CHAPTER 2

MENTAL HEALTH – THE CASE FOR CHANGE

2.1   This committee is neither the first to inquire into Australia's mental health services, nor the first to find them wanting. When the Human Rights and Equal Opportunity Commission (HREOC) conducted an inquiry into human rights and mental illness (generally known as the Burdekin Report) in the early 1990s, it found serious problems in the area of mental health. The Commission concluded that:

> In general, the savings resulting from deinstitutionalisation have not been redirected to mental health services in the community. These remain seriously underfunded, as do the non-government organisations which struggle to support consumers and their carers…Poor inter-sectoral links, the ambivalent stance of the private sector and a reluctance on the part of government agencies to co-operate in the delivery of services to people with mental illness have contributed to the alarming situation described in this report. While the Inquiry welcomes the initiative recently taken by governments in endorsing a *National Mental Health Policy* and *Plan*, a major injection of resources will be needed before we are in a position to comply with our international obligations under the UN Principles for the Protection of Persons with Mental Illness.[1]

2.2   In the time that it took Burdekin and the HREOC to conduct that inquiry, federal, state and territory governments cooperated to produce the National Mental Health Strategy. Signed off by governments in 1992, the aims of this strategy are to:

> Promote the mental health of the Australian community;

> To, where possible, prevent the development of mental disorder;

> Reduce the impact of mental disorders on individuals, families and the community; and

> Assure the rights of people with mental disorder.[2]

2.3   The Final Report of the 1997 Evaluation of the first National Mental Health Strategy indicated that when the National Mental Health Strategy was first implemented in 1992, mental health services were 'in a poor state'.[3] However, while mental health services had improved the evaluation recognised that the strategy had

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1   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, p. 908.

2   Australian Health Ministers, *National Mental Health Plan 2003–2008*, 2003, p. 6.

3   National Mental Health Strategy Evaluation Steering Committee, *Evaluation of the National Mental Health Strategy Final Report*, 1997, p. 1.

'raised awareness of previously hidden problem areas' and that much work remained to be done.[4]

2.4   The 2003 evaluation of the Second National Mental Health Plan was, if anything, less positive in outlook. While recognising a range of achievements, it said:

> However, the extent and pace of progress has not universally been viewed as satisfactory. In particular, the national community consultations reveal a high level of dissatisfaction. However, it should be noted that progress has been constrained by the level of resources available for mental health and by varying commitment to mental health care reform. While the aims of the Second Plan have been an appropriate guide to change, what has been lacking is effective implementation. The failures have not been due to lack of clear and appropriate directions, but rather to failures in investment and commitment.[5]

2.5   Around that same time, the Mental Health Council of Australia released its *Out of Hospital, Out of Mind!* report. This was a collaborative effort of the Mental Health Council of Australia, a national peak non-government organisation (NGO) for consumers, carers, professional associations and health care providers, and the Brain and Mind Research Institute. The report made a harsh judgement of the results of reforms over the previous decade:

> For over ten years, our national policy and government-driven reform processes have championed the appropriate move to non-institutional forms of care. The findings from this national and comprehensive consultation are stark. The overwhelming perception of those who currently use or provide services is that we have now arrived at a position of 'OUT OF HOSPITAL, OUT OF MIND!'. That is, one of the most chronically disadvantaged groups in this country continues to be ignored. After two five-year National Mental Health Plans this does not represent a failure of policy, but rather a failure of implementation. This includes poor government administration and accountability, lack of ongoing government commitment to genuine reform and failure to support the degree of community development required to achieve high quality mental health care outside institutions.[6]

2.6   Two years later this was followed by a second collaborative report *Not for Service*, released on 19 October 2005, which was similarly scathing about consumers' experiences in the mental health system. It concluded that 'after 12 years of mental

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4   National Mental Health Strategy Evaluation Steering Committee, *Evaluation of the National Mental Health Strategy Final Report*, 1997, p. 1.

5   Steering Committee for the Evaluation of the Second National Mental Health Plan, *Evaluation of the Second National Mental Health Plan*, 2003, p. 3.

