ACROD

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ACROD SUBMISSION TO THE SENATE SELECT COMMITTEE ON THE PROVISION OF MENTAL HEALTH SERVICES IN AUSTRALIA

Summary

The principal focus of this submission is the provision of services by specialist disability agencies to people with psychiatric disabilities, albeit in the broader context of mental health care in Australia. The submission specifically addresses:

- definitional and conceptual issues; and the implications for inter-sectoral collaboration;
- dual diagnosis;
- the significance of episodic mental illness;
- the status of autism as a disability;
- barriers to employment; and
- a comparison with the interface between aged care and disability services.

The key recommendation is for a process that clarifies the pertinent definitions; argues for significantly greater knowledge transfer among all service providers; improves the collection of accurate and informative data; and provides a basis for consistent needs assessment, review and service delivery, with a view to enhancing linkages among the relevant service providers to secure effective integration. This applies with particular force to the need for greater attention to and funding for early — pre-crisis — intervention.

Introduction

As the National Industry Association for Disability Services, ACROD welcomes the opportunity to make a submission to the Senate Inquiry into Mental Health.

We do so with particular regard to the following terms of reference:

- 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;

- 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;

- the appropriate role of the private and non-government sectors; and

- 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.

The general question of mental illness is now receiving the national attention it has long required. ACROD notes in particular the contributions being made by the Mental Health Council of Australia and the Human Rights and Equal Opportunities Commission in educating the public about the several issues involved and in proposing policy options to deal with it.[1]

'The weight of evidence presented to the Committee highlights that mental health services in New South Wales need revolutionary improvement. Deinstitutionalisation, without adequate community care, has resulted in a new form of institutionalisation: homelessness and imprisonment.'

NSW Parliamentary Committee on the consequences of deinstitutionalisation, 2002.

This submission focuses on matters of direct application to ACROD members. But it does so with regard to the broader context of mental health services in Australia (and which other interested parties will doubtless address in more detail). Given that our main proposal is the need for better coordination among services, based on a consistent means of identifying mental illness and devising early and appropriate intervention, it is important at the outset to stress the need to recognise and improve linkages among the several agencies concerned.

Definitional issues, knowledge transfer and data collection

As demonstrated in the latest Productivity Commission report on government services, any working definition of mental health is necessarily broad, and takes into account a wide range of service providers. The Commission's main definition is as follows:

Mental health relates to an individual's ability to negotiate the daily

[1] See in particular I. Hickie, G. Groom & P. McGorry, 'Australian mental health reform: time for real outcomes', *Medical Journal of Australia,* 182, 8, 2005. The authors stress the need for 'a radical rethink', proposing that at least 60 per cent of people with a mental illness should receive care; that an extra $1 billion a year should be spent on mental health; but that this also requires simultaneous structural reform.

> challenges and social interactions of life without experiencing undue emotional or behavioural incapacity ... Problems and disorders that interfere with this ability and diminish quality of life and productivity include cognitive, emotional and behavioural disorders.[2]

The services involved include public hospitals, primary and community health, aged care, school education, corrective services, emergency management and services for people with a disability.

ACROD members deal with the last category, providing support in the areas of employment, accommodation, children's services, respite care and social participation.[3] The number of people of all ages with a reported psychiatric disability is estimated at 768,900 or 4.1 per cent per cent of the total population. Of these 398,300 or 2.1 per cent have a severe or profound disability. This compares with 503,000 or 2.7 per cent with one or more intellectual disabilities, of whom 301,900 or 1.6 per cent have a severe or profound disability.[4] Approximately 26 per cent of people receiving the Disability Support Pension and 30 per cent of Open Employment clients are recognised to have a psychiatric disability.

These figures, however, should be treated with caution. The incidence of mental illness in general is far more widespread. The Australian Bureau of Statistics has estimated (using 1998 data) that 2,383,000 or one in six adults have an identifiable mental disorder; and that the rate for those aged between 18 and 24 is 27 per cent.[5] More generally, mental illnesses are the third leading cause of overall disease burden; and in terms of morbidity — measured by life years lost to disability — they are the leading cause of disease burden.

