The Senate

# Select Committee on Mental Health

## A national approach to mental health – from crisis to community

**Final report**

April 2006

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# Chapter 1

# Introduction

1.1 This is the second and final report of the Senate Select Committee on Mental Health, complementing the first report, tabled in the Senate on 30 March 2006.

## Terms of reference

1.2 On the 8 March 2005, the Senate created a Select Committee on Mental Health, to conduct a wide-ranging inquiry into:

(a) the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;

(b) the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

(c) opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

(d) the appropriate role of the private and non-government sectors;

(e) the extent to which unmet need in supported accommodation, employment, family and social support services, is a barrier to better mental health outcomes;

(f) the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

(g) the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

(h) the role of primary health care in promotion, prevention, early detection and chronic care management;

(i) opportunities for reducing the effects of iatrogenesis and promoting recovery-focused care through consumer involvement, peer support and education of the mental health workforce, and for services to be consumer-operated;

(j) the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

(k) the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;

(l) the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

(m) the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

(n) the current state of mental health research, the adequacy of its funding and the extent to which best practice is disseminated;

(o) the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards; and

(p) the potential for new modes of delivery of mental health care, including e-technology.

1.3 The committee was initially asked to report to the Senate by 6 October 2005. However a strong public response to the committee's work led the Senate on 18 August 2005 to extend the committee's reporting deadline to 30 March 2006. A further extension was granted on 1 March 2006, allowing the committee to report at any time prior to 28 April 2006.

## Two reports – a package of reforms

1.4 As the committee's inquiry progressed, the urgent need for reform in the area of mental health gathered momentum in the eyes of the public and among governments. In February 2006 the Council of Australian Governments (CoAG) agreed to initiate a rapid process of discussion and policy development on mental health, with an action plan to be developed by June 2006. The committee was committed to ensuring that its inquiry and findings had a significant influence on this important reform process. It therefore decided to divide its report into two parts. The first report, *A national approach to mental health – from crisis to community*, was tabled in the Senate on 30 March 2006. That report, representing the bulk of the committee's work, provided a wide-ranging review of many aspects of mental health care in Australia and delivered a set of important, unanimous recommendations that the committee believes should be addressed in the CoAG reform process.

1.5 This second, and final, report sets out further detailed recommendations that arise from the committee's inquiry and findings in particular areas of concern. These recommendations are no less important than those set out in the first report.

1.6 In delivering its first report in March 2006, the committee intended that all levels of government have ample opportunity to ensure that the report's recommendations are acted upon within the current CoAG reform process. Important key directions, including substantial increases to mental health funding, the establishment of community-based mental health centres and multi-disciplinary treatment teams, and funding of national bodies for monitoring and accountability, consumer and carer advocacy and mental health research were set out in the first report. This report provides further recommendations for action, within the broader framework set out in the first report. The committee now looks forward to governments acting upon the full suite of recommendations set out in the combined reports.

## Recent developments

1.7 The committee is pleased to note the Prime Minister's announcement on 5 April 2006 of federal funding of $1.8 billion over five years to improve mental health services in Australia. The committee notes that the announced commitments, including increased access to psychologists and other mental health professionals working in multi-disciplinary teams, increased services for families and carers, increases in the mental health workforce and community awareness programmes respond in part to a number of the committee's recommendations. It is important that the government now ensures that the detail of the announced commitments meets the real community needs of consumers, carers, families and others, presented in the committee's first report.

1.8 It is also important that state and federal governments now work together to implement the committee's full range of recommendations. The committee heard repeatedly throughout its inquiry that a collaborative, integrated response is required to achieve outcomes in the area of mental health.

## Structure of the second report

1.9 In order to comprehensively represent the committee's findings and recommendations, Chapter 2 of this report presents the recommendations of *A national approach to mental health – from crisis to community*. Chapter 3 sets out the committee's further conclusions and recommendations.

1.10 This report is much shorter than the first. It does not attempt to summarise the important and complex issues canvassed in the first report. However, the committee does wish to repeat in this report its thanks to all those who contributed to the inquiry. This committee has received overwhelming community support. Consumers, carers, families, peak bodies, professional groups, health care providers, government departments and many other individuals made submissions and gave their time to share their knowledge and expertise. Many people opened their lives to share with us personal, often traumatic, experiences and we are deeply grateful.

# Chapter 2

## Recommendations of *A national approach to mental health – from crisis to community*

2.1 On 30 March 2006 the committee's first report, *A national approach to mental health – from crisis to community*, was tabled in the Senate. This chapter presents the recommendations contained in that report.