6   G. Groom, I. Hickie, and T. Davenport. *'Out of Hospital, Out of Mind!' A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008*, Canberra, Mental Health Council of Australia, 2003. p. ii.

health reform in Australia, any person seeking mental health care runs the serious risk that his or her basic needs will be ignored, trivialised or neglected'.[7]

2.7   Another major mental health NGO, SANE Australia, produced an annual report on progress in mental health service provision and stigma reduction. It was even more blunt in its assessment of the state of mental health services:

> Mental health services are in crisis to varying degrees all around Australia, barely able to cope with people experiencing acute episodes of illness, let alone provide ongoing treatment and support…
>
> The National Mental Health Strategy is in retreat on many fronts, with old-style psychiatric institutions still in place, community-based services being drawn back into hospitals, prison psychiatric units being built instead of discrete forensic hospitals, and prisons becoming de facto psychiatric institutions.[8]

2.8   While there had been inquiries and strategies at the national level, individual states and territories have also examined aspects of mental health in their jurisdictions, with reports often preceding significant policy initiatives. These inquiries have included:

- In NSW, a Legislative Council Inquiry into Mental Health Services[9]

- In NSW, the NSW Auditor General's report on emergency mental health services[10]

- In Victoria, the Victorian Auditor General's Inquiry on Mental Health Services for People in Crisis[11]

- In the Northern Territory, the review of the NT Department of Health and Community Services[12]

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7   Mental Health Council of Australia and the Brain and Mind Research Institute, *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia: Summary*, Mental Health Council of Australia, Canberra, 2005, p. 12.

8   SANE Australia, *Dare to Care! SANE Mental Health Report 2004*, p. 1, http://www.sane.org/images/assets/Research_reports_and_images/MHR2004text.pdf (accessed January 2006).

9   New South Wales, Parliament. Legislative Council. Select Committee on Mental Health, *Inquiry into mental health services in New South Wales*, 2002, http://www.parliament.nsw.gov.au/prod/parlment/committee.nsf/4bb1ef733c6a672cca256e420 066a938/f742b6b2e561abdeca256c73002b7f87!OpenDocument (accessed January 2006).

10   New South Wales, Auditor General, *Performance Audit: Emergency Mental Health Services*, October 2005, http://www.audit.nsw.gov.au/publications/reports/performance/2005/mental_health/mentalhealt h-contents.html (accessed January 2006).

11   Victoria, Auditor General, *Mental Health Services for People in Crisis*, October 2002, http://www.audit.vic.gov.au/reports_par/agp81cv.html (accessed January 2006).

- In South Australia, the South Australian Ombudsman's Inquiry into Treatment of Mental Health Patients[13]

- In South Australia, a Legislative Council Select Committee Inquiry into Assessment and Treatment Services for People with Mental Health Disorders[14]

- In Western Australia, the review of the *Mental Health Act 1996* and the *Criminal Law (Mentally Impaired Defendants) Act 1996*[15]

- In Western Australia, a Legislative Council Inquiry into Mental Health Services[16]

- In Tasmania, the *Bridging The Gap* Report, a review of mental health services in Tasmania.[17]

2.9   Despite the many plans, and the progress made, analysis of mental health in Australia in the National Mental Health Report found that:

- Since 1993, mental health has not increased its shared of health spending

- There remains a high level of need in the community for mental health services

- There is uneven expenditure on mental health between and within states and territories, which is even more uneven when it comes to the utilisation of NGOs

- The reduction in stand-alone psychiatric facilities (which was an objective of the National Mental Health Strategy) has taken place alongside increased

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12   Banscott Health Consulting, *Report of the Review of the Northern Territory Department of Health and Community Services,* 2003, http://www.nt.gov.au/health/dept_review/index.shtml (accessed January 2006).

13   South Australian Ombudsman, *Annual Report 2001-02: Section 26 Reports*.

14   South Australia, Legislative Council, *Select Committee inquiry into Assessment and Treatment Services for People with Mental Health Disorders, Interim Report*, 16 February 2006, http://www.parliament.sa.gov.au/committees/committee.asp?doCmd=show&intID=113 (accessed February 2006).