More specifically, with regard to ACROD services, many of those identified as having primarily psychiatric disabilities also have other disabilities — usually intellectual, but also physical — and the judgement about which is primary is often contestable. Indeed, in many cases the distinction between primary and secondary disabling conditions is in itself open to question.

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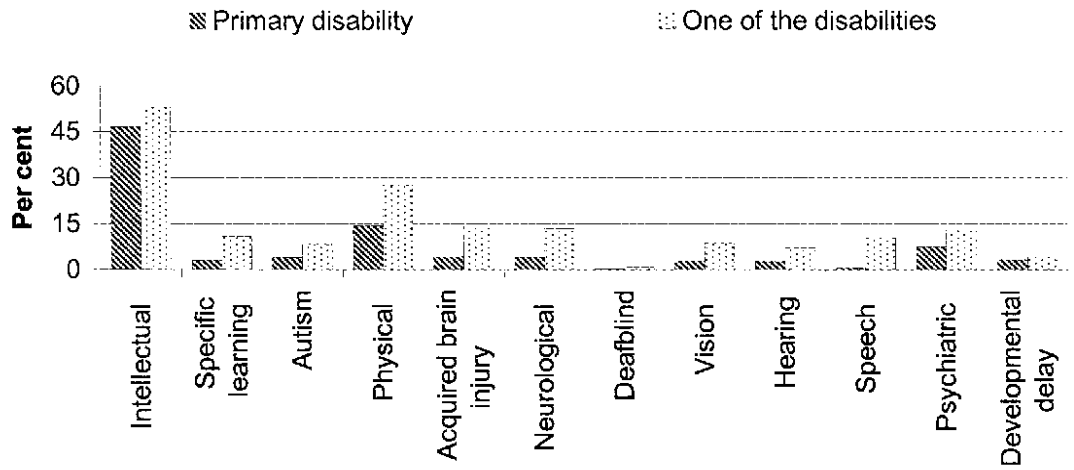
[2] Productivity Commission, *Report on Government Services 2005,* Canberra 2005, p. 11.33. It should be noted the Commission also offers another definition: 'the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, the optimal development and use of mental abilities (cognitive, affective and relational) and the achievement of individual and collective goals consistent with justice' (p. 11.34). The different emphases are indicative of the general definitional problem and of its impact on data collection and evidence.

[3] Employment services fall into two categories: Open Employment services which apply specialist skills to assist people with disabilities to prepare for, find and maintain employment; and Business Services, which provide long-term supported employment for people with more severe disabilities.

[4] Australian Institute of Health and Welfare, *Australia's Welfare 2003,*Canberra 2003, pp. 344-5. The Institute identifies psychiatric disability as 'associated with clinically recognisable symptoms and behaviour patterns frequently associated with distress that may impair personal functioning in normal social activity' (ibid., p. 342).

[5] The Hon. John von Doussa QC, Keynote address to the National Mental Health Strategy — Future Challenges Meeting Broader Community Need, November 2003. Commonwealth documentation on the National Mental Health Strategy puts the estimate at more than 20 per cent of the adult population.

Service users by disability group, 1 January 2003 to 30 June 2003



Source: *Productivity Commission,* Report on Government Services 2005, p. 13:10.

This highlights the central importance of definitional and conceptual clarity. Precisely because the notion of mental health is of its nature amorphous, it is crucial it be used with functional consistency among the various services of which people with mental illness may become clients. It is necessary to avoid confusion among policy makers and all types of service provider. Both initial needs assessment and subsequent reviews require sensitivity to the individual's particular condition and the ways in which it may be expected to change over time.

The practical implications are considerable. They include the danger that people may be streamed into the wrong service system and thus receive the wrong service response. There are also obvious implications for the question of unmet need. An inevitably vague concept at the best of times, 'unmet need' becomes especially problematical when there is variation among organising definitions. Precisely because of this, it is essential that estimates of the problem be taken more seriously and carefully than in the case of more tractable data.

