# The Richmond Fellowships of Australia
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A compilation of thoughts from Richmond Fellowship:

Canberra
Sydney
Queensland
Melbourne
Tasmania
Western Australia


**"Senate Select Committee on Mental Health"**
**Response to the Terms of reference.**

## Introduction and Preamble

In Australia there is a critical mass of expertise, solid contemporary service delivery models and an abundance of energy to assist people who experience mental illness to create a life of meaning and connection with their community of choice. It is the opinion of The Richmond Fellowships of Australia that the challenge to the Senate Select Committee on Mental Health is to identify the barriers to what could be but is not currently an integrated, efficient and effective set of psychiatric services. To put it another way, how can government and non-government service providers best assist people who experience mental illness recover?

The Richmond Fellowships of Australia is an alliance of 6 separately managed and governed Richmond Fellowship organisations namely: RF Queensland, RF ACT, RF NSW, RF WA, RF Tasmania and RF Victoria.

Recovery from the affects of a mental illness are seen within the non-government sector as the desired outcome of any system or process that responds to people with mental illness. Patricia Deegan, a mental health consumer advocate, theorist and psychologist states:

> **Recovery does not refer to an endproduct or result. It does not mean that my friend (with quadriplegia) and I were 'cured'. In fact, our recovery is marked by an ever-deepening acceptance of our limitations. But now rather than being an occasion for despair, we find that our personal limitations are the grounds from which springs our own unique possibilities.**Recovery involves developing unique possibilities for the person with a psychiatric disability. The non-government sector is best placed to provide an environment and suite of services that support the unique possibilities of recovery from the effects of a psychiatric disability.

David Whitwell, a medically trained clinician caused significant consternation amongst the psychiatric rehabilitation sector by making the bold statement:

**Recovery is a Myth, promulgated by over-optimistic therapists of all persuasions.**So if Recovery was the desired outcome of psychiatric services in Contemporary Australia then how is it that Recovery is also a myth. Dr Whitwell later explained what he meant by such heresy:

> **Recovery is a very positive and uplifting word. It has been linked into a limited medical model where it does not fit. 'Personal recovery' may be a better term as it stresses the individual, and gets away from the idea that this is something that we can do to people.**

The Richmond Fellowships of Australia would argue that there is an important role for medical treatment of people with mental illness. Contemporary psychiatry and psychology are slowly moving in their practice towards principles of Recovery. In agreement with David Whitwell, The Richmond Fellowships of Australia would argue that Recovery from the effects of mental illness is best done by a person not to a person with a mental illness. The non-government sector with its flexible workforce and contemporary models of psychiatric rehabilitation is best placed to provide the appropriate services that assist people Recover from the effects of mental illness. Recovery is best done by Mental Health consumers in a home-like environment, not in a hospital environment.

According to William Anthony the mission of a Recovery-focussed psychiatric service is:

> **To help people with psychiatric disabilities increase their functioning so that they can be successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention.**

Psychiatric Rehabilitation, the service that is provided by service providers to help a person with a mental illness to Recover, can be seen as successful when the person with a mental illness has the least amount of ongoing professional intervention. Choice, hope and satisfaction in living a life worth living are hallmarks of Recovery from a mental illness. The Richmond Fellowships of Australia can play a greater role in the provision of Recovery-focussed services.

# Vulnerabilities and Recommendations

The Richmond Fellowships of Australia wish to make the following comments and recommendations to the Senate Select Committee on Mental Health:

**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;**

Vulnerability

A(1) Limited and variable (across states) funding to the non-government sector and the community based system of care.

Recommendations

A(1) Increase the percentage to non-government organisations 15% of the mental health budget of each state.

**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;**

Vulnerability

B(1) Patchwork of models of service provision across the range of service delivery portals such as prevention, early intervention, acute care, community care, after hours crisis services and respite care.

Recommendations

B(1) Development of Strategic Plan for the non-government sector as well as Strategic Plan for the States and for Federal Mental Health.

**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;**

Vulnerability

C(1) Limited service options (such as CCU and supported accommodation)

Recommendations

C(1) Fund pilot programmes that offer alternative service options.

C(2) Increase diversity of service options and in service providers delivering established government services.

C(3) Increase access to psychologist mode of service (directly to MH consumer or in supporting NGO's).