15   C.D.J. Holman, J.S. Titmus, J. Rapp, *The Way Forward. Synthesis of the Review of the Mental Health Act* 1996. Perth: Government of Western Australia, 2003, http://www.health.wa.gov.au/mhareview/reports/index.cfm (accessed January 2006).

16   Western Australia, Legislative Council. Standing Committee on Environment and Public Affairs, 2004, *A Petition on the Provision of Mental Health services in Western Australia - Interim Report*, Tabled Paper No. 2899.

17   Tasmania, Department of Health and Human Services, *Bridging the Gap: Review of Mental Health Services*, October 2004, http://www.dhhs.tas.gov.au/agency/publications/documents/mhs_review2004%5B1%5D.pdf (accessed January 2006).

demand for mental health care, 'in particular, for acute inpatient care', something regarded by consumers and carers as 'needing urgent attention'.[18]

Issues central to the inquiry

2.10   This committee heard an enormous range of evidence, about many different issues. On some questions there was strong consensus, on others there was vigorous disagreement. Many of the issues raised in the reports and reviews outlined above remain critical and seriously in need of attention.

2.11   There is an urgent need for **more mental health services**. Whatever debates there are about what those services should be, there is consensus that at present there is simply not enough mental health care. The point was often made that in no other sector of health care would it be regarded as acceptable that 60 per cent of people with needs received no service. Even more frequently it was pointed out that the proportion of the health budget spent on mental health care bears no relation to the proportion of the disease burden attributable to mental illness. It is all very well to say, as some did, that there should not be a direct relativity between those two indicators,[19] but no one has mounted a credible defence of the current level of spending. Given the decades of under-spending in infrastructure, the mental health workforce and services and the fact that mental illness causes a greater level of years lived with disability than any other category of disease, it should surely be a spending priority: if anything, it might be expected to get more than a proportionate share of the budget. Instead, it has been suggested that 'it is likely that overall mental health spending as a proportion of national health spending is now actually declining'.[20]

2.12   The limited **resources available are not always well utilised**. The 'revolving door syndrome' described by many witnesses suggests the current focus almost exclusively on the most seriously ill is not working. Psychiatrists are scarce outside capital cities. General practitioners (GPs) are more readily available but only a small proportion have undertaken more than rudimentary training in mental health. Clinical psychologists, however, are largely excluded from Medicare rebate funded services, despite their capacity to deliver evidence-based treatment particularly for high prevalence disorders.

2.13   Public psychiatric hospital beds are scarce, yet many are occupied by people who should be treated by more suitable lower cost services. While acute bed shortages are very common, the neglect of timely, early stage intervention may be responsible for much of that acute demand.

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18   Department of Health and Ageing, *National Mental Health Report 2005*, p. 7.

19   Mr Philip Davies, Acting Secretary, Department of Health and Ageing, *Committee Hansard*, 7 October 2005, p. 53.

20   I. Hickie, G. Groom and T. Davenport, *Investing in Australia's Future: The Personal, Social and Economic Benefits of Good Mental health – Summary*, December 2004, p. 9.

2.14   Case workers typically have too many consumers, placing strains on the quality of the attention they give.

2.15   The non-government sector has the potential to be more than just a minor player as its role in some other countries shows. Consumers are not sufficiently engaged in the design and delivery of services. Families, carers and consumers are not always recognised, supported or even consulted.

2.16   **Deinstitutionalisation has not been achieved**. At worst, Australia has shifted care for the seriously ill from stand-alone psychiatric institutions to prisons. The rate of mental illness amongst inmates is unacceptably high. Further, while beds in public stand-alone psychiatric hospitals have shrunk, private ones have expanded, albeit offering services to people with much less debilitating illnesses than those now being admitted to the public system. The committee received little evidence to suggest that the incomplete form of deinstitutionalisation practised in Australia had improved health or welfare outcomes. Low levels of employment and high rates of homelessness are just two of the indicators of failure, not of deinstitutionalisation but of what was supposed to be the provision of at least comparable mental health services in the community to which seriously ill people had been released.