One of the main weaknesses of the current system is the lack of knowledge transfer among the several service providers involved in dealing with people who have mental illness and the concurrent lack of inter-sectoral collaboration. Because of the continuing prevalence of the medical model of mental illness, health and allied services tend to be viewed as primary (if not superior) and all others as secondary (if not, in extremis, optional). The need to promote inter-sectoral partnerships was a central policy recommendation of the first National Mental Health Plan, but this objective has not been realised in practice. The 2003-08 Plan has the same emphasis. It is essential that this time it be given effect.

The formal distinction the Productivity Commission makes between mental disorders and mental health problems illustrates the practical significance of this issue. A disorder is defined as 'a diagnosable illness that significantly interferes with an individual's cognitive, emotional and/or social abilities'; while a problem is 'diminished cognitive, emotional and/or social abilities, but not to the extent that the criteria for a mental disorder are met'.[6] It is evident that assessment in borderline cases is extremely difficult with a considerable margin for error; and that any projection of unmet need will be inexact. This is exacerbated when mental illness is associated with some other physical or intellectual disability.

Dual diagnosis

Indeed, 'dual diagnosis' is the most significant general mental health issue facing ACROD services. This term refers to cases of individuals with at least two disabilities.[7] The most common combination is that of psychiatric and intellectual disabilities, though the term is also used in cases involving substance abuse in addition to one or more disabilities.[8] There are thus in many cases two sources of misunderstanding: the varying identification of mental illness and the possibility of confusion between intellectual and psychiatric disability.

Given the general preference for quantitative data, it is understandable the more quantitatively applicable traits should be preferred. Intellectual or physical disabilities are relatively straightforward to identify. They also tend to be constant and predictable. Psychological or psychiatric disabilities are far less so. There is also an understandable, if mistaken, common assumption that intellectual or physical disability is somehow more fundamental than a mental impairment. The practical result is that people with psychiatric disabilities are often put into agencies or institutions where their needs are not recognised and their treatment, if any, could be counter-productive.

Paradoxically, there is a danger of two opposed errors: the 'siloing' of people into a single category when at least two conditions are present; and the conflation of two conditions requiring distinct forms of treatment. In both instances, the individual's needs — which should be paramount — are

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[6] Productivity Commission, op. cit., p. 11.34.

[7] The general categories are intellectual/learning disability; psychiatric disability; sensory/speech disability; and physical/diverse, including acquired brain injury.

[8] To complicate matters, the ABS includes substance abuse disorder itself as a mental disorder. The coexistence of mental illness and substance abuse is well documented. ACT Health, for example, estimates that 'up to 80%' of people with a diagnosed mental illness also have a diagnosis of problematic substance abuse. Conversely, that up to 20 per cent of people presenting at alcohol and drug services have a co-existing mental illness. ACT Department of Health and Community Care, *Dual Diagnosis Stopping the merry-go-round*, April 1999, p. 1. Again, however, the reliability of data depends on definitions. The Victorian Government estimates that about 64 per cent of psychiatric in-patients have a current or previous drug abuse problem, with about 75 per cent of people with substance problems having a mental illness.
(www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Dual_diagnosis?)

subordinated to administrative convenience, if not financial economising.[9]

More generally, there is a serious lack of integration — or ordinary communication — between mental health and intellectual disability services, with no single point of entry and standard form of needs assessment. The result can be faulty diagnosis and unsuitable service provision or treatment. A not uncommon problem, for example, is the inappropriate use of medication on people with intellectual disabilities because of the misconception that their 'challenging behaviour' results from a perceived mental illness. Conversely, people with a severe mental illness may have this condition ignored because they also have an intellectual disability.

CASE STUDY ONE

J is a 32-year-old male with bipolar disorder. He gained a job through a disability employment service provider, working continuously for 24 weeks. A fortnight before the 26 weeks work needed for a Case Based Funding (CBF) Worker Outcome he again became seriously ill. J lost his job and was suspended from CBF for three months.

