CATHOLIC HEALTH AUSTRALIA

CHA SUBMISSION TO THE SENATE SELECT COMMITTEE ON MENTAL HEALTH

MAY 2005

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The Catholic health, aged and community care sector

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Dear Committee Secretary

Please find attached Catholic Health Australia's (CHA's) Submission to the Senate Select Committee's Inquiry on Mental Health.

With less than 40% of people suffering a mental illness actually accessing care and with professionals working in the system completely over-stretched, it is fair to say that Australia's mental health system is facing a crisis.

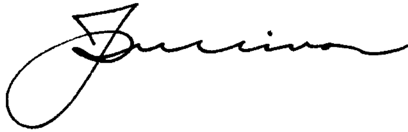
Australia's efforts in mental health look good on paper. The National Mental Health Policy and subsequent National Mental Health Strategies provide laudable goals and objectives. However, the rising incidence of mental illness and the level of disease burden have simply not been matched with sufficient resources at both Commonwealth and State/Territory levels.

This submission covers a broad range of issues including:

- The inadequacy of resources dedicated to mental health and the resulting lack of appropriate services to meet need;
- A focus on some of the groups in our community who are being particularly under-serviced;
- Issues associated with accessing services through Medicare and through the private health system;
- Mental health workforce issues;
- Support for consumers, carers and non-government organisations; and
- The need to improve cross-sectoral approaches such as housing, transport, employment and income support.

I welcome the opportunity to provide further evidence on the issues raised in this submission to a Senate Committee hearing. If you require any further information please contact me on 02 6260 5980 or email: francisss@cha.org.au.

Yours sincerely



FRANCIS SULLIVAN
Chief Executive Officer

Catholic Health Australia – Background

Catholic Health Australia (CHA) is the largest non-government provider grouping of health, community and aged care services in Australia, nationally representing Catholic health care sponsors, systems, facilities, and related organisations and services.

The sector comprises providers of the highest quality care in a network of services ranging from acute care to community based services. These services have been developed throughout the course of Australia's development in response to community needs. The service providers carry on centuries-old traditions of bringing Christ's healing ministry to those who suffer – the ill, the disabled, the elderly, the disadvantaged, the marginalised, the poor, serving those that others with a profit motive do not. The services return the benefits derived from their businesses to their services and to the community; they do not operate for profit; they are church and charitable organisations.

The Catholic health and aged care ministry is broad, encompassing many aspects of human services. Services cover aged care, disability services, family services, paediatric, children and youth services, mental health services, palliative care, alcohol and drug services, veterans' health, primary care, acute care, non acute care, step down transitional, rehabilitation, diagnostics, preventive public health, medical and bioethics research institutes.

The Catholic health, community and aged care ministry is defined by these interrelated foundational principles:

The Sector Snapshot

18,000 residential aged care beds
5393 independent living and retirement units
4,651 Community Aged Care Packages (CACP) and thousands of people assisted through the Home and Community Care Program (HACC) and other community care support
65 hospitals
8,500 hospital beds
46 privately funded hospitals
19 publicly funded hospitals
7 teaching hospitals
8 dedicated hospices and palliative care services
17 rural and regional hospitals
157 rural and regional aged care services

Dignity: Each person has an intrinsic value and inalienable right to life. Everyone has a right to essential comprehensive health care.
Respect for Human Life: From the moment of conception to natural death, each person has inherent dignity and a right to life consistent with that dignity.
Human Equality: Equality of all persons comes from their essential dignity. While differences are part of God's plan, social and cultural discrimination in fundamental rights are not part of God's design.
Service: Health care is a social good. It is a service, not a commodity used for maximising profit.
Common Good: Social conditions should allow people to reach their full human potential and to realise their human dignity. Equitable access to care, developing research and training, and conducting professional inquiry into the social, ethical and cultural aspects of health, builds social conditions and communities that respect human life and allow people to realise their potential.
Association: Every person is both sacred and special. How we organise society – in economics, politics, law and policy – directly affects human dignity and the capacity of individuals to grow in community.

Preference for the Poor: Priority must be given to the needs and opportunities of the poor and disadvantaged. This encompasses economic, cultural and individual notions of poverty and disadvantage.
Stewardship: Health resources should be prudently developed, maintained and shared in the interests of the community as a whole and balanced with resources needed for essential human services.
Subsidiarity: The identified needs of individuals and the community are best addressed at the level where responses and resources are available, appropriate and effective.

Introduction to CHA's Submission

> *"I renew my appeal that, everyone, in accordance with their responsibility, commit themselves to defending the dignity and rights of people suffering from mental illness. May no one remain indifferent to these our brothers and sisters. The Church looks with respect and affection on those who suffer from this affliction, and urges the entire human family to accept them, giving special care to the poorest and most abandoned."* Pope John Paul II [1]

The Catholic Church sector provides a range of mental health care and services to the Australian community through its various health and welfare arms. Providers in the Catholic sector experience daily the gaps in our mental health system while at the same time witnessing the enormous benefits and gains that can be achieved through providing quality care and services to people with mental illness.

In the health and aged care sector, Catholic providers deliver a whole spectrum of mental health services ranging from targeted services for children to specialist dementia care in residential aged care facilities; from providing services to high acuity patients in inner city public hospitals to outreach services to remote Indigenous communities; from community care and respite services to a number of private hospitals devoted to psychiatric care. It is from this extensive experience and the mission of the Catholic health and aged care sector reflected in the foundational principles above that this submission is written.

Mental Health in Australia – it's time to act

Australia is not alone in facing a major increase in the demand and need for high quality and effective mental health services.

> Mental illnesses are increasingly recognised as a major health challenge in both developing and developed countries. As disorders such as depression, anxiety, alcohol and other substance misuse, schizophrenia and manic-depressive illness are extremely common, they now pose a

[1] Pope John Paul II, General Audience, 4 April 2001.

> significant threat to both social and economic development. In the next 20 years, the incidence of all these disorders is expected to rise as will the complication rates in terms of physical health problems, premature death and lifelong disability.[2]

The message is clear - while efforts can and should be directed towards preventing mental illness, there is inevitably going to be an increasing need for mental health services. As a nation we do have a choice in how we meet the needs of people affected by mental illness. To date, Australia has chosen to devote considerable time and energy in developing strategies and plans to improve mental health service delivery. In many respects, mental health policy has come a long way, particularly since the development of the National Mental Health Policy in 1992 by Australian Health Ministers. However, as will become clear in this submission to the Senate Select Committee on Mental Health this policy intention has not been adequately resourced to be truly effective and as such is not providing the care needed by some of the most vulnerable people in our community.

Australia has some positives to build on. The National Mental Health Policy and resulting National Mental Health Plans provide a solid foundation for our efforts in this area. On paper, Australia has worthy goals and objectives. In terms of progress, some gains have been made. There has been a clear shift to improve the dignity of people following the move from an institutionalisation model to community based care. The level of awareness about mental health has improved in the Australian community together with an increased openness to discuss the topic in public discussions.[3] There have been some changes to provide further support to General Practitioners (GPs) such as the *Better Outcomes for Mental Health Program* and through Medicare Plus the ability for GPs to refer people to a psychologist under Medicare (noting that is only for people with complex and chronic needs and is restricted to five sessions). The Government's commitment to the Suicide Prevention Strategy is worthy of note and support as are many of the campaigns to reduce discrimination and stigma.