2.17   To be clear, the committee does not doubt the necessity to end the century-old practice of locking people with mental illness away with little expectation of recovery or reintegration into society.

2.18   **Mainstreaming has its limitations.** Most acute care beds are now provided in psychiatric wards of general hospitals. However the environments of these wards can be less than therapeutic for seriously ill people in disturbed states.

2.19   Mobile crisis teams set up in some states now typically attend fewer crises, for under-resourcing and security related reasons, and are more likely to be found in over-stretched accident and emergency departments of general hospitals. The committee heard alarming accounts of the physical and chemical restraint of patients due to lack of expertise in treating people with mental illness, lack of acute psychiatric beds and the inappropriateness of emergency department settings for those experiencing serious and psychotic episodes.

2.20   Community-based mental health centres in NSW, along with their resources, are being mainstreamed onto sites in hospital grounds despite the difficulty of accessing them and a reluctance to visit those facilities by the many people whose previous experience in hospitals was negative. The committee received little evidence that stigma was reduced through this kind of mainstreaming.

2.21   There is **inadequate community-based care**. Expansion of community-based services is supposed to be part of mental health policy, but there has been a lack of funding and commitment to this objective.

2.22   The National Mental Health Strategy was developed in response to clear evidence that community-based treatment has better health outcomes and less life

disruption for the majority of individuals with acute and long-term mental illness. The evidence also suggests that brief admissions to acute psychiatric wards within general hospitals backed up by ready access to 24 hour clinical services and a well-staffed range of supported residential facilities in the community, including in the person's home, is superior to hospital-centred care, particularly that provided in stand-alone psychiatric facilities. The committee notes that this approach is in line with the Australian National Mental Health Service Standards but that no state or territory has yet provided local community-based care in any comprehensive way.

2.23   The National Mental Health Strategy aimed to not only shift services from institutions to local communities but to recognise the right of people to live in the 'least restrictive' circumstances and to develop strong links with groups of consumers, families, GPs, the non-government sector and local services like housing, general disability services, social security and employment.

2.24   People with mental illness are treated in some states as outpatients in public area mental health services but, as with inpatient beds, services are stretched and available only to the most unwell. Others, it is expected, will be treated as private patients by GPs and psychiatrists. However, shortages of doctors, particularly those willing and able to deal with often complex psychiatric conditions and to bulk bill for their services, make this an inadequate response. The ideal of publicly funded, integrated teams of psychiatrists, psychologists and psychiatric nurses who can respond in a timely fashion with accurate assessment and effective treatment of a wide range of mental health conditions is missing. Lack of respite and rehabilitation beds, discharge planning from hospital and clinical support in short and medium term supported accommodation and work opportunities contribute to the expensive, revolving door syndrome of repeat acute care admissions.

2.25   For the not-insignificant minority who are severely disabled by their illness and need ongoing secure care, it is considered by the committee that there should be adequate, spacious secure sites in the environment of general hospitals where patients have access to a range of rehabilitative services and general physical health care. These are in addition to secure forensic facilities, which while different in some respects, should also provide rehabilitative services and have the ability to ensure general physical health care needs are met.

2.26   **Prevention is definitely better than cure**. Everyone seems agreed on the value of raising awareness of mental illness, of reducing stigma, and of prevention and early intervention programs. Such initiatives are frequently cited as being both clinically effective and less costly. However, it is not clear that funding is following this clinical consensus. This type of program is being trialled, but there is room for further expansion. However, data has already shown that many people currently do not seek treatment for their illness, and there is little point striving for reduction in the stigma and increased awareness, if people find there is no support available when they take the first step toward getting help. Stigma reduction and education campaigns will need to be matched with growth in resources for treatment.

2.27   Quality of care appears to **vary greatly from place to place**. The availability of health care professionals, particularly those other than GPs, plummets outside the capital cities. Each state and territory has its services organised differently, and the range in quality of treatment between jurisdictions surprised and at times disturbed the committee. Some health care institutions have unacceptable standards of care. The National Mental Health Strategy appears not to have made any difference to marked differences in care and treatment across a patchy and fragmented system. It was said that many states had still not implemented the first National Mental Health Plan and were years behind leaders such as Victoria in service delivery. The response to criticisms and mental health crises by many governments has been to fund pilot projects and offer short-term grants for worthwhile programs. This work is rarely evaluated or funded more universally.