The employment agency tried to get J a case manager with the local Community Mental Health team when some of the early warning signs of his illness became apparent. Community Mental Health did not consider J to be a high need case, so no manager was assigned. His condition worsened to the point where he agreed voluntarily to go to intake (crisis care). The employment service had to accompany J to make sure he got there safely, the only alternative being to call the police. J was immediately admitted to hospital, remaining there for six weeks. During this time he lost his private accommodation.

It was only because of his critical illness that J was able to obtain mental health support. But by this time it was too late to stop him losing his job and his accommodation.

J's illness is now relatively stable, but he is still struggling to regain confidence and is not yet able to look for work. He is too embarrassed by his behaviour during his illness to contact his former employer and explain the circumstances, and is therefore unable to get a reference. We keep in regular contact with J to help him get him back into in the labour market.

The clearest instance of inappropriate treatment is the incarceration of people with both intellectual and psychological disabilities whose criminal behaviour would not meet the standard test of *mens rea*. Needless to say, the trauma of

[9] For example, the cost of maintaining a prisoner in jail (in NSW) is $50,000-$60,000. A mental health bed in the public hospital system costs up to $200,000 a year.

prison life only serves to worsen any pre-existing mental problems.[10]

Recent figures from NSW Corrections Health indicate, among other things, that:

- The 12-month prevalence of psychosis among the state's prisoners is 30 times higher than in the general Australian community.
- Seventy-eight per cent of male and 90 per cent of female prisoners are classified as having a psychiatric disorder in the previous 12 months.
- One in 12 has attempted to commit suicide in the same period.
- Forty-six per cent of reception and 38 per cent of sentenced inmates have suffered a mental illness in the previous year.
- Between four and seven per cent of sentenced inmates suffer a functional psychotic illness.
- The largest sub-group of the various prison populations (varying from 15-25 per cent) comprises those suffering from some form of intellectual or developmental disability[11]

The first concern of all agencies should be to meet the needs of the individuals for whom they provide a service. The most serious risk for those with a dual diagnosis is that their assessment will not reflect their particular needs but the administrative requirements of the provider (and ultimately government). This can result in unsuitable service provision and, without effective review, a long-term deterioration of the individual's condition.

Definitional clarity, accurate needs assessment and proper service provision go hand in hand. The issue of conceptual precision is not an academic but an eminently practical one, with serious implications for the well being of the heterogenous range of individuals affected — especially with regard, as noted, to the danger of individuals being streamed into the wrong service system.

The impact of episodic illness

A significant aspect of psychological disability is its episodic nature. This poses a particular problem for all employment agencies, but especially Open Employment services. As mentioned, predictability can be difficult. This gives

[10] For a more detailed argument, see S. Henderson, 'Mental illness and the criminal justice system', *Mental Health Co-ordinating Council*, May 2003.

[11] Quoted by Professor C. Puplick of the University of Wollongong Health Department, *Ockham's Razor*, ABC transcript, 20 March 2005, www.abc.net.au/rn/science/ockham/stories/s1325679.htm Professor Puplick also notes that NSW is the only mainland jurisdiction to imprison forensic patients: that is, people found not guilty by reason of mental illness.

rise to a number of potential difficulties. Among them:

- Needs assessment and the determination of service eligibility may be problematical. Most obviously, eligibility for the Disability Support Pension may vary, depending on the state of an individual's mental health at the time of assessment. (An individual is not either capable or incapable of doing the minimum number of hours' work, but sometimes capable, other times not. The needs assessment can easily be skewed.)

- Results-based accountability and performance reporting for service agreements may be affected. The requisite benchmarks, milestones or performance indicators cannot be predicted or met as readily as in the case of people with physical or intellectual disabilities. Quality control and risk management are affected at all stages.

- The kind of support Open Employment services have to provide will also vary, according to the individual's ongoing mental condition. The episodic nature of the disability introduces a variable which is likely to require a greater level of personalised support, with no additional funding.

