The Senate

Select Committee on
Mental Health

A national approach to mental
health – from crisis to community

First report

March 2006

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ACRONYMS

AARN	Association for Australian Rural Nurses
ACOSS	Australian Council of Social Services
ACON	AIDS Council of NSW
ACPM	Australian College of Psychological Medicine
ACROD	National Industry Association for Disability Services
ADGP	Australian Divisions of General Practice
AGCA	Australian Guidance and Counselling Association
AHA	Australian Healthcare Association
AHCA	Australian Health Care Agreements
AHMAC	Australian Health Ministers' Advisory Council
AHPA	Australian Health Promotion Association
AICAFMA	Australian Infant, Child, Adolescent and Family Mental Health Association
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
AMHCN	Australian Mental Health Consumer Network
AMHS	Adult Mental Health Services
AMWAC	Australian Medical Workforce Advisory Committee
ANZCMHN	Australian and New Zealand College of Mental Health Nurses
AOD/A&OD	Alcohol and Other Drugs
APHA	Australian Private Hospitals Association
APHCAP	Aboriginal Primary Health Care Access Program

ATODS	Alcohol, Tobacco and Other Drugs Services
ARAFMI	Association of Relatives and Friends of the Mentally Ill
BOMHC	Better Outcomes in Mental Health Care
BWCC	Brisbane Women's Correctional Centre
CALD	Culturally and Linguistically Diverse
CAMHSAC	West Australian Child and Adolescent Mental Health Services Advisory Committee
CCISC	Comprehensive Continuous Integrated System of Care
CCLCG	Combined Community Legal Centres Group
CDO	CentreLink Disability Officer
CoAG	Council of Australian Governments
COPMI	Children of Parents with a Mental Illness
CRS	Commonwealth Rehabilitation Service
CSHA	Commonwealth-State Housing Agreement
CTO	Community Treatment Order
CWCA	Comprehensive Work Capacity Assessment
DALY	Disability-adjusted life years
DEWR	Department of Employment and Workplace Relations
DIMA	Department of Immigration and Multicultural Affairs *(previously 'Department of Immigration and Multicultural and Indigenous Affairs')*
DoHA	Department of Health and Ageing
DPP	Director of Public Prosecutions
DSM-IVR	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition
DSP	Disability Support Pension
DVA	Department of Veterans' Affairs
EACACOV	Eastern and Central Africa Communities of Victoria Inc

ESH	Environmental Safety and Health
FaCSIA	Department of Families, Community Services and Indigenous Affairs *(previously 'Department of Family and Community Services')*
FASSTT	Forum of Australian Services for Survivors of Torture and Trauma
GCDC	Gold Coast Drug Council
GLBT	Gay, Lesbian, Bi-sexual and Transgender
GP	General Practitioner
GVAMHS	Goulburn Valley Area Mental Health Service
HASI	Housing and Support Initiative
HCRRA	Health Consumers of Rural and Remote Australia
HREOC	Human Rights and Equal Opportunity Commission
IHSS	Integrated Humanitarian Settlement Strategy
ICD-10	International Classification of Diseases, 10th Edition
MBS	Medical Benefits Schedule
MHCA	Mental Health Council of Australia
MH-CCP	Mental Health-Clinical Care and Prevention
MHLC	Mental Health Legal Centre
NCOSS	Council of Social Service of New South Wales
NGO	Non-government Organisation
NHMRC	National Health and Medical Research Council
NMHR	National Mental Health Report
NMHS	National Mental Health Strategy
NNPPSCC	National Network of Private Psychiatric Sector Consumers and their Carers
NRHA	National Rural Health Alliance
OATSIH	Office of Aboriginal and Torres Strait Islander Health

OECD	Organisation for Economic Co-operation and Development
PACCOA	Probation and Community Corrections Officers' Association Incorporated
PACFA	Psychotherapy and Counselling Federation of Australia
PANDA	Post and Antenatal Depression Association
PARC	Prevention and Recovery Care
PASTT	Program of Assistance to Survivors of Torture and Trauma
PBS	Pharmaceutical Benefits Schedule
PHC	Primary Health Care
PHICC	Private Health Insurance Complaints Commissioner
PHIO	Private Health Insurance Ombudsman
PILCH	Public Interest Law Clearing House
PND	Postnatal Depression
PSP	Personal Support Program
QPTA	Queensland Public Tenants Association Inc
RACGP	Royal Australian College of General Practitioners
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCNA	Royal College of Nursing Australia
SAAP	Supported Accommodation Assistance Program
SEWB	Social and Emotional Wellbeing
SPA	Suicide Prevention Australia
SRRP	Specialist Residential Rehabilitation Program
TPV	Temporary Protection Visa
VMIAC	Victorian Mental Illness Awareness Council
WAACHS	Western Australian Aboriginal Child Health Survey