2.28   **Some mental illnesses receive more attention than others**, in part as a result of the focus on 'serious mental illness' in the National Mental Health Strategy.[21] Across the country, the Committee heard about people with borderline personality disorder experiencing discrimination and lack of effective treatment. Particular conditions such as obsessive compulsive disorder, self harming, post-natal depression and often fatal eating disorders lack specialised treatment support and get lost in the current attention on psychotic mental illnesses.

2.29   **Service silos are preventing effective care**. This problem is most serious in the areas of dual diagnosis and the justice system. People with drug or alcohol problems as well as mental illness are shuffled between services unable and sometimes unwilling to treat both conditions. Dual diagnosis is still not effectively addressed, despite it being the expectation rather than the exception amongst people with mental illness, particularly those ending up in the criminal justice system. Police cells, courts and jails are filling with those experiencing mental illness, who are getting inadequate treatment or none at all in environments that are anything but therapeutic. Those in jail are frequently discharged with little or no transitional support, increasing the chances of recidivism, not to mention the cost of what is often a high level of seclusion and surveillance afforded them in prison.

2.30   **Some people get more mental health care than others**. The complex needs of asylum seekers, particularly if they are in immigration detention, have not been adequately catered for, although the committee is pleased by recent reforms in this area. Cases such as that of Cornelia Rau highlight how some people, whether suspected illegal immigrants or the homeless, are less likely to be considered as potentially having a mentally illness, and less likely to receive proper diagnosis and treatment. Spending on mental health in children and youth is not commensurate with prevalence or opportunities for early intervention. There is also a significant divide between rich and poor. People who are poor and/or do not have private health insurance have fewer treatment options, and appear particularly unlikely to be able to

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21   See for example, Australian Health Ministers, *National Mental Health Plan 1992*, April 1992, Section 2.

afford ongoing treatment for anxiety disorders or depression. Nowhere is this more evident than in Indigenous communities.

2.31   The **dominant medical model is hampering improvement** in mental health care. Psychiatry, while central to the treatment of mental illness, by its own admission is not always able to explain many of the causes and pathways of mental illness. The Committee discerned much frustration among consumers and carers that, despite the persistence of the mysteries of the mind, psychiatric responses often seem rigid and unaccommodating of alternative approaches. Pharmaceutical treatments are certainly improving but their use is also growing at extremely rapid rates, as is Commonwealth expenditure under the Pharmaceutical Benefits Schedule yet psychologists qualified to deliver evidence-based 'talking therapies' are significantly under-utilised in publicly-funded mental health care. Australia has very few psychotherapists and alternative therapies get short shrift, despite some evidence of success. As in other fields of medicine, there must be a move toward more multidisciplinary care approaches to health, and a move away from the narrow medical model. There is a need to counter the effects of stigma due to poor knowledge of appropriate interventions for mental illness among health professionals, as well as among the public. Consumers are often marginalised in the design and conduct of research and the evaluation of treatments.

2.32   These are some of the recurrent themes expressed by many different groups and individuals as the committee travelled around the country The experiences related to the committee, and the facts set out for it, were depressingly similar to those presented in the Burdekin Report ten years earlier. However, there has been progress as well.

Recent initiatives around the country

2.33   The harsh criticisms made by HREOC, the Mental Health Council of Australia and others, and the limited progress documented in reports on mental health services, are well founded. Nevertheless, there have also been successful and substantial initiatives taken by NGOs and by state, territory and federal governments in recent years.

2.34   The non-government sector has been responsible for putting forward many good programs and ideas for combating mental illness. It has been at the forefront of seeking to make the goals of the National Mental Health Strategy a reality. Examples brought to the committee's attention include:

- Partnerships in community-based care, bringing clinical care together with accommodation and other services[22]

- Programs aimed at addressing interactions between mental illness, drug dependency and homelessness[23]

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22   An example visited by the committee was the partnership between the Mental Illness Fellowship Victoria and the Goulburn Valley Area Health Service, at Shepparton.