However, for those people working in the field of mental health everyday, it is a system in crisis. It is chronically underfunded and committed staff suffer from collapsing infrastructure and lack the basic support they need to undertake their jobs effectively. In the opinion of one worker in the Catholic sector who has recently worked in the New Zealand system, Australia's system is equivalent to that expected in a developing or third-world country. With the resources that Australia has, including consecutive budget surpluses, this is a disgrace.

Issues of accountability are also problematic. While the National Mental Health Strategy and Plans are agreed by both Federal and State/Territory governments - as with many health services in Australia - both levels of government are able to deflect responsibility and accountability by blaming the other level of government for any deficiencies in the system.

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[2] Hickie, I., Groom, G. & Davenport, T. *Investing in Australia's Future: the Personal, Social and Economic Benefits of Good Mental Health.* 2004. Canberra: National Mental Health Council, p8.

[3] For example, Andrew Denton in the popular ABC program "Enough Rope" openly discussed mental health issues with a number of guests and members of the audience.

Users of the mental health system find it deficient. The Evaluation of the Second National Mental Health Plan noted that despite the considerable progress made towards community care, community treatment options are perceived to be unavailable or inadequate. Mental health consumers are still isolated from their communities and a common view is that mental health providers, particularly those in the public sector, continue to function within an institutional framework, fostering dependence rather than recovery.[4]

The need for increased services across the mental health service spectrum is clear. In Australia, the general view is that one in five people will experience a mental health illness, while the World Health Organisation considers that the figure is even higher stating that one in every four people, or 25% of individuals, develop one or more mental or behavioural disorders at some stage in life, both in developed and developing countries.[5] The need is further exacerbated by the climate of our times. The Mental Health Council of Australia in their report *Out of Hospital, Out of Mind* pointed to the new pressures on the mental health system including the negative impact on Australian families, and particularly young children, of the ongoing threats of domestic and international terrorism, the stress of war and continued drought conditions.[6]

While it is clear that demand for services will only increase, we know that there is already a drastic gap between those in need and those who actually receive a service. Less than 40% of people with mental disorders receive any mental health care in a 12-month period compared with almost 80% for other common physical health problems.[7]

CHA cannot fathom that Governments across the board would know this statistic and not take adequate measures to change this deeply troubling situation. One of the primary reasons why the mental health system is inadequate is because the resources devoted to mental health have not kept pace with the need for services. This is further discussed in the following section.

Inadequacy of Resources Devoted to Mental Health

While there is dispute about the level of government expenditure devoted to mental health and what percentage of Gross Domestic Product (GDP) this constitutes[8], reports cite that Australia spends 7% of its health budget on mental health while mental health

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[4] Steering Committee for the Evaluation of the 2nd National Mental Health Plan 1998-2003, *Evaluation of the Second National Mental Health Plan*. 2003. Canberra: Commonwealth of Australia, p16

[5] World Health Organisation, Fact Sheet: 'Mental and Neurological Disorders', The World Health Report 2001, accessed on website www.who.int/en

[6] Groom, G., Hickie, I. & Davenport, T. *Out of Hospital, Out of Mind: A Report Detailing Mental Health Services in 2002 and Community Priorities for National Mental Health Policy for 2003-2008*. 2003. Canberra: Mental Health Council of Australia, p1.

[7] Andrews, G., Henderson, S. & Hall, W. *Comorbidity, disability and service utilisation: Overview of the Australian National Mental Health Survey.* British Journal of Psychiatry 2001, 178:145-153, cited in Hickie, I., Groom, G., McGorry, P., Davenport, T. & Luscombe, G. *Australian Mental Health Reform: Time for Read Outcomes.* Medical Journal of Australia, 2005. 182 (8): 401-406.

[8] See Whiteford, H.A & Buckingham, W.J. *Ten Years of Mental Health Service Reform in Australia: Are we Getting it Right?* Medical Journal of Australia, 2005. 182 (8):396-400.

accounts for 13% of the total disease burden (death and disability) and nearly 30% of the non-fatal disease burden in Australia.[9] The Australian Government's own report on the National Mental Health Strategy while reporting increases in mental health spending had to concede that increases in mental health expenditure have 'kept mental health expenditure in step with movement in the broader health industry…In this respect, mental health has not significantly increased its position in terms of relative spending within the overall health sector'.[10]

Added to this, this same report acknowledged that Federal Government increases in mental health spending (while only maintaining the same share of the overall health budget) were mainly attributable (66%) to growth in expenditure on psychiatric drugs provided through the Pharmaceutical Benefits Scheme (PBS). In other words, the increases in expenditure have not led to commensurate increases in infrastructure, service funding and workforce initiatives in the mental health sector. One can only conclude that the Australian Government's share of investment in these areas is falling behind.

This is also supported by comparisons with other first-world countries. Although such comparisons can only ever be estimated given the different data collection and reporting methods, the 7% of GDP committed by the Australian Government pales in comparison to other developed countries which spend 10 to 14% of their total health expenditure on mental health.[11]

Mental health is a shared responsibility in Australia, split between the Australian Government and the States and Territories. While the States also argue that they have increased their funding commitment to mental health, gaps in public hospital service delivery and in support for community care tell a different story. The extent of this underfunding varies between the States as clearly outlined in the 2004 National Mental Health Report which identified that the considerable variation between the jurisdictions that existed at the commencement of the National Mental Health Strategy in 1992 was still evident in the 2001-02 data. Further, the gap between the highest spending and the lowest spending jurisdiction has decreased only marginally over the 1993 to 2002 period.[12] This would indicate that the ability to access a service and indeed the level of service a person with a mental health illness receives may be dependent on where they live. This is not a just situation.

Reports of consumers and carers' experience of the mental health system often refer to the lack of accountability for mental health funds.[13] This will only be further exacerbated because of the withdrawal of the "maintenance of effort" clause for mental health services in the 2003-08 Health Care Agreements[14] and the most recent National Mental Health

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[9] Mathers, C., Vos, T., Stevenson, C. *The Burden of Disease and Injury in Australia. AIHW Cat No PHE 17.* 1999. Canberra: Australian Institute of Health and Welfare - cited in Groom et al (2003).

[10] Australian Government, *National Mental Health Report: Summary of Changes in Australian's Mental Health Services Under the Mental Health Strategy 1993-2002 Eighth Report.* 2004. Canberra: Commonwealth of Australia, p15.

[11] Mental Health Council of Australia, *Fact Sheet: Key Issues*, accessed (21 April 2005) on website www.mhca.com.au/public/factSheets/KeyIssues.html.

[12] *National Mental Health Report 2004*, p16-17.

[13] see, Groom et al, *Out of Hospital, Out of Mind.*

[14] Whiteford et al, 2005.

Plan 2003-2008 failing to define specific targets for increased investment or enhanced care.[15] Experience from mental health practitioners in the Catholic sector have also identified a concern that the lack of State Government accountability for mental health dollars leads them to believe that there is extensive leakage to other areas of the health sector.