**d. the appropriate role of the private and non-government sectors;**

Vulnerability

D(1) Disparity in pay levels (NGO sector staff paid less than government sector staff).

D(2) Lack of clinical work done by NGO sector.

D(3) Lack of cooperation between private sector psychiatry and NGO sector.

D(4) Keeping GPs informed of contemporary service options.

Recommendations

D(1) Indexation of grants based on the cpi.

D(2) Offer a diverse range of contemporary service models such as Assertive Community Treatment (ACT)

D3) Develop memorandums of understanding (MOU) in sharing sensitive information with other agencies and especially private psychiatrists.

D(4) Develop ongoing training package for GPs, sector press release distributed to GPs or e-based information (a website) dedicated to reviewing service options, model referral procedures etc for people with a mental illness.

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

Vulnerability

E(1) There are several reasons for how people with a mental illness struggle to find and keep appropriate accommodation.

E(2) There are several significant barriers to people with a mental illness training for, finding and keeping a job of choice.

E(3) Hospitalisation and the precipitating psychotic or depressive behaviour causes significant social isolation and alienation of a mental health consumer's social supports and family.

E(4) New mutual obligation for people with psychiatric disability on Centrelink payments.

Recommendations

E(1) Fund several accommodation options such as compassionate landlord, cluster homes, supported independent living, respite, crisis and other.

E(2) Conduct Research into the barriers to employment for people with a mental illness.

E(3) Implement recommendations to the barriers to employment for people with a mental illness.

E(4) Develop recommendations and guidelines for the inclusion of social supports and family of a person with a mental illness during their acute care and subsequent psychiatric rehabilitation.

E(5) Provide targeted support and increase flexibility in the mutual obligation requirement for people with a mental illness and receiving a Centrelink payment.

**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;**

Vulnerability

F(1) Adolescent mental health consumer need significantly greater flexible and creative services to respond to their more immediate needs and emphasis on their present situation.

F(2) The Baby Boomer generation is aging and there will be an increase incidence in aged care of depression, psychosis and dementia.

F(3) Rural MH consumer critical mass and infrastructure needs (especially in northern WA, NT and SA).

F(4) There are limited Indigenous-friendly mental health Psychiatric Rehabilitation Training and service provision.

F(5) There is a high comorbidity between illicit drug use and mental illness. Mental illness impacts on drug rehabilitation and drug use impacts on psychiatric rehabilitation. There are limited dual diagnosis programmes responding to comorbid drug misuse and mental illness.

Recommendation

F(1) Develop a variety of relevant, flexible and intensive service provision models for adolescent mental health consumers.

F(2) Set out protocols for the provision of care of aged mental health consumers amongst the aged care sector (commonwealth) and the mental health sector(state).

F(3) Set up training programmes amongst aged care services in responding to mental health issues.

F(3) Develop and resource mentoring programme such as the mentoring programme proposed in WA for the implementation of Service standards in the NGO sector.

F(4) Work collaboratively with Indigenous services to develop and deliver Indigenous-friendly mental health Psychiatric Rehabilitation Training and service provision.

F(5) Develop and establish dual diagnosis programmes responding to comorbid drug misuse and mental illness.

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

Vulnerability

G(1) More is expected from non-government organisations with regard to standards implementation and corporate governance without appropriate resources and support.

G(2) The reluctance of mental health consumers and their social supports accessing mental health services.

Recommendation

G(1) Provide for service contract concessions or competitive grants to implement corporate governance strategies and service standard improvement, or quality assurance systems in the non-government sector.

G(2) Develop partnerships between psychiatric rehabilitation services delivery and carer, family and consumer support services.

G(3) Research the reasons how people access or don't access psychiatric rehabilitation services in Australia and solutions to this phenomenon especially during early psychosis.

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

Vulnerability

H(1) The perceived conflict between confidentiality/privacy and inclusion of social supports in the psychiatric rehabilitation process.

H(2) Lack of knowledge of GPs with current, local psychiatric rehabilitation services.

Recommendation

H(1) Develop memorandum of understanding and training programmes for both primary health care and psychiatric rehabilitation services on issues of privacy and inclusion of social supports.

H(2) Provide state relevant e-information on current psychiatric rehabilitation, employment and accommodation options for mental health consumers that would be relevant for GP and other primary health care professionals.

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

Vulnerability

I(1) Paucity of consumer run programmes.

