Australian Government

SENATE INQUIRY INTO THE PROVISION OF MENTAL HEALTH SERVICES IN AUSTRALIA

Submission

The Contribution of the Australian Government to Mental Health in Australia

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Executive summary

In Australia, as in many other developed countries, the prevalence of mental illness is high. Approximately one in five adults will experience a mental illness in any given 12 month period,[3] and about one in seven children and adolescents will experience behavioural or emotional problems over a six month period.[4] Many more people are indirectly affected by mental illness through their role as family members, carers, friends and workmates.

The experience of mental illness is different for each individual. Some people may experience a single episode of mental illness and recover fully. For others, however, mental illness will have an ongoing effect, and may profoundly influence their quality of life. They may experience high levels of functional impairment, persistent symptoms, comorbidities and sometimes side effects of medication. The stigma associated with mental illness may compound this, impacting on their opportunities to form relationships, their ability to live independently, and their opportunities to maintain employment or to secure stable housing.

The Australian Government acknowledges that for some mental health consumers their illness may have a profound, ongoing influence on their quality of life, including significant social, emotional and economic impacts for their family and friends.

There have been improvements in the treatment of mental illness with advances in both pharmacological and psychosocial interventions. Better medications, subsidised by the Pharmaceutical Benefits Scheme, are available for depression, anxiety and psychosis as well as other mental disorders. Improved psychosocial treatments, especially cognitive behavioural therapies, are also available.

The Australian Government and the state and territory governments have different roles in mental health care. State and territory governments are primarily responsible for the delivery and management of mental health services. The Australian Government's primary roles are in providing leadership on mental health issues of national significance and in funding programs, for example:

- primary care services through GPs and other programs;
- medical and pharmaceutical benefits funding;
- funding to states and territories for services through the Australian Health Care Agreements; and
- programs to support mental health consumers from special population groups including, veterans and Indigenous Australians.

A range of mainstream programs and services are also provided by the Australian Government which provide essential support for people with a mental illness. These include income support, social and community services, disability programs, and housing assistance programs.

Australia was one of the first countries to develop and implement a national framework for mental health reform when the National Mental Health Strategy was jointly developed and adopted by all Australian health ministers in 1992. It has received worldwide recognition for its vision, direction and strategic approach.

In the decade since the introduction of the National Mental Health Strategy, the mental health service system has: moved from one that relied heavily on stand-alone psychiatric hospitals, to one that involves a greater balance of in-patient and community based services; is better integrated with the general health sector and with sectors outside health that affect the lives of people with mental illness; and is more able to meet the range of mental health needs in the community.

In addition, expenditure on mental health has increased by 65 per cent in real terms, with Australian Government expenditure increasing by 128 per cent since 1992. Consistent national reporting of resources and services at the state and territory level has also been introduced.

As well as the significant achievements in mental health service reform over this period, the focus on outcomes for consumers has been improving. National standards for mental health services have been introduced to improve the quality of services, and by June 2003 were being used by 90 per cent of all public sector mental health services. Consumers and carers are now integral participants in national policy forums and committees, including sub-committees of the National Mental Health Working Group and as members of national project reference groups. Funding is also provided under the National Mental Health Strategy for consumers and carers to attend key conferences and forums. All state and territory based legislation has been reviewed to ensure that it is consistent with the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.

The latest national data, published by the Australian Bureau of Statistics (ABS) for the decade ending 2003, shows that since 1997 there has been a downward trend in the overall number of people dying as a result of suicide. In particular, suicide deaths of young people aged 15 to 24 years have decreased significantly. This age group has been the focus of many of the Australian Government's suicide prevention initiatives since the inception of the National Youth Suicide Prevention Strategy in 1995.

Although significant achievements had been made, the Australian, state and territory governments recognised the need for ongoing implementation of the National Mental Health Strategy and reaffirmed their commitment to national mental health reform by endorsing the National Mental Health Plan 2003–2008.

The National Mental Health Strategy provides a sound policy framework for mental health care nationally and lays the foundation for collaboration between the Australian Government, states and territories, and between government and non-government organisations.

In 2001-02, the Australian Government provided funding of $1,146 million, or 37 per cent of all health funding directed to mental health. For every dollar spent by the Australian Government on specific mental health services, an additional $3.20 is spent on providing community and income support services to assist people with mental illness.

Of the $42 billion the Australian Government provides to the states and territories through the Australian Health Care Agreements (2003-08) for public hospitals, specific funding of $331 million is available for public sector mental health reform. In addition, over the same period, $66 million in Commonwealth Own Purpose Outlays funding is available for national reform activities and a further $6 million per year is available from the National Mental Health Program for national strategic mental health projects.

While much has been achieved in mental health service reform since the introduction of the National Mental Health Strategy, the Australian Government acknowledges that there is still work to be done to further improve the outcomes for consumers.

The National Mental Health Plan (2003-08) is designed to further consolidate and strengthen mental health care reform through its four priority themes: focusing on prevention and mental health promotion; improving service responsiveness and strengthening quality; and fostering research, innovation and sustainability.

Future efforts need to address these issues, as well as focusing on improving access to and information about services and programs at the consumer level, and coordination at the system level.

The Australian Government will continue to work within its current policy framework to ensure that better outcomes are achieved from its increased investment in mental health care

Part 1: Mental Health in Australia

Mental health is a state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential. It includes being able to work productively and contribute to community life. On the other hand, mental health problems and mental illness refer to the range of cognitive, emotional and behavioural disorders that interfere with the lives and productivity of people.

The Australian Government acknowledges that for some mental health consumers, their illness may have a profound, ongoing influence on their quality of life, including significant social, emotional and economic impacts for their family and friends.

The burden of mental illness

In Australia, as in many other Western countries, the prevalence of mental illness is high. Approximately one in five adults will experience a mental illness in any given 12 month period,[3] and about one in seven children and adolescents will experience behavioural or emotional problems over a six-month period.[4] There is no difference in prevalence between Australia and other Western countries.

The high prevalence of mental illness, combined with the significant disability associated with it, results in substantial burden. The burden of mental illness in Australia is ranked behind only heart disease and cancer in contribution to the total burden of disease in Australia. Depression and anxiety account for over half of this burden, with depression being the leading single cause of disability among all disorders.[5]

Most Australians will be affected by mental illness, either directly, or indirectly by being involved with someone who has a mental illness.

The experience of mental illness is different for each individual. Mental illness has many causes, can manifest itself in different ways, and can have different outcomes. Some people may experience a single episode of mental illness and recover fully. For others, however, mental illness will have an ongoing effect, and may profoundly influence their quality of life. They may experience high levels of functional impairment, persistent symptoms, comorbidities and, sometimes, side effects of medication. The stigma associated with mental illness may compound this, impacting on their opportunities to form relationships, gain employment, and secure stable housing and so on.

At a national level, the economic costs of mental disorders are substantial. In addition to the direct and indirect government outlays summarised in Table 2, mental disorders are estimated to account for substantial lost productivity in the workplace. For example, in Australia it is estimated that absenteeism due to depression accounts for around six million working days lost each year, at a cost to employers of approximately $1.2 billion. In addition, depression is estimated to reduce workers' performance by at least 40 per cent. For the Australian workforce as a whole, this equates to around 30 million working days per year with reduced productivity, at a cost to employers of approximately $2.3 billion. (WORC Project 2000)

Disability and discrimination

People with mental health issues are protected by the anti-discrimination provisions of the *Disability Discrimination Act 1992* (DDA). The DDA was enacted to eliminate, as far as possible, discrimination against people on the grounds of disability, and to ensure that people with disability have the same rights to equality before the law as the rest of the community.

Mental health service provision

Mental health service provision within the Australian health care system is characterised by multiple providers working in specialised mental health services, primary care services and other health services. For the purposes of the current document, these are defined as follows:

- Specialised mental health services are those in which the primary function is to provide treatment, rehabilitation or community support for people affected by mental illness, and in which such activities are delivered from a service or facility which is readily identifiable as both specialised and serving a mental health function.[8]

- Primary care services are those providing socially appropriate, universally accessible, scientifically sound first level care, supported by integrated referral systems. They do so in a way that gives priority to those in most need, maximises community and individual self-reliance and participation, and involves collaboration with other sectors.[9]

- Other health services include those not classified as primary care or specialised mental health care services, but provide some form of mental health care or rehabilitation.

These services are provided in the public sector, the private sector and the non-government sector.

Public sector services include psychiatric hospitals, psychiatric units in general hospitals, community residential units and community mental health services. The term private sector applies to a range of providers including private psychiatrists, general practitioners, private psychiatric hospitals and private allied health professionals, primarily psychologists. The non-government sector includes private, not for profit, community managed organisations, which promote self-help, provide support and advocacy, or provide specialised accommodation and rehabilitation services.

Table 1 summarises the matrix of mental health service provision in Australia. The table is not exhaustive, and highlights key examples only.

Table 1 Who provides mental health care and support in Australia? Some key examples

	Primary care	Other health services	Specialised mental health services
Public sector	• Community health centres • Aboriginal Medical Services	• Public aged care homes • Emergency departments • Non-psychiatric units in public hospitals	State and territory mental health services, comprising: • psychiatric hospitals • psychiatric units in general hospitals • community mental health services • community residential units • vocational rehabilitation services • child and adolescent services
Private sector	• General practitioners • Allied health professionals	• Private aged care homes • Psychiatric units in private hospitals	• Private psychiatrists • Private psychiatric hospitals • Private psychologists
Non-government sector	• Disability support services • Tele-counselling services		• Specialised accommodation and rehabilitation services

The role of government and the private sector in the provision of mental health services

The Australian Government and the state and territory governments have different roles in mental health care. The Australian Government's primary roles are in funding services and in providing leadership on mental health issues of national significance. State and territory governments are primarily responsible for the delivery and management of mental health services.

Within the Australian health system, the private sector delivers a significant proportion of primary, specialist and allied health care through a medical workforce that includes general practitioners, specialists, pharmacists, physiotherapists and dentists.

The private psychiatric hospital sector is also growing. In 2002, it provided 23 per cent of all psychiatric beds (up from 14 per cent in 1993) and employed 11 per cent of the mental health workforce (up by 80 per cent since 1993).

The private sector operates private hospitals and through health funds offers private health insurance.

Australian Government programs to support people with mental illness

A range of programs and services are provided by the Australian Government to support people with a mental illness, including mental health care programs, mainstream programs that provide income support as well as social and community support, and targeted programs that provide additional support to people who have a mental illness and who are also part of a special population group. Table 2 summarises these.

Table 2 Whole of government support available to people with a mental illness

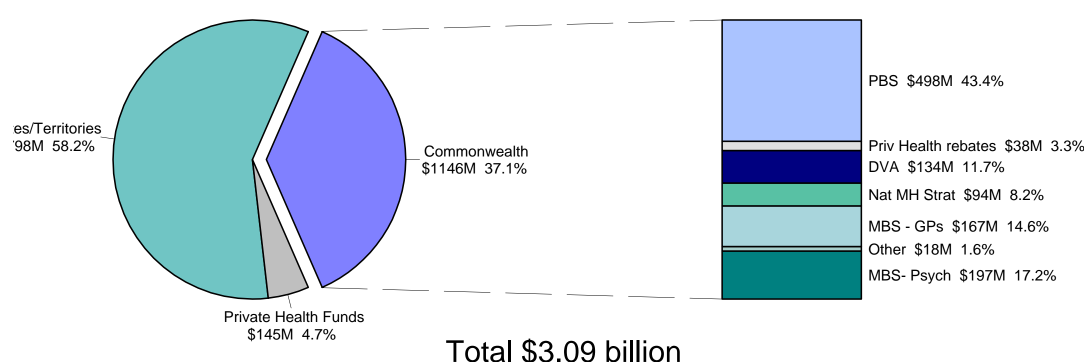
Health care programs	Mainstream programs	Targeted programs
Medical Benefits Schedule	Workforce participation	Indigenous Australians
Pharmaceutical Benefits Scheme	Income support	Veterans
Private health insurance	Families and communities	New migrants
National Mental Health Strategy national funding	Housing	Immigration detainees
Better Outcomes in Mental Health Care	Homelessness	People with disabilities
Youth Mental Health Initiative	Information technology	Ageing population
National Suicide Prevention Strategy	Rural and regional	Substance users
beyondblue: the national depression initiative	Research and data collection	Young people
National Comorbidity Initiative	Primary Care Programs	People with chronic diseases
Commonwealth Own Purpose Outlay Funding	Workforce and Training	People in the criminal justice system

The financing of mental health services

Australian Government

The Australian Government is a major contributor to programs that support mental health and the provision of mental health services. In 2001–02, it provided funding of $1146 million, or 37 per cent of all health funding directed to mental health (see Figure 1).

Figure 1 Distribution of recurrent spending on mental health services, 2001–02



Reproduced from the *National Mental Health Report 2004*{Australian Government Department of Health and Ageing, 2004 #26}).

The Australian Government provides funding of $42 billion to states and territories for public hospitals, through which services are provided in approximately half of state and territory hospitals. Specific funding of $331 million is provided to the states and territories through the Australian Health Care Agreements (2003–08), for public sector mental health reform. In addition, over the same period, $66 million in Commonwealth Own Purpose Outlay funding is available for national reform activities. A further $6 million per year is available under the National Mental Health Program. The Australian Government Department of Health and Ageing administers the latter two funding amounts.

The Australian Government also provides direct or indirect funding for the major private sector services, including private psychiatrists and general practitioners through the Medicare Benefits Schedule (MBS), medications through the Pharmaceutical Benefits Scheme (PBS), and by offering a 30 per cent rebate and higher rebates for older Australians for private health insurance.

The Medicare Benefits Schedule (Medicare) is a major part of the national health care infrastructure and enables high quality health care that is affordable and accessible to all Australians, including those with a mental illness. General benefits include:

- free treatment as a public patient in a public hospital; and
- the Medicare rebate, which pays 100 per cent of the schedule fee for GP attendances and 85 per cent of the schedule fee for attendances by a consultant psychiatrist.

Specific benefits related to mental illness to support the care of people in rural and remote Australia include:

- payment for clients located in rural and remote areas for consultations via tele-psychiatry for assessment, diagnosis and treatment by a consultant psychiatrist; and
- payment for multidisciplinary team case conferences organised by a consultant psychiatrist or other specialist and conducted face to face, by telephone or by video link, or a combination of these.

Estimates of expenditure for mental health care provided by GPs have been calculated at 6.1 per cent of total MBS benefits paid for all GP consultations as in the National Mental Health Report 2004 (see Table 3).

Table 3 Medicare Benefits Schedule mental health expenditure ($ million)

	Consultant psychiatrists	Total GP*
2002–03	197.5	169.3
2003–04	201.3	175.6

Due to developments in the MBS item structure since 2001–02, current data are not strictly comparable with data provided for the National Health Report 2004 but there is a close correlation.

The Pharmaceutical Benefits Scheme (PBS) aims to provide all Medicare eligible persons with access to a comprehensive range of cost-effective prescription medications that are affordable both to the individual and the community. Table 4 provides information about expenditure on drugs related to mental health conditions.

Table 4 Pharmaceutical Benefits Scheme Mental Health Expenditure 2003-04 drugs related to mental health

Drug type	Data	Total
Antipsychotics	Number of scripts dispensed	1,586,107
	Sum of benefit paid	$229.995 million
Anxiolytics	Number of scripts dispensed	3,341,964
	Sum of benefit paid	$16.885 million
Hypnotics and sedatives	Number of scripts dispensed	3,045,796
	Sum of benefit paid	$12.68 million
Antidepressants	Number of scripts dispensed	12,184,283
	Sum of benefit paid	$331.918 million
Total number of scripts		**20,158,150**
Total sum of benefits		**$591.472 million**

State and territory governments

As the other major funders of mental health services in Australia, the states and territories add to the funding provided by the Australian Government under the Australian Health Care Agreements, and then disburse this funding to local public sector in-patient and community based services, and to some non-government sector services. In 2001–02, states and territories contributed $1798 million, or 58 per cent, of all direct funding (see Figure 1).

Private health industry

In addition to the funding provided by Australian and state and territory governments, private health insurance funds also have a role to play in mental health care financing.