If Australia is going to be serious about tackling the mental health issues of the 21st Century, this sloppiness in accountability and commitment to real funding increases cannot continue.

Recommendations:

- **Support the Mental Health Council of Australia (Out of Hospital, Out of Mind) recommendation that mental health expenditure should be increased to at least 12% of national health expenditure.**

- **Set policies across Commonwealth and State/Territory Governments to ensure mental health budgets are quarantined from budget cuts or leakages to other programs, and publish annual reports on budgets and actual expenditure.**

- **Apply real indexation of health grants to be matched by States/Territories to ensure that there is adequate financing of mental health services, reflecting growth, demand and severity of illness in society.**

Lack of Appropriate and Necessary Mental Health Services

When asked about the state of mental health services across Australia, professionals in the Catholic sector are resounding in their view that there are simply not enough services to meet the needs of people with mental illness. It is not an understatement to state that many mental health services in Australia are in a state of crisis and in many cases are simply existing because of the good will and commitment of the staff who work in the system.

The policy shift in the National Mental Health Policy beginning in 1992 to move from an institution-based model of care to one of care based in the community was certainly a welcome shift and had as one of its principles improving the dignity of people suffering from mental illness. However, what has become clear to those working in the system and outside observers is that the closure of institutional facilities over the last decade has not translated into adequately funded community based support services. Neither has the closure of facilities diminished the demand placed on public hospitals. Public hospitals are dealing with patients who have the highest acuity in terms of mental illness. Emergency departments are experiencing increasing numbers of presentations of people with severe mental illness.

[15] Hickie, I.B., Groom, G.I, McGorry, P.D., Davenport, T.A. & Luscombe, G.M. *Australian Mental Health Reform: Time for Real Outcomes,* Medical Journal of Australia, 2005. 182 (8): 401-406.

The International Mid-Term Review of the Second National Mental Health Plan for Australia identified that in many metropolitan areas, despite the provision of early intervention teams, some people with severely disabling mental health problems feel that they cannot access treatment and care unless they are in an advanced state of illness, and that, when they are in crisis, the response they receive is often slow and unreliable.[16]

Australia is lacking in an appropriate continuum of care across the spectrum and volume of services that should include prevention, early intervention, acute and continuing care. An appropriate continuum of care would include ready access to acute and not-acute community based specialist assessment; forensic and extended care inpatient beds; and access to government and non-government support services including income support, employment, housing, social networking, mental health promotion, early intervention programs and primary healthcare.

The absence of an appropriate continuum of care skews service delivery to one end with higher acuity and the associated higher risks and costs involved. One Catholic public hospital cited the increasing pressure on acute beds with occupancies rising from 85% to 98% over the past five years. Further, acuity of the inpatient unit is dangerously high with the majority of patients brought in by a law enforcement agency (37%) or admitted via the emergency department (30%). On average, 83% of patients are scheduled involuntarily under the Mental Health Act.

In part, some of this situation has arisen because of the dramatic reduction in acute psychiatric beds as one outcome of the National Mental Health Policy. Again while the policy intent behind this movement was laudable, the situation has now arisen that because of the higher acuity of patients in the public hospital system, the management of these patients can be dangerous when occupancies are so high. In addition, lack of access to inpatient rehabilitation beds and community based step down beds prolongs recovery and length of stay. This, in turn, leads to bed blocking and reduced access for patients requiring acute admission in the community (the lack of rehabilitation and step-down beds is discussed further below).

In many instances the State Governments have not funded public hospitals to update the mental health acute care units and their ageing design has added to the problems of high occupancy and inability to offer the preferred type of care mental health professionals should be able to provide. In many cases the inpatient units of public hospitals were built at the time when there were large Psychiatric institutions and inpatient care at public hospitals was often only provided for short periods. The situation has now arisen that many patients are spending extended periods in public hospitals because of the lack of community or other intensive care options. In many cases public facilities need to be redesigned and updated to reflect their patient mix and the changing patterns of length of stays. Dedicated funding needs to be allocated for this to occur.

Non-government organisations also provide a large component of the services for people with mental illness. The St Vincent de Paul Society is one such organisation providing services across the health, aged care and welfare sectors and meeting the needs of many people suffering from mental illness. Society staff and volunteers witness first-hand

[16] Trotter Betts, V. & Thornicroft, G, *International Mid-Term Review of the Second National Mental Health Plan.* 2001. Canberra: Australia, p 11.

the gaps in service delivery and the people who often fall through the cracks and miss out on existing service provision. The Society has commented on the devastating consequences of not funding the move from institutional care to community care adequately or appropriately.

> Deinstitutionalisation has fallen down for some people because short-sighted governments, and the medical professionals charged with the responsibility of mental health in our community, have used the process to drastically cut costs. The resources gained from the sale of public mental hospital sites and other 'windfalls' have not been redeployed within the community. Far from being cost-effective, the smaller community-based services are often overstretched and unable to assist except in an absolute emergency.[17]

Non-government organisations such as the St Vincent de Paul Society provide a great deal of the care and support for people with mental illness. Most non-government organisations are operating on shoestring budgets and funding provided by governments is often well below what it costs to provide the services.

Non-government organisations are also picking up the pieces when government services or acute services fail to meet the needs of people with mental illness. In some respects, governments may not even know the full extent of the shortfall or gaps in their services because non-government and charitable organisations are funding care through their own cross subsidisation from other services or through unfunded volunteering initiatives.

Non-government organisations are a major player in the mental health sector but this is not adequately reflected in government policy and planning processes. There is much more scope for all levels of government to engage the non-government sector in mental health planning, policy and program implementation. This would provide governments with a clearer understanding of where service gaps are being identified and assistance with strategies for addressing these needs.

The contribution made by the non-government sector, and which indeed, *could* be made with appropriate policy and funding parameters is an area which should be further developed. With appropriate resourcing, many non-government organisations would welcome the opportunity to accept more responsibility for the mental health care of those with mental illness. Catholic hospitals have expressed willingness to develop integrated models of care between the public, non-government and private sectors. Pilot funding for such initiatives would help these initiatives develop and grow.

Recommendations:

- **Ensure models of financing community based mental health care are comparative to appropriate acute services. This will ensure that people who need a particular level of service are able to access it and there are no barriers to care because of outdated models of financing at State and Territory level.**

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[17] St Vincent de Paul Society NSW/ACT, *A Long Road to Recovery: A Social Justice Statement on Mental Health*, July 2001, p15.

