Senate Select Committee on Mental Health

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Questions on Notice
to
Mental Health Council of Australia

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Question 1

CHAIR—... Another big funding issue is the grants and project based funding versus the recurrent funding. I did not see this in your recommendations but I wonder whether you have a view about reform of that system.

Australia is often known as "the land of pilots", and with good reason. The mental health sector is littered with project and pilots that are funded for a short period and then abandoned. Successful programs are not picked up and implemented in other areas and evidence-base established by this work can be lost. This trend creates a number of difficulties for organisations and programs that receive short-term, time-limited funding.

From a service delivery perspective, consumers (and their carers and family members) frequently report considerable distress, with consequent impacts on their mental health, when a successful and functioning program is cancelled. The loss of support, uncertainty regarding where it may come from and the general upheaval can have considerable impact on health and wellbeing. Consumers are then required to find alternative support if it is available, and re-establish a working and trusting relationship with those involved.

From the organisational perspective, uncertainty regarding tenure and the inability to offer long-term job security acts as a barrier to the recruitment and retention of quality staff. Loss of corporate knowledge, disruption to timelines and the time and expense spent on recruiting a replacement are all highly disruptive factors, particularly for small organisations. Likewise, organisations can be prevented from engaging in long term planning and from pursuing long term projects.

At the same time, the MHCA recognises the need for ongoing evaluation and accountability measures to ensure programs / pilots and organisations are performing and aligned with Australia's National Mental Health Strategy.

The MHCA recommends that evidence-based programs are supported for a minimum of three years prior to any determination of continued funding (subject to one-year reviews for governance).

Question 2

Also, what have you discovered in your work about public attitudes? You say that funding overall for mental health services should be increased from six per cent

of the health budget to 12 per cent. Is that backed, in your work, by attitudes out there in the general public? If the government go down that path are they going to be criticised or congratulated on it?

There are 2 ways of answering this question.

The first is to argue that in the face of a considerable body of evidence demonstrating the current crisis in mental health in Australia, the burden of disease that mental illness and mental health problems represent and the economic costs to Australia of not providing care, it is unacceptable to determine funding based on its popularity with the general public. Indeed, one can easily point out that the parlous state of mental health services are a direct result of such attitudes.

It is also important to understand that, as demonstrated by the MHCA and Brain and Research Institute report *Investing in Australia's Future* (2004), many of the economic and social costs relating to mental illness are preventable. Prevention and early intervention services are necessary to reduce the need for acute services; community-based services are considerably cheaper than acute. Therefore, while an increase in funding of 6% to 12% represents a large output in the short term, over time this investment will lead to improvements in a number of fields such as increased employment participation and decreased acute-care costs.

The second answer to this question is to note that public awareness regarding mental health is improving in a number of areas. The MHCA has received strong support from the mental health sector for *Not for Service*, which included the call for increased funding as a key recommendation. There is increasing public awareness of prevalence rates for mental illness, understanding of the implications of different mental disorders, and of the poor state of Australia's mental health system. This is not to say that stigma is no longer a problem, but public awareness campaigns and programs are having an impact and will continue to improve understanding and attitudes towards mental illness.

Media coverage of mental health issues continues to grow, particularly in media such as print and radio, and the role of individuals such as Alan Jones has done much to raise the profile of mental health.

A recent survey by Research Australia provides an indication of public attitudes towards mental health. The survey ranked mental health as the fourth highest priority as a health issue requiring increased research into prevention and cure.

Question 3

One of your recommendations is that drug and alcohol services and mental health be integrated. What does that mean? Does it mean that we should close down drug and alcohol services and create a new body or a new model that does the work of both mental health and drug and alcohol services?

There is a need to retain separate drug and alcohol services and mental health services. Both streams service clients with distinct and separate needs and requiring different treatment approaches and environments. Likewise, those

working in D&A will have very different skills sets and training from those working in mental health.

However, due to the high prevalence of people with comorbid mental health and drug and/or alcohol problems (commonly known as 'dual diagnosis'), there is also a need to ensure that there are services available that can provide good clinical care for people with a dual diagnosis. People a dual diagnosis are recognised as often having poorer health and social outcomes.

Refusal of some mental health or alcohol and other drug services to treat people with dual diagnosis creates significant service gaps, and people end up continually shifting between mental health services and alcohol and other drug services without ever receiving effective treatment from either. This is commonly known as the 'service silo' effect.

Specialised services are required to bring the skill sets of both the mental health and the drug and alcohol sectors together. Such services should be available through either mental health, drug and alcohol services, or as an independent entity. The housing of specialised a dual diagnosis services should be determined according to localised service structuring and availability.

Question 4

It would be interesting to have a response from the council to the remarks that were made when the department presented to us. Its response—which I think was half in jest but probably fairly realistic—to the reforms being slow was, 'Well, 25 years would not be a long time.' It would be useful to have your realistic assessment of what is possible should all the parties have the leadership and willingness to achieve the reforms that are necessary.

The MHCA is willing to accept that major health reform takes a long period of time, but completely rejects the assertion that 25 years is a reasonable period of time for change to be effected. What enterprise accepts a 25-year turnaround strategy?

The problem with the answer provided is that the Department cannot point to clear nation-wide outcomes from the 12-13 years of "reform". So to say it may take 25 years is not based on clear and consistent national data showing how far we have come. The MHCA and the mental health sector have lost confidence that the current National Mental Health 2003-2008 and its implementation will deliver the health outcomes that all Australians have the right to expect.

Question 5

I have one final question. The committee has found amazingly good examples of practice; it is patchy—one in one state and one in another. Do you think it is reasonable for us to suggest that we highlight these examples of good practice and suggest that we even make them a bit prescriptive? I know that it is difficult because you have horses for courses, as it were. But it seems to me that a youth service that works in the western part of Melbourne must be applicable in other parts of the country. It must be the case that a good program in New South

Wales for eating disorders could also be replicated in other places. Do you see any dangers for the committee if it were to go down that path?

The MHCA strongly encourages the Committee highlight examples of good practice. It is important to acknowledge those individuals and organisations producing outstanding work and promote these achievements to the rest of the sector.

The MHCA also supports the notion of establishing a process to identify and assess pockets of excellence and promote their application nationally. However, the MHCA cautions the Committee that any such process must take full account of the strengths and weaknesses of a program as well as local factors that may affect its implementation elsewhere. A systematic approach to identifying, analysing and promoting examples of good practice is required.