The main parties in the provision of private sector psychiatric services are private hospitals, doctors and health funds. Private hospitals are involved in the delivery of services and health funds provide funding for services through health insurance. Health insurance funds provide rebates for a range of services provided in the private sector by private psychiatrists, general practitioners and private hospitals. In 2001-02, they provided $145 million, or 5 per cent of all funding. (see Figure 1).

Health insurance funding of private psychiatric hospitals grew by 17 per cent over the 10 years from 1993-2002 which, combined with the estimated $38 million per year injected by the private health insurance rebate, resulted in an increase in the number of private beds (38 per cent), consumer days (59 per cent) and separations (270 per cent).

The *National Health Act 1953* requires all health funds to offer benefits for psychiatric, palliative and rehabilitation care in all their hospital products. The government contributes to the funding of private health insurance through the Private Health Insurance Rebate, and from April 2005, the higher rebates for older Australians.

Further information on the delivery of mental health services and benefits paid by health funds is provided in **Attachment 1**.

Consumers

Consumers[a] also have a role in mental health care financing as they pay for some services themselves, either paying the full cost or a co-payment. These are predominantly for private sector services, but co-payments may also be required for other services.

[a] Throughout the remainder of this document, the term ‘consumers’ is used rather than ‘patients’. The term ‘consumer’ has become commonplace under the National Mental Health Strategy, because it implies the rights of people concerning their treatment and place in the broader community.

Estimates of total government spending attributable to mental health

Estimating the cost to government of mental illness is a complex undertaking and needs to take account of both the specialised mental health services funded by governments, and the indirect costs incurred in providing assistance through mainstream human service programs to people who require assistance due to mental illness.

Table 5 provides a broad overview of total direct and indirect costs for 2001–02. Further information on the compilation of data for Table 5 is at **Attachment 2.**

Based on conservative estimates, it highlights the substantial costs to governments that arise from mental illness in the Australian community. Government outlays for mainstream support services accessed by people with mental illness roughly match the funds allocated for specialist mental health treatment and care. For the Australian Government, the impact is more significant. For every dollar spent by the Australian Government on mental health services in the specialised sector, an additional $3.20 is spent on providing community and income support services to assist people with mental illness

Table 5 Government direct and indirect expenditure on mental health in Australia, 2001–02

		$Millions [d]
Australian Government		
Direct expenditure [a]	National Mental Health Strategy	94.2
	Medicare Benefits Schedule — psychiatrists	196.9
	Medicare Benefits Schedule — general practitioners	167.3
	Pharmaceutical Benefits Scheme	497.8
	Private health insurance rebates	37.7
	Department of Veterans' Affairs [e]	133.8
	Other	18.2
	Subtotal direct	1,145.8
Indirect expenditure [b, c]	National Suicide Prevention Strategy	9.8
	Income support payments	1,968.3
	Workforce participation programs	70.5
	DVA disability compensation payments	180.0
	Housing and accommodation programs	108.9
	Disability services	42.6
	Aged care residential and community services	1,258.5
	Home and community care	10.0
	Subtotal indirect	3,648.6
Total Australian Government		4,794.4
State and territory governments		
Direct expenditure [b]	New South Wales	562.6
	Victoria	477.8
	Queensland	310.9
	Western Australia	212.1
	South Australia	145.8
	Tasmania	44.3
	Australian Capital Territory	27.2
	Northern Territory	16.9
	Total states and territories	1,797.6
Total direct expenditure (Australian Government, states and territories)		2,943.4
Total indirect (Australian Government only)		3,648.6
	Total expenditure	6,592.0

a 'Direct expenditure' refers to expenditure dedicated to the provision of specialised mental health services and related activities. Source for data: National Mental Health Report 2004.

b 'Indirect expenditure' refers to the estimated costs to the Australian Government of providing other social, support and income security programs for people affected by mental illness. Estimates of indirect expenditure by states and territories are not available. Source for data: as provided by relevant Australian Government departments.

c Indirect expenditure estimates made by relevant Australian Government departments are based on best available data and are conservative. A range of related program areas where estimates that could not be made are excluded from totals. Estimates may changes as more accurate data become available.

d Totals may not tally due to rounding error.

e DVA have revised estimated direct spending on mental health for 2001-02 to $126.8m. This correction will be reflected when the National Mental Health Report 2005 is published later in 2005.

Part 2: The National Mental Health Strategy

The National Mental Health Strategy, which commenced in 1992, has underpinned the mental health reform process in Australia, including providing Australian and state and territory governments and non-government organisations with direction for the change required. The Australian Government has provided leadership and resources to support these changes and substantial achievements have been made to date.

The first decade of the National Mental Health Strategy

In the early 1960s, a process of deinstitutionalisation began which saw the number of psychiatric beds across Australia decrease from 30,000 in 1965 to approximately 8000 in 1993, with limited development of equivalent community services. At the same time, Australia's population doubled. By the 1980s, there was increasing concern that the situation was unacceptable, and that the mental health system had been seriously neglected in policy, planning and funding terms.

In 1992 the Australian Government and state and territory governments collaborated in the development of a strategic framework for the delivery of mental health services. All Australian health ministers formally adopted a National Mental Health Policy.[12, 13] The policy, which is implemented through a series of five-year National Mental Health Plans[1, 14, 15] and underpinned by the Mental Health Statement of Rights and Responsibilities,[16] became known as the National Mental Health Strategy (NMHS).

The aims of the National Mental Health Strategy are:

- to promote the mental health of the Australian community;
- where possible, to prevent the development of mental health problem;
- to reduce the impact of mental health problem on individuals, families and the community; and
- to assure the rights of people with a mental health problem.

The different, but complementary, roles and responsibilities of the Australian Government and the state and territory governments, described in Part 1, are reflected in their respective commitments to the National Mental Health Strategy. Reform under the National Mental Health Strategy is progressed through the National Mental Health Working Group (NMHWG), reporting to Health Ministers through the Australian Health Ministers' Advisory Council (AHMAC). The NMHWG also acts as a forum to advise on and monitor the implementation of the National Mental Health Strategy.

Priority areas for reform in the First and Second National Mental Health Plans

The First National Mental Health Plan,[14] (1992 – 97) focused on achieving structural reforms within state and territory based public sector specialised mental health services. This was in response to the legacy of deinstitutionalisation that took place in the previous 30 years, where resources were taken from stand alone psychiatric hospitals with insufficient appropriate community supports. The first plan focused on:

- mainstreaming, or moving acute beds from psychiatric hospitals into general hospitals;
- integration, or bringing together in-patient and community services to promote continuity of care;
- intersectoral collaboration, through partnerships with other sectors that impact on the quality of life of people with mental illness (eg housing, justice); and
- strengthening consumers' rights by giving them a voice in policy making and planning and by addressing deficiencies in relevant legislation.[14]

At the end of 1997, Australian health ministers endorsed the second National Mental Health Plan,[15] which was designed to consolidate ongoing reform activities by:

- adding a focus on mental health promotion and mental illness prevention;
- focussing on closer integration of the public mental health sector with other parts of the health sector and broader social support services; and
- examining issues of service quality and effectiveness.

The second National Mental Health Plan expanded the focus from severe and disabling low-prevalence disorders to include high-prevalence illnesses, such as depression and anxiety disorders.

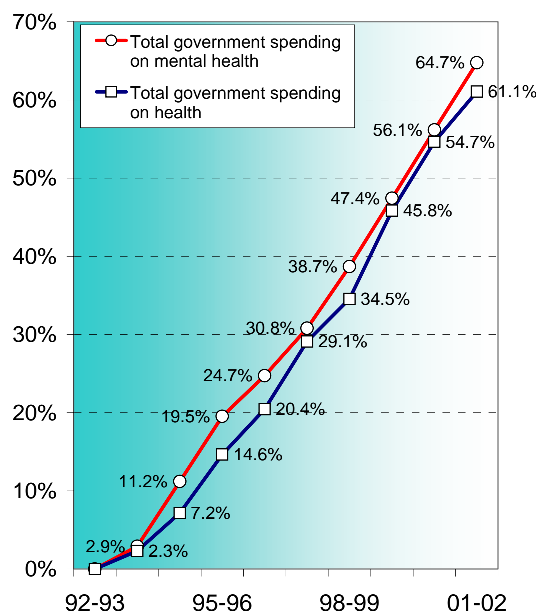
Achievements under the First and Second National Mental Health Plans

Increased resources

In terms of resources, there have been significant increases in expenditure on mental health during the life of the National Mental Health Strategy (NMHS) — in 2001–02, total spending on mental health services was $3.1 billion, a 65 per cent increase in real terms since 1992–93 (see Figure 2). As a proportion of overall health expenditure, this is similar to other developed countries. The overall additional expenditure comprised increases in Australian Government expenditure of 128 per cent and increases in state and territory expenditure of 40 per cent.

This 65 per cent increase in mental health expenditure parallels growth in overall health expenditure during the first decade of the National Mental Health Strategy[8, 17] (see Figure 2).

Figure 2 Growth in government mental health expenditure and overall health expenditure



Reproduced from the *National Mental Health Report 2004* Australian Government Department of Health and Ageing, 2004 #26

Reforms in service delivery

There has been considerable change to the way mental health care is delivered as a result of the population based approach to mental health introduced as part of the second plan. The system has moved from one that relied heavily on stand alone psychiatric hospitals to one that involves a greater balance of in-patient and community based services, is better integrated with the general health sector and with sectors outside health that affect the lives of people with mental illness, and is more able to meet the range of mental health needs in the community.

Between 1993–94 and 2001–02, the proportion of state and territory resources directed to community based care rose from 29 per cent to 51 per cent, and the number of full-time equivalent clinical staff per 100,000 employed in community services increased by 109 per cent in parallel with this spending growth. In 1993–94, 73 per cent of psychiatric beds were located in stand alone hospitals, and accounted for half of all states and territory expenditure on mental health care. By 2001–02, 39 per cent of psychiatric beds were in stand alone hospitals, and consumed 29 per cent of state and territory mental health resources.[11, 17]

Outcomes for consumers

The regular assessment of consumer outcomes has been a priority of the National Mental Health Strategy since it was first agreed by Health Ministers in 1992. There has been an increased emphasis on accountability and quality assurance, for example, the development of the National Standards for Mental Health Services.[18] By June 2003, almost 50 per cent of all public sector mental health services had been reviewed against these standards, and another 40 per cent have begun the review process.

The Australian Government funded studies that reviewed[19] and field-tested[20] survey instruments for regularly measuring outcomes for consumers. Measuring changes in levels of functioning and severity of symptoms for consumers has become routine in both the public and private sectors, providing a means of evaluating whether those receiving care are benefiting. The production and reporting of national and state and territory data is a valuable by-product of these consumer assessments.[21]

Consumers and carers are now integral participants in national policy forums and committees, including sub-committees of the National Mental Health Working Group and as members of national project reference groups. Funding is also provided under the National Mental Health Program for consumers and carers to attend key conferences and forums.

Reducing stigma

Steps were taken early in the life of the National Mental Health Strategy to promote mental health in the community and reduce the stigma and discrimination experienced by people with a mental illness. In response to the research, a range of initiatives was launched early in the first National Mental Health Plan under an $8 million Community Awareness Program. In addition, a number of mental health promotion initiatives have continued under the National Mental Health Plan (2003-2008).

Part of the early work under the National Mental Health Strategy was the recognition of the importance of promoting the mental health of young people through partnerships with school communities. A pilot program, known as MindMatters, trialed a whole school approach to addressing mental health issues in secondary schools, including teacher resources and training. The pilot received widespread support from students and teachers and was extended nationally in March 2000.

National stakeholder input

At a national and state and territory level, the Australian Government has provided support for various non-government organisations that represent key stakeholders and resourced them to be able to provide their viewpoint to governments.

The Mental Health Council of Australia is the peak independent, national representative network of organisations, including the relevant peak mental health professional groups, and individuals committed to achieving quality mental health for all Australians. Consumers and carers account for 25 per cent of its membership.

Another key group is the Strategic Planning Group for Private Psychiatric Services which brings together major stakeholders from the private sector to work on developing a common agenda for service development. Membership includes the Australian Medical Association, the Royal Australian and New Zealand College of Psychiatrists, the Royal Australian College of General Practitioners, Australian Private Hospitals Association, the Australian Private Health Insurance Association, mental health consumers and carers, and representatives from relevant government departments.

Legislation

The Australian Government provided leadership to ensure that all state and territory based legislation was introduced or amended to align with the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.[22]

Evaluation of the National Mental Health Strategy

Australia was one of the first countries to develop and implement a national framework for mental health reform. The National Mental Health Strategy has been internationally recognised and used by other countries to inform their policy (see **Attachment 3**).

Two formal evaluations of the National Mental Health Strategy have been undertaken, involving widespread community consultation, commentary by international experts and data from the National Mental Health Reports. Together, these evaluations point to substantial reform:

- the mental health system has strengthened its capacity to respond to the needs of people with mental illness by moving towards the provision of mental health care within the mainstream health system and through community care;
- the workforce providing mental health care has changed substantially — the role of primary health care (including general practice) is acknowledged as a critical area complementing the specialised mental health workforce; and
- the mental health agenda has broadened from a focus on treatment to include the entire spectrum of interventions, including mental health promotion, mental illness prevention, early intervention, rehabilitation and recovery.[20]

The National Mental Health Plan (2003-2008)

The National Mental Health Plan (2003-2008) is organised around four priority themes designed to consolidate and strengthen reform. It focuses on: promoting mental health; preventing mental health problems and mental illness; improving service responsiveness and strengthening quality; and fostering research, innovation and sustainability.

The National Mental Health Plan (2003-2008) strengthens the implementation of the population health approach introduced in the second plan.[23, 24] It recognises that the determinants of mental health comprise a range of psychosocial and environmental factors including income, poverty, employment, education and access to community resources, as well as demographic factors. It also recognises the effect of mental illnesses occurring together with drug and alcohol problems and other conditions.

Initiatives to promote mental health and reduce the impact of mental illness must be relevant to the needs of particular population groups, and encompass the entire spectrum of interventions from prevention to recovery and relapse prevention.[24, 25]

The Australian Government is currently undertaking significant national work in all these areas under the National Mental Health Plan (2003-2008), and these initiatives are described throughout the remainder of the submission. These national strategic initiatives are funded from the $66 million Commonwealth Own Purpose Outlay funds and the $6 million National Mental Health Program. This is in addition to the funding provided to state and territory governments under the Australian Health Care Agreements (see Table 6).

Table 6 Funding for current National Mental Health Strategy initiatives

Name of program	Funding ($ millions)	Funding period
National Mental Health Program	$6 per year	recurrent
Australian Health Care Agreements – Mental Health to states and territories	$331	2003-08
Australian Health Care Agreements - Commonwealth Own Purpose Outlays	$ 66	2003-08

Part 3: Promoting Mental Health

Promoting mentally healthy lifestyles and practices across the whole population, including for people with mental health problems and mental illness, enhances the protective factors for mental health which may lead to sustained emotional and social wellbeing of people across their lifespan and in the places they live and work. Mental health promotion is now being embraced by mental health consumers and in health and other settings as a means of proactively addressing mental health issues with people who may be at risk of developing mental health problems in the future.

The *Promotion, Prevention and Early Intervention for Mental Health Action Plan and Monograph*[26] is the national strategic framework to address the promotion, prevention and early intervention priorities under the National Mental Health Strategy. It draws on available evidence and describes strategies to enhance protective factors and reduce risk factors known to be associated with mental illness. A key outcome of mental health promotion initiatives is to increase mental health literacy across the community, to increase early help seeking, and to decrease the level of stigma experienced by people with a mental illness.

Media

How the media reports and portrays mental illness, and incidents involving people with mental illness, has a powerful influence on community attitudes to mental illness, including how people interact with mental health consumers.

Funded under the National Mental Health Program, the MindFrame National Media Initiative has proactively worked with the media industry to report and portray mental illness and suicide issues responsibly, accurately and sensitively in all its forms: print, broadcast, film, advertising and internet. This is being achieved through training sessions with the media, supported by print, web-based and CD resources. A total of 76 educational briefings to major media organisations have been held since January 2004 in all states and territories including regional centres. To ensure the future media workforce is also being educated about mental health issues, a program called ResponseAbility, is now in over 90 per cent of universities with media and journalism undergraduate degrees. Further information on ResponseAbility is available at http://www.responseability.org.