### Seeking CoAG agreement on more community care

**Recommendation 1**

**2.2 The committee recommends that COAG initiates:**

- **A substantial overall increase in funding for mental health services over time, to more closely reflect the disease burden and to satisfy the very significant unmet need.**

  **Note: evidence suggests that the mental health budget should, by 2012, reach between 9 and 12 percent of the total health budget and whilst significant investment is required in mental health in the short to medium term, it is anticipated that early intervention and community-based care would deliver savings in the long term.**

- **From this additional funding, the establishment of a *Better Mental Health in the Community* initiative, comprising a large number of community-based mental health centres, the distribution primarily determined on the basis of populations and their needs. (Assuming populations of around 60 000, this would represent 300 to 400 community based mental health centres nationwide.) The *Better Mental Health in the Community* program should be rolled out over 4-5 years with governments contributing as follows:**

  - **States and territories to provide infrastructure for and ongoing management of mental health centres**
  - **Commonwealth to establish new direct Medicare recurrent funded arrangements for employed or contracted mental health staff in these centres – psychiatrists, psychologists, general practitioners (GPs), psychiatric nurses and social workers – with the expectation that services would be provided at times of greatest demand, including after hours and on weekends.**

- **The linking of resourcing for mental health to the two principles of rights to services, and responsiveness to needs of populations, including:**

  - **Establishment of defined mental health regions nationwide and commit to equitable mental health funding to each, basing this on Health Needs Index weightings.**

- **Development of population-specific budgets, mental health plans and evidence based protocols for children, youth, aged, culturally and linguistically diverse (CALD) communities and Indigenous people.**
- **Definition of benchmark ratios of mental health professionals to populations, based on analysing numbers needed to meet the population's mental health care needs now and in the medium and long term, recognising the range of health professions relevant to the sector.**
- **Designation of an agreed number and distribution of community based mental health centres for youth 12 to 25 years of age, those with dual diagnoses and for specialist geriatric and Indigenous mental health, where appropriate.**

- **The Australian Government reform the Better Outcomes initiative to include a new set of Medicare mental health schedule fees and rebates for combinations of private consulting psychiatrists, GPs and psychologists who agree to work together or in conjunction with mental health centres under integrated, collaborative arrangements in the management of primary mental health services. Consideration should be given to the Divisions of General Practice managing the reformed Better Outcomes, perhaps restructured as Divisions of Primary Health.**

## Developing mental health strategies

2.3 The above recommendation lies at the heart of the committee's vision of a mental health care system that is more accessible, more community centred and better resourced. However, more coordinated and effective planning should also pay big dividends for mental health, including reforms to the National Mental Health Strategy, as well as developing concrete plans in some specific areas of mental health.

**Recommendation 2**

**2.4 The committee recommends that the Australian Health Ministers agree to:**

- **Reform the National Mental Health Strategy (NMHS) to guarantee the right of people with mental illness to access services in the least restrictive environment, to be actively engaged in determining their treatment and to be assisted in social reintegration and underpin those rights with legislation.**
- **Include in the next NMHS Plan specific, measurable targets and consumer and/or health outcomes that are monitored and reported on annually.**
- **Agree to develop specific national mental health action plans for addressing child and adolescent, youth, aged, CALD communities and Indigenous Australians.**

- **Ensure that the objectives in the next NMHS Plan increase emphasis on delivery of community care, prevention and early intervention, providing a more appropriate balance between these services and acute and emergency care.**
- **Integrate the NMHS, National Drug Strategy, National Suicide Prevention Strategy and the National Alcohol Strategy and the delivery of services under these strategies.**
- **Agree that building public mental health services of high quality and high regard is a key to addressing mental health workforce issues.**

**Recommendation 3**

**2.5 The committee recommends that the Australian Health Ministers agree to establish a timeline and implementation plan for the National Statement of Principles for Forensic Mental Health**

## Advocacy, monitoring and research

2.6 The committee heard extensive evidence of the need to strengthen consumer advocacy, improve mental health research, and create more rigorous monitoring of the implementation of mental health policy objectives. The committee is of the view that a range of organisations can contribute to achieving these goals. The following recommendation aims to spread a range of tasks across some existing, and some new, organisations that work on mental health and human rights.

**Recommendation 4**

**2.7 The committee recommends that Australian Health Ministers agree to**

- **Fund and empower the *Mental Health Council of Australia* to:**
  - **report annually on progress under the NMHS**
  - **conduct annual independent investigation, monitoring and reporting of services and Commonwealth/state expenditure**
  - **identify gaps in service provision, training and performance of the workforce, and**
  - **report on measurable targets such as suicide rates, homelessness, use of involuntary treatment orders, medication rates for high prevalence disorders, incarceration rates, and rates of engagement in education and the workforce.**
- **Establish and fund a *National Mental Health Advisory Committee* made up of consumers, carers and service providers to:**
  - **advise CoAG on consumer and carer issues**
  - **be an advocate for mental wellbeing, resilience and illness prevention**
  - **promote consumer involvement in service provision**

- **promote the recovery model in mental health**
- **promote community and school-based education and stigma reduction, and**
- **promote and manage mental health first aid programs aiming for 6% of the population to be trained and accredited, targeting those with the greatest probability of coming in contact with mental health issues – teachers, police, welfare workers, and family carers.**

- **Establish and fund a joint *Commonwealth-State Mental Health Institute* to**
  - **develop a prioritised national framework for research and pilot programs**
  - **review evidence-based research on health needs and cost effectiveness of treatments**
  - **disseminate best practice service standards, and**
  - **assist with establishing service targets and integration of services.**
- **Provide recurrent funding to the *Human Rights & Equal Opportunity Commission* (HREOC) to:**
  - **monitor human rights abuses and discrimination in employment, education and service provision of those with mental disability**
  - **liaise with state and federal ombudsmen to identify trends and systemic failures that give rise to complaints, and**
  - **investigate discrimination against people with mental illness in Supported Accommodation Assistance Program (SAAP), respite and private and public rental housing,**