- **Develop strategies across all levels of government to effectively engage the non-government sector in mental health planning, policy and program implementation.**

- **Increase funding across Commonwealth and State/Territory governments for initiatives which support integrated models of care between the public, non-government and private sectors.**

Need for further rehabilitation and step-down care options

Increasing access to rehabilitation and step-down care options would provide an immediate improvement in the care provided to people with mental illness and their carers. This service is consistently reported by consumers and carers to be lacking.[18] Because of the inadequacy of these services, people are receiving inappropriate treatment which has serious consequences for themselves and risks the safety of their carers and staff working in the community. Andrews (2005) has pointed out that:

> Community mental health services have grown as the number of hospital places has decreased. However, the absence of rehabilitation beds means that staff are being asked to care for people in the community who should be in supervised residential places.[19]

CHA contends that this gap between acute care and community care is a major reason for readmission and slower recovery times. More rehabilitation and step-down beds should be funded as a priority. Further options to provide better transitional care are to fund 'transition teams' to support patients after discharge to reduce readmission and the establishment of 'acute and sub-acute sections' and 'safe or transitional houses' similar to domestic violence refuges, to service those who are not prioritised for hospitalisation but require support.[20]

Recommendation:

- **Substantially increase funding for rehabilitation and step-down care facilities and beds.**

Underserviced Groups

As stated at the beginning of this submission, the Catholic sector works in the mental health field across a range of geographical locations and service types. In their day to day experience, mental health professionals in the Catholic sector have witnessed the gaps in service delivery and the populations of people who are underserved. The feedback from the Catholic sector supports the findings of the international review of the

[18] Groom *et al,* Out of Hospital, Out of Mind, p19

[19] Andrews, G. *The Crisis in Mental Health: the Chariot needs one Horseman*, Medical Journal of Australia. (2005). 182(8): 372-373.

[20] Groom *et al*, Out of Hospital, Out of Mind, p19.

2nd National Mental Health Plan which identified particular groups who are underserved in the current health environment. These are:

- Aboriginal and Torres Strait Islander communities
- Persons in forensic mental health settings
- Mentally ill prisoners
- People in detention centres who have mental health problems; and
- Persons who live in rural and remote areas.[21]

CHA contends that these population groups continue to be underserved and that both Federal and State/Territory Governments should be making further progress in meeting the needs of these groups through implementation of the recommendations contained in the International Mid-Term Review of the Second National Mental Health Plan and the Evaluation of the Second National Mental Health Plan.

While some progress may have been made in these areas, there remains a chronic lack of appropriate services to meet the needs of Indigenous Australians. Further research should be undertaken into the specific needs of Indigenous Australians as it has been identified that:

> the nature and extent of mental illness in the Aboriginal and Torres Strait Islander populations and problems of their emotional and social wellbeing is not well understood, nor are effective and acceptable interventions widely available.[22]

People in rural and remote localities remain underserviced because of a lack of infrastructure and innovative policy approaches. As with many aspects of rural and remote health care, a chronic workforce shortage means that Australians living in these locations cannot access basic health services. Receiving specialist care in rural and remote Australia is all but impossible as the medical psychiatric workforce is poorly distributed and largely sited in the metropolitan areas.[23] Clearly, some of the models which enable some innovation in this area need to be further enhanced such as the *More Allied Health Services* Program and telepsychiatry funded through the Medical Benefits Schedule.

Since the publication of the two above mentioned evaluations, reports continue to escalate on the deficient treatment of people in detention centres and in prisons. In fact, it appears that in many cases rather than bringing mental health models into prisons and detention centres, law and order models are being brought into mental health treatment.

> In some states, there appears to be an increasing trend towards a "law and order" rather than a clinical-care approach. Accounts from consumers and carers emphasises increased use of physical security

[21] Mid-term Review of Second National Mental Health Plan for Australia, p 12
[22] Ibid, p12.
[23] Ibid, p11.

> measures, forced detention, increased use of sedation, protection of staff rather than patients, and rebuilding new separate secure areas.[24]

At the same time reports point towards the inadequacy of forensic systems and the increasing demand for psychiatric services within the prison system and experts have called for national standards to be developed for such services within the next five years.[25]

Jesuit Social Services have extensive experience working with marginalised people including people in prisons and young people in contact with the criminal justice system and/or suffering from mental illness, substance abuse or a combination of these. It has been noted by Jesuit Social Services that while mental health budgets have remained stagnant in relative terms, expenditure on prisons is rising at a rapid rate. These two facts are related:

> Much of the recent dramatic increase in the Australian prison population can be explained by the relationship between untreated mental health needs, subsequent illegal use of drugs as a form of self-medication, and the eventual intervention by instrumentalities of the criminal justice system.[26]

Clearly more can be done to prevent people with mental illness entering the criminal justice system in the first place, and for those in the prison/remand system, increased resources need to be devoted to providing appropriate mental health services to support recovery and rehabilitation.

The Evaluation of the 2nd National Mental Health Plan correctly pointed to the need to develop suitable programs for refugees or people who have experienced displacement, torture and trauma and stressed the importance of a heightened need for prevention and early intervention.[27] Unfortunately Australia has not heeded this call. In fact our treatment of refugees is one of the most shameful examples of failing to see the human dignity of all people. When people are locked up and treated in a way that further exacerbates the trauma they have already experienced, we deserve the condemnation that national and international human rights groups have voiced.

The tragic case of Cornelia Rau earlier in 2005 demonstrated what an appalling state of mental health care in detention centres across this country. The need for improved services and national standards for care is paramount.

Other groups that CHA draws attention to where services are inadequate include:

- Children and youth
- Ageing Australians

[24] Mental Health Council of Australia, *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia,* cited in Hickie *et al* 2005.

[25] Hickie, I.B., Groon, G.L., McGorry, P.D., Davenport, T.A. & Luscombe, G.M. *Australian Mental Health Reform: Time for Real Outcomes*, Medical Journal of Australia. 2005. 182 (8): 401-406.

[26] Norden, Peter SJ, *Prison is Not A Healthy Place*: ANEX Harm Reduction Conference, July 2004 (Fr Peter Norden is the Policy Director, Jesuit Social Services)

[27] Evaluation of the Second National Mental Health Plan, p29.

- People with a dual diagnosis
- 40 to 55 year olds who are often homeless

Children and Youth

Academic reports supported by the experience of health professionals working in the Catholic health sector, point towards an existing shortfall in services for children and youth. This need is increasing and if action is not taken, the shortfall will dramatically increase. Hickie *et al* (2005) have pointed to the fact that while incidence of mental illness will continue to increase across the board, this will particularly be the case for younger people, partly because of the current social and environmental factors including increased family breakdown, decreasing participation in other community-based structures such as churches, sporting and recreational associations and social clubs and increased exposure to substances such as cannabis and illicit stimulants.[28] Other evaluations have pointed to the fact that in general the specialist mental health service system remains adult focused[29] and that there is significant lack of services, dollars, and providers throughout Australia for children and youth services, including residential, respite, community options, acute and family interventions.[30]

Feedback from within the Catholic sector has pointed to a shortage of care and support services offered to young people and their families. Youth are at a particular disadvantage because they are often not deemed acute enough for admission to a public hospital and often do not access private health services because the services provided may not be appropriate for young people and/or they simply cannot afford the necessary level of private health cover. At such a vulnerable time in their life, further options need to be pursued to give young people access to age-appropriate services and care options. Appropriate care at this time will rehabilitate and often prevent long-term illness while inappropriate care at this time can lead to ongoing mental health issues and increasing illness throughout their life.