I(2) Sporadic training and support for a variety of consumers to get involved in service delivery and training, Board and committee participation, and peer support.

I(3) Limited openness of staff having had a mental illness themselves (ie staff keep their own mental illness Recovery private)

Recommendation

I(1) Offer seeding grants for consumer programmes particularly for those programmes run in partnership with a larger service provider.

I(2) Funded consumer representatives for key committees.

I(3) Develop strategies for a more integrated training and support programmes for consumer involvement in service delivery and development.

I(4) Identify the impediments to appropriate disclosure of staff who successfully Recovery from a mental illness.

I(5) Develop recommendations as top how to promote Recovery stories in contemporary Psychiatric Rehabilitation services.

**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;**

Vulnerability

J(1) Bizarre, antisocial, or illegal behaviour can lead to unnecessary criminal convictions even with current legislation.

Recommendation

J(1) Develop recommendations as to how to work with police and the criminal justice system in responding to the behaviour of mental health consumers to prevent unnecessary criminal charges and incarceration.

**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;**

Vulnerability

K(1) Extended hospitalisation in locked and open psychiatric wards.

Recommendation

K(1) Look for alternatives in the non-government sector to detention and seclusion responses to mental health consumers.

K(2) Develop a range of restrictive services (different levels of restriction) and promote the least restrictive model of service delivery.

K(3) Provide real choice to mental health consumers with the limits of the Mental Health Acts.

**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;**

Vulnerability

L(1) Community non-involvement in service delivery.

L(2) Community ignorance about what mental illness is and the holding of misconceptions about mental illness.

L(3) Hostile response by some members of the public and local government authorities to residential psychiatric services being established in their community

Recommendation

L(1) Develop an Action Plan for community education and involvement in psychiatric rehabilitation service establishment and involvement.

L(2) Develop recommendations and options for services who wish to establish psychiatric rehabilitation services in a new suburb or town.

**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;**

Vulnerability

M(1) Poor primary health outcomes for mental health consumers. Mental health consumers are less likely to be diagnosed with health problems, less likely to complete treatment, and less likely to receive state of the art treatment.

M(2) Employment agencies funding are linked with long term placement of mental health consumers that access their services. As a result mental health consumers with some degree of work readiness are supported whereas only limited resources are reserved for mental health consumers needing work readiness training and support.

M(3) Limited sharing of information between agencies.

M(4) Insufficient support and superficially planned transition between hospital environment and the community in mental health consumers entering and exiting the hospital-based psychiatric services.

Recommendation

M(1) Develop an Action Plan with the involvement of the non-government organisations in improving the poor primary health outcomes for mental health consumers.

M(2) Provide separate funding to employment agencies for the specific development of work readiness.

M(3) Provide opportunities for an integrated forum or symposia to exchange ideas and develop greater understanding of the service opportunities and limits of the services working in the housing, employment, law enforcement psychiatric rehabilitation sector.

M(4) Identify the barriers to psychiatric hospitalisation exit and entry planning.

M(5) Develop memorandums of understanding between mental health clinics/hospitals and the non-government sector.

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

Vulnerability

N(1) Sporadic qualitative and quantitative research in psychiatric rehabilitation service delivery effectiveness and efficiency in Australia.

N(2) Limited support for the development of psychiatric rehabilitation tools and their applications in Australia (eg the Continuity of Life Interview (COLI) in WA).

N(3) Limited Action research as part of funding and service contracts with non-government organisations.

Recommendation

N(1) Provide ongoing grants for qualitative and quantitative research in psychiatric rehabilitation effectiveness and efficiency, rehabilitation tool development and application, and action research.

**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;**

Vulnerability

N(1) Lack of resources, support and funding for the development and implementation of psychiatric rehabilitation outcome measures in non-government organisations.

N(2) Limited knowledge, application, and experience of quality assurance systems and their uses for non-government and government psychiatric services.

Recommendation

N(1) Offer reduction in service contract obligation or provide one off grants to implement the development of new outcome measures and/or the application of quality systems.

N(2) Provide forums, workshops and mentoring in the application of national and state service standards.

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

Vulnerability

P(1) Little experience or models for the use of e-technology in mental health care.

Recommendation

P(1) Provide exposure and experience to non-government organisation of the use of e-technology to deliver psychiatric rehabilitation services.