- Mental illness awareness and education programs[24]

- Online support services for consumers or carers[25]

- A range of services in which consumers are playing key roles[26]

- Training programs, such as mental health first aid.[27]

2.35   There are many government initiatives in the area of mental health, discussed below, and in later chapters. Overall, the great breadth of the goals in National Mental Health Plans makes it difficult to assess the extent to which government initiatives systematically address priority needs. New proposals seem patchy, not consistent between jurisdictions, and sometimes lack sustainable funding (discussed further in Chapter 4). With inadequate funding in the system as a whole, and an overemphasis being placed on acute care, established programs may well be valuable but limit expenditure in other worthy areas.

2.36   The Australian Government expressed its role in addressing and managing mental health in Australia as providing leadership on mental health issues at the national level and to fund programs.[28] This includes medical and pharmaceutical benefits funding, the delivery of primary care services through GPs, the provision of funding through the Australian Health Care Agreements, and programs to support special needs groups. The Australian Government also provides a range of other programs such as income support, social services and housing assistance programs.

2.37   Since the launch of the National Mental Health Strategy, recurrent government expenditure on mental health from 1992-93 to 2002-03 has increased by 73 per cent (real terms).[29] The largest item of Commonwealth expenditure and area of fastest growth has been the subsidising of medicines under the Pharmaceutical Benefits Scheme. Commonwealth initiatives have included:

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23   Examples include the Homeless and Drug Dependency Trial initiated in Melbourne by Hanover Welfare Services, the Salvation Army and St Vincent de Paul. Hanover Welfare Services, *Submission 403*, pp. 9–10.

24   Mental Illness Education ACT, *Submission 354*; Dr Simon Bridge, *Submission 500*.

25   depressioNet, *Submission 475*; ANU Centre for Mental Health Research, *Submission 186*; beyondblue, *Submission 363*; beyondblue, http://www.beyondblue.org.au/index.aspx (accessed March 2006).

26   Many of the NGO programs included consumers as consumer researchers, consultants and advocates.

27   Professor Anthony Jorm and Ms Betty Kitchener, *Submission 47*.

28   Australian Government, *Submission 476,* p. 1.

29   Department of Health and Ageing, *National Mental Health Report 2005*, p. 21.

- National standards for mental health services, with a review of almost 50 per cent of all public service mental health services completed and 40 per cent currently under review.[30]

- A national system of reporting on mental health resources and services.[31]

- Introduction of new Medicare items through the *Better Outcomes in Mental Health* program and mental health training funding for participating GPs.[32]

- Funding for consumers and carers to attend key mental health conferences and forums.[33]

- A review of State and Territory-based legislation to ensure consistency with United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.[34]

2.38   State and Territory Governments essentially deliver and manage mental health services within their respective jurisdictions.[35] Since the launch of the National Mental Health Strategy, each jurisdiction has implemented reforms and recent initiatives include:

2.39   **Victoria**

- Primary Mental Health and Early Intervention Teams to assist primary health providers in the recognition of mental illness at an early stage and provide specialist consultation.[36]

- $3.5 million provided on an annual basis to *beyondblue*, the NGO promoting community awareness of depression, its treatment and prevention.[37]

- Funding for projects tracking population attitudes (anti-discrimination, promotion of economic participation and social inclusion for particular groups including refugees, young people, rural, indigenous and older people) and research assessing the effectiveness of mental health care initiatives.[38]

- Funding some newer pharmaceuticals not covered under the Pharmaceutical Benefits Scheme.[39]

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30   *Submission 476,* p. 18.

31   Australian Government, *Submission 476,* p. 52.

32   *Submission 476,* pp.10–11, 33.

33   *Submission 476,* p. 3.

34   *Submission 476,* p. 3.

35   *Submission 476,* p. 1.

36   Victorian Minister for Health – Victorian Government, *Submission 445,* pp. [6,] [11].

37   *Submission 445,* p. [6].

38   *Submission 445,* p. [12].

39   *Submission 445,* p. [9].