Given these difficulties, there is a perverse incentive not to take on clients with mental health problems. One of the reasons many ACROD members face financial pressure is that they are reluctant to accept this incentive, resulting in inadequate funding for the level of support they actually provide.[12]

In addition to these general problems, recent federal court decisions (notably the 2003 High Court ruling in Purvis v NSW) have raised concerns that the notion of 'reasonable adjustment' — by employers to accommodate people with psychiatric disabilities under the terms of the Disability Discrimination Act (DDA) — may be subject to a far more restricted judicial interpretation than was previously the case.

The Human Rights Commissioner and Acting Disability Discrimination Commissioner has noted that such recent decisions could be seen as 'treating the DDA as covering only a lack of formal equality'. This, the Commissioner argues, is contrary to the intention of Parliament and 'would render the Act virtually worthless to people with any psychiatric disability that requires any significant accommodation'.[13]

CASE STUDY TWO

A is a 37 year-old male with depression and alcohol and other drug (AOD) abuse problems. The two are co-occurring, the AOD worsening with each

[12] However, it should be noted that disability services which specialise in the provision of support to people with psychiatric disabilities are allowed greater flexibility in their outlet capacity to reflect the impact of episodic conditions.
[13] Dr Sev Ozdowski, Mental health Council of Australia Annual Board Dinner speech, June 2004.

depressive episode. He has had employment support from a disability employment service for the past seven years.

The service often receives phone calls from A when he is in crisis. At these times he is usually intoxicated, abusive and threatening self-harm and suicide. He also loses case management from Community Mental Health between episodes. He is not considered a high need case while working.

The employment service has tried in the past to get AOD intervention and/or mental health crisis team intervention when A is ill. The mental health crisis team will not assist because he is under the influence of alcohol, drugs or both, and the AOD counselling services will not assist until he is sober. The only remaining option is to call the police. Unfortunately, this has been required on several occasions for A's safety and that of others. He is now on a good behaviour bond.

The most suitable jobs for A require a police check. If he breaks his bond it will be extremely difficult for him to find employment. This pattern has existed for A for the last seven years. Without proper access to timely mental health and AOD support it is likely that A will ultimately become unemployable.

The status of autism as a disability

Complicating matters further is the uncertain status of autism as a recognised disability. The collective notion of Autism Spectrum Disorders or Conditions may include Autism *simpliciter*, Asperger Syndrome, PDD-NOS and Atypical autism. Any of these may be associated with moderate, severe, or profound disability of an intellectual, physical and/or psychiatric nature.[14] The degree to which autism should be considered as a facet of mental illness thus depends on which conditions are included in the general classification and which kinds of disability they are associated with. The commonly quoted figure is that about one person in 100 has an autism spectrum disorder ranging from very mild to profoundly impaired.[15]

There is also a movement which has gained fairly significant support in the United States and United Kingdom for autism to be considered not as a disability at all, but as a distinctive culture, like Deaf culture. While Britain's National Autistic Society accepts that many individuals experience profound impairment and are properly recognised as having a disability or disabilities, those with less severe impairment consider themselves functioning members of society. The chief executive has written: 'They don't want to be patronised but do want people to recognise their condition — not to try to "cure" them but to recognise that they have a different outlook.'

[14] Autism Council of Australia, *Submission to the Lists of Recognised Disabilities Review*, December 2003, p. 1.
[15] No author, 'Support widens for the Autistic Liberation Front', *Sunday Telegraph*, 9 January 2005.

Interfaces

There is a parallel between service provision for psychiatric and other disabilities and the linkages (more precisely: the lack thereof) between aged care and disability service systems. Those who are ageing may have acquired disabilities specific to the ageing process; or alternatively have long-term disabilities which are exacerbated by ageing. Given the foundational emphasis on meeting individual needs — and all other things being equal — it should be crucial that the linkages between the systems reflect appropriate service provision for client needs.

All other things are not equal. Service linkages are woefully inadequate, with several boundaries militating against effective service delivery. To a large extent, these boundaries reflect accountability requirements and the structure of government programs and departments. Only NSW, for example, has a shadow minister with responsibility for mental health alone. Even in Victoria, where disability and mental health services are administered by the same department, the branches are quite separate, with mental health linked to the Health portfolio and disability services to Community Services. Elsewhere (and as confirmed by the Productivity Commission report) mental health services are spread across several departments. The demarcation of portfolio responsibilities solidifies what can to individual clients seem an arbitrary distinction between services.