2.8 The committee believes other measures should also be introduced that would strengthen leadership and consumer advocacy in mental health, including the following:

**Recommendation 5**

**2.9 The committee recommends that Australian Health Ministers agree to recognise mental health as a designated ministerial responsibility in federal, state and territory departments of health**

**Recommendation 6**

**2.10 The committee recommends that state and territory governments agree to harmonise Mental Health Acts relating to involuntary treatment and admission 'sectioning', and establish inter-state arrangements for treatment where the strict application of state and territory responsibility can mean far longer distances must be travelled to access services than could be the case.**

**Recommendation 7**

**2.11 The committee recommends that all governments establish benchmarks for the employment of consumer and carer consultants in mental health services, including forensic mental health services, and that all service providers have formal mechanisms for consumer and carer participation.**

2.12 Progress in mental health reform will rely on being able to assess the changing nature of mental health service provision, and on boosting the mental health research effort significantly. The committee believes that better information and research about mental health is something that could be a useful part of a CoAG package of reforms.

**Recommendation 8**

**2.13 The committee recommends that the Australian Institute of Health and Welfare should collect comprehensive data on mental health service provision such as the number of people receiving treatment and the nature of that treatment, public and private, and on population wide indicators of mental health and wellbeing.**

**Recommendation 9**

**2.14 The committee recommends that the Australian Government increase funding to the National Health and Medical Research Council (NHMRC), to enable an increase in research funding on mental health from $15 million,[1] at least doubling it to $30 million per year.**

## Other joint government initiatives

2.15 The committee heard about a host of other reforms and service delivery proposals that could deliver better mental health services. They have been discussed throughout the first report. In its first report the committee mentioned two that it believed would require cooperative action by governments and could be considered as part of the current CoAG process.

**Recommendation 10**

**2.16 The committee recommends that Australian Health Ministers consider the creation of a national emergency 1800 telephone helpline, resourced to provide mental health crisis responses 24 hours a day, 7 days a week and staffed by personnel with expertise in mental health.**

1 A. Jorm, K. Griffiths, H. Christensen and J. Medway, 'Research priorities in mental health, Part 1: an evaluation of the current research effort against the criteria of disease burden and health system costs', *Australian and New Zealand Journal of Psychiatry*, vol. 36, 2002, p. 325.

**Recommendation 11**

**2.17 The committee recommends that Australian Health Ministers agree that funding for SAAP be increased overall, and that there be dedicated resources within that funding for clients with complex needs including dual diagnosis.**

## Recommendations for specific governments

The committee put forward the following recommendations for Australian, state and territory government action, for consideration within the context of CoAG negotiations:

***Further recommendations for specific Australian Government action***

**Recommendation 12**

**2.18 The committee recommends that the Australian Government**

- **Increase the number of funded places and financial incentives in accredited medical and allied health training courses to meet future mental health workforce demands.**
- **Substantially increase job support for people with mental illness, recognising its therapeutic value and provide tax incentives for businesses employing people with mental illness.**
- **Fund public education campaigns and programs for prevention and reduction in substance abuse.**
- **Consider tax incentives, wage replacement schemes and other financial support for employers to provide more flexible transitions into work, in hours worked, timing of work and workload and the provision of mental health services for those employees needing assistance in the workplace.**

***Further recommendations for state and territory government action***

**Recommendation 13**

**2.19 The committee recommends that state and territory governments**

- **Establish more respite and step up/step down accommodation options in conjunction with the federal government *Better Mental Health in the Community* program.**
- **Provide long-stay in-patient facilities with a focus on rehabilitation for patients with severe and chronic mental disability, co-located with general hospitals but set in spacious, home-like environments.**
- **Ensure safe environments for consumers in acute, long-stay and emergency settings, including gender and age group separation.**
- **Provide specialised mental health and dual diagnosis spaces or departments (as appropriate) within emergency departments in general hospitals.**

- **Establish more longer term supported, community-based housing for people with mental illnesses with links to community mental health centres for clinical support.**
- **Increase funding to establish more detoxification and rehabilitation services for people with drug and alcohol abuse disorders.**
- **That there be specialized inpatient facilities for people with dual diagnosis.**
- **Establish specialised programs within designated community mental health facilities to treat conditions such as eating disorders, perinatal depression and personality disorders.**
- **Transfer responsibility for mental health in general prisons to the department within each state or territory with portfolio responsibility for health.**
- **Increase levels of consumer involvement in mental health services, including consumer representation at all levels and provision of funding to consumer-run mental health services.**

2.20 The committee hopes this report will be a step forward in the process of improving mental health services in Australia. It looks forward to the adoption of the recommendations included here by CoAG and by all Australian governments.

# Chapter 3

# Further recommendations

3.1 In this chapter, the committee makes a large number of recommendations. They reflect the wide and detailed terms of reference given to the committee by the Senate, the large number of issues brought to the committee, and the intensive interest shown by many individuals and organisations in the committee's work.

3.2 The following recommendations arise out of evidence received, as set out in submissions and hearings, and reflected in the committee's extensive first report. They have been grouped according to the major themes of the inquiry.

3.3 There were many cases where the committee was asked to give its backing to particular programs or support expansion of specific initiatives. While in some outstanding cases certain programs are singled out for special mention, on the whole the committee preferred to focus on principles and types of service, rather than particular practices or service providers. The fact that some services are not mentioned by name should not be taken to mean the committee was not supportive of their work.