- $5 million to deliver psychiatric disability rehabilitation and support services to assist people with mental illness, their families and carers.[40]

2.40 Queensland

- Development of the Queensland State Forensic Mental Health Plan and Standards[41] and the creation of new mental health positions in associated areas.[42]

- 'Implementation of the Voluntary Referral Program for mental health.'[43]

- Launch of *Project 300,* to assist in rehabilitating people undergoing extended psychiatric treatment.[44]

- Inpatient beds redistributed into regional centres[45] and the Queensland Centre for Rural and Remote Mental Health established to deliver programs to people in regional areas.[46]

- Establishment of Crisis Intervention Teams between the Queensland Police Service and health service agencies[47] and Mental Health Child Safety Support Teams.[48]

- Funding a post-graduate psychiatry program to increase the number of specialist trainees across the State.[49]

2.41 Western Australia

- Enhanced interactions between mental health service providers, consumers, carers and funding groups.[50]

- Significant capital works undertaken to reform community services.[51]

- Implementation of 'routine collection of consumer outcome measures' and training of mental health workers in using the system.[52]

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40 *Submission 445A,* p. [3].

41 Queensland Government, *Submission 377A,* p. 74.

42 Queensland Government, *Submission 377,* pp.24–25, 29.

43 *Submission 377A,* p. 74.

44 *Submission 377A,* pp. 23–5, 74.

45 *Submission 377A,* p. 4; *Submission 377,* p. 13.

46 *Submission 377A,* p. 65.

47 *Submission 377A,* pp. 12, 74.

48 *Submission 377A,* p. 10.

49 *Submission 377,* p. 33.

50 Department of Health – Government of Western Australia, *Submission 376,* p. 6.

51 *Submission 376,* p. 6.

52 *Submission 376,* p. 8.

2.42   **Northern Territory**

- The *Northern Territory Criminal Code (Mental Impairment and Unfitness to be Tried) Act 2002* amended to ensure offenders with a mental health illness are assessed and treatment is available in the 'least restrictive' environment.[53]

- The Mental Health and Substance Misuse Project commenced in 2004, bringing together mental health providers with organisations treating substance abuse.[54]

- The new Primary Health Care Service was established in Darwin to link mental health consumers with GPs in the community.[55]

- Revised policies and procedures have been implemented for risk assessment, complaints management and provision of information to consumers and carers.[56]

- Modifications to address safety issues in inpatient facilities are complete, or nearing completion.[57]

2.43   **ACT**

- As part of the ACT's comprehensive forensic mental health model, the *Criminal Code (Mental Impairment) Amendment Bill 2006* was introduced on 16 February 2006, clarifying definitions of mental impairment for offenders and alleged offenders.[58]

- $20 million to NGOs for mental health services and non-clinical support, such as education, supported accommodation and respite, and counselling.[59]

- Discharge planners in inpatient units to assist in the transition of inpatients back into the community.[60]

- Additional mental health officer positions across mental health care services.[61]

- Mobile Intensive Treatment Teams to support consumers living in the community who have high level needs.[62]

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53   Northern Territory Government, *Submission 393,* p. 25.

54   *Submission 393,* pp. 31–32.

55   *Submission 393,* p. 32.

56   *Submission 393,* p. 31.

57   *Submission 393,* p. 31.

58   Mr Jon Stanhope, Chief Minister Australian Capital Territory, *Forensic Mental Health Model Takes Step Forward,* 16 February 2006. http://www.chiefminister.act.gov.au/

59   Minister for Health – ACT Government, *Submission 165,* pp. 2–3; Minister for Health – ACT Government, *Submission 165A,* p. 5.

60   *Submission 165,* p. 3.

61   *Submission 165,* p. 4.