Private hospitals in the Catholic system have identified concerns with providing care to children and young people. A shortage of beds for this group exists in private hospitals as well as the public system. In addition, services for children and particularly adolescents are often associated with long stays and very intensive care. Hospitals have expressed concern that the ‘standard’ conditions imposed by health funds (such as short lengths of stay and low per diem funding) restricts the level of service that can be provided within the funding caps. (Private health issues are discussed in further detail later in this submission).

Several Catholic sector providers have stated that increased in-home support and respite services would go a long way to meeting the needs of young people and their families. Another gap which has been identified is the need for in-home support and respite for parents with a mental illness who have young children. Some Catholic providers have also pointed to a lack of peri-natal mental health care and appropriate services for mothers suffering from acute post-natal depression. Inadequate care at this critical time

[28] References cited in Hickie *et al*, 2005.
[29] Evaluation of the Second National Mental Health Plan, p24
[30] International Mid-Term Review of the Second National Mental Health Plan, p 12.

can leave mothers and their families in a desperate situation and lead to much more serious consequences for the mother and family in the future.

The issue of dual diagnosis is also relevant to young people and is discussed further below.

Ageing Australians

In many respects, Australia has made significant gains in the care needs of older people who have mental health issues. The support for dementia in the 2004 Federal Election campaign including making dementia a national health priority demonstrates that governments in Australia have recognised this particular aspect of mental health care as an important one worthy of investment and attention. Australia also has a good residential and community care sector that provides support to older people including for their mental health needs and these services and programs should continue to be supported and enhanced.

In Australia there can be confusion and fragmentation about the linkages between the aged care program and general mental health services. The International Mid-Term of Review of the Second National Mental Health Plan correctly pointed to the need to plan for the growing number of people over 65, particularly in the area of psycho-geriatric services which is progressing too slowly for the emerging need. This review also pointed to lack of clarity between the responsibilities of the general health sector and aged care mental health services with respect to those with physical illnesses or disabilities and cognitive impairment.[31]

So while Australia has made some substantial gains in the treatment of mental health illness in older people, there is a long way to go and as the population ages, Australia needs to devote further resources and commitment to reducing the current fragmentation of service delivery and build better links between the professional aged care and mental health services including between geriatricians and psycho-geriatricians.

People with a Dual Diagnosis

One of the areas of greatest challenge in mental health is in cases of dual diagnosis, in particular when a person has both a mental illness and suffers from substance abuse. The administrative separation of mental health and substance abuse services at Commonwealth and State/Territory level can act against the interests of those with dual diagnosis.[32]

On the other hand, there is a view that full service integration is not the solution to the current fragmented system. The *Out of Hospital, Out of Mind Report* certainly concurred with the view that service provision for those with dual diagnosis needed significant improvement. However, the Report also noted that full service integration may be detrimental to those who do not have a dual diagnosis. In fact it was reported that such

[31] Ibid, p12, 17
[32] Ibid, p17

integration could lead to further stigmatisation if mental illness and substance abuse were always closely associated.[33]

There is a delicate balancing act that needs to occur. For those who have a dual diagnosis, there can be fragmentation and confusion in the disparate services and this needs addressing. However, this cannot be done in a way that assumes mental illness and substance abuse always go together. Further work needs to be done to develop appropriate service responses to integrate services where this is appropriate.

40 to 55 year olds with chronic mental illness and the homeless

This group is not generally identified in the literature and evaluations on mental health delivery in Australia. However, an inner-city Catholic community care provider has identified this group as missing out in the current health system. This group often have long term/chronic mental health issues, poor adaptive behaviour and are socially isolated. They often require ongoing support which is not going to be met by short-term intervention and the extent of their illness excludes them from early intervention and rehabilitation services. They are particularly disadvantaged because of their age as they are not picked up by early intervention and rehabilitation services (where they exist) and are too young to be eligible for aged care services including home and community care packages.

Many people in this group are homeless (noting however, that the concerns related to homeless people with mental illness extend well beyond this age group). Providers of emergency accommodation and support services such as the St Vincent de Paul Society have noted the devastating consequences of insufficient funded crisis accommodation beds and a lack of appropriate mental health services for people who are homeless.[34] Those who are already marginalised, become even more so.

In one Catholic inner-city hospital, 60% of the patients admitted to the mental health inpatient unit are of no fixed address, while many of the other 40% are either transiently homeless, are visitors to the area or live in hostel accommodation in the inner city.

Clearly, further work needs to be done by both levels of government to meet the needs of this group who are currently falling between the cracks of the range of mental health, drug and alcohol, disability and housing services.

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[33] Groom et al, *Out of Hospital, Out of Mind*, p30-31.

[34] See St Vincent de Paul, *A Long Road to Recovery: A Social Justice Statement on Mental Health*, SVDP NSW/ACT, July 2001 and Sydney City Mission, Society of St Vincent de Paul, Salvation Army, Wesley Mission and the Haymarket Foundation, *Shifting the Deckchairs: Homeless People and Mental Health Services in Inner City Sydney,* August 1997.

The following is a case study from a Catholic hospital provider reflecting a service that met the needs of one man who was in his fifties, homeless and suffering from a mental illness.

Case Study – John in Sydney

Recognising this need of providing services to homeless people with a mental illness, one of our member organisations designed a Service to respond to that need. The Service commenced in 1997 following a comprehensive feasibility study on the needs of homeless people in Sydney's inner Western Suburbs.

The consultant's concluded that the essential aspects of the project should be:
Supported accommodation services accepting of the target group
Affordable housing within the community
Recreational, vocational and social opportunities for residents
Clinical support resources and the ability to rely on these resources
Support services such as advocacy, information and advisory services
Compliance with the broad principles contained in the National Standards for Mental Health Services, the New South Wales Disability Services Act (1993) and the NSW Disability Services Standards Financial viability.

This non-clinical Service continues today offering accommodation, support and advocacy. The clinical support comes from the various Mental Health Teams located in the Sydney Metropolitan Area. Clients normally present as homeless with poor medication compliance, no regular doctor, poor budgetary skills and no support systems. It is the experience of the staff that if these areas are addressed things improve and clients become more self-sufficient and can ultimately move into independent living arrangements.

The story of John (not his real name) is just one example of the positive outcomes that have been achieved and could be replicated with appropriate resourcing. John, now aged 55 years, was first referred to the Service in 1998 after being hospitalised for six months. His history indicated that he had several previous admissions and each time he had been discharged to arranged accommodation it only lasted a few weeks after which he ended up living on the street and the cycle would begin again. He would be picked up by the police and taken to hospital in an acute psychotic state.

John was interviewed and accepted into the accommodation program. Support structures were put in place to assist John with:
A medication compliance.
B finding a general practitioner or case manager.
C social skills.
D budgeting skills.
All was not plain sailing and over the next six months many issues arose, for example, not being able to manage his money. John would purchase cigarettes rather than medication. It was at this stage he was readmitted to hospital in an acute psychotic and paranoid state.
John returned to the Service sometime later after agreeing that his finances be managed by the Protective Commission. Over the next two years he built up a trust with staff and whilst being very compliant with the program he was at times very delusional. In September 2001 he was offered a Department of Housing unit in the inner city. John was given assistance to furnish the unit and move in. Even though John continues to maintain contact with the Service, he is now able to live with dignity and independence.