WHO	World Health Organisation
YLD	Years lost due to disability
YLL	Years of life lost (due to mortality)
YSAS	Youth Substance Abuse Service

Foreword to the Senate Select Committee on Mental Health's First Report

This inquiry by the Select Committee on Mental Health has been a unique opportunity to meet with people in the mental health sector, be they consumers, carers, health professionals or administrators. The committee has been given enormous community support, received the results of many peoples' hard work, and been shown great hospitality wherever it has gone. I want to thank everyone who has assisted the committee and its work.

This is the committee's first report. It provides a wide-ranging review of many aspects of mental health care in Australia, and delivers a set of important, unanimous recommendations. In a few weeks the committee will deliver a second, shorter report.

The decision to divide its report into two parts was the result of a particular confluence of events. As it conducted its inquiry, the committee was inundated with submissions and other evidence about the need for change in the field of mental health. Fuelled by this evidence, and by the hard work of others including the Mental Health Council of Australia and the Human Rights and Equal Opportunity Commission, mental health reform is now rightly at the top of the policy agenda for governments around the country.

In February 2006 the Council of Australian Governments agreed to initiate a rapid process of discussion and policy development on mental health. The committee was committed to ensuring that its inquiry and findings had a significant influence on this important reform process. It therefore decided to report to the Senate the bulk of its work and a suite of recommendations that the committee believes should be addressed in the CoAG policy reform discussions.

In the coming weeks the committee will table a brief second report. This will set out some more detailed recommendations that arise from the committee's findings in particular areas of concern. These recommendations will be no less important than those set out in this first report, but the committee wanted to ensure that there was no delay in providing vital input to the CoAG process.

The committee looks forward to CoAG's adoption of the recommendations included here, and to all governments, agencies and organisations responding to the recommendations that will be included in the second report.

Senator Lyn Allison

Chair

CHAPTER 1

THE CHALLENGE OF MENTAL HEALTH

Introduction

1.1 Millions of Australians experience mental illness at some stage in their lives, survive that experience, and continue to live and work happily. The committee heard from many people in that situation. Mr John Olsen described his experience with acute schizophrenia:

> I am one of the lucky ones…When I take medication, the period from being [too] sick to becoming well and being discharged from hospital may take as little as one or two weeks. Then I am ready and quite happy to go. Within the next few months I get back to more or less 100 per cent of my previous functioning. I am very lucky in that the medications work very well for me; they suit me. I have not been as well in my life as I am now that I am taking Risperdal. I do not mean that as an advertisement for the drug itself, but it means that I am the lucky type of person with the genotype that the treatment works for. That is how I can be a consumer advocate and maintain a three-day-a-week job. I also do voluntary work on a community housing board.[1]

1.2 Dr Simon Bridge is a doctor in the Cairns area, who came and gave valuable evidence to the committee from his experience as a general practitioner (GP) with an interest in mental health. He has produced a pamphlet aimed at helping reduce suicide, and is an advocate for the role of GPs in mental health. He works as a doctor, but also suffers from bipolar disorder.[2]

1.3 Ms Leanne Pethick gave evidence in Melbourne. A former Telstra executive and Chief Executive Officer of depressioNet, Ms Pethick has suffered with depression. She described the struggle to continue working while coming to grips with a diagnosis of a mental illness. However she also talked about her happy and successful working life that has continued since recognising and learning to manage her depression.[3]

1.4 Despite the many examples of people who successfully recover from, or manage, their illness, no one can be involved in the field of mental health and remain unaware of the tragic loss of life that can befall people who experience a serious mental illness. As former Victorian Premier and Chair of beyondblue Jeff Kennett remarked in evidence in Melbourne, each day around 'eight or nine Australians take

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1   Mr John Olsen, *Committee Hansard* 27 July 2005, p. 76.

