission 8,* pp 1–2.

37 Professor P McGorry, *Submission 8,* p. 1.

38 Professor P McGorry, *Submission 8,* p. 2.

39 Professor P McGorry, *Submission 8,* p. 1.

40 Mental Health Council of Australia, *Submission 21*, p. 2.

41 Mental Health Council of Australia, *Submission 21*, p. 3.

42 Mental Health Council of Australia, *Submission 21*, p. 2.

Need for further reform

5.29 Witnesses commented on significant underlying problems within the mental health system and stated that the Commonwealth's proposals do not address these problems.

5.30 Professor Patrick McGorry argued that mental health has been 'largely neglected' and that there was a 'mismatch between the urgency to act, scale of the need and power of Government rhetoric on the one hand and the timidity of action on the other'.[43] The MHCA similarly commented:

> …despite the rhetoric, state, territory and Australian governments do not seem to be committed to providing appropriate mental health services for consumers and carers or the Australian community.[44]

5.31 The MHCA also stated that 'the disconnect between the policy documents, the words, the plans and people's experiences is huge'.[45]

5.32 The MHCA argued strongly that since the release of the National Health and Hospitals Reform Commission final report in July 2009 and development of the National Health and Hospital Network, the focus of the Government has been on the hospital sector with 'only limited changes in the form of new funding initiatives to the mental health sector'.[46] The MHCA continued that:

> These announcements are not the strategic approach to reform that is needed in the sector. They do little to address the cycle in which mental health funding is used to support the increasing need for acute services in the hospital sector and little to address the urgent areas of unmet need in mental health, particularly in the community sector. If use of mental health funding in this way continues to remain a priority for state, area, local health services and hospitals, the access to mental health services, community support and early interventions that are so desperately needed will continue to remain elusive.[47]

5.33 Professor Patrick McGorry also commented on the focus on the hospital system, in particular, the increase in funding to decrease hospital waiting lists by a relatively small amount while the 'hidden' waiting list in mental health is much more serious. Professor McGorry stated:

> I just think it is logically bizarre that we see billions of dollars invested in reducing waiting lists by this much in the acute hospital system while we

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43 Professor P McGorry, *Submission 8,* p. 4.

44 Mental Health Council of Australia, *Submission 21*, p. 10.

45 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 97.

46 Mental Health Council of Australia, *Submission 21*, p. 1.

47 Mental Health Council of Australia, *Submission 21*, p. 2.

> have got hundreds of thousands and even millions of Australians whose lives are at risk because of that other waiting list being totally neglected.[48]

5.34 Professor McGorry also questioned why this 'critically underperforming area of Australian healthcare has been largely neglected – with only confusing and unconvincing reasons offered to date'. He also stated that:

> It also remains unclear as to whether the Government has a plan to address this neglect. The current 4th National Mental Health Plan is manifestly inadequate and lacks vision, priorities and any evaluative framework of goals, targets and indicators or mechanism for accountability.[49]

5.35 Professor McGorry maintained that a new mental health investment program was needed which has an 'explicit overarching goal of ensuring Australia's mental health system is progressively scaled up to meet the same standards of quality and accessibility as our physical health system by 2020'.[50] He continued that:

> Until the Government announces a clear vision of mental health reform and a plan with specific targets to achieve it, and a serious growth strategy, confidence will continue to drain away from the mental health sector.[51]

5.36 Professor McGorry also argued that that health reform without mental health reform is 'both unfair and unlikely to succeed'. Professor McGorry stated:

> Better mental health means that we are more likely to enjoy better physical health. When we do become physically ill our stays in hospital are much shorter if our mental health is better. On top of that, these physical health benefits are further enhanced with better personal and social outcomes such as better career and educational success and reduced incidence of unplanned pregnancies, homelessness, violence and stress on families. It is actually a no-brainer that we need to invest in both physical and mental health care.
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> However, most Australian communities are provided with an outdated model of health care that seeks to heal bodies but neglects minds…Australians are two to three times more likely to access quality care for physical health as for mental health. In other words, there is a huge discrepancy that is unfair, produces worse health and social outcomes and, perhaps more importantly from the point of view of the government at the moment, it wastes precious resources. This neglect is terribly wasteful. We have very good cost effectiveness studies showing that money is saved by early investment is mental health care.[52]

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48 Professor P McGorry, *Committee Hansard*, 8.6.10, p. 17.