CHA contends that one of the reasons there are gaps in services generally and why certain groups continue to fall through the cracks is because both levels of government are not really held accountable for the mental health status of their communities. Governments should be aiming towards marked percentage improvements in the health status and quality of life in the population generally and in particular for vulnerable groups.

While it has been pointed out that mental illness incidence across countries is on the rise, this is no reason to shy away from bolder, ambitious targets that would demonstrate Australia's real commitment to meeting this emerging need and slowing, and indeed reducing this trend.

Recommendations:

- **Commonwealth and State/Territory Governments to set targets for improvements in mental health outcomes across the community and for specific groups in greatest need and be held accountable for meeting these targets.**
- **Develop national standards of care for the mental health needs of people in prisons and immigration detention centres.**
- **Substantially increase services to children and adolescents including further funding to increase family and home visiting programs.**
- **At both the Commonwealth and State/Territory levels, foster greater links and joint funding for combined aged care and mental health services.**
- **Undertake further research on best practice models for providing services to Indigenous people and people with a dual diagnosis.**
- **Provide grant funding to non-government organisations providing care to those in the middle-aged category who often miss out on existing services and often have complex needs.**
- **Increase the funding available to organisations that provide comprehensive services to homeless people with mental illness.**

Medicare and Mental Health

As referred to earlier in this submission, less than 40% of people who have a mental illness access some form of care. When care is accessed it is mostly provided through

GPs. CHA supports the concern raised in the *Out of Hospital, Out of Mind* report that the declining levels of bulk billing will result in fewer people accessing the care they need. We note that GP bulk billing rates have started to increase over the last twelve months and this may begin to allow greater access to GPs for those who need to – including those with mental health conditions. This is a welcome development, however, we will need to watch closely to see if this increase is sustained over time. Unfortunately, the recent increases in the Medicare Safety net thresholds mean that those on lower incomes will be less likely to receive the care they need if it is going to involve significant out of pocket costs including those that may arise from repeated visits to GPs or psychiatrists as in the case of mental illness.

The situation may be worse when accessing a private psychiatrist. In a familiar tale in the changing Australian health landscape, the level of user contributions in paying for psychiatry services has been on the rise. Using figures outlined in the National Mental Health Report 2004, Hickie *et al* (2005) found that since 1995-96, total out-of-pocket expenses per attendance increased by 48.6%[35]. While CHA notes the recent figures which indicate some reductions on copayments across general practice and psychiatric services, it is imperative that health funding policy ensures people on meagre incomes have the options and capacity to access GP and specialist psychiatric services when and as they need it.

On a positive note, the Australian Government's *Better Outcomes in Mental Health Care* program has been a welcome step in providing GPs with greater access to education and training on mental health and accessing resources such as psychiatrist support to help with the issues presenting in their practice. The Strengthening Medicare initiative to enable GPs to provide referral to psychologists was a welcome initiative. However, the eligibility for this initiative is very restricted and the support limited to five sessions.

Clearly there is scope to expand these type of initiatives and build on the gains made to increase access to support and advice for GPs, encourage GPs to have longer consultations with patients who have mental illness and increase the scope of Medicare to enable referrals to allied health professionals where this is the treatment deemed appropriate. Experience in the Catholic sector also lends support to the role of liaison workers to operate at the interface between primary healthcare, specialists, and public mental health services to look after people who no longer need ongoing specialist care.

Recommendations:

- **Use the MBS to support increased access to longer consultations with GPs, greater use of allied health and telehealth options.**
- **Fund liaison officer positions to provide better links between general practice, mental health specialists such as Psychiatrists and the public mental health services.**

Mental Health and the Private Health Sector

[35] Hickie *et al*, 2005.

Private health care is making a significant contribution to mental health care in Australia. As part of their mission, many private Catholic hospitals provide mental health care services, often providing specialty services and offering assistance to those who cannot afford to pay through their charitable and social accountability programs.

There has been a substantial growth in the private psychiatric hospital sector over the course of the National Mental Health Strategy. The number of hospital providers and total inpatient bed capacity have both increased by 38% and revenue by 107% between 1992-93 and 2001-02. This 2004 Report also points out that these increases have occurred in parallel with reductions in the size of the public sector inpatient system, elevating the relative contribution made by the private sector in providing in-patient psychiatric care in Australia.[36]

The increasing use of private hospitals has to a certain extent been the result of greater collaboration between the private hospitals, the Australian Government and private health insurers. There have clearly been some moves to support innovative solutions to mental health funding in the private sector. The National Mental Health Report 2004 identifies that alternative funding approaches have been adopted such as ‘hospital in the home’ that enable treatment in the patient’s home environment to avoid the requirement to be physically located in the hospital where this is clinically unnecessary.[37]

While some private health insurers are demonstrating willingness to negotiate contracts with private sector providers that offer a range of inpatient and home based care models in metropolitan areas, this is not always the case. In the experience of one Catholic provider with considerable experience in psychiatric care provision, domiciliary services are almost a thing of the past as far as most health funds are concerned. In their experience, while there is considerable talk about deinstitutionalisation and community-based care, the health funds’ unwillingness to fund home care/visits renders such initiatives to be simply rhetorical.

Catholic providers have expressed a concern that health funds are resistant to fund programs that include socialisation components and there is often a view that only ‘hard-core’ clinical treatment is considered therapeutic and worthy of funding. Other ‘soft-core’ elements that complete the holistic approach are discouraged or rejected outright. For example, some hospitals have found health funds not to be supportive of the introduction of new services such as inpatient mother-baby units to assist new mothers and families in dealing with post-natal depression. As stated by one hospital provider, this seems a short-sighted view when considering the longer term health implications of not dealing with the issue in the early years.

A concern has been expressed within the Catholic sector that through the specifications set down by funds as to what will and won’t be funded, the health funds (through control of the funding for private operators) can effectively dictate how ‘good psychiatry’ ought to be practiced, and for smaller hospital providers there is simply no choice but to abide by

[36] National Mental Health Report 2004, p35.
[37] Ibid, p 35-36.

what is prescribed. For example, many private health insurers fund episodic payments and step down after 14 days and this makes some psychiatric services unviable for private hospitals.

Many smaller private hospital providers in rural and regional Australia face a difficult contracting environment in which funders are generally unwilling to negotiate contracts that come close to meeting the costs of providing mental health services, although at times they may be the only provider willing to provide a service that enables the patient to be accommodated and treated within reasonable geographic proximity to family and friend support structures.

The Catholic private hospital sector has also identified concerns with the rigidity of the private health funding system – which under the provisions of the *National Health Act* limits health funds to only paying for services from hospital tables that relate to in-hospital treatment and only to items for which a Medicare benefit is available. Access to funding from private health insurers for services provided by other professionals such as psychologists, social workers, nurse practitioners and occupational therapists is either not available or only available to those with ancillary cover from some allied health practitioners on a limited basis. Benefits are generally capped in terms of either total benefit paid over a 12 month period or number of services or both. The end result is that benefits available often fall well short of the fees charged in order to access these services. In many instances it is the care and services provided by these professionals that would be most beneficial to a person, but the funding structures do not encourage or support their use. The involvement of such professionals at the right time may be more efficacious and cost-effective than those services that are currently funded.