2   Dr Simon Bridge, *Committee Hansard* 5 August 2005, p. 76.

3   Ms Leanne Pethick, *Committee Hansard* 5 July 2005, pp. 82–86.

their life—suicide—as a result of depressive illnesses'.[4] As the committee undertook its work, it was informed by submitter Ms Dianne Gaddin that her daughter Tracy, for whom Dianne had cared for years, finally took her own life in November 2005. Many individual submissions to the committee came from parents and siblings of people who had experienced mental illness, and all too often lives had ended in suicide, accidents or fatal confrontations with police.

1.5   The high levels of stigma, high rates of death, low levels of access to services, and poor employment outcomes for people with mental illness are amongst the many indicators that show that there must be reforms in mental health if these tragic statistics are to be improved. This inquiry is one part of the process of securing those reforms.

Terms of Reference

1.6   On the 8 March 2005, the Senate created a Select Committee on Mental Health, to conduct a wide-ranging inquiry into:

(a)   the extent to which the National Mental Health Strategy, the resources committed to it and the division of responsibility for policy and funding between all levels of government have achieved its aims and objectives, and the barriers to progress;

(b)   the adequacy of various modes of care for people with a mental illness, in particular, prevention, early intervention, acute care, community care, after hours crisis services and respite care;

(c)   opportunities for improving coordination and delivery of funding and services at all levels of government to ensure appropriate and comprehensive care is provided throughout the episode of care;

(d)   the appropriate role of the private and non-government sectors;

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

(f)   the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

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

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

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4   Mr Jeff Kennett, Chairman, *beyondblue*, *Committee Hansard* 4 July 2005, p. 4.

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

(j) the overrepresentation of people with a mental illness in the criminal justice system and in custody, the extent to which these environments give rise to mental illness, the adequacy of legislation and processes in protecting their human rights and the use of diversion programs for such people;

(k) the practice of detention and seclusion within mental health facilities and the extent to which it is compatible with human rights instruments, humane treatment and care standards, and proven practice in promoting engagement and minimising treatment refusal and coercion;

(l) the adequacy of education in de-stigmatising mental illness and disorders and in providing support service information to people affected by mental illness and their families and carers;

(m) the proficiency and accountability of agencies, such as housing, employment, law enforcement and general health services, in dealing appropriately with people affected by mental illness;

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

(o) the adequacy of data collection, outcome measures and quality control for monitoring and evaluating mental health services at all levels of government and opportunities to link funding with compliance with national standards; and

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

1.7　　The committee was initially asked to report to the Senate by 6 October 2005. However a strong public response to the committee's work led the Senate on 18 August 2005 to extend the committee's reporting deadline to 30 March 2006. A further extension was granted on 1 March 2006, allowing the Committee to report at any time prior to 28 April 2006. In view of the importance of the issue and the desire to have a significant impact on the CoAG reform process, the Committee decided to report on March 30.

Conduct of the inquiry

1.8　　Reflecting a high level of community interest in mental health issues, the committee received over 600 submissions from individuals and organisations. It also received a further 200 submissions from people who spent time in institutional and foster care during childhood. Many submitters provided other reports and publications, for which the committee was grateful. Overall, the committee received in excess of ten thousand pages of written material.

1.9   Many submissions told personal stories of living with mental illness, and of living with or caring for someone suffering from mental illness. Many of these people found it painful to come forward and speak about their experiences, and the committee was grateful for their willingness to do so. Special thanks should go to the young people from ORYGEN Youth Health who met with the committee and gave evidence at the Melbourne hearings, and the young people who gave evidence as part of a confidential submission on DVD, put together by Australian Infant Child Adolescent Family Mental Health Association. The committee wishes also to thank several consumers and carers who came to hearings to give confidential evidence to the committee.

1.10   The committee was concerned, when receiving such submissions, to balance the desire to publish as much of the material submitted to it as possible, with the desire to protect the privacy of individuals. These same issues were faced by the National Inquiry into the Human Rights of People with Mental Illness (the Burdekin Report) in 1993.[5] There is still significant stigma associated with having a mental illness. The committee did not want to create any additional difficulties for people with such an illness by publicising their identity, particularly when the person with the illness was often not the person making the submission. For these reasons, the committee decided to keep many submissions confidential, or to publish them with the name or other identifying details of the submitter withheld. In other cases, the committee published material only after submitters supplied written consent from third parties mentioned in their submissions.