The success of this strategy can be seen in the general decrease of sensational reporting of suicide, together with the inclusion in news reports of mental health information and contacts details for where people can seek help. Further information on MindFrame is available at http://www.mindframe-media.info.

Mental health publications

An effective way to get information to people is via publications which are available in places where they are seeking help. A range of publications, funded by the National Mental Health Program, aim to raise community awareness of mental health, mental health problems and mental illnesses. Publications such as the *What Is?* series of brochures help to increase knowledge of the types of mental illness and include information on eating disorders, anxiety, depression, bipolar disorder, and schizophrenia. These and other brochures are widely available from doctors rooms, health centres, chemists, schools etc. Millions of publications are distributed, on request, every year under the National Mental Health Strategy. The review of existing materials and the development of new publications is part of the ongoing effort to reduce the stigma associated with mental illness.

Schools

The development of young people is characterised by increasing autonomy, less control by parents and increased influence of peers. This means that adolescence can be a time of increased risk exposure to situations that may lead to poor mental health outcomes for some young people. Australian and international research clearly indicates that young people who have strong relationships with their family, friends, school personnel or within their community are more resilient than other young people. They are more able to cope with life's challenging and difficult situations.

Through resilience building, young people are supported in dealing with life's stresses and they gain greater confidence to deal with issues and problems that may arise in everyday life. In addition, when young people have some knowledge and understanding about mental illness, they are more likely to seek help for themselves if needed, or to offer support to friends or family with mental health problems, including to encourage them to seek professional help. Further information about young people's mental health is in **Attachment 4.**

The school environment plays a central role in shaping young people's development and is a key setting for increasing protective factors and reducing risk factors for future mental health problems. It is also a key setting for providing information about mental illness, promoting help seeking and increasing understanding about the circumstances of people living with mental illness.

MindMatters: A mental health promotion resource for secondary schools

The MindMatters national initiative, funded under the National Mental Health Program, is providing this education to young people as part of their secondary schooling. MindMatters provides print and web-based resources and professional development for school leaders and teachers, to encourage schools to provide a mentally healthy school environment through changes to policy, procedures and practices where necessary. Resources are also provided to help teachers integrate relevant mental health into the schools curriculum including topics on dealing with bullying and harassment, increasing resilience, and understanding mental illnesses.

Since March 2000, MindMatters has become a mainstream school education program with 2212 secondary schools (79 per cent) sending more than 49,000 staff for professional development. Approximately 88 per cent of these schools have indicated that they plan to implement MindMatters, including engaging and working closely with parents on these issues.

The independent evaluation is showing significant uptake and impacts, for example, some case study schools are attributing their involvement with MindMatters to improvements in retention rates, truancy, suspensions and relationships between staff and students. Further information is available from the MindMatters website found at: http://www.curriculum.edu.au/mindmatters.

To ensure future teachers are also being educated about mental health issues, a program called ResponseAbility, is now in over 90 per cent of universities with a secondary teacher undergraduate degree. Further information on ResponseAbility is available at http://www.responseability.org.

Resilience Education and Drug Information

Complementary to MindMatters is Resilience Education and Drug Information (REDI), funded under the National School Drug Education Program, a suite of school drug education resources focusing on preventing and reducing harm from drug use by building more resilient young people. A range of resources are available to assist teachers to gain an understanding of current research and practice in the area of resilience, and to increase student knowledge and understanding of decision making, self talk and being assertive, problem predicting and solving, and help seeking behaviour. Further information can be found at http://www.redi.gov.au.

National Safe Schools Framework

The National Safe Schools Framework, endorsed by all state and territory Ministers of Education, provides an agreed set of guiding principles for promoting safe school environments and emphasises the need for schools to respond proactively to incidents of victimisation or abuse, to clearly document steps and outcomes for managing incidents, and to work closely with parents on these issues, especially when their children become involved in incidents, either as victims or perpetrators. Details of the framework are available at http://www.mceetya.edu.au/whatsnew.htm. The development of the *Bullying No Way!* website (http://www.bullyingnoway.com.au) provides teachers, parents and students with strategies and resources to address bullying, harassment and violence.

Indigenous education rural and remote initiative

The Australian Government's National School Drug Education Strategy assist Indigenous and rural or remote school communities to more effectively address drug related issues for their students and families. There are common risk and protective factors for mental illness and drug use and common outcomes for schools programs. The program specifically targets Indigenous students living in rural and remote areas and will also direct funding through state education authorities for students living in rural and remote areas, including Indigenous and non-Indigenous students.

Health and mental health services and professionals

The Australian Network for the Promotion, Prevention and Early Intervention for mental Health (Auseinet) is working to help mainstream health promotion practices in the mental health, health and other relevant sectors. This involves actively working with and providing information to state and territory governments, general practitioners, consumer and carer groups and Aboriginal and Torres Strait Islander communities. It includes providing networks to disseminate good practice and the latest research finding, including via journals, publications, websites and workshops. The Auseinet network consists of more than 6000 individuals and stakeholder organisations, including a network of approximately 785 consumer and carer organisations. Auseinet has a comprehensive website (http://auseinet.flinders.edu.au) and also hosts the national suicide prevention website (http://www.livingisforeveryone.com.au).

The work to educate health and mental health professionals and to mainstream health promotion into these health and mental health workplaces is in its early stages and needs consolidation, with further information and training opportunities to be provided.

Further information on MindFrame, MindMatters and Auseinet is in **Attachment 5.** Some key age groups and settings for future national attention under the National Mental Health Strategy could include early childhood and primary school aged children, young adults, people in the workplace, and older people.

Human Rights and Equal Opportunity Commission

The Human Rights and Equal Opportunity Commission (HREOC) promotes awareness and respect for human rights in the community. HREOC consults with peak bodies, conducts public inquiries, undertakes research and publicises the results online, through the media and in printed reports. Its website (http://www.humanrights.gov.au) is a key educational tool that provides an up-to-date human rights education resource for students, teachers, employers, the legal profession and government and non-government agencies.

Part 4: Preventing Mental Illness and Suicide

Many consumers support initiatives to prevent the onset of mental illness as they want others to avoid the hardships they have experienced as mental health consumers. Preventing mental health problems and mental illness involves understanding the factors that heighten the risk of these occurring and the factors that are protective against them. Protective factors reduce the likelihood that a mental health problem will develop and risk factors increase this risk. The presence of more protective factors, regardless of the number of risk factors, has been shown to lower the level of overall risk. There is a range of protective and risk factors related to individual characteristics, family factors, the school context, life events and community and cultural factors.[26]

National Suicide Prevention Strategy

Suicide and mental illness are closely interlinked, with mental illness being the major known risk factor for suicide. In Australia in 2002, 2320 people died by suicide; more than the number who died in road traffic accidents.[4] Completed suicide is not the only concern; suicide attempts and suicidal ideation are also troubling and prevalent. In any given year, 0.3 per cent of adults will attempt suicide, and 2.9 per cent will have thoughts of taking their own lives.[5]

The National Suicide Prevention Strategy (NSPS), which began in 1999, builds on the achievements of the earlier National Youth Suicide Prevention Strategy (1995–1999) and while retaining a special focus on youth, includes Australians across the lifespan.

The *Living Is For Everyone (LIFE) a framework for prevention of suicide and self-harm in Australia* has been developed to guide action under the NSPS. Its aims are to: reduce suicide in all age groups of the Australian population; to enhance resilience and resourcefulness, to reduce the prevalence of risk factors for suicide; to increase support for those affected by suicide and suicidal behaviours; and to provide a whole of community approach to suicide prevention.

Since 1999, the Australian Government has provided $10 million annually for the development of national and community models of suicide prevention in line with the LIFE Framework.[25] Some 170 community-based suicide prevention programs have been funded in all states and territories and 25 national projects have also been developed, many with joint funding from the National Mental Health Program.

The national suicide prevention website (http://www.livingisforeveryone.com.au) has been developed by the Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) to ensure the exchange of information and learnings under the National Suicide Prevention Strategy.

Relapse Prevention

Many consumers consider relapse prevention one of the most significant prevention strategies available to them. Relapse prevention is a specific component of the recovery process that involves empowering people with mental illness to recognise early warning signs of relapse and develop appropriate response plans.

During 2004, a national consultation about the role of relapse prevention in the recovery process was undertaken with consumers, families and carers, service providers, peak bodies, and policy makers. The outcome of this was a number of documents to inform policy, programs and practice in continuing care to prevent further episodes of mental illness for people who have been seriously affected by mental illness. It is intended that this work will provide the impetus and directions for changes in practice that support reorientation of the mental health care system so that all people, services, organisations and governments work with a recovery orientation.

Telephone and internet services

For some people using the telephone and the internet is their preferred means of seeking help. Lifeline Australia and Kids Help Line have been funded by the Australian Government to provide 24 hour counselling and mental health information via the telephone and the internet, resulting in increased access to care across Australia, as well as offering an alternative that is complementary to face to face services.

Lifeline Australia is the peak body for the 42 Lifeline Centres around Australia, which provide services from 59 locations, half of which are in rural and remote areas. Lifeline Centres provide a 24 hour telephone counselling service in addition to providing information, referral and associated services in local areas.

Kids Help Line provides a free 24 hour national telephone and online counselling service for children and young people aged five to 18 years of age in Australia, and seeks to assist young people develop strategies and skills that enable them to more effectively manage their own lives. Professional staff deliver telephone and web-counselling services and respond to approximately 10,000 phone calls and 500 online contacts each week.

Telephone counselling services are well established and may require some ongoing Australian Government support for links to other national projects that would benefit from these services. Internet counselling is in its early stages of development, but progress to date indicates that future investment could be worthwhile in meeting the needs of some people, including those with depression.

Youth Mental Health Initiative

The Australian Government has committed $69 million to June 2009 for young people with mental health problems. This funding will support the primary health care system in the detection, early intervention and ongoing management of young people with mental health problems. Included will be young people with complex mental health needs connected to substance use issues. The outcomes will include improved access to appropriate services for young people, and better linkages between services for young people in their local areas. Fostering education and training efforts for general practitioners and allied health professionals, with the aim of enhancing the care they provide to young people with mental health problems, is also a key objective.

MindMatters Plus

The MindMatters program also has elements which help schools to better help their students with high support needs. Through MindMatters Plus, schools are able to access a range of best practice programs for preventing mental health problems, as well as other supportive resources and information about helping students with high support needs.

To assist teachers and school counsellors to have ready access to their local GPs, MindMatters Plus GP is facilitating sustainable referral pathways between schools and their local Division of General Practice. The initiative aims to bring schools and the primary health care sector together to help develop networks of care within the local community.

beyondblue: the national depression initiative

beyondblue was launched in 2000, with an Australian Government commitment of $17.5 million over five years. beyondblue is an independent national initiative designed to raise awareness, build networks and motivate action in the area of depression prevention. It has five priority areas for action: community awareness and destigmatisation, consumer and carer participation, prevention and early intervention, primary care, and targeted research. The Australian Government has committed further funding of $39.6 million to beyondblue over four years from 2005–09. This additional funding will support beyondblue in changing community attitudes, and improving services for people with depression. Further details about beyondblue can be found on its website at http://www.beyondblue.org.au/.

Supporting recovery for Australians following a disaster or emergency

Disaster and emergencies put greater strain on individuals, families and communities, particularly for those with pre-existing mental health disorders. Exposure to trauma associated with a disaster, the death of a loved one, or loss or damage to a person's home or immediate environment, can lead to future or increased mental health problems.

Timely and effective recovery services can minimise the incidence and severity of mental health issues in the affected population following disasters and emergencies. While disaster management is primarily a state/territory responsibility, the Australian Government works closely with state and territory government and non-government agencies in supporting Australians to recover following disasters or emergencies.

Case Study 1

Jessica is a 17 year old schoolgirl living in a large regional centre and studying for her final exams. She has started experiencing mood swings and anxiety, emotions which she has not had before. Jessica is not only worried about her upcoming exams, but has also been arguing with several of her school friends. She is also very worried about her mother who has been withdrawn and depressed. Jessica feels that she is losing control of things in her life but has felt too embarrassed to talk to anyone about this.

Her school has been participating in MindMatters where the importance of looking after all aspects of heath and wellbeing has been discussed and where advice has been provided on how to seek help. This has encouraged Jessica to accept that many people need to work things through with a professional and has given her confidence to talk to the school counsellor.

The local newspaper, after receiving feedback from SANE's Stigmawatch program about the inappropriate reporting of local suicides, decided to adopt some of the advice provided in the quick reference guides from the Mindframe Media Initiative on reporting suicide and mental health issues.

So when the local Rotary club runs a community forum on mental health, funded by the National Mental Health Plan, the newspaper supports the initiative by promoting the event and providing some factual information on depression.

Encouraged by her discussions with the school counsellor and what she reads in the newspaper, Jessica takes a different approach to dealing with her friends and also talks to her mother about attending the forum. Her mother agrees and hears a speaker who has had depression. She comes to realises that she has many of the same symptoms and makes an appointment to see her GP where she receives advice on managing her condition and supporting Jessica.

Many prevention initiatives will continue to be implemented with funding from the National Mental Health Program, the National Suicide Prevention Strategy, *beyondblue* and the Youth Mental Health Initiative. The National Suicide Prevention Strategy will continue to be funded beyond June 2006, and the key priorities for the future of this Strategy will be shaped by evaluation activity currently underway. Evaluation activities will also shape the future of the MindMatters initiative, and lessons and resources from the pilots of MindMatters Plus and MindMatters Plus GP will be integrated into the main MindMatters program as schools add this element to their existing MindMatters work, and as divisions of general practice continue to embrace a local role in supporting pathways of care for young people in schools. The development of a primary school focused MindMatters program will offer opportunities for broader promotion and prevention activities.

Part 5: Improving Mental Health Service Delivery

Since its commencement, a key goal of the National Mental Health Strategy has been to improve the quality of care received by consumers from mental health services. While state and territory governments deliver public mental health services, almost half the funding for the services is provided under the Australian Health Care Agreements.

In addition to contributing funding to mental health services, the Australian Government is committed to helping ensure the standard of care provided is as high as possible. It does this by: facilitating the use of consistent standards for the delivery of care across Australia; promoting strategies to improve safety and reduce harm in environments that provide care; and promoting the use of common performance indicators to evaluate mental health service delivery. Data on these measures is collected and analysed nationally and information on progress is regularly provided to mental health services to contribute to the ongoing review and development of clinical practice.

There have been improvements in the treatment of mental illness with advances in both pharmacological and psychosocial interventions. Better medications, subsidised by the Pharmaceutical Benefits Scheme, are available for depression, anxiety and psychosis as well as other mental disorders. Improved psychosocial treatments, especially cognitive behavioural therapies, are also available.

Service standards for mental health services

National Standards for Mental Health Services were developed during the first decade of the National Mental Health Strategy.[18] These service standards are comprehensive, and designed to promote care, treatment and support that are respectful of consumers' rights and in line with international standards for quality.

The six principles that underpin the standards are empowering for the consumer and cover: choice and access to a range of specialised mental health; services delivered with the appropriate social, cultural and developmental context; specialised mental health treatment and support services provided in a continuous and coordinated manner; comprehensive care including during the onset, acute, rehabilitation, and recovery phases of mental illness; care to suit an individual's needs; and care which imposes the least restriction on the rights and choices of the consumer.

The standards are being used by accreditation agencies to review mental health services, and the majority of services have been, or are being reviewed against the standards. For further information see **Attachment 6**.

Key performance indicators for mental health services

In 2004 all jurisdictions agreed to adopt a new performance indicator framework for evaluating mental health service delivery in the public sector.[33] The framework defines a set of phase one indicators that are based on the National Health Performance Framework adopted by all Australian health ministers in 2001, and linked to the strategic directions of the National Mental Health Plan (2003-2008). The indicators proposed cover the domains of service efficiency, effectiveness, appropriateness, access, continuity and capability, all central concepts to understanding how a mental health service functions.

It is expected that the agreed performance indicators will be implemented progressively by each state and territory over the remaining period of the National Mental Health Plan (2003-2008). To further guide the work, the Australian Government is establishing a series of national benchmarking forums in which invited mental health agencies will trial the indicators and use them for the purpose of improving local service delivery.

Completion of the National Health Performance Framework will involve the development of key performance indicators for mental health, and developing measures that can be used nationally, including measures of consumer perceptions of care, and carer burden, to better gauge service responsiveness.