CASE STUDY THREE

M is a 35-year-old woman with an intellectual disability and an anxiety disorder. She is on a final warning at her workplace, because as her anxiety worsens she tends to behave inappropriately. Only the support provided by the disability employment service has saved her from becoming unemployed.

The service has engaged professional behavioural intervention for M, but this has not been greatly successful. It is likely she will eventually lose her job. The employment service — a specialist psychiatric service — considers M would be better served by professional mental health support, as her inappropriate behaviours are triggered by her anxiety disorder. Because M has a dual diagnosis and is employed, she is not considered a high need case, so mental health teams will not engage with her.

The employment service knows from past experience that should M reach crisis point her dual diagnosis status makes it unlikely she will be admitted into acute care within the mental health system.

The lack of flexibility is a general feature of disability service policy. In part this is because of the divisions of responsibility between Commonwealth and State/Territory agencies under the terms of the Commonwealth State and Territory Disability Agreement (CSTDA). While there is in principle support for improved cross-jurisdictional service linkages, in practice the pathways are limited.

A further complication is governments' focus on managing rather than responding to demand and needs. This leads to a concern with equitable rationing methods instead of enhanced responsiveness to client needs and improved access to services.

Barriers to employment

It is generally agreed — and a cornerstone of current federal government philosophy and policy — that paid employment is the most effective means by which all individuals can achieve a meaningful role in society. This holds true *a fortiori* for individuals suffering a mental illness. It helps reduce the social marginalisation that tends to exacerbate the mental disorder in the first place. It can enhance self-esteem and control symptoms. At a more abstract but personally significant level, it can help these individuals assume something like the full rights of citizenship. Employment, in short, may be the best way in many cases of dealing with mental illness.

Yet, paradoxically, employment is far more difficult to find and retain for the very people who could benefit from it most. There are several reasons for this. Among the more important are the following (in no particular order as the hierarchy of barriers will vary according to individual cases).

- There are the inherent barriers associated with the various forms of mental illness itself. These include social as well as the more obvious cognitive, and perceptual skills needed for ordinary employment.

- There are several forms of stigma associated with mental illness, held by various groups including those who provide services for people thus affected. They include the general community, employers, potential or actual fellow employees, service providers — some in the Job Network — and the mentally ill themselves.

- There are inadequate provisions for educational and training facilities to aid the transition from care to work.

- The provision of health-based services in itself may work against effective workforce participation. Reflecting the medical model of mental illness, it may easily be thought that symptom control is sufficient 'treatment' to deal with the overall illness. Employment — or the training that might lead to it — may be considered an extra benefit, rather than the primary goal.

- Pharmacological and other forms of treatment provided by health-based services may have a significant impact on individuals' ability to undertake or be offered employment. Even where vocational interventions are taken seriously, they may again be considered secondary.

- As already noted, government funding structures reinforce the institutional divide among the various agencies, militating against the integration of

service provision which ought to provide complementary treatment, training and employment help.

There are two main policy implications to all this. The first is that employment — and the training necessary to enable it — ought to have a higher priority as an *end* of treatment and service provision. In other words, in as many cases as possible some form of participation in the workforce should be the goal of all agencies.

To this end, there should be a serious attempt to effect inter-sectoral collaboration, with employment service providers (in all forms) regarded as an integral part of the overall process. In policy terms, this is a long-term goal which will most effectively be achieved by a revision in the training of all services. Put bluntly, it will not be a question of the occasional inter-agency workshop, but of an overhaul of personnel training in which, for example, there is more accredited multi-disciplinary training — as between psychiatric and vocational curricula — at an acceptably high level. It is evident such a comprehensive commitment to knowledge transfer will be not only a long-term objective, but also a relatively expensive one.