3.4 The committee is confident that all parties involved in mental health will take notice of and respond to the recommendations. It believes that it is imperative that all Australian Health Ministers recognise and acknowledge that genuine collaboration between all levels of government is necessary to address the current 'crisis' in mental health service delivery. The committee looks forward to closer partnerships between the many professions involved in mental health care, including doctors, psychologists, nurses, social workers, counsellors and occupational therapists. And it looks forward to a health care system that produces better outcomes for consumers and carers.

## Monitoring and research

**Recommendation 14**

**3.5 That over the next three years, all states and territories:**

- **report on service providers' performance against the National Standards for Mental Health Services;**
- **review the National Standards (as agreed in the Second National Mental Health Plan but not so far delivered);**
- **include in the review development of performance indicators for mental health inpatient and dual diagnosis services which focus on the effectiveness of treatment, discharge plans and follow up in the community; and**
- **implement and report against these indicators.**

**Recommendation 15**

**3.6 That all states and territories review their systems of monitoring and reporting on the extent of use of seclusion and restraint (based on agreed definitions), with each jurisdiction to publicly report the extent of use on a regular basis.**

**Recommendation 16**

**3.7 That an evaluation of the effectiveness of online services, for example depressioNet and MoodGym be undertaken, with a view to promoting such services as integral components of primary mental health care services, and to enhance access to mental health services in rural and remote areas.**

## Consumers' rights and roles

**Recommendation 17**

**3.8 That policies and procedures be implemented that will reduce the use of involuntary and coercive treatment, particularly where physical and chemical restraints are used and where drugs have harmful side effects.**

**Recommendation 18**

**3.9 That the Human Rights and Equal Opportunity Commission (HREOC) be requested to complete its important work on advance directives and protocols that would recognise the rights of consumers to, for instance, identify substitute decision-makers, appropriate treatments and other financial, medical and personal decisions, particularly for the care of children.**

**Recommendation 19**

**3.10 That the *National Mental Health Advisory Committee* and *Commonwealth-State Mental Health Institute* work collaboratively to ensure that consumers are routinely involved in the design and conduct of mental health research and the evaluation of treatments.**

## Prevention and early intervention

**Recommendation 20**

**3.11 That the Australian Government allocates recurrent funding to ensure prevention and early intervention programs in the education system are ongoing, including funding for evaluation and continuous improvement of these programs.**

**Recommendation 21**

**3.12 That the Department of Health and Ageing:**

- **review *MindMatters* in secondary schools, and on this basis consider expanding it to all schools, including an equivalent program in primary schools; and**

- **examine the feasibility of expanding the *MindMatters Plus* and *MindMatters Plus GP* initiatives nationwide.**

**Recommendation 22**

**3.13 That the Australian Government fund and implement a nationwide mass media mental illness stigma reduction and education campaign.**

## Community treatment

**Recommendation 23**

**3.14 That state and territory governments and mental health service providers significantly increase the use of the assertive community treatment model and active case management to support people with severe and prolonged mental illness to live in the community.**

**Recommendation 24**

**3.15 That local government provide leadership through endorsement of the creation of community-based services for people with mental illness in their jurisdictions, and through helping overcome stigma and community resistance to such services.**

**Recommendation 25**

**3.16 That all jurisdictions implement appropriate legislative reforms to ensure Community Treatment Orders can be given effect, regardless of the state or territory that the person with mental illness may be located in at a given time.**

**Recommendation 26**

**3.17 That reporting of 'community based services' in the National Mental Health Report be revised to separately identify ambulatory and any other 'community' care services provided at general hospitals including at outpatient services.**

**Recommendation 27**

**3.18 That state and territory governments refrain from dismantling community-based mental health services, for co-location with general hospitals.**

## NGOs

**Recommendation 28**

**3.19 That with respect to the non-government, not-for-profit sector:**

- **the sector be given a greater role in delivering mental health services;**
- **governments recognise the problems associated with the short-term, non-recurrent grant approach to funding and move to more secure funding decision-making, based on evaluations of effectiveness; and**

- **at a minimum that grants to NGO mental health providers be indexed based on the CPI.**

**Recommendation 29**

**3.20 Further to recommendation 10 in the committee's first report, support be provided for base load recurrent funding for specialist telephone services, assessed on a case by case basis.**

## Workforce and training

**Recommendation 30**

**3.21 That the Australian Government, after consultation with the sector, consider funding stand-alone specialist degrees for mental health nurses as an alternative to current post-graduate specialisation.**

**Recommendation 31**

**3.22 That supported placements for nursing and allied health students be provided in mental health services.**

**Recommendation 32**

**3.23 That current undergraduate nursing programs be reviewed to ensure greater consistency and increased content in the psychiatric components offered in courses (currently they vary from between zero and 17.4 per cent).**

**Recommendation 33**

**3.24 That, as a priority, the number of funded positions available in postgraduate programs in psychiatric/mental health nursing be increased.**

**Recommendation 34**

**3.25 That universities work collaboratively with general practices and community mental health facilities to expand temporary work placement programs for postgraduate psychology and other allied health students.**