1.11   The committee accepts that not every individual or organisation was able to be satisfied by the committee's resolution of these competing needs. It is hoped that all individuals and organisations understand the difficulty of balancing publication with privacy. Everyone participating in the inquiry should be assured that the committee takes every submission and every case very seriously. Whether or not individual cases were publicly published or quoted in the report, they were all considered by the committee, giving it a great many insights into the difficult path faced by consumers, carers and workers in addressing mental illness.

1.12   The committee held one of the most extensive series of public hearings organised by a Senate Committee, totalling seventeen days of hearings, across every capital city, as well as in Cairns and the Gold Coast. It took over 1500 pages of oral evidence from 302 witnesses, some of whom travelled long distances to participate in the hearings, from locations as remote as Alice Springs and the Gulf of Carpentaria. During the course of hearings, committee members often asked individuals and organisations to provide answers on notice to numerous questions. Witnesses were extremely helpful in responding to these requests, and the list of material provided is shown at Appendix 4.

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5   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, p. 7.

1.13   The committee also made visits to various mental health facilities and programs around the country. These included

- At Port Hedland:
    - Port Hedland Mental Health Unit
    - Port Hedland Regional Hospital
    - Gemini Medical Services
    - Ms Pauline Robinson, psychologist in private practice
    - Wirraka Maya Health Service
- At Port Augusta:
    - Baxter Immigration Detention Facility
    - Pika Wiya Clinic
    - Community members and Aboriginal health workers
- At Melbourne:
    - ORYGEN Youth Health
    - Thomas Embling Hospital
- At Shepparton:
    - Two joint projects of the Goulburn Valley Area Mental Health Services and the Mental Illness Fellowship Victoria: the Specialist Residential Rehabilitation Service; and Prevention and Recovery Care.

1.14   The committee is grateful to the many individuals and organisations in each location who worked hard to make these visits possible and very informative.

1.15   In addition, individual members of the committee visited other facilities or organisations including Deer Park Women's Prison in Victoria and Brisbane Women's Correctional Centre in Queensland, as well as visiting a world-leading mental health program in Trieste, Italy. It met with representatives of the New Zealand Mental Health Commission. The committee thanks these and many other groups for their assistance and cooperation.

1.16   The committee benefited from the expertise of staff of the Parliamentary Library, and the devoted assistance of Hansard and broadcasting staff at every hearing. The committee was assisted by secretary Ian Holland, and secretariat staff Terry Brown, Robyn Clough, Tim Davies, Lisa Fenn, Eleesa Hodgkinson, Lisa Hornsby, Jill Manning, Kelly Paxman and Loes Slattery.

An inquiry in a time of rapid change

1.17   During the course of the inquiry, there were significant events in the area of mental health policy. These included:

- The release on 14 July 2005 of the 'Palmer Report': the Inquiry in to the Circumstances of the Immigration Detention of Cornelia Rau, which raised concerns about mental health care in prisons and in immigration detention

- The release on 19 October 2005 of the *Not for Service* report, a joint project of the Mental Health Council of Australia, the Human Rights and Equal Opportunity Commission and the Brain and Mind Research Institute

- The release on 21 December 2005 of the National Mental Health Report 2005, which provided a ten year view of trends across the First and Second National Mental Health Plans

- Discussion of mental health reform at the Council of Australian Governments (CoAG) meeting in Canberra on 10 February 2006

- Announcement on 1 March 2006 of reforms to immigration services, particularly in the area of mental health.[6]

1.18   During the same period some states and territories also announced new initiatives in the area of mental health. Some of these are discussed in Chapter 2 and in the final chapter of the report. The many recent developments serve to highlight the attention that is currently being devoted to mental health, and to underline the need for change. The CoAG meeting resulted in a commitment for officials to develop a plan of action on mental health by June 2006. The committee expects that this report, together with the evidence assembled during the inquiry will have a significant bearing on the form taken by that action plan.

1.19   The committee hopes that the current level of concern will be translated into action by everyone responsible for mental health in Australia.

The committee's approach to this report

1.20   This report is structured around major issues in mental health, and major groupings affected by mental health policy. Had the committee attempted to write a chapter on each and every individual element of the terms of reference, the report would have been excessively long, and would have diverted attention from key issues. Drawing on the experience of the Burdekin Report[7], the *Not for Service* report,[8] and the committee's own evidence, this report focuses on key issues in mental health, key relationships, and key groups for which special concerns were raised during the course of the inquiry.