- The MindMatters School Project to increase awareness and understanding of mental health issues in schools and other educational institutions.[63]

- From 1 July 2005, a system to monitor the use of seclusion and restraint of people with a mental illness.[64]

- New campaigns to increase the recruitment and retention of specialist mental health staff.[65]

2.44 **NSW**

- The Integrated Services Project for Clients with Challenging Behaviour pilot program to assist people with a mental illness with long term housing support and care.[66]

- Mental Health – Clinical Care and Prevention model released, estimating the number of people in age groups with mental illness and linking the varying levels of severity with treatments required from mental health care providers.[67]

- Funding to NGOs to deliver community services.[68]

- A range of initiatives addressing the needs of people with both a mental illness and a substance abuse disorder.[69]

- Pilot programs specially targeting people with a mental illness who are from culturally and linguistically diverse backgrounds.[70]

- Skilling the mental health care workforce through training programs, including a Graduate Certificate in Mental Health for General Practitioners.[71]

- Community Forensic Mental Health Service established to provide consultation and case management.[72]

- An exposure draft of a new Mental Health Bill for NSW (which was to be tabled in late 2005,[73] but now expected in the first half of 2006).

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62 Minister for Health – ACT Government, *Submission 165,* p. 4.

63 *Submission 165,* p. 5.

64 Minister for Health – ACT Government, *Submission 165A,* p. 15.

65 *Submission 165,* pp. 5–6.

66 NSW Health – NSW Government, *Submission 470*, p. 6.

67 *Submission 470*, p. 18.

68 *Submission 470*, p. 31.

69 *Submission 470*, p. 41.

70 *Submission 470*, p. 42.

71 *Submission 470*, p. 32.

72 *Submission 470*, p. 50.

73 *Submission 470*, p. 7.

2.45   **South Australia**

- 'an Australian-first pilot program between mental health services and ambulance services of specially trained crews of mental health staff and ambulance paramedics who are available (initially only in the northern and southern metropolitan areas) to attend call-outs to crisis situations throughout the night'.[74]

- $25 million extra in grant monies for non-government community health services in 2004/2005'.[75]

- A pilot project on 'Perinatal and Infant Mental Health in the Community'.[76]

- Reforms in the area of supported accommodation.[77]

- A Memorandum of Understanding between the Commonwealth (Department of Immigration and Multicultural Affairs) and the State Government of SA (Department of Health) for health services to immigration detainees.[78]

- A Magistrates Court Diversion Program and planning for new forensic mental health facilities.[79]

2.46   **Tasmania**

- 62 packages of care to support clients to live in the community.

- A 12 bed high support community facility in Launceston.

- 12 bed cluster houses for supported accommodation in the South and the North West Coast.

- A total of 48 new clinical positions across a range of mental health care settings.

- $3.78m to drive quality and safety improvements, assist with the application of the Mental Health Act and develop a mother and baby service.

- $4.52m to upgrade existing mental health and NGOs' facilities and services.[80]

- Acceptance of recommendations and action to be taken to reform Ward 1E at Launceston General Hospital, which had been the subject of complaints.[81]

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74   Department of Health – South Australia Government, *Submission 506*, p. 3.

75   *Submission 506*, p. 4. More details were given in Department of Health – South Australia Government, *Submission 506A*.

76   *Submission 506*, p. 4.

77   *Submission 506*, p. 6.

78   *Submission 506*, p. 10.

79   *Submission 506*, p. 16. See Magistrates Court of South Australia *Submission 175* for more detail on this initiative.

80   Tasmanian Government, *Submission 502*, p. 7.

81   *Submission 502*, pp. 7–8.

2.47   The committee thus recognises that efforts are being made in the area of mental health, indeed it sought examples of good practice that are expanded upon elsewhere. It recognises, too, that there are some signs that the pace of improvement is increasing. As Professor Ian Hickie recently remarked, the ground is shifting rapidly, and 'finally…the situation has some hope of genuinely changing'.[82]

2.48   Nevertheless, the committee encountered a widespread dissatisfaction with the state of service, and a strong consensus for the need for further change. The view is widespread that more resources are needed in mental health, but also that the way resources are used needs to change. Chapter 4 outlines how mental health is resourced and discusses how it might be reformed. Later chapters tackle many questions surrounding how resources need to be directed and what services need to be expanded. The conclusion to this report discusses future directions for mental health in the context of the National Mental Health Strategy.

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82   Ruth Pollard, 'Out of the wilderness for mental health', *Sydney Morning Herald*, 26 January 2006, p. 2.