## Crisis response

**Recommendation 35**

**3.26 That mobile intensive treatment teams or crisis assessment teams be adequately resourced to provide mental health crisis responses 24 hours a day, 7 days a week, minimising the need for police and ambulance attendance and, in many cases, avoiding inpatient admission.**

## Treatment responses

**Recommendation 36**

**3.27 That access to effective non-pharmacological treatment options be improved across the mental health system through:**

- **Better access to therapies (including so-called 'talking therapies') provided by psychologists, psychotherapists and counsellors with particular attention to therapy for people with histories of child abuse and neglect; and**
- **Greater investment in research of alternative treatments.**

## Housing

### Recommendation 37

**3.28 That federal, state and territory governments ensure that the full range of short, medium and long-term supported accommodation is available to those with mental illness who need it. Modes of innovative service delivery that should be considered include:**

- **The Housing and Support Initiative (HASI), a joint initiative between the NSW departments of Health and Housing and local NGOs, providing coordinated disability support, accommodation and health services to people requiring high-level support to live in the community. A 12-month trial in South Eastern Sydney showed a decrease in inpatient bed days for patients enrolled in HASI from 197 days to 32 days.[1]**
- **The *Project 300* program, conducted in Queensland to assist 300 consumers to move from psychiatric treatment and rehabilitation facilities to the community. The 18-month evaluation reported 'improved well being for people with significant disability' and following discharge, 'individuals continued to demonstrate improvements in symptoms, clinical functioning and quality of life. Remarkably few disadvantages for the clients were identified. Only 3 of the 218 clients discharged returned to long-term care'.[2]**

### Recommendation 38

**3.29 That each state and territory establish formal measures to better manage public and private tenancies to address the needs of people with mental illness living in the community.**

### Recommendation 39

**3.30 That each state and territory provide specialist crisis accommodation services for people with dual diagnosis and complex conditions involving disruptive behaviour.**

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1 NSW Health – NSW Government *Submission 470,* p. 33.

2 *Submission 288*, Attachment Two 'Evaluation of 'Project 300', p. 17.

## Employment and income support services

**Recommendation 40**

**3.31 That disability open employment service arrangements be reviewed, to consider:**

- **creation of a regular automatic provider review process;**
- **increasing funding;**
- **the results-based performance reporting in disability open employment providers' service agreements, to take account of the episodic nature of mental illness; and**
- **removal of funding caps for providers who demonstrate high demand for their services and the capacity to respond effectively to that demand.**

**Recommendation 41**

**3.32 That the federal, state and territory governments sponsor a regular forum for disability open employment providers, consumers and carers, to facilitate information and knowledge exchange in relation to employment assistance for people with mental illness.**

**Recommendation 42**

**3.33 That nationwide workplace education and advocacy programs be rolled out to counter workplace stigma and promote employment for people with mental illness.**

**Recommendation 43**

**3.34 That the Australian Government review the services of the Commonwealth Rehabilitation Service and the compliance requirements of NewStart and Youth Allowance to ensure that they address the special needs of people living with enduring and episodic mental illnesses.**

**Recommendation 44**

**3.35 That the Australian Government review the extent to which experiences of mental illness, dual diagnosis and homelessness impact upon people's ability to access the Disability Support Pension.**

## Families and carers

**Recommendation 45**

**3.36 That government health, welfare and income support agencies recognise the special needs and income and cost implications of caring for people with mental illness, in determining eligibility for, and amount of, carers' allowance available.**

**Recommendation 46**

**3.37 That each jurisdiction establish a register of community care services delivered within the public, private and NGO sectors, to be made a available as a resource for consumers and carers.**

**Recommendation 47**

**3.38 That recurrent funding is provided to develop and disseminate community-based programs providing peer support, training and information to carers and families, addressing issues such as education about the causes of, treatments for and recovery from mental illness, support services available, building family resilience and parenting skills, and meeting the special needs of young carers.**

**Recommendation 48**

**3.39 That governments increase targeted, intensive programs for high risk parents such as those with personality disorder, substance abuse disorders and parents with a history of abuse and neglect.**

**Recommendation 49**

**3.40 That funding be allocated to develop and expand services specifically designed for supporting children who have a parent or parents with mental illness.**

**Recommendation 50**

**3.41 That there be an evaluation of the effectiveness of the *Parentline* telephone counselling service that assists parents and carers in Queensland and the Northern Territory with behavioural management, parenting skills, and interpersonal relationships, with the view to expanding the service across all states and territories.**

**Recommendation 51**

**3.42 That better links be created between child and maternal health services and mental health services, and funding be provided for programs to assist families identified through maternal and child health services as having, or at risk of, mental health issues.**

**Recommendation 52**

**3.43 That there be a commitment to the provision of mental health services for care leavers recommended in the Senate Community Affairs References Committee Report *Forgotten Australians, A report on Australians who experienced institutional or out-of-home care as children*.**

**Recommendation 53**

**3.44 That the Australian Health Ministers agree to establish a national post-natal depression helpline and provide recurrent funding for its operation.**

**Recommendation 54**

**3.45 That the Australian Health Ministers develop a national strategy for perinatal health services, including early identification, intervention, prevention and education and support of new parents regarding perinatal mental illness.**

## Paying for mental health care

**Recommendation 55**

**3.46 That the Australian Government reviews the adequacy of benefits for psychiatric illnesses among health insurance products, and take action to outlaw products that are not 'fit for purpose'.**