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6   Department of Immigration and Multicultural Affairs, *On the move to improve – DIMA's progress on Palmer,* http://www.immi.gov.au/department/dima_improvements/index.htm (accessed March 2006).

7   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness – Report of the National Inquiry into the Human Rights of People with Mental Illness*, Canberra 1993.

8   Mental Health Council of Australia and the Brain and Mind Research Institute, *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia*, Mental Health Council of Australia, Canberra, 2005.

What is mental health?

1.21   The National Mental Health Plan 2003-2008 (the Plan) defines mental health as 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

and that:

> Mental health describes the capacity of individuals and groups to interact, inclusively and equitably, with one another and with their environment in ways that promote subjective wellbeing, and optimise opportunities for development and the use of mental abilities. [9]

Mental illness (or mental disorder) is described in the Plan as:

> a clinically diagnosable disorder that significantly interferes with an individuals cognitive, emotional or social abilities.[10]

1.22   The diagnosis of mental illness is defined in terms of classifications listed within two professional publications, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, and, the International Classification of Diseases, Tenth Edition. However, these manuals include as mental illness things generally excluded in Australian health care planning, particularly drug and alcohol disorders, and dementia. Indeed, this exclusion typifies one of the recurrent themes of this report: barriers between services provided for different illnesses and different population groups.

1.23   There are many different mental illnesses, just as there are many different physical diseases. Mental illnesses can be classified in different ways. One of the commonest is the reference to *high prevalence* and *low prevalence* disorders. The most widely known high prevalence disorders are depression and anxiety disorders. Around 20 percent of people may experience depression at some stage in their lives, while about 10 percent of people may experience an anxiety disorder. These high prevalence disorders can be extremely serious, but often go unnoticed and untreated, particularly if a sufferer is not acutely ill. The most widely known low prevalence disorders are schizophrenia and bipolar disorder, which at some stage in their lives may affect about one percent and two percent of the population respectively.[11] More information about mental illnesses is included in Appendix 1.

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9   Australian Health Ministers, *National Mental Health Plan 2003-2008*, 2003, p. 5.

10   Australian Health Ministers, National Mental Health Plan 2003-2008, 2003, p. 5.

11   Data about mental illness is available from numerous sources, including SANE Australia, *Facts and Figures about Mental Illness*, fact sheet, 2005, http://www.sane.org/images/assets/Factsheets-PDF/fs13_facts&figures.pdf (accessed February 2006).

1.24   Beyond these relatively well known illnesses, however, are many others including eating disorders, drug and alcohol disorders and personality disorders. It is also not uncommon for people to experience more than one condition. The interactions between them can be complex, and are not always well understood. Managing the interactions between disorders can be very important to effective treatment, and evidence about some of these interactions, such as between drug use and other mental illnesses, or between dementia and other mental illnesses, featured prominently in evidence to the committee.

Talking about mental illness

1.25   The committee would like to comment briefly on the language used in this report.[12] It is a measure of how traumatic some people find their experience of mental illness, and of attempts to manage it, that they speak of being 'survivors'.[13] The term is a reference to surviving their illness, which is understandable, given that people with mental illnesses such as depression, schizophrenia, and borderline personality disorder face a far higher risk of death and disablement than the rest of the community. For some, however, describing themselves as survivors is also a reference to surviving their treatment, which can sometimes be experienced as confronting, violent, painful or a breach of their human rights. In this sense of the term individuals can refer to themselves as 'survivors of psychiatry'.

1.26   Most commonly in Australia, people speak of being 'consumers': that is, consumers of mental health services. This language arose out of a desire to entrench the idea that people with a mental illness use health care services and as such have expectations and rights in relation to those services. It was an important step in recognising that mental health services should meet consumer needs, just as other services attempt to give consumers what they want.

1.27   At the same time, the committee recognises that talking of 'consumers' has its limitations. Most of the time, the idea of being a consumer is a positive one: it is linked to the idea of wanting the thing that is consumed, whether it is whitegoods or holidays. In contrast, to *want* mental health services generally means to experience mental illness, something most people want to *avoid*. In this context, some people find use of the term 'consumer' inappropriate. More troublingly, evidence suggests that the majority of Australians who experience mental illness get no help. How can one be a consumer, when one does not get any help in the first place? Use of the term 'consumer' can hide the fact that most people with mental illness in fact never become 'consumers' of services they may desperately need.