49 Professor P McGorry, *Submission 8*, p. 1.

50 Professor P McGorry, *Submission 8*, p. 1.

51 Professor P McGorry, *Submission 8*, p. 4.

52 Professor P McGorry. *Committee Hansard*, 8.6.10, p. 9.

5.37 Professor David Penington argued that the recommendations of the 2006 Senate Select Committee on Mental Health inquiry report in relation to mental health funding should be revisited.[53]

5.38 The Consumers Health Forum of Australia also raised concerns in relation to what it saw as a lack of integration of mental health as part of the reform package:

> CHF is concerned by the absence of significant new mental health funding in the 2010-11 Budget, and the lack of any detailed plans around mental health as part of the National Health and Hospitals Network. We argue that it is essential that mental health is included as a fundamental element of the National Health and Hospitals Network, so that mental health care and treatment are integrated with the models of health services delivery.[54]

5.39 Submitters raised a number of other issues in relation to mental health services. The MHCA noted for example, that there was a need for greater accountability mechanisms to drive mental health reform. The MHCA argued:

> There is little or no comprehensive national public reporting of significant areas of interest to mental health consumers and carers such as health outcomes or service quality indicators. This means that there is little urgency for change and no way of evaluating the outcomes of initiatives that are implemented.[55]

5.40 In evidence, Mr Crosbie commented further that there were no measures of people's mental illness in Australia and what happens to them. There is limited data on use of mental health services 'but we do not know whether [people with mental illness] got better, how beneficial those interactions were and the degree to which it actually meets needs'. Mr Crosbie concluded:

> …it is this public transparency and accountability about people's experience of mental illness, their attempts to access care and the quality of care they get that need to be accurately documented or at least reflected if we are going to get real reform.
>
> I must say the health minister has made some quite powerful statements about the need to better document and to be more transparent and we strongly support those statements, but we are yet to see that reflected in the kinds of processes that have led to this agreement so we have real concerns about the degree to which they are going to offer the benefit that they potentially offer because there is a lack of transparency and a lack of accountability.[56]

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53 Professor D Penington, *Submission 7*, p. 9.

54 Consumers Health Forum of Australia, *Submission 2*, p. 3.

55 Mental Health Council of Australia, *Submission 21*, p. 7.

56 Mr D Crosbie, CEO, Mental Health Council of Australia, *Committee Hansard*, 7.6.10, p. 98.

5.41 The Dietitians Association of Australia noted that as a high proportion of consumers with mental health conditions also have co-morbidities, some of which develop as a side effect of pharmaceutical intervention, there needs to be a 'concomitant allocation of funding for allied health services such as dieticians to prevent and treat obesity, diabetes, and cardiovascular disease'.[57]

5.42 The ACMHN raised concerns that the coordinated care packages under the Access to Allied Psychological Services (ATAPS) program were to be introduced at the expense of removing mental health Social Workers and Occupational Therapists from the Better Access initiative, noting moreover, that mental health nurses working under the ATAPS were 'well placed to provide coordinated care packages as well as mental health Social Workers and Occupational Therapists'.[58]

5.43 The RACGP welcomed the funding for adolescent and young adult mental health services but lamented the lack of recognition and support for the role that GPs play in the early detention and treatment of mental illness and of the need for coordination between GPs, allied health professionals and other community support services.[59] The RACGP argued that the Medicare Benefits Scheme needs to be appropriately structured to allow GPs to dedicate time required to assess and understand their patients' mental health needs, provide cognitive and/or pharmaceutical treatment, and that of ongoing monitoring of their patients' condition.[60]

Conclusion

5.44 The promised leadership on mental health by the Commonwealth has evaporated. What has emerged with the announced reforms is a small, incremental change to the system which will do very little to address inequity in access to services and decrease unmet need for mental health services.

5.45 The committee notes the comments by Professor Patrick McGorry who pointed to the excellent evidence-based programs which are available in this country that, if provided with adequate funding could have a tremendous, positive impact for those Australians with mental illness. In particular, expanded funding for the *Headspace* and EPPIC programs would see many more young people access services.

5.46 The committee also notes that there is overwhelming evidence that the benefits of providing increased access for young people far outweigh the additional cost to the health budget. The reduction of disability, the improvement in survival rates, the decrease in use of services and improved outcomes point to the high cost effectiveness of early intervention programs. Professor McGorry stated that the costs

57 Dietitians Association of Australia, *Submission 5*, p. 2.

58 Australian College of Mental Health Nurses, *Submission 23*, p. 1.

59 Royal Australian College of General Practitioners, *Submission 15*, p. 3.

60 Royal Australian College of General Practitioners, *Submission 15*, p. 3.

are three times as much over an eight-year period if a person goes through the normal late intervention system.[61]

5.47 The committee considers that the Commonwealth has not delivered on its promise of reform of mental health services. Indeed, Professor Mendoza's comments in his letter of resignation show that the Rudd Government has not only failed to deliver, but is also falsely claiming achievements of the Coalition Government as its own:

> It is now abundantly clear that there is no vision or commitment from the Rudd Government to mental health…
>
> The Rudd Government is publicly claiming credit for the increased investment in mental health when almost all of this is a consequence of the work of the Howard Government.[62]

5.48 Rather than honesty and accountability from the Rudd Government, the empty rhetoric continues and inadequate levels of mental health services remain.

61 Professor P McGorry, *Committee Hansard*, 8.6.10, p. 12.

62 Mendoza Letter to Minister Roxon 18 June 2010, can be found at: http://www.theage.com.au/pdf/resignation.pdf