**Recommendation 56**

**3.47 That the Australian Government review the arrangements governing the portability of benefits between health funds where a contract of service between a health fund and a private hospital or provider ends, so as to increase the opportunity for patients to remain with their existing mental health specialist if they so choose.**

## Justice system

**Recommendation 57**

**3.48 That there be a significant expansion of mental health courts and diversion programs, focussed on keeping people with mental illness out of prison and supporting them with health, housing and employment services that will reduce offending behaviour and assist with recovery.**

**Recommendation 58**

**3.49 That responsibility for the decision to release forensic patients be placed routinely with mental health courts or mental health tribunals within each state and territory.**

**Recommendation 59**

**3.50 That state and territory governments aim as far as possible for the treatment of all people with mental illness in the justice system to take place in forensic facilities that are physically and operationally separate from prisons, and incorporate this aim into infrastructure planning, and that the Thomas Embling Hospital in Victoria be used as a model for such facilities.**

**Recommendation 60**

**3.51 That the Australian, state and territory governments review funding for prescription medicines and medical care to examine anomalies and differences in quality of care between community primary care and care currently provided in prisons.**

**Recommendation 61**

**3.52 That governments establish protocols for mental health assessments for prisoners on entry into the criminal justice system.**

**Recommendation 62**

**3.53 That the *Commonwealth-State Health Research Institute* in conjunction with forensic mental health services investigate best practice models for the delivery of forensic mental health care to adolescents.**

**Recommendation 63**

**3.54 That the states establish separate dedicated forensic mental health facilities for women with a number of beds that reflects the prevalence of women with mental illness in prisons.**

**Recommendation 64**

**3.55 That HREOC be tasked to undertake a national review of the treatment of women with mental health problems within the criminal justice and prison systems.**

**Recommendation 65**

**3.56 That state and territory governments, taking into account best practice models, substantially increase the provision of step-down supported accommodation programs to facilitate reintegration into the community following release from incarceration and forensic facilities.**

## Dual diagnosis

**Recommendation 66**

**3.57 That a more holistic approach be taken in community-based mental health centres, particularly those for young people, integrating other related services, peer supports and drug and alcohol services with mental health services.**

**Recommendation 67**

**3.58 That in reforming the Better Outcomes in Mental Health program the Australian Government considers mechanisms which enable general practitioners and other mental health professionals to provide services not only in private practices but also in environments targeting youth needs.**

**Recommendation 68**

**3.59 That the state and territory governments reform dual diagnosis services to achieve greater consistency, and that the Mental Health Council of Australia, in reporting on progress under the National Mental Health Strategy, report state specific progress in the reform of dual diagnosis services.**

**Recommendation 69**

**3.60 That state and federal governments agree on and implement a national action plan to upgrade skills for assessment, referral and treatment of dual diagnosis, including:**

- **the development of training modules for dual diagnosis for undergraduate nurses and other allied health professionals;**
- **the development of nationally consistent training modules in dual diagnosis for mental health and drug and alcohol service providers;**
- **incentive-based training opportunities for general practitioners to build knowledge of dual diagnosis.**

**Recommendation 70**

**3.61 That state and federal governments facilitate within their service agencies:**

- **training on the implementation of service protocols and memoranda of understanding at a local level;**
- **rotation of staff across agencies in the different service sectors to promote cross-skilling; and**
- **targeted strategies to increase numbers and upgrade skills among Indigenous health care workers to address the complex needs of Aboriginal and Torres Strait Islander communities.**

**Recommendation 71**

**3.62 That undergraduate and postgraduate medical courses give greater emphasis to the specific needs of people with developmental disabilities who are affected by mental illness, and that centres of expertise be established to improve assessment and treatments.**

## Children and youth

**Recommendation 72**

**3.63 That governments promote education and awareness training for health care providers and the community on the risks of pharmacological mental health treatment for children and young people and ensure the availability of family supports and alternative therapies.**

**Recommendation 73**

**3.64 That, utilising expertise from clinical psychology, clinical psychiatry and institutes of mental health research, standardised risk assessment tools and processes for identifying at-risk children be developed specifically for use in a range of community and health settings.**

**Recommendation 74**

**3.65 That the Australian Government commits recurrent funding to ensure the future sustainability of the National Youth Mental Health Foundation.**

## Older people

**Recommendation 75**

**3.66 That governments develop and provide education and awareness training for health care providers, aged care providers and the community on mental health problems in older Australians.**

## CALD communities and refugees

**Recommendation 76**

**3.67 That state and territory mental health services provide CALD consumers, their carers and families with information on their rights under state and territory legislation in an understandable manner appropriate to their language and culture.**

**Recommendation 77**

**3.68 That the Australian Government review funding levels to providers of mental health services to refugee communities, to ensure those levels reflect the high levels of need amongst this population.**

**Recommendation 78**

**3.69 That appropriate assessment protocols for CALD consumers be developed and disseminated to increase the capacity of primary care providers to detect and manage the early signs and symptoms of mental health problems and mental illness.**

**Recommendation 79**

**3.70 That culturally specific mental health services be developed in partnership between all levels of government, migrant resource centres and other organisations, including the Forum of Australian Services for Survivors of Torture and Trauma.**