1.28   On the other hand, in an environment where – as the Mental Health Council of Australia has highlighted – just getting some service can be a challenge, being a

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12   There is a useful discussion of the terminology used in discussing mental illness in J. Meagher, *Partnership or Pretence*, Psychiatric Rehabilitation Association, NSW, 2002.

13   See for example, insane australia, *Submission 2*, p. 2.

consumer of mental health services still serves as a positive reminder that those services should be there, available for all who need them.

1.29   The committee has accepted the prevalent use of the term 'consumer' and uses it throughout this report. Two other terms are also used. The report refers to 'people experiencing mental illness' or 'people with a mental illness', partly to acknowledge that not all people who face mental illness ever receive help (in contrast to the implication of the term 'consumer'). The terms also remind us that people *experience* mental illness, they are not 'the mentally ill'. Many of us will experience an episode of mental illness at some time, but we will also be free of that illness for most of our lives.

1.30   Finally, in those contexts where it seems clearly appropriate, the report refers to 'patients', particularly when talking about clinical relationships with medical professionals.

CHAPTER 2

MENTAL HEALTH – THE CASE FOR CHANGE

2.1   This committee is neither the first to inquire into Australia's mental health services, nor the first to find them wanting. When the Human Rights and Equal Opportunity Commission (HREOC) conducted an inquiry into human rights and mental illness (generally known as the Burdekin Report) in the early 1990s, it found serious problems in the area of mental health. The Commission concluded that:

> In general, the savings resulting from deinstitutionalisation have not been redirected to mental health services in the community. These remain seriously underfunded, as do the non-government organisations which struggle to support consumers and their carers…Poor inter-sectoral links, the ambivalent stance of the private sector and a reluctance on the part of government agencies to co-operate in the delivery of services to people with mental illness have contributed to the alarming situation described in this report. While the Inquiry welcomes the initiative recently taken by governments in endorsing a *National Mental Health Policy* and *Plan*, a major injection of resources will be needed before we are in a position to comply with our international obligations under the UN Principles for the Protection of Persons with Mental Illness.[1]

2.2   In the time that it took Burdekin and the HREOC to conduct that inquiry, federal, state and territory governments cooperated to produce the National Mental Health Strategy. Signed off by governments in 1992, the aims of this strategy are to:

> Promote the mental health of the Australian community;
>
> To, where possible, prevent the development of mental disorder;
>
> Reduce the impact of mental disorders on individuals, families and the community; and
>
> Assure the rights of people with mental disorder.[2]

2.3   The Final Report of the 1997 Evaluation of the first National Mental Health Strategy indicated that when the National Mental Health Strategy was first implemented in 1992, mental health services were 'in a poor state'.[3] However, while mental health services had improved the evaluation recognised that the strategy had

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1   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, p. 908.

2   Australian Health Ministers, *National Mental Health Plan 2003–2008*, 2003, p. 6.

3   National Mental Health Strategy Evaluation Steering Committee, *Evaluation of the National Mental Health Strategy Final Report*, 1997, p. 1.

'raised awareness of previously hidden problem areas' and that much work remained to be done.[4]

2.4   The 2003 evaluation of the Second National Mental Health Plan was, if anything, less positive in outlook. While recognising a range of achievements, it said:

> However, the extent and pace of progress has not universally been viewed as satisfactory. In particular, the national community consultations reveal a high level of dissatisfaction. However, it should be noted that progress has been constrained by the level of resources available for mental health and by varying commitment to mental health care reform. While the aims of the Second Plan have been an appropriate guide to change, what has been lacking is effective implementation. The failures have not been due to lack of clear and appropriate directions, but rather to failures in investment and commitment.[5]

2.5   Around that same time, the Mental Health Council of Australia released its *Out of Hospital, Out of Mind!* report. This was a collaborative effort of the Mental Health Council of Australia, a national peak non-government organisation (NGO) for consumers, carers, professional associations and health care providers, and the Brain and Mind Research Institute. The report made a harsh judgement of the results of reforms over the previous decade:

> For over ten years, our national policy and government-driven reform processes have championed the appropriate move to non-institutional forms of care. The findings from this national and comprehensive consultation are stark. The overwhelming perception of those who currently use or provide services is that we have now arrived at a position of 'OUT OF HOSPITAL, OUT OF MIND!'. That is, one of the most chronically disadvantaged groups in this country continues to be ignored. After two five-year National Mental Health Plans this does not represent a failure of policy, but rather a failure of implementation. This includes poor government administration and accountability, lack of ongoing government commitment to genuine reform and failure to support the degree of community development required to achieve high quality mental health care outside institutions.[6]

2.6   Two years later this was followed by a second collaborative report *Not for Service*, released on 19 October 2005, which was similarly scathing about consumers' experiences in the mental health system. It concluded that 'after 12 years of mental

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4   National Mental Health Strategy Evaluation Steering Committee, *Evaluation of the National Mental Health Strategy Final Report*, 1997, p. 1.

5   Steering Committee for the Evaluation of the Second National Mental Health Plan, *Evaluation of the Second National Mental Health Plan*, 2003, p. 3.

6   G. Groom, I. Hickie, and T. Davenport. *'Out of Hospital, Out of Mind!' A report detailing mental health services in Australia in 2002 and community priorities for national mental health policy for 2003-2008*, Canberra, Mental Health Council of Australia, 2003. p. ii.

health reform in Australia, any person seeking mental health care runs the serious risk that his or her basic needs will be ignored, trivialised or neglected'.[7]

2.7   Another major mental health NGO, SANE Australia, produced an annual report on progress in mental health service provision and stigma reduction. It was even more blunt in its assessment of the state of mental health services:

> Mental health services are in crisis to varying degrees all around Australia, barely able to cope with people experiencing acute episodes of illness, let alone provide ongoing treatment and support…

> The National Mental Health Strategy is in retreat on many fronts, with old-style psychiatric institutions still in place, community-based services being drawn back into hospitals, prison psychiatric units being built instead of discrete forensic hospitals, and prisons becoming de facto psychiatric institutions.[8]

2.8   While there had been inquiries and strategies at the national level, individual states and territories have also examined aspects of mental health in their jurisdictions, with reports often preceding significant policy initiatives. These inquiries have included:

- In NSW, a Legislative Council Inquiry into Mental Health Services[9]

- In NSW, the NSW Auditor General's report on emergency mental health services[10]

- In Victoria, the Victorian Auditor General's Inquiry on Mental Health Services for People in Crisis[11]

- In the Northern Territory, the review of the NT Department of Health and Community Services[12]

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7   Mental Health Council of Australia and the Brain and Mind Research Institute, *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia: Summary*, Mental Health Council of Australia, Canberra, 2005, p. 12.

8   SANE Australia, *Dare to Care! SANE Mental Health Report 2004*, p. 1, http://www.sane.org/images/assets/Research_reports_and_images/MHR2004text.pdf (accessed January 2006).

9   New South Wales, Parliament. Legislative Council. Select Committee on Mental Health, *Inquiry into mental health services in New South Wales*, 2002, http://www.parliament.nsw.gov.au/prod/parlment/committee.nsf/4bb1ef733c6a672cca256e420 066a938/f742b6b2e561abdeca256c73002b7f87!OpenDocument (accessed January 2006).

10   New South Wales, Auditor General, *Performance Audit: Emergency Mental Health Services*, October 2005, http://www.audit.nsw.gov.au/publications/reports/performance/2005/mental_health/mentalhealt h-contents.html (accessed January 2006).

11   Victoria, Auditor General, *Mental Health Services for People in Crisis*, October 2002, http://www.audit.vic.gov.au/reports_par/agp81cv.html (accessed January 2006).

- In South Australia, the South Australian Ombudsman's Inquiry into Treatment of Mental Health Patients[13]

- In South Australia, a Legislative Council Select Committee Inquiry into Assessment and Treatment Services for People with Mental Health Disorders[14]

- In Western Australia, the review of the *Mental Health Act 1996* and the *Criminal Law (Mentally Impaired Defendants) Act 1996*[15]

- In Western Australia, a Legislative Council Inquiry into Mental Health Services[16]

- In Tasmania, the *Bridging The Gap* Report, a review of mental health services in Tasmania.[17]

2.9   Despite the many plans, and the progress made, analysis of mental health in Australia in the National Mental Health Report found that:

- Since 1993, mental health has not increased its shared of health spending

- There remains a high level of need in the community for mental health services

- There is uneven expenditure on mental health between and within states and territories, which is even more uneven when it comes to the utilisation of NGOs

- The reduction in stand-alone psychiatric facilities (which was an objective of the National Mental Health Strategy) has taken place alongside increased

12   Banscott Health Consulting, *Report of the Review of the Northern Territory Department of Health and Community Services,* 2003, http://www.nt.gov.au/health/dept_review/index.shtml (accessed January 2006).