Safety and quality

The Australian Government is providing national direction in identifying, avoiding and reducing harm in environments that provide care to people with mental illness, including emergency departments and emergency services. The *National Safety Priorities in Mental Health*: *A national plan for reducing harm* identifies four national priority areas where stakeholders agree adverse events can be reduced and safety improved for people experiencing mental illness. They are: reducing suicide and deliberate self-harm in mental health and related health care settings; reducing and where possible eliminating, the use of restraint and seclusion; and safe transport of people experiencing mental illness.

Once the *National Safety Priorities in Mental Health*: *A national plan for reducing harm* has been released work will begin on specific strategies to address the national priorities identified in the plan, including beginning the process of reducing, and where possible eliminating, the use of seclusion in Australian mental health services.

Monitoring outcomes for consumers

While defining service standards and ensuring a safe environment are important, services need to deliver high quality outcomes for consumers. The emphasis on health outcomes and information systems to support service quality improvement has been gaining momentum in the wider health sector for several years. Increasing focus is being given to the responsibility of health care providers to use outcome measures to contribute to the ongoing review and development of clinical practice as well as to inform health service planning, policy development and the broader community. The National Mental Health Plan (2003-2008) continues to support further development and implementation of routine outcome measurement. All states and territories have agreed to provide the Australian Government with de-identified, consumer level outcome data.

Australia has made remarkable progress with the routine collection of outcome data, and is recognised as an international leader in this regard.[30] By June 2003:

- approximately 57 per cent of Australian public mental health services had commenced the process of consumer outcome measurement;
- an estimated 10,000 clinicians had participated in training sessions for the collection and use of outcome information, representing approximately 60 per cent of the public sector mental health workforce;
- information systems in all states and territories had been overhauled, or commenced the upgrade process, to accommodate the new requirements; and
- states and territories had begun the process of pooling data at the national level, contributing approximately 70,000 de-identified records for which outcome data had been collected.[31]

Nationally aggregated reports have been produced to feed back these outcome data to the states and territories. These reports are developed with input from stakeholders, in order to ensure their clinical and management utility.

A national model for the collection and reporting of outcomes has also been introduced in the private hospital sector. The model aims to establish systems for the routine collection of information that enable the relative effectiveness of various models of care to be determined. The introduction of standard measures of consumer outcome as an integral part of service delivery is central to the model. The approach taken parallels that being introduced in public mental health services, with measures of outcome completed both by clinicians and consumers at admission and discharge from care. Information collected in this way is pooled subsequently at the national level in de-identified format for analysis and feedback to participating hospitals. More detail regarding routine outcome measurement in Australia can be found at http://www.mhnocc.org/.

Mental health workforce

Essential to improving mental health service delivery is the competence and expertise of the mental health professional delivering the services. The Australian Government has provided support for the development of practice standards for the five major professions employed in mental health services and the development of clinical practice guidelines for specific mental illnesses. Further information about this work is provided under Part 6 Expanding and Up-skilling the Mental Health Workforce.

Information technology

Improved internet and broadband connectivity among households and medical and mental health care providers, combined with increasing development and use of e-health and tele-diagnostic applications, is enabling increased use of information technology for mental health service provision.

It is also providing many Australians with access to a wide range of online mental health resources that offer interactive features such as bulletin boards and support networks. These new modes of online health care delivery make mental health information and services available to a wide range of consumers. Further information is in **Attachment 7.**

Regional Partnerships Program

The Regional Partnerships Program, managed by the Department of Transport and Regional Services, delivers on the Australian Government's approach to regional development, which is to work in partnership with communities, government and the private sector to foster the development of self-reliant communities and regions. This involves work related to infrastructure development and improving access to services. A number of programs are funded across Australia, and many provide services relevant to the needs of people with mental illness.

The Regional Women's Advisory Council (RWAC) was established in 1999 by the Deputy Prime Minister and Minister for Transport and Regional Services to provide the perspective of rural women on issues that affect communities in regional, rural and remote Australia. The council provides independent advice directly to the Deputy Prime Minister. The council is concerned about the impact of prolonged stress on the physical and mental health of people in rural and remote Australia and access to mental health services for these people. Specific issues identified by council include depression and suicide in rural and regional areas. The council members have acknowledged that mental health services are limited in regional, rural and remote Australia.

Part 6: Expanding and Up-skilling the Mental Health Workforce

A mental health workforce must have enough clinicians from the various professions to meet the growing need for care. These clinicians must be appropriately trained, experienced and accessible if mental health consumers are to receive quality care when they need it.

Most people use the primary care sector when they have a mental health problem. Options available in this sector for professional advice about the promotion of mental health and the prevention and early detection of mental health problems and ongoing treatment are being greatly expanded. This is especially true for the ongoing care of people with mental illnesses, particularly high-prevalence mental health problems such as depression and anxiety, but extends to the management of people with chronic and complex conditions. Australians with a family GP are increasingly able to receive mental health care integrated with their physical care.

General practitioners make up a significant proportion of the primary health care workforce, and as a single group of providers, deliver the majority of mental health care to people with mental health related conditions (up to 10 million consultations per year).[27, 28]

The Australian Government investment in increasing the skills of the existing GP workforce, and in facilitating routine access to a skilled allied health professional workforce, particularly psychologists, is building a strong foundation for the effective management of mental health to be mainstreamed and integrated with the management of other health conditions.

Better Outcomes in Mental Health Care initiative

Traditionally, however, general practitioners have not been optimally equipped to provide this care, being hampered by lack of training and funding disincentives.[29]

In response to this, the Australian Government provided funding for the Better Outcomes in Mental Health Care initiative in July 2001. The initiative supports the achievement of better outcomes for people with mental health problems by: providing GPs with training; introducing incentives to GPs for delivering structured, quality care; and enabling access by GPs and consumers to allied health professionals and psychiatrists. The initiative has five related components:

- education and training for general practitioners to familiarise them with the initiative and to increase their mental health care skills and knowledge;
- 3 Step Mental Health Process which rewards best practice mental health care by general practitioners by providing remuneration for assessment, care planning and review of consumers with mental health problems;
- increased remuneration to general practitioners for the extra time they spend with mental health consumers providing focused psychological strategies;

- access to allied psychological services to enable general practitioners registered with the initiative to access focused psychological strategies for their consumers from allied health professionals; and
- access to psychiatrist support for GPs by providing remuneration to psychiatrists who participate in case conferencing with other health providers, and who provide mental health consumer management advice via the GP Psych Support service.

To date approximately 20 per cent of general practitioners have undertaken training and sought accreditation, resulting in increased knowledge and skills in mental health for participating general practitioners. As at January 2005, there were 4008 GPs registered to participate in the 3 Step Mental Health process. In 2003–04, 13,908 payments were made to GPs for completing the 3 Step Mental Health process. 93 per cent of Divisions of General Practice have taken up the Access to Allied Health Services element.

These initiatives provide mental health consumers with increased choice about the type of treatment available to them in their local community and at a cost comparable to other services provided under Medicare. For example, treatment options offered to consumers by their GP can now include referral to a psychologist, the provision of focused psychological strategies by a general practitioner accredited with the 3 Step Mental Health process, or referral to a psychiatrist, whichever is most appropriate.

This approach improves continuity of care for consumers between their GP and their psychiatrists, or their GP and their psychologist or other care providers. Better coordination of care between service providers is an issue consumers groups have long sought to be addressed.

Specialist mental health expertise for general practitioners is available from the GP Psych Support service, operating nationally to provide all general practitioners with telephone, facsimile and email access to quality consumer management advice from psychiatrists, within a 24 hour timeframe, seven days a week. Currently, an average of 50 requests for advice is handled by the service each week. General practitioners who have used the service find it effective in getting timely access to clinical information from psychiatrists to assist them to help their mental health consumers.

Through the Better Outcomes in Mental Health Care initiative consumers now receive quality mental health care from general practitioners and other primary care health professionals. However more needs to be done, especially in terms of engaging more GPs to use the components available in the Better Outcomes initiative. In recognition of this the Australian Government has committed $228.5 million over four years from 2005-09 in supporting GPs in their role as primary carers of people with mental illness.

Enhanced Primary Care program

Complimentary to the Better Outcomes in Mental Health Care initiative is the Enhanced Primary Care program which has a number of innovative mainstream services to support primary health care providers to deliver quality and better integrated services for all Australians, including people with mental health problems. These include enhanced primary care Medical Benefits Schedule (MBS) items to support GPs in providing more coordinated care for people with chronic conditions and complex care needs. The EPC program provides a framework for a multidisciplinary approach to health. The EPC items that GPs may use to treat patients with chronic and complex care needs are:

- Multidisciplinary case conferencing which focus on the consumer's immediate needs and supports the consumer's GP to consult with other health care providers such as nurses, mental health workers and social workers, as well as community care services and medical specialists, to ensure that care is organised properly; and

- Multidisciplinary care plans* which address longer term needs of consumers and include a written, comprehensive, plan of action that sets out the health care needs of a consumer and the kind of services and supports required to meet those needs. Consumers receiving care under a GP care plan may also access rebates from Medicare for up to five allied health services under the Allied Health and Dental Care Initiative.

In addition, EPC health assessments for older Australians provide preventative medical care, including an assessment of mental health for those 75 years of age and over or 55 years and over for Indigenous Australians. Expenditure related to Enhanced Primary Care items is provided in Table 7 and related to EPC items in Table 8.

Table 7 Expenditure on EPC Items (July 2003-June 2004)

Benefits claimed	$ (millions)
Health assessments	$31.887
Care planning	$30.825
Case conferencing	$2.183

Table 8 Benefits claimed for allied health services to April 2005

Allied health service	Benefits $ (thousands)
Psychologists	$802,427
Mental health workers	$ 22,049

*New EPC Medicare items for chronic disease management are being introduced from 1 July 2005 to replace EPC multidisciplinary care planning items, which will be phased out by November 2005. The new items enable GPs to choose between items for GP care planning or team-assisted care planning (or use both), depending on the needs of patients. For patients with chronic conditions, a GP will be able to develop a 'GP management plan'. For patients with chronic and complex care needs, this plan may be supplemented by 'team care arrangements', which would involve at least two other health or care providers. Both items can be used to provide coordinated care for patients with mental health problems. Patients with both a GP management plan and team care arrangements will be able to access the MBS items for allied health and dental care services.

More Allied Health Services program

The More Allied Health Services funds 66 Divisions of General Practice with at least five per cent of their population living in rural areas to provide clinical care by allied health professionals to rural communities. General practitioners refer clients to allied health professionals, based on patient need, and the GP provides ongoing medical care and assessment. The client generally receives treatment from the allied health professional free of charge. Further information is provided in **Attachment 8**.

Regional Health Services Program

Funding is provided through the Regional Health Services sub-program of the Rural Health Strategy to support primary and allied health services in small rural and remote communities of up to 5000 people. At present, 115 Regional Health Services (RHS) are providing primary and allied health care to more than 1000 communities. Of these RHS, 74 provide some mental health services, for example, psychologists delivering clinical mental health assistance to clients in remote locations using a fly-in, fly-out approach, clinics for people with a mental illness focusing on one-to-one care and group programs, and counselling services for adolescents.

Case Study 2

Susan is a 28 year old woman who has a healthy four month old girl whom she cares for full time. As part of her pregnancy Susan attended ante-natal classes where she learnt about the signs and symptoms of post-natal depression, both through printed information from beyondblue and discussion within the class. Even though her husband and family are supportive, Susan has recently been feeling exceptionally teary, unable to focus on daily tasks and is unable to sleep. She decided to talk to her GP who has completed the training offered through the Better Outcomes in Mental Health Care Program and recognised the symptoms of post natal depression.

As Susan was breast feeding her baby, her GP sought specialist advice on the use of medication and was able to get this through Psych support service within 24 hours. After discussion with the service it was decided the depression could be managed with focussed psychological therapy rather than medication. The GP was then able to refer her for six sessions of psychological support and counselling. This was organised and funded through the Better Outcomes in Mental Health Care Program and helped her to deal with her post-natal depression and get back on her feet.

The GP was able to spend more time with Susan and was rewarded for the best practice care provided to her through specific MBS items designed to support best practice primary mental health care.

The GP was aware that, if necessary, she could have referred Susan to a psychiatrist for assessment and the development of a care plan, that she, together with Susan, could implement. In this circumstance the psychiatrist could have used the new MBS psychiatry items, introduced in May 2005, for referred assessment, which provides an incentive to psychiatrist to support GPs by providing advice on their management of mental health consumers.

Enhancing the mental health workforce

Australia is short of nurses, doctors and some other health professionals. The problem is acute in mental health and a serious impediment to improving the care of people with mental health problems. The shortage is in both primary care and specialist psychiatric services.

The Australian Government is investing $1.5 billion over five years to address overall medical workforce shortages. There is a range of strategies to strengthen the medical workforce and it is expected these will increase the number of full time equivalent doctors by more than 1500 by 2007. There is a special focus on GP shortages, especially in the outer metropolitan areas of the main capital cities and in rural areas across Australia.

In addition, a number of programs are improving the access of people living in rural, remote and regional Australia to specialists, including psychiatrists working in child and adolescent psychiatry, and psychogeriatric services.

Particular attention is being paid to the supply and distribution of the nursing workforce with a considerable additional investment being undertaken in undergraduate nursing places and scholarships to attract and retain nurses in the profession, particularly in rural and remote areas and aged care. Further information is provided in **Attachment 9**

Addressing shortages in the health workforce is critical to the successful implementation of future mental health reform and to the ongoing improvement in mental health care being received by consumers.

Practice standards for the mental health workforce

The Australian Government has provided support for the development of practice standards for the five major professions employed in mental health services: psychiatrists, nurses, psychologists, social workers and occupational therapists. With collaboration from these professional groups, the *National Practice Standards for the Mental Health Workforce*[34] were finalised in 2002. There are 12 standards that define the shared knowledge, skills and attitudes required by all professionals working in a multidisciplinary mental health environment. They are intended for use in conjunction with each of the professional groups' discipline specific practice competencies. The standards are to be implemented during the life of the National Mental Health Plan (2003-2008).[17]

Clinical practice guidelines

The Australian Government has provided funding to the Royal Australian and New Zealand College of Psychiatrists for the development of clinical practice guidelines for specific mental illnesses. Separate evidence-based guidelines for clinicians and evidence-based guidelines for consumers have been developed in the following five priority areas: schizophrenia; major depression; bipolar disorder; panic disorder and agoraphobia; and anorexia nervosa. They are available at http://www.ranzcp.org/publicarea/cpg.asp.

The Australian Government will be working with the states and territories through the soon to be established National Mental Health Workforce Advisory Committee, to progress issues in relation to workforce education, retention and sustainability in the mental health sector. This activity will aim to improve the quality of mental health consumer care and service unmet needs by: making the mental health sector a more attractive place to work; retaining staff; developing innovative approaches in the delivery of services; and ensuring best practice and quality care are high priorities.

Part 7: Financial Support for Mental Health Consumers

While for some people the impact of their mental illness may be minimal, for others it can be serious and highly disabling, and for many the symptoms and their impact fluctuate. Mental illness can reduce a person's capacity for independent living, weaken family and social supports, increase the risk of relationship problems and impact on a person's ability to find and keep a job.

Mental illness and disability

Mental illness represents a major category of disability condition under the Australian Government's Disability Support Pension (DSP). Of the total number of DSP[b] customers at June 2004, those with a psychiatric/psychological condition were the second largest customer group (25.4 per cent), behind those with musculo-skeletal and connective tissue conditions (34.0 per cent).

The Australian Government Departments of Family and Community Services (FaCS) and the Department of Employment and Workplace Relations (DEWR) are responsible for forming policy, and funding and providing payments and services to support people with a disability, their families and their carers. At a whole of government level, these responsibilities include carriage of the Commonwealth Disability Strategy, which requires government organisations to incorporate the needs of people with a disability in the early planning stages of their policy and service delivery processes. The principles of the strategy also include meeting the needs of people with a mental illness who are seeking to access government services or information. .

The Commonwealth State Territory Disability Agreement administered by FaCS provides the national framework for the delivery, funding and development of specialist disability services for people with disabilities. Under this agreement, advocacy is a shared responsibility of the Australian Government and the state and territory governments.

The National Disability Advisory Council was set up in 1996 to create better links between government, people with disabilities and their families. It provides advice to the Minister for Family and Community Services on disability related issues and encourages consultation between the Australian Government and the disability sector.