Recommendations

There are three practical tasks it is in the interests of all those concerned with mental illness to address. *First* — as stressed throughout — there is a need for greater definitional and conceptual clarity, leading to greater and more systemic knowledge transfer. The point of these improved linkages is to facilitate collaborative responses by service streams to reflect and cater for the complex needs of the individual; as well as interventions that prevent personal problems escalating to crisis point. (The focus on crisis intervention is the response of a system strapped for funds.) To reiterate: this is one of the major concerns of the first National Mental Health Plan which now needs to be realised.

Secondly, and related to this, there is a need for more accurate and comprehensive data. As illustrated by the question of whether substance abuse is a form of mental illness, inconsistency over basic terms can lead to potentially misleading statistical evidence. It is generally recognised that the extent of mental illness is seriously underestimated.[16] As argued above, in the case of dual diagnosis there is an inherent bias towards identifying physical or intellectual disability as the primary condition.

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[16] As an illustration, Victorian Education Department figures show there are 23,083 Victorian students in school disability and language disorder programs in 2005, which marks a rise of 74 per cent compared with 2000. According to the Royal Children's Hospital expert said the figures were 'a significant underestimate', with most academics believing at least 10 per cent of school children have extra learning needs.

Third, there has to be greater consistency among services in the methodology of needs assessment and review, with the aim of improving linkages among the various agencies. Specifically, this will involve re-examining the interface between psychiatric and disability services (as with the interface between ageing and disability).

To these ends, ACROD *recommends* a joint initiative of major stakeholders to propose:

- Consistent definitions and cross-service procedures for the identification, assessment and treatment of people with recognisable mental disorders — including appropriate reviews, and with a full costing.

- An overhaul of training in all services which have people with mental illness as their clients, with a specific view to facilitating greater inter-sectoral collaboration.

- A review of government portfolio responsibilities at both commonwealth and state level to overcome the structural deficiencies in both policy and funding which currently reinforce sectoral disarticulation.

ACROD stresses that this proposal has the practical object of improving service provision for people with mental illness. It is not a proposal to engage in theoretical niceties but to focus on the concrete needs of a particularly vulnerable section of the community.

Conclusion

The major criticism to be made of current practice is that too many people with mental health problems or disorders 'fall through the gaps' and receive inappropriate services. While a central element of the National Mental Health Strategy is to move from an institutionally-based health system to one that is consumer-focused, the several factors canvassed — in particular, the lack of inter-sectoral collaboration — have undermined that objective.

Specifically for ACROD's clients, the tendency to conflate intellectual and psychiatric disability, or to categorise one condition as primary and the other as secondary, has meant that the true extent of mental illness in the population tends to be underestimated. Twelve years of mental health reform have not yet tackled the issue properly. This inquiry provides an opportunity to do so; and to provide the foundation for the kind of humane and adequately funded mental health system that a country as rich as Australia should have provided long ago.

About ACROD

ACROD is the national peak body for disability services. Its purpose is to equip and enable its members to develop quality services and life opportunities for Australians with disabilities.

ACROD's membership includes 550 non-government, non-profit organisations, which collectively operate several thousand services for Australians with all types of disabilities, including intellectual, physical, psychiatric and sensory. ACROD's members are located in every State and Territory in Australia and range in size from very small to very large.

In seeking to achieve its purpose, ACROD provides a wide range of advice and information to the disability services sector through its publications, conferences and seminars. Its consultative structures include a system of issues-based National Committees and State Sub-Committees, forums and interest groups that operate by correspondence/email, teleconferences and face-to-face meetings. ACROD's submissions to Government are developed in consultation with members.

ACROD also seeks to influence public policy so that it responds to the needs of people with disabilities. ACROD works with Government on all significant disability matters. It is currently represented on more than 20 Commonwealth Government (or quasi-Government) reference groups, working parties and advisory groups, and on numerous State and Territory committees.

ACROD has a National Secretariat in Canberra and offices in every State and Territory that focus on State issues in disability. The organisation as a whole is governed by a national Board which includes the elected Chair from each State/Territory Division as well as representatives elected directly by members.