**Recommendation 80**

**3.71 That funding be provided to develop and disseminate throughout CALD communities translated information delivered in a variety of media about early signs and symptoms of mental health problems and mental disorders, where to get help and how to provide support.**

**Recommendation 81**

**3.72 That**

- **there be a review of health care policies for the delivery of health care for refugee and asylum seekers in both the Australian community and**

**Australian run detention centres, with a view to developing more culturally sensitive and comprehensive policies and standards that recognise the complex needs of asylum seekers; and**

- **there be consideration of providing access to Medicare rebates during refugee determination processes.**

## Rural and remote

**Recommendation 82**

**3.73 That there be wider availability of community information, services, and initiatives for raising awareness of mental health issues in rural and remote areas.**

**Recommendation 83**

**3.74 That in determining the allocation of community-based mental health centres and ratios of mental health professionals to populations (Recommendation 1) remoteness and other factors of disadvantage be included in the formulae.**

**Recommendation 84**

**3.75 That greater flexibility in the allocation of Medicare provider numbers for mental health service provision (for instance psychiatric nurse practitioners and counsellors), is exercised in rural and remote areas in recognition of the shortage of psychiatrists and psychologists in these areas.**

**Recommendation 85**

**3.76 That state and territory governments provide and support greater training to the existing medical workforce in the treatment of mental illness and ensure that the special needs of people with mental illness are considered when acute care services in rural areas are being reviewed.**

**Recommendation 86**

**3.77 That ongoing incentives and supports be provided to GPs and mental health professionals to promote working in rural and remote areas.**

**Recommendation 87**

**3.78 That a review be commissioned into the adequacy of income support and travel assistance allowances for carers in rural and remote areas, who have to travel long distances to access treatment and support.**

**Recommendation 88**

**3.79 In recognition that in rural areas police and ambulance services often attend and manage crisis situations without specialist assistance, ensure that rural police and ambulance services are a high priority for mental health first aid training.**

## Indigenous

**Recommendation 89**

**3.80 That 'Indigenous only' education venues for Indigenous health workers are adequately funded and supported to provide collaborative, culturally affirming learning environments for Indigenous people. Consideration should be directed to extending the capacity of facilities such as the Bachelor Institute Indigenous College, the Djirruwang Program at Charles Sturt University, or the introduction of scholarships for Indigenous health professionals, and incorporation of Indigenous Health curriculum in mainstream courses.**

**Recommendation 90**

**3.81 That governments fund the *Commonwealth-State Mental Health Institute* in collaboration with the National Aboriginal Community Controlled Health Organisation to research the most effective means of addressing Indigenous mental health needs, including the development of appropriate diagnostic tools for assessment of mental illness among the Indigenous population, collection of data and provision of information.**

**Recommendation 91**

**3.82 That governments direct recurrent funding to Indigenous community controlled health services to administer the development, implementation and evaluation of appropriate mental health programs.**

Senator Lyn Allison
Chair

# Appendix 1

## Submissions and answers to questions on notice

This appendix provides a list of additional submissions and answers to questions on notice received after 30 March 2006. The answers to questions on notice have been accepted and numbered as additional submissions.

The appendix also lists submitters who provided submissions in the form of a standard letter.

### Submissions

377B Queensland Government

502A Tasmanian Department of Health and Human Services

559 The Royal Australasian College of Physicians, Australasian Faculty of Public Health Medicine

560 Community Living Association

***Proforma letters***

***Submissions from care leavers (Submission 370)***

As noted in its first report, the committee received many submissions in the form of a standard letter from people who spent time in institutional and foster care during childhood. The following submitters provided these letters:

Marion Hopwood
Ms Rhonda Griechen
Mr Clem Apted
Mr James Buchanan
Mr William Henry Ward
Mr Barry Dillon
Ms Brenda Hodge
Mr Stephen Anthony Douglas
Mr Martin John O'Malley
Ms Lisa Stevans
Mr Michael Aird Snell
Mr Danny Hewat
Mr Raymond Henry Carrie
Robert Pyne

Ms Heather May
Ms Gwenda Collier
Mr George Parton
Ms Marlene Goudie
Mr Peter James Watts
Ms Delma Nilsen
Mr Barry Stanley Melkings
Mr William Edward Wilson
Ms Karen Gail Bowe-Ryan
Terri Back
Ms Margery Crawford
Ms Natasha Kallerberg
Mr John James Looby
Ms Janet Grigg
Ms Shirely Weldon
Mr Edie Prosser
Mr Colin McAuliffe
Mr John Clow
Mr Lindsay Mason
Mr Ray Shingles
G Brown
Ms Elizabeth Doherty
M/s Carol McDonald
Ms Patricia Charter
Ms Julie Graeme
Ms Yvonne Smith
Ms Naomi Newland
Ms Elaine Herman
Mr John McNally
Mr Richard Ivers
Mr Stephen Woodland
Mr Thomas Lindsay Ellis
Mr Ian Morwood
Ms Juliette Margaret Clough
Mr Peter Brownbill
Mr Thomas Reginald Murnane
Ms Daphne Gould
Ms Suzette Keys
Mr Robert Thompson
Coral Jarvis
Tracey Mary Fell
Peter John Hills
Suzanne Bowers
Robyn Muller
David McGrath
Robert Moss