Further information is in **Attachment 10**.

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[b] DSP statistics only report the primary disability that qualifies the person for payment. The data does not pick up, or provide a complete description of, other conditions a person may have. For example, a person's primary condition may be a physical disability but an associated mental disability (such as depression) will not be recorded in the DSP data. Indeed, the prevalence of comorbidity (the occurrence of more than one disorder at the same time) among different forms of mental disorders (e.g., anxiety and substance use), as well as among mental disorders and physical conditions (e.g., physical disability and depression) is high (ABS 1998). Recent research also shows that the prevalence of moderate to severe mental disability (as assessed by the SF-36) among those in receipt of DSP is greater than the incidence of primary psychiatric/psychological conditions recorded in the DSP data (Butterworth, Crosier et al. 2004).

Assistance for accessing income support

Like everyone else in the community, people with mental illness need adequate financial support, either through income support payments or through paid employment. An individual's circumstance, and the nature and course of their mental illness over time, may see them move between paid employment and the need for income support, requiring a flexible system and sensitive approach from service providers. During an episode of illness a person may be unable to work and require access to sickness benefits before being able to return to work, while for another individual, they may be able to return to work after the onset of mental illness, but require assistance to do so. For some individuals the illness may be so disabling that a disability support pension is needed.

Income support payments

For those mental health consumers requiring income support, a number of Australian Government programs are available depending on individual circumstances.

- the **Disability support pension** which is available for people with a psychiatric impairment who are unable to do any work for at least 30 hours a week;

- **Sickness allowance** which is available for people who are temporarily unable to undertake their usual work or study due to illness, and have a job or study to return to when they are fit;

- **Newstart allowance** for unemployed people between the ages of 21 years and the pension age, who are seeking paid work or undertaking other activities to improve their employment prospects; and

- **Youth allowance** for full time students up to 24 years and other young people up to 21 years of age where they are engaged in activities, including education, training, and job search, that will enhance their capacity to earn an income.

Table 9 provides information about funding across the various income support programs, including, where available, funding for people with a mental health condition. Further information about these payments is in **Attachment 11**.

Table 9 Funding for income support

Payment	Customers	Total funding ($million)	Funding period	% recipients with mental health condition	Total funding for people with a mental health condition ($million)
Disability Support Pension	623,926	$5,849.8	2000-01	22.6	$1,322.1
	658,915	$6,400.4	2001-02	23.7	$1,516.9
	673,334	$6,851.6	2002-03	24.7	$1,692.3
	696,742	$7,492.5	2003–04	25.4	$1,903.1
Sickness Allowance	10,942	$95.6	2000-01	22.6	$21.6
	9,522	$93.7	2001-02	22.4	$21
	8, 755	$85.5	2002-03	22.8	$19.5
	8,478	$85.4	2003–04	22.6	$19.3
Newstart Allowance	575,971	$4,885.4	2000-01	N/A	N/A
	545,535	$5,078.2	2001-02		
	512,332	$4,831.1	2002-03		
	483,093	$4,754.7	2003–04		
Youth Allowance	359,590	$2,101.9	2000-01	N/A[a]	N/A[a]
	395,496	$2,213.7	2001-02		
	400,980	$2,235	2002-03		
	381,805	$2,257.4	2003–04		
Mobility Allowance	37,574	$59.4	2000-01	8.4	$5
	41,997	$67.9	2001-02	9.0	$6.1
	44,997	$75.0	2002-03	9.6	$7.2
	47,402	$82.2	2003–04	10.2	$8.4
Parenting Payment	416,661 (PPS)[b]	$3,862	2000-01	N/A	N/A
	205,379 (PPP)[b]	$1,464	2000-01		
	427,846 (PPS)	$4,146	2001-02		
	191,576 (PPP)	$1,426	2001-02		
	436,958 (PPS)	$4,350	2002-03		
	181,405 (PPP)	$1,381	2002-03		
	449,312 (PPS)	$4,657	2003-04		
	177,157 (PPP)	$1,338	2003-04		

a Indicates that data are not available from DEWR administrative systems
b Indicates Parent Payment partnered (PPP) or single (PPS)

Centrelink

For people experiencing mental illness, accessing information about the range of available income support payments, determining what support is available for their situation, and completing the necessary requirements, including the paperwork and attendance at Centrelink, can be daunting.

Centrelink offices have trained staff able to work with mental health consumers including:

- Centrelink disability officers who assist customers with illnesses, injuries or disabilities to overcome barriers and develop a pathway to social and economic participation. They also provide an internal consultancy and training service to other staff who provide assistance to people with disabilities.

- Centrelink's 500 social workers who conduct assessments of customers with mental illness, including being attuned to issues of suicide prevention, and make referrals to appropriate local services. In addition to face-to-face services, Centrelink also has a national social work call-centre line for the provision of counselling and support to customers over the telephone. In 2004, Centrelink's social workers assisted 12,316 people with mental illness and another 2031 people who were potentially at risk of suicide. Centrelink's social work services play a key role in establishing and maintaining links with mental health and other relevant services.

- Centrelink's 250 psychologists who provide a national service, including travelling to rural and remote locations. They target early identification in relation to mental health problems or mental illness for people on income support payments. This includes referring customers to appropriate services for assistance and promotion of mental health literacy to help with better understanding and management of their condition.

Centrelink staff ensure mental health consumers receive their income support entitlements, or have access to programs to assist their return to work, including an assessment of appropriate education, or training if needed. In some instances Centrelink may be a first point of contact with people not already in the health or mental health system and can initiate referrals for appropriate assessment and care. Further information about Centrelink services is in **Attachment 12**.

Assistance for finding and keeping a job

A range of services are available to assist mental health consumers looking for work, including those who need additional support to find work or to keep their current position.

Employment and pre-vocational assistance

In addition to mainstream employment assistance provided through the job network, two services administered by the Department of Employment and Workplace Relations are available to assist people with mental illness:

- The Disability Open Employment Services, which assists job seekers with disabilities who have significant or ongoing support needs, by providing training, job placement and on the job support. In 2003-04 around 12,000 people with a psychiatric disability were assisted.

- The Personal Support Program bridges the gap between crisis assistance and employment assistance programs. It provides assistance to people whose non-vocational barriers (such as homelessness, mental health problems or mental illness, drug or gambling problems) prevent them from getting a job or benefiting from employment assistance services. As at 1 November 2004, there had been 7828 participants on the program with a mental health barrier.

Further information about training and support programs is in **Attachment 13**.

Vocational rehabilitation

CRS Australia (previously Commonwealth Rehabilitation Service) delivers vocational rehabilitation services to people of working age who have a disability, injury or health condition. Rehabilitation programs are tailored to individual needs and can include vocational assessment and counselling, job preparation, placement and training, injury management and workplace modifications. Vocational rehabilitation assists people to manage the impact of their condition and helps them to gain and keep a job.

CRS Australia currently provides services through 176 outlets across Australia, and assists more than 35,000 job seekers with disabilities annually to gain or retain employment. As announced in the 2005–06 budget, the Australian Government has committed an additional $186 million to fund an additional 41,700 places for three years from July 2006.

At present, 29 per cent of CRS clients have a mental health condition as their primary disability. CRS Australia employs approximately 1100 rehabilitation consultants from a range of allied health backgrounds, including psychologists, social workers, occupational therapists, physiotherapists, rehabilitation counsellors, and speech pathologists. The *Disability Services Act 1986* (DSA) guides the context in which CRS Australia offers rehabilitation services to clients.

CRS Australia also assists mental health consumers undertaking vocational rehabilitation who are experiencing non-disability related barriers which are impacting on their ability to make progress in their programs. This is achieved by identifying opportunities for better service coordination and pathways for people in their local communities, including facilitating referral appropriate agencies. Further information is in **Attachment 14** and from http://www.crsaustralia.gov.au.

Support to employers

Financial incentives are available to employers who employ workers with disabilities. Administered by the Department of Employment and Workplace Relations this includes the Wage Subsidy Scheme with the aim of improving workers' competitiveness by increasing their skills and experience, and the Workplace Modifications Scheme where employers are assisted to provide employment opportunities through the provision of specialist equipment. In addition, the 2005–06 budget provided $1 million over two years for research into the area of mental health and income support, including the development of tools for employers to provide practical advice about employing people with mental health problems.

Information about funding for programs to help people find work is in Table 10.

Table 10 Funding for workforce participation

Payment	Customers	Total funding ($million)	Funding period
Disability Open Employment Services	69,431 (estimate)	$846.5	2006–09
Personal Support Program	70,000 (estimate)	$323.1	2006–09
Vocational Rehabilitation Services (CRS)	76,700	$634.8	2006–09
Wage Subsidy Scheme		$19.4	2005–09
Workplace Modification		$28.2	2005–09
Mental health (research)		$1	2005–07

Part 8: Social Support for Mental Health Consumers

People with a mental illness are part of families and communities and may experience circumstances or hardships unrelated to their mental illness. This includes family relationship problems, financial hardship, caring for their children, and housing issues. For other people who have no history of mental health problems, these hardships can place them at risk of developing a mental health problem or mental illness.

Families experiencing relationship breakdown

Families who experience relationship breakdown have a higher incidence of poor mental health.[3] Women who have experienced violence from a current or former partner are four to five times more likely to report depression than other women.[46] 45 per cent of sole mothers in receipt of income support experience a diagnosable mental illness.[47] While the evidence for causal relationships is limited, mental illness may contribute to family breakdown and family breakdown is likely to contribute to anxiety and depression.

The Australian Government has a strong commitment to improving the lives of Australians by helping to build the capacity and wellbeing of individuals, families and communities and provides assistance to individuals, couples and families. The Family Relationships Services Program provides family relationship services to men, women and children across Australia, using education, mediation, therapy, skills training and counselling. Further information about the Family Relationships Services Program is in **Attachment 15**.

Family Court of Australia

The Family Court of Australia (the court) deals with many people where the relationship between family separation and mental health is of particular concern. The court is committed to resolving or determining family disputes, driven by the needs of families and children, and continues to invest significantly in integrating mental health strategies into every aspect of client services. Most recently, the court, in conjunction with the Federal Magistrates Court, has developed the Mental Health Support Project to ensure the court's systems and processes are as supportive as possible of people's mental health and to assist staff of the court to support the mental health and emotional wellbeing of clients by promoting awareness, providing skills and putting in place supporting infrastructure.

Child Support Agency

The Child Support Agency (CSA) has also been proactive in looking for ways to better meet the emotional needs of parents at separation, and other crisis points following separation, and has developed resource materials and increased services to support parents through the emotional and financial difficulties which often surface during this time. CSA has clear procedures in place to ensure that parents who may be at risk of self harm, or of harming others, are appropriately supported.

Further information about the National Mental Health Program funded projects undertaken by the Family Court of Australia and the Child Support Agency is in **Attachment 16**.

Children of parents with a mental illness

In families affected by mental illness, the children may need additional support and care. Where a mental health consumer is also a parent, the children may be at increased risk of developing psychosocial and mental health problems themselves. In particular, the mental illness of a parent can impact upon: the formation of a healthy attachment between an infant and parent; the development of emotional and behavioural problems in toddlers; the ability to make a successful transition to school (as a result of separation anxiety and poor school readiness); and the risk of developing conduct disorder, depression and anxiety in adolescence.[49]

Parents with a mental illness may resist telling service providers they have children, or not seek assistance for their children, because they are afraid the authorities will remove the children from their care. This needs sensitive and careful handling by service providers, as well as consideration by mental health consumers and their children. For example, a parent with a mental illness may work with their GP, their family and friends and their children to put in place a care plan for the children that can be implemented in the event of a serious illness relapse.

The Children of Parents with a Mental Illness (COPMI) project, funded under the National Mental Health Program, provides parents, children and service providers with information and resources to better address this issue. Further information on the COPMI project is at http://www.aicafmha.net.au/.

Children in out-of-home care

The majority of children who come into out-of-home care, including the care of relatives, do so because of child abuse and neglect. A major characteristic of families of children in care relates to the presence of diagnosed mental health conditions, alone or with other associated patterns of entrenched substance abuse and domestic violence. Children in out-of-home care are at particularly high risk of poor long-term outcomes such as mental illness, drug and alcohol addiction and welfare dependency. Because of their experiences, these children can exhibit post-traumatic stress disorder, and behavioural problems as well as psychological, emotional and social difficulties.

The Australian Government is working with the state and territory governments to progress an improved approach to issues relating to children in out-of-home care. This includes the National Plan for Foster Children, Young People and their Carers (2004-06) and the development of Council of Australian Governments' (COAG) report on children in extended family care.

Gaps that have been identified by research and anecdotal evidence include the need for access to therapeutic services for both children and carers, and respite for carers. Other risks to children and carers in this situation include the increasing emotional and financial pressure in providing care for children with increasingly complex needs and difficult behaviours, and a steady rise in the number of children and young people in out-of-home care, with relatively fewer people willing to take on the role of foster caring.

Further information about children of parents with a mental illness and children in out-of-home care is in **Attachment 17**.

Support for children at risk or with special needs

A range of mainstream programs and benefits are available to supports children at risk and those with special needs including, the Stronger Families and Communities Strategy, Playgroups, Child Care Benefits, Special Child Care Benefits and the National Agenda for Early Childhood. Further information about these programs is in **Attachment 18**.

People experiencing financial hardship

A devastating outcome for a metal health consumer can be financial hardship, for themselves and their families. Also, financial hardship can be associated with increased psychological distress and mental illness.[50–54]

The Australian Government supports programs to educate people to better manage their financial affairs and to increase their understanding of the factors contributing to financial hardship. Grants are also made to community and charitable organisations under the Emergency Relief Program to provide emergency assistance to individuals and families in financial crisis. The Smith Family reports that around 21 per cent of the people who present for emergency relief have mental health problems or mental illness, including emotional difficulties and depression.[55] Further information about programs to assist people experiencing financial hardship is in **Attachment 19**.

Housing and homelessness

Some people with a mental illness may experience difficulties in accessing housing, experience disruptions of tenancies (eg due to hospital admissions), have fluctuating ability to maintain their tenancies, and be unable to afford stable housing.[60] Evaluations of consumer preferences for housing demonstrate that most adults with a mental illness prefer to live independently rather than in a group home.[61] There is also evidence that severe mental illness, such as psychosis, is a risk factor for, rather than a consequence of, homelessness[62] and that effective treatment for people with psychosis, early in their illness, can prevent homelessness.

Affordable housing and rent assistance

The Australian Government has made a substantial commitment to help the states and territories supply appropriate, affordable and secure social housing by providing around $4.75 billion under the five year Commonwealth-State Housing Agreement. While strategic directions for housing assistance are subject to Australian Government agreement, the management and delivery of public and community housing and crisis accommodation are the responsibility of individual state and territory governments.

Rent Assistance has a significant impact on increasing housing affordability for income support recipients and low income families participating in the private rental market. This provides recipients with a greater degree of choice and flexibility in their choice of dwelling and location. Australian Government expenditure on rent assistance for 2004–05 is expected to be $2.05 billion.

Crisis accommodation

Evidence suggests that the incidence of mental illness among the homeless population is high. One study found that approximately 75 per cent of homeless people in Sydney have a mental health problem, and more than 50 per cent of young people accessing housing and homelessness agencies have a mental health problem.[58]

Crisis accommodation and services are a key element of care for homeless people experiencing mental illness and the Australian Government has provided $833 million over five years to the states and territories as part of the current Supported Accommodation Assistance Program (SAAP) (IV) Agreement (2000–05) to provide this care. Even so, compared with other areas of expressed client needs, assistance with mental health problems or mental illness has one of the highest levels of unmet need in the provision of SAAP services. The Australian government's offer for the SAAP V agreement seeks increased state and territory contribution to such areas of need.

Further information about housing and homelessness is in **Attachment 20**

Home and Community Care (HACC) Program

To enhance the independence of people and support them staying in their own homes, the Home and Community Care (HACC) Program provides a range of support including, nursing and allied health care, meals and other food services, domestic assistance and personal care, home modification and maintenance, transport, and respite care.