The packaging by some private health funds of mental health as an 'optional' extra, rather than an essential component of health, leads many people without cover for mental health and psychiatric services. Even when mental health is included in the insurance coverage, portability of private health insurance can be problematic and is an area that could be markedly improved with appropriate policy and legislative responses. For psychiatric services a problem exists whereby some funds have been imposing on privately insured health fund members who transfer from another fund a waiting period or "benefit limitation period" (which is where you don't have to wait, but you get paid less for a certain time) for services such as psychiatry and rehabilitation. This has been done notwithstanding that a member has already served out the relevant waiting periods with the fund they have left. The current wording of the *National Health Act* and Regulations can be interpreted to allow funds to impose these restrictions. This situation currently means that if someone leaves a fund that no longer has a contract with a hospital or didn't have a contract with a hospital, and joins another fund that does have a contract with a hospital, this is essentially seen as an upgrade in the health insurance product and a waiting period is required.

Given the pressure the government has placed on people to take out private health insurance, this is an unfair system which unnecessarily penalises people who are making decisions about which health fund will best meet their family's needs and enable them to access appropriate care in a suitable location. CHA supports calls to improve the portability arrangements between health funds.

The Catholic private hospital sector has also identified that neither Medicare or private health fund payments adequately meet the costs of providing mental health services to particular groups such as culturally and linguistically diverse people, young people and people with a chronic serious mental illness. These people are often provided with services funded by the charitable works of the Catholic hospital sector or where appropriate service cannot be provided in the private system, people may need to be referred to an already overstretched public system.

CHA supports a major role for private hospitals in the delivery of mental health care, however is concerned that it is only those who can afford high levels of private health insurance coverage that receive the extra benefits provided by many private hospitals. For people on lower incomes, the higher level of premiums for mental coverage and/or the gap between service cost and private health cover insurance benefit payment is a barrier for many people.

Private health insurers have placed too many restrictions on the types of services they will fund and by their rigid funding controls have essentially defined how private mental health and psychiatric services are delivered in Australia. This is not in the interests of consumers, health professionals and for the community generally.

Recommendations:

- **The Commonwealth Government to work with the private health insurance industry to ensure that mental health cover is appropriately funded under private health premiums and not considered an optional extra.**

- **Work with the private health insurance industry to examine models which will enable greater funding of allied health professionals providing mental health services; support innovative service models and which will ensure rural and remote hospitals are fully funded to provide mental health care.**

- **The Commonwealth Government to work with the private health insurance industry and amend the *National Health Act* to ensure portability of access to psychiatry services when changing health funds.**

Mental Health and Workforce Issues

As with many parts of the health workforce, mental health worker shortages are common across all jurisdictions. As an area of increasing need, this does not bode well for providing high quality care and support for people with mental illness now and into the future. While mental health shares many characteristics with the rest of the health

workforce, the need to look at ways of supporting the existing workforce and encourage others to join it are particularly paramount in the mental health sector. Andrews (2005) claims that psychiatrists in training, who staff public hospitals and community services, find it uncongenial and resolve to leave the public system; and nurses who are no longer trained within the system resolve not to enter it.[38]

Governments have been aware of the workforce deficit for some time. The International Mid-Term Review of the 2nd Mental Health Plan referred to:

> a serious, if not critical, mental health workforce shortage in numbers, poor distribution of providers of all disciplines, and outmoded delivery models in practice and reimbursement that do not achieve the maximum services for the workforce that exists.[39]

Attempts to attract health professionals from other areas of the health system simply take from one limited pool to top-up another limited pool. Clearly measures need to be implemented to attract and retain health professionals with mental health expertise. However, this should not be done at the expense of other areas of the health sector.

Some areas of mental health service delivery require a concerted effort to attract and retain qualified staff such as in the area of mental health service delivery for Indigenous Australians. Further resources and commitments should be made to developing partnership programs with generic mental health services and targeted training programs to increase the participation of Aboriginal health workers in mental health service provision. Scholarship programs to train Aboriginal medical practitioners and nurses in mental health, as well as specialised training programs in mental health for all health professionals working with Aboriginal communities would assist.

Access to training and professional development opportunities is critical in attracting and retaining staff in all fields of mental health service delivery. In State/Territory public health budgets, staff from the Catholic sector have reported that there is simply no funding or extremely limited funding for professional development or training and addressing this situation alone would go some way to encouraging professionals to stay in the sector.

Other measures which have been mentioned in this submission have included opening Medicare and Private Health insurance further to enable allied health professionals to take some of the case work in mental health. This would take some of the pressure off over-stretched GPs and nurses while at the same time providing all health professionals with greater access to multi-disciplinary working environments.

Providers in the Catholic sector have also identified that there is considerable scope to improve the private/public psychiatry interface. The experience of private psychiatrists is valuable and if more of this experience could be shared with the public sector, the benefits to patients and the mental workforce would be substantial. Further policy and funding models need to be explored across government to encourage private

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[38] Andrews, G. 2005 *op cit.*

[39] International Mid-Term Review of the Second National Mental Health Plan, p11.

psychiatrists to do more public sessions and to share their expertise with the public sector mental health workforce.

Mental health must also be part of more general measures that all levels of Government must be adopting to increase the general capacity of the health sector to meet Australia's future health needs.

Recommendation:

- **Develop policy and funding models to encourage private psychiatrists to do more public sessions and to share their expertise with the public sector mental health workforce.**

Carer/Consumer Involvement

Across the health and aged care system, carers provide the backbone for the support and care provided to people who for a range of reasons are not able to fully care for themselves. This is certainly the case in mental health. According to one report, carers on average contribute 104 hours per week care for a person with a mental illness.[40]

For this reason carers together with mental health consumers should have a greater voice in the policy and programs which are provided by governments and non-government organisations. Further, carers should be able to access all the care and support they need to help them in their caring role. In this regard, Australia has certainly paid lip service to including carers and consumers in policy and planning processes. However, in several of the reviews undertaken on the state of the mental health system over the years, there is a constant criticism that carers and consumer feel excluded from the decisions that most affect them.

> Whilst the principles of consumer and carer participation in the development, implementation and evaluation of the mental health system appear to be enshrined in the National Mental Health Policy and Plans, there appears to be a lack of genuine consumer and carer involvement in mental health care or reform at the jurisdictional, regional and local levels.[41]

Similarly the 2004 National Mental Health Report found that consumers and carers consistently argue that, although progress has been made in the structural arrangements for their representation at state and territory levels, substantial work remains to create a 'client responsive' culture in mental health services.[42]

Clearly there is more work to be done in involving carers and consumers in all aspects of the policy, planning and delivery of mental health services across all levels of government

[40] Mental Health Council of Australia/Carers Association of Australia Inc, *Carers of People with Mental Illness Project Report,* June 2000, p 4
[41] Groom et al, *Out of Hospital, Out of Mind,* p16.
[42] *National Mental Health Report* 2004, p9.

and within service facilities. In various consultations, consumers and carers have raised the importance of consumer and carer networks and non-government organisations as critical to the success of the National Mental Health Strategy[43]; voiced concern about the capacity of mainstream support mechanisms to target the needs of people with mental

health illness and their carers [44]; and called for increases in funding for respite care and research into models of respite care.[45]

Professionals working in Catholic sector have identified the lack of respite services to be a major barrier to care and support. One professional who has experience of the United Kingdom and New Zealand systems expressed alarm at Australia's dismal effort in providing this support. In these other countries, respite was considered a standard component of the continuum of care. The lack of respite care means that a significant group of people are admitted to hospital when they could be more adequately and appropriately cared for in community based residential settings.