Allison Ewens
Wayne Forbes
Joy Crane Ms Eve Deller
C McMahon
Ms Betsey Ashdown (nee Rowles)
Mr Darryl Moroney
Ms Shirley Wood (nee Younie)
Mrs Shirley May Powe (nee Haig)
Mr Peter Schrőder
Ms Susan Kendall
Mr Geoffrey Scott Taylor
Mr Anthony Sheedy
Ms Jenny Page (nee McInnes)
Ms Jeanette Longley (nee Richardson)
Ms Jo-An McIntyre
Ms Jeanine Davidson
Mr Robert James Andrews
Ms Gwendoline Ann Robinson
E J Forse
Ms Sandra Campbell
Mr David Martin
Ms Catherine Olga Davis
Mr David William Anthes
Ms Muriel Valmai Dekker (nee Willson)
Ms Olga Allison (nee Makin)
Ms Lorraine Gwendoline Rodgers
Mrs Sandra Marylynn Booker (Irving)
Ms Patricia Walter
Ms Jeanette May Barnacle
Mr Gibson Owen
Ms Gwenda Collier
Ms Jeanette Longley
J Tresillian
Mr Frank Londrigan
Ms Beverley Poultr (Carter)
Mr Michael John Miller
Ms Heather Templeman
Ms Janice Curtis (nee Crawford)
Ms Rhonda Wardman
Ms Diane Edith O'Hehir Witchard
Vernetar O'Hehir Lohse
Ms Kathy Snell
Ms Theresa Richards
Mr Wayne Chamley
Mr Bernard Barrett
Ms Josephine Ruby "Anna" Cavanough

Ms Barbara  Read
Ms Daphne Irene Holland (nee Crowther)
Ms Coral Margaret White (nee Greaves)
Mrs Janette Maria Nathan (nee Blake)
Ms Irene Denise Byrne
Ms Charlene Simpson (formerly Goring)
Ms Marylyn  Belsham (Smith)
Ms Thelma Irene Matthews (nee Hobbs)
Bryan Hartas
George Slater
Mark Wellington
Robyn Harry
Miss Emily Kopacka
Debra Harris
Wally Atkinson
Harriett Stanwell
J Pollentine
Valerie Jordan
Ms Irene Kalves
Sally Johnson
Ms Sherrie Else
Ms Janice Byrne
Mr Bill McLeary
Mr Eric Rogers
Ms Sonia St Claire
Mr Robert Golding
Mr John Bicknell
N Harris
Mr Barry Hill
Ms Grace Stratti
Mr Nigel Shew
Ms Joan Thornman
Mr Garry Shooks
Ms Cheryl Howell
Ms Jennifer Tiffen
Mr Peter Sinclair
Mr John  Glynn
Mr Alan Radcliffe
Chris Lea
Ms Phillipa Miridiu
Ms Lorraine Lowe
Ms Lorraine Davis
Ms Beth Edwards
Ms Lindianne Beary
Ms Julie Cartledge
Mr Brian Tooehy

Mr John Westbury
Mr Kenneth Merton
Mr Bryan Cronin
Ms Jean Holbrook
Ms Leonie Sheedy
Mr John Priestley
J Laughlin
Mr Ron Robinson
Ms Teresa Pollard
Mr Bill Cremen
Mr David Cook
Mr Barry Coldrey
Ms Robyn Mason
J Ivers
Mr Michael Bowen
Mr Scott Cooper
Ms Julie Walker
Ms Maureen Green
Merlene Pugh
Ms Janette Russ
Mr Gordon Waters
Dian Wiren
Ms Heather Wofts
Michael Francis Lewis (Varden)
Andrew Stephen Fisk
Ivey Thomas (Nee Smith)
William Amos
Barbara McMullen
Mrs Debra Walsh
Daryl Miechel
Kristine King
Cynthia Joyce Pledger
Sue Treweek
Violet Richardson

***Submissions regarding mental health funding and the justice system (Submission 154)***

Also noted in the first report, many submitters sent in a standard letter concerning lack of funding for mental health issues, and over-representation of people with mental illness in the criminal justice system. The following submitters provided these letters:

Toni Anderson
Marian Forster
Susan Forster
Craig Stanley-Jones
Kathy Lane
P G Crawley
Kelly Rivas
Lorraine Dickson
Patricia Fawcett
C Holt
Ben Lojkin
Darren Wilkinson
S Gallaway
R Holloway
Trevor Starick
John Berry
Lisa Pollard
M Patten
M Penfold
R J Vale
Vanessa Schultz
Renee Duckmanton
Leanne Knowles
Kim Begelhole
Nga Bach Thi Nguyen
R Wallis
Craig Carey
Emma Heaton
S Joynt
M Chewin
P Bower
M Cool
Allan
A Touy
M Kingdom
Charles Doyle
Darren Wilkinson
W McShane
A Chisholm

M Jenner
Colleen McRae
Edwin Lynn Forster
Sylvia Pattison
Viki Cooper
Claire Lees
Luke Reinikka
R Rolfe
Troy Scott
Margaret Cannon
Marcel Cole
P Rent
Stella Vlemmix
T Murray
S Adams
Annmarie Savona
S Chippindale
Courtney Griggs
M Seybourne
Ms Debra Eldemire

Signatures illegible (12)