The HACC Program is a joint Australian Government, state and territory government initiative to which the Australian Government nationally contributes approximately 60 per cent of program funding and maintains a broad strategic policy role. State and territory governments contribute approximately 40 per cent of program funding. In 2005–06, the Australian Government will provide an estimated $857.8 million to the HACC Program, which is an increase of 8.33 per cent over 2004–05. Should all states and territories agree to match the Australian Government's offer of funding, a total of $1.409 billion will be provided nationally for the HACC Program in 2005–06.

Support for carers

Research on the overall health of carers indicates that the responsibilities and stresses of caring can have an adverse impact on the mental health of some carers, for example:

- The Carers Association of Australia found that two-thirds of all carers felt that providing care had directly affected their overall mental and emotional wellbeing. Of those affected, 85 per cent reported that caring had made their mental and emotional wellbeing worse or much worse, with the major changes being feeling sad or depressed, or worried and anxious.[56]

- Palliative Care Australia found that carers of terminally ill people often develop their own health problems, including mental health problems or mental illness, and that caring reduces their opportunities for relationships, education, employment or holidays, all of which can have flow-on effects on carers' mental health.[57]

Support programs

The Australian Government recognises that carers of people with a mental illness may face issues and problems that are particular to their situation. These carers can access a range of programs and services provided for carers by the Australian Government, including:

- the National Respite for Carers Program, which helps carers take a break from caring (administered by DoHA);

- Commonwealth State Territory Disability Agreements, which provide funding for state and territory government respite care (managed by FaCS);

- the Home and Community Care Program (managed by DoHA);

- the Veterans' Home Care Program, as well as a range of community based respite services (managed by DVA);

- the National Carers Counselling Program, which provides counselling from qualified counsellors on issues that are specific to carers' needs, such as depression, stress-related issues, grief and loss and coping skills (managed by DoHA); and

- the Carer Payment or Carer Allowance for financial assistance (administered by FaCS).

Targeted assistance is also available to young carers. Since January 2005, young carers at risk of prematurely leaving school, or the vocational equivalent, have been provided with additional respite, support and information services. Young carers will have access to up to five hours in-home respite per week during the school term and can have access to one fortnight of respite care each year to undertake activities such as studying for exams, training or recreation. In addition young carers will be able to access age-appropriate information, advice and referral services including an information network, a hotline and on-line advice.

Further information about carers is in **Attachment 21**.

Case Study 3

Abdul is a 21 year old man living alone and working as a machinist in a factory nearby. He recently experienced voices talking about him in a derogatory way, and started to believe he was being followed and spied on. His friends took him to the local hospital where he was admitted and diagnosed with schizophrenia.

His hospital experience was significantly better than it would have been 15 years ago. He was able to be treated in the general hospital and not transferred to a mental hospital in the next town. The hospital had recently been accredited under the National Mental Health Standards and Abdul was seen by allied health staff who provided him and his parents with information about his condition. He was not locked in the ward but prescribed new antipsychotic medication which have much fewer side effects. His condition improved before he left hospital and he was visited by the community mental health nurse who will continue to see him at home. Arrangements for him to see the community psychiatrist were made before he left hospital.

Abdul was keen to remain in his apartment and not go back to live with his parents. The nurse realised he would need help initially with his daily activities, such as shopping, cleaning and cooking meals, so organised Health and Community Care services to help him with these. When she discovered Abdul’s lease would not be renewed because of his disruptive behavior before his admission, she arranged for the local supported accommodation service to assess him for alternative accommodation.

Although his schizophrenia is improving, Abdul is not yet able to return to work and the factory employing him did not keep his job open and he was retrenched. The community health nurse put him in touch with CRS Australia which provided vocational rehabilitation and assisted him to find another job. While he was doing this, Centrelink provided him with income support.

Abdul was fortunate to be put in touch with the services he needed. Coordinating the care that people with a mental illness and associated psychiatric disability require doesn’t always happen as smoothly as this.

Part 9: Utilising Mental Health Research and Data Collections

Research to understand aetiology and improve treatments

The growing burden of disease attributable to mental illness in Australia, together with the increasing complexity of mental illnesses, means there is a need for increased knowledge and understanding of the aetiology of mental health problems and mental illness as well as better treatments and cures.

National Health and Medical Research Council

The National Health and Medical Research Council, through its Research Committee, is currently providing $27.28 million for mental health research and training, an increase from $18.51 million in 2003. Further information is in **Attachment 22**.

Research for policy development and improved service delivery

These research projects are funded under the National Mental Health Strategy.

Assessing Cost Effectiveness – Mental Health study

The Australian Government, in conjunction with the Victorian Department of Human Services, commissioned the Assessing Cost Effectiveness — Mental Health (ACE-MH) study to explore whether the effectiveness and efficiency of Australia's mental health services could be improved by directing available resources toward best practice cost effective services.[37] To date it has identified a range of best buys, and prompted consideration of potential inefficiencies in the system.

Burden of disease research

The Australian Government is providing funding to the University of Queensland and the Clinical Research Unit for Anxiety and Depression at the University of New South Wales to undertake a program of collaborative, policy relevant research, consultation and related activities to contribute to the reduction of the burden of disease associated with mental illness and to explore innovative models of care.

Work Outcomes Research Cost Benefit Project

The Australian Government has funded the Queensland Centre for Mental Health Research (The University of Queensland) to undertake a major applied research project, known as the Work Outcomes Research Cost Benefit (WORC) Project. The WORC Project is a significant prospective study exploring productivity gains (cost benefit in dollar terms) flowing from the proactive screening and treatment of depression in Australian workplaces. Like the burden of disease research, the results of the WORC Project are being made available to decision makers as they emerge.

Routine data collection

Establishing the evidence base for policy and service reform

As part of its leadership role, the Australian Government has a commitment to monitoring and ensuring accountability for mental health services. Few national policy areas in Australia have been subject to an equivalent level of reporting and accountability as that required under the National Mental Health Strategy. This occurs through:

- the annual National Survey of Mental Health Services which collects mental health expenditure data at the organisational level in each state and territory and presents a break down of how specialised mental health services are provided;
- the National Mental Health Report which presents this survey data and is the main vehicle for monitoring the performance of governments in progressing reforms under the National Mental Health Strategy;
- National Minimum Data Sets for mental health which provide consumer and establishment level data on consumers admitted to in-patient settings and being seen in the community; and
- National Key Performance Indicators for Australian public mental health services which have been agreed for implementation with further work proceeding to develop mental health measures to cover the full spectrum of the National Health Performance Framework.

Australian Institute of Health and Welfare

The Australian Institute of Health and Welfare (AIHW) is Australia's national agency for health and welfare statistics and information and undertakes a range of statistical work specifically related to mental health care services and to people with mental illness. Further information is in **Attachment 23**.

One-off data collections - The National Survey of Mental Health and Wellbeing

Early in the life of the National Mental Health Strategy there was recognition that sound Australian epidemiological evidence was necessary to underpin the reform process. For this reason, the Australian Government commissioned the National Survey of Mental Health and Wellbeing to determine the prevalence of different mental illnesses and comorbidities, rates of service use, and levels of unmet need. The survey comprised three separate components: a survey of more than 10,000 adults,[3] a survey of 3800 adults with low-prevalence disorders,[35] and a survey of 4500 children and adolescents.[4] The three surveys were conducted in the late 1990s, but the analysis has been ongoing.[36]

The findings from the National Survey of Mental Health and Wellbeing have been widely used to inform policy and service reform. For example, the adult high-prevalence survey revealed that the majority of people with a mental illness receive treatment from their general practitioner. This led to policy developments to better equip general practitioners to cater for these consumers, most notably the Better Outcomes in Mental Health Care initiative. Plans are now under way for a second National Survey of Mental Health and Wellbeing, to be conducted at the end of 2007.

Part 10: Special Population Groups

Some people with a mental illness are from population groups that experience other high risk factors with respect to their health and wellbeing. The care and treatment of these people needs to be provided within the context of their broader circumstances, including cultural background, age, previous adverse life events and other physical health problems.

Indigenous Australians

Indigenous Australians make up 2.4 per cent of the Australian population, approximately 450,000 out of a total Australian population of 20 million. The health disadvantage of Indigenous Australians relative to non-Indigenous Australians includes an average life expectancy at birth which is around 20 years lower than the average life expectancy at birth for all Australians. Indigenous Australians' mental health and emotional and social wellbeing is also an area of significant disadvantage.

The recently published second volume of the Western Australian Aboriginal Child Health Survey (WAACHS), *The Social and Emotional Wellbeing of Aboriginal Children and Young People*,[68] found that 24 per cent of Aboriginal children are at high risk of clinically significant emotional or behavioural difficulties, compared with an equivalent figure of 15 per cent in the general population. More than one in six (16 per cent) young people aged 12–17 years had seriously considered ending their own life in the 12 months before the survey. Of these, 39 per cent had attempted suicide. Further information about the health disadvantage of Indigenous Australians is in **Attachment 24**.

Office of Indigenous Policy Coordination

Indigenous specific programs are administered by mainstream agencies. Under a whole of government approach, the Office of Indigenous Policy Coordination, within the Australian Government Department of Immigration and Multicultural and Indigenous Affairs (DIMA), and its network of Indigenous Coordination Centres, are working with mainstream agencies and communities to ensure a coordinated approach to service delivery, which provides tailored responses to Indigenous community needs.

Health policy and programs

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) within the Australian Government Department of Health and Ageing (DoHA) has a key role, in partnership with other stakeholders, in developing national policies and strategies for improving the health of Indigenous Australians. OATSIH also has responsibility to ensure that mainstream services meet their responsibilities to Indigenous Australians, and that other sectors are aware of the impacts that their policies and programs have on Indigenous Australian health outcomes.

The *National Strategic Framework for Aboriginal and Torres Strait Islander Social and Emotional Wellbeing and Mental Health 2004–2009* (the SEWB Framework) was endorsed by the Australian Health Ministers' Advisory Council in December 2004. It aims to provide a framework for action by all governments and communities to improve the social and emotional wellbeing and mental health needs of Indigenous Australians over the next five years.

The Mental Health Program is supported by the *National Aboriginal and Torres Strait Islander Emotional and Social Wellbeing (Mental Health) Action Plan*. The funding allocation is recurrent at approximately $5.8 million per year, which funds 12 regional centres and 19 mental health services. The primary goal of the regional centres is to provide training and professional support to the Indigenous Australians health and emotional and social wellbeing workforce, including Bringing Them Home Counsellors and Link Up workers. Funding also supports the Charles Sturt University's Djirruwang Aboriginal and Torres Strait Islander Mental Health program, which provides a tertiary level course in mental health for Indigenous Australians.

The Bringing Them Home (BTH) program supports a broad approach to providing counselling and education to address the healing of the whole community. In total, 106 counsellor positions have now been allocated across all states and territories. National performance indicators available for the 2002–03 financial year show that BTH counsellors had more than 37,000 client contacts that year, an increase from 28,500 reported in 2001–02. Approximately 66 per cent of BTH counsellors were Indigenous Australians, with 29 per cent personally and directly affected by past removal practices. The BTH program has also allocated $7.7 million over 2002–03 to 2004–05 to support the expansion of regional centres, bringing the total number to 16. For the three financial years 2002–03 to 2004–05, the funding allocation for BTH programs is $37.72 million.

The Link Up program funds a national network of services to provide support, guidance and assistance to Indigenous Australians affected by past removal policies to trace their family history and potentially reunite then with their families. Since the program commenced in 1998–99, it has provided assistance to almost 27,000 people and has reunited around 1050 clients with their families. For the three financial years 2002–03 to 2004–05, the funding allocation is $11.76 million.

Further information about the Office for Aboriginal and Torres Strait Islander Health programs is in **Attachment 24**.

Aboriginal Primary Health Care Services

Aboriginal Primary Health Care Services are funded by the Australian Government under the Aboriginal and Torres Strait Islander Health Program. In 2005-09, $1434 million is being provided for Indigenous specific health programs with the bulk of this funding being provided to health service organisations. 206 services are funded to provide comprehensive primary health care and/or substance use specific services in holistic and culturally appropriate ways to the Aboriginal and Torres Strait Islander community, including many activities in relation to social and emotional wellbeing.

Workers in services deal with trans-generational issues of loss, grief, trauma, dispossession and separation from families, as well as supporting people through grieving processes. The primary health care services have reported[c] that in 2002-03, 83,900 episodes of care were provided by their emotional and social wellbeing staff. These figures represented around four per cent of total episodes of care provided. The services employed 176 full time equivalent emotional and social wellbeing staff as at 30 June 2003. In 2002-03, 42 substance use specific services reported that they had addressed issues of depression, hopelessness or despair (95 per cent), anxiety or stress (90 per cent), and family/community violence (90 per cent). As at 30 June 2003 there were 188 full time equivalent counsellor positions paid by these services.

Indigenous Australians in the legal system

In 2003, the Australian Institute of Health and Welfare[65] reported that Indigenous people with mental illness or emotional distress may not only cause Indigenous Australians to come into contact with the criminal justice system but that Indigenous persons in the legal system were at high risk with respect to metal illness.

The Indigenous Law and Justice Policy, *Framework and Policy Directions for the Delivery of Legal Aid Services To Indigenous Australians,* provides comprehensive program delivery information, including a description of the requirements of funded organisations in relation to the provision of legal aid services for Indigenous people.

The Australian Government provides funding for Family Violence Prevention Legal Services (FVPLS) to assist Indigenous adults and children who are victims of family violence (including sexual abuse), or who are at immediate risk of such violence. There are 13 FVPLS units in operation around Australia, with an additional 13 units to be established in rural and remote high need areas during 2005.

Funding is also provided to advocate for the advancement of the legal rights of Indigenous Australians by promoting effective cooperation, coordination and liaison between Indigenous Australians, state, territory governments, the Australian Government and other bodies. The Law and Justice Advocacy Program is complemented by other Indigenous law and justice programs, and supports Indigenous Australians in developing policy, law reform initiatives, and delivering community legal education and information.

The Australian Government also provides funding to develop and undertake activities that will reduce Indigenous Australians' adverse contact with the legal system. The program facilitates activities that will rehabilitate and support Indigenous Australians who have Indigenous-specific programs or policies that are improving the resilience of communities and providing choices for families and children include been incarcerated or are in custody. The Prevention, Diversion and Rehabilitation program complements the other Indigenous law and justice programs and funds activities that will lessen the need for legal aid.

Other Indigenous Programs

A range of Indigenous specific programs and policies are supported by the Australian Government, including improving the resilience of individuals and communities. Descriptions of these programs are in **Attachment 25**.

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[c] Based on Service Activity Reports by 134 of a total of 206 Aboriginal Primary Health Care services.

The veteran community

The veteran community is generally perceived within the wider community as a special group with specific circumstances. It is widely considered that a higher prevalence of posttraumatic stress disorder (PTSD), anxiety and depression exists within the veteran community when compared with the wider population. Additionally, evidence from the governments' study on the *Morbidity of Vietnam Veterans* (1998) identified that the children of Vietnam veterans were a high-risk group for suicide or accidental death.

Policy

The Australian Government, through the Australian Government Department of Veterans' Affairs (DVA), currently spends approximately $129.5 million annually on mental health services targeted at the veteran community. The policy, *Towards Better Mental Health for the Veteran Community* was developed in 2001 within the context of the National Mental Health Strategy (NMHS) and its five-year plans. The DVA mental health strategy is working to effect similar goals and changes as the National Mental Health Strategy. Through the DVA mental health strategy, the veteran community is able to access integrated mental health care, incorporating strategies for prevention, early intervention, treatment, rehabilitation and maintenance of good mental health.

DVA is refocusing attention towards broader veteran mental health needs (not just PTSD) and developing strategies to address the impact of alcohol and substance use, and the mental health problems of the aged. It is also developing ways to improve access to mental health care for those living in rural and remote locations.

Programs

The government has introduced a number of initiatives that aim to reduce the burden of mental health problems and illness in the veteran community including Vietnam Veterans Counselling Service, the Alcohol Management Plan, and the Crisis Relief or Time Out program.

All eligible veterans can now get treatment for anxiety and depression under the *Veterans' Entitlement Act 1986* (VEA), regardless of whether these conditions are service related. Previously, only Vietnam veterans had access to such treatment. This will enable veterans to receive help as early as possible to improve their health and wellbeing.

The Australian Government, through DVA, offers a range of programs to support veterans, including those with mental health conditions, in improving workforce participation.