It is imperative that all governments increase measures which ensure that carers and consumers of mental health services are actively engaged in the policy and planning of mental health services. Token measures are patronising and don't lead to service delivery improvements. Service providers including hospitals and community care providers must also take this commitment seriously and build on existing consultative mechanisms with consumers and carers. Improved funding for employment of consumer consultants would enable a more active role for consumers and carers in service development and staff education.

Further, all support measures whether provided in the mainstream health or community care sector, particularly respite must be examined across the board to identify the barriers to access by people with mental health and their carers. More respite services must be provided as a priority. Respite is a relatively low-cost but effective support mechanism to give carers a break and to minimise crisis situations and unnecessary referral to more complex and expensive treatments.

Recommendations:

- **Commonwealth and State/Territory governments and non-government organisations to work with consumers, carers to develop effective strategies to ensure carers and consumers are active participants in policy and funding decisions that affect them.**

- **Substantially increase the level of funding available for respite services – this need is seen across the spectrum of all health services – aged care, mental health and disability, suggesting the need for a more concerted respite strategy by government.**

[43] Groom et al, *Out of Hospital, Out of Mind,* p17
[44] *Carers of People with Mental Illness Project Report*, p5.
[45] Groom et al, *Out of Hospital, Out of Mind,* p18.

Cross-Sectoral Linkages

Experience from within the Catholic health and aged care sectors suggests there is a lot more work that can be done to improve cross-sectoral working. Mental health is not just a health issue. It impacts - and is impacted by - policies and programs in housing, transport, education, employment, disability, geriatrics, child and family services to name a few.

Mental health consumers not only have to battle the funding and program splits between Commonwealth and State/Territory levels, but they also have to navigate their way around siloed funding across the various programs areas.

The National Mental Health Plan 2003-08 does refer to outcomes and directions that aim to foster better linkages between the various sectors and feedback would suggest that some States and Territories are at various stages in developing these linkages. However, the *Out of Hospital, Out of Mind* Report found that when consumers are discharged from hospital, it is not uncommon for them to be left without any accommodation options and end up on the street; it was reported that many consumers lose their housing during their hospitalisation.[46] This is one obvious example where cross-sectoral issues are clearly not working.

The confusion about where to access appropriate services exists for consumers, carers and non-government organisations supporting them. In the experience of one medical professional working in the Catholic system trying to navigate the system to help patients, funding is sought from a number of relatively unrelated sources - and care – despite the best efforts of providers to collaborate with one another is patchy at best and randomly targeted at worst.

While situations like this occur, there is clearly a lot more that can be done by governments at all levels to improve inter-sectoral working and provide a more holistic model of care and support for mental with mental illness and their carers.

Recommendations:

- **Acknowledge the fundamental link between housing and mental health services providing funding flexibility in supporting organisations that enter into partnerships to ensure people with a mental illness are adequately housed in the community.**

- **All levels of government to improve cross-sectoral funding allocations and policy responses affecting mental health and produce appropriate information strategies to assist consumers, carers and non-government organisations to access the most appropriate support services to meet their needs.**

[46] Groom et al, *Out of Hospital, Out of Mind*, p20.

Summary of Submission Recommendations

- **Support the Mental Health Council of Australia (Out of Hospital, Out of Mind) recommendation that mental health expenditure should be increased to at least 12% of national health expenditure.**
- **Set policies across Commonwealth and State/Territory Governments to ensure mental health budgets are quarantined from budget cuts or leakages to other programs, and publish annual reports on budgets and actual expenditure.**
- **Apply real indexation of health grants to be matched by States/Territories to ensure that there is adequate financing of mental health services, reflecting growth, demand and severity of illness in society.**
- **Ensure models of financing community based mental health care are comparative to appropriate acute services. This will ensure that people who need a particular level of service are able to access it and there are no barriers to care because of outdated models of financing at State and Territory level.**
- **Develop strategies across all levels of government to effectively engage the non-government sector in mental health planning, policy and program implementation.**
- **Increase funding across Commonwealth and State/Territory governments for initiatives which support integrated models of care between the public, non-government and private sectors.**
- **Substantially increase funding for rehabilitation and step-down care facilities and beds.**
- **Commonwealth and State/Territory Governments to set targets for improvements in mental health outcomes across the community and for specific groups in greatest need and be held accountable for meeting these targets.**
- **Develop national standards of care for the mental health needs of people in prisons and immigration detention centres.**
- **Substantially increase services to children and adolescents including further funding to increase family and home visiting programs.**
- **At both the Commonwealth and State/Territory levels, foster greater links and joint funding for combined aged care and mental health services.**
- **Undertake further research on best practice models for providing services to Indigenous people and people with a dual diagnosis.**
- **Provide grant funding to non-government organisations providing care to those in the middle-aged category who often miss out on existing services and often have complex needs.**

- **Increase the funding available to organisations that provide comprehensive services to homeless people with mental illness.**

- **Use the MBS to support increased access to longer consultations with GPs, greater use of allied health and telehealth options.**

- **Fund liaison officer positions to provide better links between general practice, mental health specialists such as Psychiatrists and the public mental health services.**

- **The Commonwealth Government to work with the private health insurance industry to ensure that mental health cover is appropriately funded under private health premiums and not considered an optional extra.**

- **Work with the private health insurance industry to examine models which will enable greater funding of allied health professionals providing mental health services; support innovative service models and which will ensure rural and remote hospitals are fully funded to provide mental health care.**

- **The Commonwealth Government to work with the private health insurance industry and amend the *National Health Act* to ensure portability of access to psychiatry services when changing health funds.**

- **Develop policy and funding models to encourage private psychiatrists to do more public sessions and to share their expertise with the public sector mental health workforce**.

- **Commonwealth and State/Territory governments and non-government organisations to work with consumers, carers to develop effective strategies to ensure carers and consumers are active participants in policy and funding decisions that affect them.**

- **Substantially increase the level of funding available for respite services – this need is seen across the spectrum of all health services – aged care, mental health and disability, suggesting the need for a more concerted respite strategy by government.**

- **Acknowledge the fundamental link between housing and mental health services providing funding flexibility in supporting organisations that enter into partnerships to ensure people with a mental illness are adequately housed in the community.**

- **All levels of government to improve cross-sectoral funding allocations and policy responses affecting mental health and produce appropriate information strategies to assist consumers, carers and non-government organisations to access the most appropriate support services to meet their needs.**