Research and data

Mental health has been identified as a key research area within DVA, and the department has a number of research projects identified in the short to medium term. One significant piece of research commissioned by DVA was the *Pathways to Care* research in 2004 which provided an analysis of a number of indicators including a correlation between which veterans (by conflict) were receiving help for a mental health condition, how they received this help and from where, and the level of mental health services (or non service) they received.

The DVA is in the process of developing a mental health datamart as part of an extensive health centred data warehousing project that will provide a more rigorous account of referral patterns, identification of pathways to care and expenditure. Once operational, the datamart will better inform policy and planning around mental health.

Stakeholder involvement

DVA ensures departmental decisions about veteran mental health care demonstrate added value through active participation of service users, ex-service organisations, providers and the Australian Government Department of Defence. It has also developed collaborative relationships with other key stakeholders, including the Australian Divisions of General Practice, the Mental Health Council of Australia, and the Centre for Military and Veterans' Health.

Similarly, the government announced the establishment of the National Veterans Mental Health and Wellbeing Forum (NVMHW Forum) in 2004. The NVMHW Forum is an avenue for ongoing discussion on mental health issues between the veteran and defence communities, DVA, the Department of Defence, and the Australian Centre for Posttraumatic Mental Health (ACPMH) at the national level.

Further information about the DVA mental health program is in **Attachment 26**. The Australian Government currently spends approximately $129.5 million per annum on mental health services targeted at the veteran community. This expenditure is recurrent and varies slightly annually. The table 11 provides the latest expenditure figures per service.

Table 11 Funding for the veteran community — financial year 2002–03

Name of service	Expenditure ($ millions)
Private hospitals	$27,447,402
Public hospitals	$31,063,514
Consultant psychiatrists	$10,797,786
VVCS (salaries, contracted providers and programs)	$16,700,766
Pharmacy	$26,965,832
Private psychologists and social workers	$1,039,711
General practitioners	$13,819,841
Australian Centre for Posttraumatic Mental Health	$1,585,100
Total	$129,419,952

New migrants

When establishing themselves in Australia, new migrants face a multitude of challenges, including finding accommodation, work or some form of income, enrolling children in school, establishing a relationship with the Australian community and for many, developing English language skills.

The pre-migration experiences of people arriving in Australia can have an influence on an individual's settlement experience. Humanitarian entrants, in particular, may arrive with a number of emotional, psychological and physical health issues as a result of their experiences of persecution or substantial discrimination amounting to a gross violation of human rights in their home country.

Compounding pre-migration and settlement experiences are different cultural perceptions regarding mental health. Some newly arrived humanitarian entrant communities may view mental health issues as shameful and a stigma for the individual, family, tribe and community.

Integrated Humanitarian Settlement Strategy (IHSS)

The Australian Government provides assistance to new migrants through the Australian Government Department of Immigration, Multicultural and Indigenous Affairs' (DIMIA) Integrated Humanitarian Settlement Strategy (IHSS). The strategy provides intensive initial settlement support to refugees and special humanitarian entrants in their first six months after arrival. Entrants are provided with a basic package of material goods to start establishing a household in Australia, and Early Health Assessment and Intervention (EHAI).

Importantly, the EHAI service helps humanitarian entrants to address physical and psychological health problems and encourages health care providers to be sensitive to the cultural and religious identities of their clients in order to tailor effective treatment to client need. Additionally, EHAI services to humanitarian entrants include:

- a physical health screening and referral process;
- an assessment of psychological symptomatology and social functioning; and
- short-term psychosocial and psychological interventions and, where required, referral to long term counselling and casework services.

In 2003–04, the government's expenditure on EHAI services provided through DIMIA was $4.30 million.

After exiting the IHSS, humanitarian entrants have access to ongoing assistance with settlement through the Migrant Resource Centre/Migrant Service Agency network and Community Settlement Services Scheme funded agencies. If humanitarian entrants require ongoing counselling for their torture and trauma experiences, they are referred to longer-term counselling services, including those provided by the Australian Government's program of assistance to survivors of torture and trauma, which is offered by the same agencies.

Immigration detainees

The Australian Government, represented by the Australian Government Department of Immigration Multicultural and Indigenous Affairs (DIMIA) retains overall responsibility for duty of care of detainees. The Commonwealth's contract with a detention services provider provides for the management of immigration detention facilities around Australia and a range of services for detainees, including for care, welfare and security. The detention services provider has engaged specialist subcontractors to provide both general health and psychological services in the detention environment.

The contract requires these services are delivered to specifications and standards. In particular, the contract requires that detainees have access, either in a facility or externally, to a level and standard and timeliness of health services broadly consistent with those available in the Australian community, but taking into account the special needs of detainees. Mental health services delivered under the contract are informed by the National Standards for Mental Health Services.

The special needs of immigration detainees

The detainee population comprises a diversity of male and female individuals from different family, social, cultural, religious and political backgrounds. Any number of factors may influence the manifestation and nature of a detainee's particular health condition, including the situation they leave behind and the journey they embarked upon to reach Australia.

While DIMIA has a duty of care to all detainees, it has identified the following groups as having special health care needs while in immigration detention: accompanied and unaccompanied minors; accompanied and unaccompanied women; pregnant women; elderly detainees; detainees with serious health problems; detainees at risk of self harm; survivors of torture and trauma; long-term detainees; detainees with a mental illness; and detainees with a physical or intellectual disability.

The Department has progressively evolved its case management processes for detainees over time. Establishment of a Detention Case Coordination Section in DIMIA Central Office and a case management program at Baxter Immigration Detention Facility (both introduced in the second half of 2003) focussed on improving the capacity of DIMIA to respond to the individual needs of detainees. The Minister for Immigration and Multicultural and Indigenous Affairs announced on 25 May 2005 the establishment of new detention review managers in each State/Territory Office to provide additional quality assurance processes that decisions to detain people are soundly based and regularly reviewed. In addition to existing detention case management processes of the Detention Service Provider and the Department, these new positions will also keep detention arrangements for individuals under constant review at a State Office level.

Alternative detention arrangements in the community are also pursued by DIMIA with Non-Government Organisations (NGOs) for detainees with special needs. There is also ongoing dialogue with NGOs on release from detention of special needs detainees who are in protection visa processing, or appeals processes, and cannot be cared for in detention, with specific care plans a required feature of this visa class.

Health care for immigration detainees

The provision of health care to immigration detainees is undertaken at each facility through a combination of on-site health care professionals and access or referral to external health facilities and specialists. Approved operational procedures underpin the delivery of health services. Nevertheless, there is an ongoing and regular dialogue between DIMIA and the Detention Services Provider to seek ways to improve services, including mental health care services within facilities as well as access to outside care.

On entering an immigration detention facility, detainees are screened by a trained nurse for evidence of physical and mental conditions. Where a mental health issue is identified by the nurse during the induction assessment, the individual is referred to a psychologist for further investigation and, as required, ongoing intervention. Detainee care plans which reflect the special needs of detainees are developed.

When in immigration detention, detainees have access to age, gender and culturally appropriate sporting, leisure and recreational activities, and are encouraged to make use of these. These activities change over time to reflect the changing needs, number and profile of the detainee population within immigration detention facilities.

While in immigration detention, some detainees may experience mental health concerns. Many detainees have been unsuccessful in their claims to remain in Australia despite several court appeals and in this context, some may experience short-term episodes of anxiety or depression. Mental health issues are not always immediately apparent at induction and the detention services provider trains staff working with detainees to be alert to the signs that a detainee may require further intervention. Those working with detainees receive training in a number of relevant areas, including: communication issues, cultural awareness, health services and care, suicide and self-harm prevention, torture and trauma sufferers, and management of special needs.

In the detention environment, mental health issues are managed in a multidisciplinary way. Detainees in each of the facilities have access to the on-site or on-call services of qualified medical practitioners, psychologists and counsellors who provide a range of treatment options. Psychiatrists either visit facilities or detainees are referred for external specialist treatment as needed. Other specialist health services are also accessed for broader health needs. As part of an immigration detainee's treatment, the general practitioner or psychiatrist may sometimes prescribe medications. In these circumstances, the vast majority of prescriptions at any point in time are for medication, such as antidepressants to relieve anxiety or reactive depression, while a very small number are for psychotropic medication.

Detainees with mental health issues are also encouraged to participate in education and recreation programs, which can be helpful in supporting people with anxiety and depression.

In some instances, health care professionals indicate that treatment may not be able to be provided within immigration detention facilities and detainees will require referral to specialists or to use hospital out-patient services. Medical practices are followed to arrange admission to hospitals or residence in facilities other than detention facilities, with the legal provisions of the Migration Act covered through arrangements made with the relevant facility and the detention service provider.

Federal and State government agencies have and continue to work cooperatively on access to health services outside the detention facilities. Formally agreed mental health care pathways are in place in South Australia for access to state government mental health care services.

Oversight and enhancement of health care services

DIMIA staff, drawing on the advice of accredited medical specialists, monitor service delivery against contract requirements and operational procedures on an ongoing basis. DIMIA uses this and other information to make formal quarterly assessments of the detention services provider's compliance with the immigration detention standards and sanctions can be applied where agreed service standards are not met.

As required by its contract with DIMIA, the Detention Services Provider has health plans for each facility, its own internal audit processes and has been progressing the establishment of the health advisory panel. In addition, DIMIA undertakes monitoring of detainee care arrangements through internal staff and including medical professionals in specialist areas. These processes inform ongoing dialogue between DIMIA and the Detention Services Provider to make ongoing improvements to the provision of mental health care in immigration detention facilities.

Several recent events have triggered DIMIA to take further stock of current mental health service arrangements, including issues associated with the Cornelia Rau case and a recent Federal Court judgement critical of mental health care of two detainees in the Baxter Immigration Detention Facility. The Minister for Immigration and Multicultural and Indigenous Affairs announced on 25 May 2005 enhancements to health care services at Baxter IDF with the more frequent visiting of a psychiatrist and the establishment of two new psychiatric nursing positions to achieve seven day coverage, and on-call arrangements at night.

DIMIA is also implementing procedural changes and service delivery enhancements flowing from the decision, improved access to care outside detention facilities and reviewing monitoring and oversight arrangements for health care services. DIMIA is accessing further specialist medical expertise to assist it in these processes.

Immigration detention is subject to regular scrutiny from external agencies, such as Parliamentary Committees, the Human Rights and Equal Opportunity Commission, the Commonwealth Ombudsman, the Australian National Audit Office, the United Nations High Commissioner for Refugees and the Immigration Detention Advisory Group, to ensure that immigration detainees are treated humanely, decently and fairly.

People in the criminal justice system

Legislation and law enforcement

The administration of criminal law and criminal justice systems is largely a matter for individual states and territories, with the Australian Government having no express power to legislate in relation to criminal law, except to the extent that it may be connected to other federal powers. The Australian Government is only able to create offences, and determine penalties for offences against its own laws. Such offences may include social security and taxation fraud, the importation of narcotics, national security issues, cybercrime, and slavery and sexual servitude offences. A federal offender is someone who is charged with, and convicted of, such an offence.

Part IB of the *Crimes Act 1914* (Cwlth) provides for the sentencing, imprisonment and release of federal offenders. Part IB also contains provisions dealing with unfitness to be tried, acquittal because of mental illness, and sentencing alternatives for persons suffering from mental illness or intellectual disability.

On 12 July 2004, the Attorney-General referred Part IB of the *Crimes Act 1914* to the Australian Law Reform Commission (ALRC) for inquiry and report, to consider whether it is an appropriate, effective and efficient mechanism for the sentencing, imprisonment, administration and release of federal offenders.

The ALRC Issues Paper 29 — *Sentencing of Federal Offenders* — considers the prosecution and disposition of persons with mental illness or intellectual disability.[64] As with other federal offenders, states and territories provide for the care and treatment of federal offenders who are mentally ill, through hospitals, prisons and community care facilities. More detailed information can be found at http://www.austlii.edu.au/au/other/alrc/publications/issues/29/.

The provisions in the Crimes Act are not a comprehensive scheme. Certain aspects of state and territory laws in relation to the prosecution and disposition of persons with a mental illness or intellectual disability are applied to such persons accused of committing a federal offence. As part of its inquiry, the ALRC is considering whether there should be a comprehensive federal scheme in relation to the prosecution and disposition of persons with a mental illness or intellectual disability.

Forensic psychiatry

Forensic psychiatry services represent a small but critical component of public mental health services. These services assess, treat and care for people with a mental illness who are imprisoned or referred by the courts.

Specialised forensic psychiatry services are provided in the states and territories. Such services have been identified under the National Mental Health Strategy as a priority for further development. Broad agreement exists between the jurisdictions that a coordinated national approach to planning and development in forensic mental health is required.

Mental health services work with Corrections to ensure people with a mental illness are appropriately treated. In support of this, the Australian Government has liaised with state and territory governments to develop the *National Statement of Principles for Forensic Mental Health*, which was endorsed by the Australian Health Ministers' Advisory Council (AHMAC) National Mental Health Working Group and presented to the Corrective Services Administrators Conference in May 2003. The Statement provides a means to integrate more effective service delivery for a high-risk mental health population in contact with the criminal justice system. The principles also address community safety concerns, which are frequently dramatised by media attention. Further work is being undertaken in partnership with the states and territories and Corrections to develop approaches to implementation.

Linkages between problematic drug use and criminal behaviour have long been acknowledged by those coming into contact with complex needs clients. Police respond to the behaviour of people in a range of circumstances, but are often ill-equipped to address the causes of an offender's behaviour.

The Drug Use Monitoring in Australia (DUMA) program is a quarterly collection of information from police detainees in seven sites (police stations or watchhouses) across Australia. Since its inception in 1999, $5.9 million in funding for DUMA has been provided from the Australian Government's National Illicit Drug Strategy, continuing until 2007–08. The purpose of DUMA is to provide an evidence base for policy making in the arena of drugs and crime. The study monitors a key group (police detainees) involved in illicit drugs and crime markets, providing trend data on drug use, and enabling the analysis of links between drugs and crime and the collection of key strategic information on other issues of importance to law enforcement. Mental illness is one such issue, hence a mental illness addendum was included as part of the DUMA questionnaire in the third quarter of 2004.

People with chronic diseases

Mental health problems and mental illnesses, particularly depression, often co-occur with chronic disease and can impact on the complexity, progression and management of an illness.[77] In addition, there is a high prevalence of chronic disease among people with mental illness.

Risk factors that increase vulnerability to a range of chronic diseases in adulthood include adverse early life events, such as fetal exposure to tobacco smoke, low birthweight, malnutrition, repeated infections, and abuse and neglect.[78] Improving maternal physical and mental health is the key to preventing many of these risks.

Draft National Hepatitis C Strategy 2005–2008

The draft National Hepatitis C Strategy 2005–2008, due for implementation from 1 July 2005, incorporates priority action areas to address issues related to mental health and hepatitis C, including discrimination. It identifies that people with or at risk of hepatitis C can experience mental illness that can exacerbate their access to services for prevention, support and treatment.

Key priorities of the draft strategy include the training of health care professionals to provide appropriate education, prevention, care and support of people with, or at risk of, hepatitis C. This is particularly the case in relation to people with a dual diagnosis of drug and alcohol problems and mental illness, and requires recognition in other relevant national strategies and with other service providers.

Draft National HIV/AIDS Strategy

The draft National HIV/AIDS Strategy 2005-08, due for implementation from 1 July 2005, recognises the care and support needs of people living with HIV and AIDS who may have a mental illness, such as depression. The draft strategy also acknowledges the importance of people living with HIV/AIDS having access to appropriate mental health services.

The National Chronic Disease Strategy

The National Chronic Disease Strategy (NCDS) is currently being developed. It aims to provide an overarching framework that applies to all non-communicable chronic diseases and direction for improving chronic disease prevention and care across Australia.

Mental health issues will be incorporated in the NCDS in two ways: firstly in the context of the high prevalence of chronic disease among people with mental illness; and secondly, because mental health problems and mental illnesses, particularly depression, often co-occur with chronic disease and can impact on its complexity progression and management.

The ageing population

There is some evidence to suggest that ageing is associated with a reduction in susceptibility to anxiety and depression, possibly due to increased emotional control and psychological immunisation to stressful experiences.[73] The Australian Bureau of Statistics (ABS) National Survey of Mental Health and Wellbeing supports this, showing that the prevalence of common mental health problems is lower among those aged 65 and over (around 6 per cent) compared with other age groups and the Australian population in general (around 18 per cent).[74]

Despite this trend, the suicide rate for Australian men aged 65 and over is very high, with around 29 suicides per 100,000. Risk factors for depression and suicide for this age group in general include death of a spouse, experiences of loss (such as retirement, retrenchment or empty nest syndrome), social isolation and loneliness, reduction in activities, loss of independence, physical illness, and chronic pain.[75, 76]

Programs and services

The *Public Health Action Plan for an Ageing Australia (2003)* provides details of the joint recommendations of the National Public Health Partnership Group and the Positive Ageing Task Force to progress the health and wellbeing key result area of the Commonwealth, State and Territory Strategy on Healthy Ageing. In March 2004, the Community Services Ministers' Advisory Council and the Australian Health Ministers' Advisory Council endorsed mental health and social isolation as an area for future action.

The Australian Government administers a range of programs and services to promote active ageing (including physical, emotional and mental wellbeing), primarily through the Department of Health and Ageing (DoHA). The Department of Family and Community Services (FaCS) also administers a number of services that, while not directly targeting mental health among the aged, may address some risk factors. Examples of these services include:

- **Seniors Portal**, which provides older Australians with a single point of access to all relevant Australian Government programs and services, and provides access to a range of state and local government information, and selected non-government information. The site provides older Australians with information on health, lifestyle, aged care, finance, paid and volunteer work, and their legal rights and entitlements;

- **Community Portal,** a program that provides Australians with relevant up-to-date community information and services, including information and links relating to seniors' health and support groups; and

- **Volunteer Management Program,** which funds 27 Volunteer Resource Centres to provide volunteer matching and referral services to encourage Australians to be active members of their community through volunteering.

Research projects

A number of research projects have been funded by the Australian Government to investigate the mental health needs of the ageing population in the community.

Beyond Ageing Research Project for the Prevention of Depression (2003–06)

Funding of $110,000 for the first year has been committed to a community intervention study for the prevention of depression and cognitive impairment and for the improvement of mental health literacy. The Centre for Mental Health Research at the Australian National University is responsible for conducting this research and is expected to deliver its findings in late 2006.

Depression in residents of residential aged care facilities

The *Challenge Depression* project began in mid-1999 and was provided with funding of $283,000 by the Australian Government. The project was commissioned to ascertain the scale of the problem of depression amongst residents in residential aged care facilities and to make recommendations for its management.

Using the findings from the project, resource materials were developed which reinforce a systematic approach to the identification of depression and provided some tools to assist staff to do this. The materials were disseminated via a nationwide program of 53 seminars attended by more than 5000 people in 2002–03. The report of the project was released in March 2004 and a copy of the full report can be found at http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-chall-depress.htm

The dementia perspective

While dementia is included in the definition of a mental health problem, it is not considered to be a mental illness. The overlap between dementia and mental health remains problematic, with the impact felt most acutely when the person affected, or their carer, needs to interact with the mental health and aged care sectors.

Existing Australian Government programs that support people with dementia and their carers currently attract funding of more than $2.6 billion annually. The government further extended this commitment in the recent budget by allocating funding of $52.2 million over four years to assist people with dementia by making dementia a national health priority. This funding will increase support to people with dementia and their carers through a wide range of initiatives, including innovative care, assessment, hospitals, workforce, palliative care and GP initiatives that directly benefit people with dementia and their families.

Substance users

Complex interactions between mental health and substance use, such as alcohol, tobacco and illicit drugs, are recognised under the National Drug Strategy and the National Mental Health Strategy. Substance use and suicide each account for a substantial number of deaths in Australia every year. The prevalence of both non-fatal substance use and non-fatal suicide attempts is even greater.

Policy

The National Drug Strategy provides a framework for a coordinated, integrated approach to drug issues in the Australian community. It builds on the achievements and successes of the previous strategy and is complemented, supported and integrated with a range of national, state, territory, government and non-government strategies, plans and initiatives.

The strategy is consistent with Australian Government policies and practices of preventing and reducing the substantial harms associated with drug use through a three-pronged strategic approach of: supply reduction strategies to disrupt the production and supply of illicit drugs, and the control and regulation of licit substances; demand reduction strategies to prevent the uptake of harmful drug use, including abstinence orientated strategies to reduce drug use; and harm reduction strategies to reduce drug related harm to individuals and communities.

Data collection

The Australian Government funds a number of data collections on mental health and substance use. They include the 2004 National Drug Strategy Household Survey and the 2004 Illicit Drug Reporting System.

National Drug Strategy Research Centres

The Australian Government is providing funding of approximately $4.5 million in 2004-05 for three National Drug Strategy Research Centres that collectively provide the opportunity for a core research program in informing policy development and assisting in improving the effectiveness of treatment programs by disseminating new evidence that informs practice change. The following projects related to mental health are being undertaken as part of this research program:

- a project on the epidemiology of comorbidity between alcohol use disorders and mental health problems in Australia, which aims to examine the prevalence of anxiety and affective disorders in respondents with an alcohol disorder (abuse or dependence), examine the correlates of this type of alcohol-related comorbidity, and examine the patterns of alcohol consumption and severity of alcohol disorder in respondents with and without a comorbid anxiety and/or affective disorder;

- the relationship between non-fatal drug overdose, suicidality and depression, and in particular, the extent to which suicidal ideation, as opposed to fully formed intent, characterises non-fatal heroin overdoses; and

- CLIMATEschools, a school-based interactive computer program for educating adolescents on preventative health issues, including alcohol related harm, anxiety, depression and physical health and nutrition.

Programs

National Comorbidity Initiative

The Australian Government has allocated $9.7 million over five years (from 2003–04 to 2007–08) for the National Comorbidity Initiative, which aims to: improve coordination across psychiatric and mental health services, and drug treatment services; develop best practice guidelines for service delivery; and increase professional education and training. Implementation is focusing on the following four areas of activity:

- raising awareness of comorbidity among clinicians and health workers and promoting examples of good practice resources and models;
- providing support to general practitioners and other health workers to improve treatment outcomes;
- facilitating resources and information for consumers; and
- improving data systems and collection methods within the mental health and alcohol and other drugs sectors to manage comorbidity more effectively.

To date, the following projects have been implemented:

- the National Comorbidity Forum with key stakeholders (May 2004);
- a qualitative study of the barriers and incentives to treatment for comorbid illicit drug users;
- trialling a mental health screening tool and brief intervention for use within alcohol and other drug treatment services;
- development of a book of family stories, which are real life accounts from Australians who have experienced what it is like to have, or be exposed to someone who has, a drug, alcohol or mental health problem;
- release of the brochure *Feeling good* to provide information for people with substance use and mental health problems;
- contribution to the second phase of the National Drugs Campaign to provide a preventive component; and
- improvement of data collection through an analysis of general practice consumer encounter databases, review of the current data collections relevant to comorbidity, and the collection of national statistics on the provision of opioid pharmacotherapies.

Future development of the initiative will focus on dissemination of appropriate resources, development of treatment approaches, and consumer and carer involvement.

Specific Australian Government funding for the National Comorbidity Initiative is $9.7 million for the period 2003–08. Since 1997, however, the Australian Government has invested more than $1 billion in the National Illicit Drugs Strategy in supply and demand reduction initiatives that aim to reduce the burden of substance use on the Australian community.

The National Tobacco Strategy 2004–2009

The National Tobacco Strategy 2004–2009 recognises that there are several social groups in Australia that suffer a particularly high burden of tobacco related death and disease. These social groups include people suffering severe and disabling mental illness.

These groups smoke at very high rates and their expenditure on tobacco products can be a significant financial burden. They may also face higher rates of health problems than the rest of the community.

The National Tobacco Strategy indicates that highly disadvantaged social groups could benefit significantly from improved regulatory and educational measures, but recognises that barriers may exist in accessing appropriate Quit and other cessation services.

The Department is currently negotiating three projects related to smoking and mental health issues:

- the Student Project Support, to explore how smoking intervention might be cost effectively incorporated into mental health care;
- a multicomponent risk factor intervention feasibility study on people with severe mental illness; and
- a three year follow up of a randomised controlled trial of an intervention for tobacco dependence among those with psychotic illness.

Conclusions

Mental illness has many causes, can manifest itself in different ways, and can have different outcomes. Some people may experience a single episode of mental illness and recover fully. For others, however, mental illness will have an ongoing effect, and may profoundly influence their quality of life. They may experience high levels of functional impairment, persistent symptoms, co-morbidities and sometimes side effects of medication. The stigma associated with mental illness may compound this, impacting on their opportunities to form relationships, gain employment, maintain stable housing etc.

The spectrum of services required during the course of an illness include early intervention, identification, treatment and ongoing care, rehabilitation and relapse prevention. Programs that promote mental health and prevent mental illness are also important, as is the need for a comprehensive national research agenda and national data collection program.

Within the context of the National Mental Health Strategy the Australian Government has played a leadership role in establishing and supporting the mental health reform agenda in Australia since 1992. There have been significant increases in the level of direct and indirect funding for a range of services and programs.

These include the range of mainstream programs accessible by people with a mental illness, including income support payments for people with a disability, support services offered by Centrelink, vocational rehabilitation programs, and research and data collection programs. Programs administered by the Australian Government for special population groups also recognise mental illness and provide additional support, for example, among veterans and within the Indigenous community.

The National Mental Health Strategy provides a sound policy framework for mental health care nationally and lays the foundation for collaboration between jurisdictions and between government and non-government organisations. It has received world-wide recognition for its vision, direction and strategic approach.

The Australian Government has had responsibility for progressing key elements of the National Mental Health Plans which operationalise the National Mental Health Strategy. This has included: mental health promotion programs for secondary schools and the media; supporting telephone and web-based counselling; increasing general practice involvement in identifying and treating mental illness; improved quality of mental health care through service standards and key performance indicators for mental health services; practice standards for the mental health workforce and clinical practice guidelines; and national data collections.

It is clear that given the nature of the risk factors, impacts and costs associated with mental health problems, mental health is not only a public health issue but also a major social issue. Further, many solutions to common mental health problems lie with appropriate social as well as medical responses.

While it is important to deliver clinical programs targeting mental illness, there are also benefits in ensuring mainstream programs and services continue to improve their capacity to meet the legitimate needs of people with mental health problems and associated disability.

There is also scope to improve and expand a wide range of social policy initiatives to prevent the development of common mental health problems and to reduce the impact of these on individuals, families and communities. This may require increased emphasis on strategies that address lifestyle and risk factors, promotion of stable family environments, increased social cohesion, and support across the life span

Another area for future improvement is the increased access to, and information about, services and programs at the consumer level, and coordination at the system level, particularly between Australian Government departments and between the Australian Government and state and territory government and non-government services and programs.

There are still too many gaps in current programs and services, resulting in some people with mental illness falling out of the health care system. These may include those with co-morbid mental health and alcohol or drug problems, people with mental illness who are inappropriately in the criminal justice system, people in the immigration system, Indigenous Australians, and young people.

The indication of increased demand for mental health care, together with the increased expectation of high quality care from consumers and carers, will logically have an impact on how well existing resources and the current workforce can effectively meet the increased demand. Evidence would suggest that these are key areas for future attention, particularly if the pace of reform is to be increased in the future to keep pace with community expectations.

All Australian Health Ministers have agreed to revise the National Mental Health Policy during the term of the current Australian Health Care Agreements. This provides the opportunity to improve on the Policy its implementation, and for recommendations of the Inquiry to be incorporated into future national policy, programs and services for people with mental illness.

There are a number of specific areas which have been identified as general gaps to be addressed jointly by the Australian, state and territory governments, and non-government organisations, including consumers and carer organisations, through the implementation of the National Mental Health Plan (2003 – 08):

- improved funding for care and services, including in the areas of prevention and early intervention;
- more support for people with mental health problems living in the community, including the provision of adequate and appropriate accommodation, and better support for families and carers;
- a renewed focus on raising community awareness to reduce discrimination and stigmatisation of people with mental health conditions and mental illness;
- continued improvements in coordination, integration and continuity of care, including the necessary training and support for the workforce; and
- greater consumer involvement at all levels, including the development of policy, planning, implementation and evaluation of services, and research.

Abbreviations and acronyms

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Services
ACE-MH	Assessing Cost Effectiveness —– Mental Health
ACPMH	Australian Centre for Posttraumatic Mental Health
ADF	Australian Defence Force
ADGP	Australian Division of General Practice
AeJAMH	Australian e-Journal for the Advancement of Mental Health
AHEC	Australian Health Ethics Committee
AHMAC	Australian Health Ministers' Advisory Council
AICAFMHA	Australian Infant, Child, Adolescent and Family Mental Health Association Ltd
AIHW	Australian Institute of Health and Welfare
ALRC	Australian Law Reform Commission
APMHC	admitted patient mental health care
ARC	Australian Research Council
ASIST	Applied Suicide Intervention and Skills Training
ASTPRA	Advanced Specialist Training Posts in Rural Areas
Ausienet	Australian Network for Early Intervention
BTH	Bringing Them Home program
CALD	culturally and linguistically diverse
CAP	Community Awareness Program
CCB	Child Care Benefit
CCIF	Coordinated Communications Infrastructure Fund
CDO	Centrelink disability officers
CMVH	Centre for Military and Veterans' Health
COAG	Council of Australian Governments
COPMI	Children of Parents with a Mental Illness project
COPO	Commonwealth Own Purpose Outlay
CPD	continuing professional development
CRS Australia	Previously the Commonwealth Rehabilitation Service
CSA	Child Support Agency
CSHA	Commonwealth–State Housing Agreement

CSMIS	Client Services Management Information System
DALY	disability-adjusted life year
DCITA	Australian Government Department of Communications and Information Technology
DDA	*Disability Discrimination Act 1992*
DIMIA	Australian Government Department of Immigration Multicultural and Indigenous Affairs
DoHA	Australian Government Department of Health and Ageing
DSA	*Disability Services Act* 1986
DUMA	Drug Use Monitoring in Australia program
DVA	Australian Government Department of Veterans' Affairs
EHAI	Early Health Assessment and Intervention
EPC	Enhanced Primary Care program
ERP	Emergency Relief Program
FaCS	Australian Government Department of Family and Community Services
FAO	family assistance officer
FRSP	Family Relationships Services Program
FVPLS	Family Violence Prevention Legal Services
GAP	Greater Access Program
GP	general practitioner
HACC	Home and Community Care program
HiBIS	Higher Bandwidth Incentive Scheme
HREOC	Human Rights and Equal Opportunity Commission
IHSS	Integrated Humanitarian Settlement Strategy
ITOL	Information Technology Online program
JPET	Job Placement Employment and Training program
LIFE	Living is for Everyone framework
MBS	Medicare Benefits Schedule
MH-SER	Mental Health Service Entity Register
MSOAP	Medical Specialist Outreach Assistance Program
NACSP	National Advisory Council on Suicide Prevention
NCDS	National Chronic Disease Strategy
NDSHS	National Drug Strategy Household Survey
NCMHCD	National Community Mental Health Care Database
NCMHED	National Community Mental Health Establishments Database
NMDS	national minimum data set

NHMRC	National Health and Medical Research Council
NMHS	National Mental Health Strategy
NMHWG	National Mental Health Working Group
NSSF	National Safe Schools Framework
NVMHW	National Veterans Mental Health and Wellbeing Forum
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OMP	other medical practitioners
OPC	outreach program counsellors
PBS	Pharmaceutical Benefits Scheme
PDRE	Prevention, Diversion and Rehabilitation program
PHERP	Public Health Education and Research Partnership
PSP	Personal Support Program
PTSD	Post traumatic stress disorder
RA	Rent Assistance program
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RASTS	Rural Advanced Specialist Trainee Support program
REDI	Resilience Education and Drug Information
RHS	Regional Health Services
RMIF	Rural Medical Infrastructure Fund
RWAC	Regional Women's Advisory Council
SAAP	Supported Accommodation Assistance Program
SAHC	South Australian Health Commission
SCCB	Special Child Care Benefit
SNAICC	Secretariat for National Aboriginal and Islander Child Care
SPGPPS	Strategic Planning Group for Private Psychiatric Services
SREP	Specialist Re-entry Program
SSRS	Support Scheme for Rural Specialists
WAACHS	Western Australian Aboriginal Child Health Survey
WORC	Work Outcomes Research Cost Benefit project

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