13   South Australian Ombudsman, *Annual Report 2001-02: Section 26 Reports*.

14   South Australia, Legislative Council, *Select Committee inquiry into Assessment and Treatment Services for People with Mental Health Disorders, Interim Report*, 16 February 2006, http://www.parliament.sa.gov.au/committees/committee.asp?doCmd=show&intID=113 (accessed February 2006).

15   C.D.J. Holman, J.S. Titmus, J. Rapp, *The Way Forward. Synthesis of the Review of the Mental Health Act* 1996. Perth: Government of Western Australia, 2003, http://www.health.wa.gov.au/mhareview/reports/index.cfm (accessed January 2006).

16   Western Australia, Legislative Council. Standing Committee on Environment and Public Affairs, 2004, *A Petition on the Provision of Mental Health services in Western Australia - Interim Report*, Tabled Paper No. 2899.

17   Tasmania, Department of Health and Human Services, *Bridging the Gap: Review of Mental Health Services*, October 2004, http://www.dhhs.tas.gov.au/agency/publications/documents/mhs_review2004%5B1%5D.pdf (accessed January 2006).

demand for mental health care, 'in particular, for acute inpatient care', something regarded by consumers and carers as 'needing urgent attention'.[18]

Issues central to the inquiry

2.10   This committee heard an enormous range of evidence, about many different issues. On some questions there was strong consensus, on others there was vigorous disagreement. Many of the issues raised in the reports and reviews outlined above remain critical and seriously in need of attention.

2.11   There is an urgent need for **more mental health services**. Whatever debates there are about what those services should be, there is consensus that at present there is simply not enough mental health care. The point was often made that in no other sector of health care would it be regarded as acceptable that 60 per cent of people with needs received no service. Even more frequently it was pointed out that the proportion of the health budget spent on mental health care bears no relation to the proportion of the disease burden attributable to mental illness. It is all very well to say, as some did, that there should not be a direct relativity between those two indicators,[19] but no one has mounted a credible defence of the current level of spending. Given the decades of under-spending in infrastructure, the mental health workforce and services and the fact that mental illness causes a greater level of years lived with disability than any other category of disease, it should surely be a spending priority: if anything, it might be expected to get more than a proportionate share of the budget. Instead, it has been suggested that 'it is likely that overall mental health spending as a proportion of national health spending is now actually declining'.[20]

2.12   The limited **resources available are not always well utilised**. The 'revolving door syndrome' described by many witnesses suggests the current focus almost exclusively on the most seriously ill is not working. Psychiatrists are scarce outside capital cities. General practitioners (GPs) are more readily available but only a small proportion have undertaken more than rudimentary training in mental health. Clinical psychologists, however, are largely excluded from Medicare rebate funded services, despite their capacity to deliver evidence-based treatment particularly for high prevalence disorders.

2.13   Public psychiatric hospital beds are scarce, yet many are occupied by people who should be treated by more suitable lower cost services. While acute bed shortages are very common, the neglect of timely, early stage intervention may be responsible for much of that acute demand.

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18   Department of Health and Ageing, *National Mental Health Report 2005*, p. 7.

19   Mr Philip Davies, Acting Secretary, Department of Health and Ageing, *Committee Hansard*, 7 October 2005, p. 53.

20   I. Hickie, G. Groom and T. Davenport, *Investing in Australia's Future: The Personal, Social and Economic Benefits of Good Mental health – Summary*, December 2004, p. 9.

2.14   Case workers typically have too many consumers, placing strains on the quality of the attention they give.

2.15   The non-government sector has the potential to be more than just a minor player as its role in some other countries shows. Consumers are not sufficiently engaged in the design and delivery of services. Families, carers and consumers are not always recognised, supported or even consulted.

2.16   **Deinstitutionalisation has not been achieved**. At worst, Australia has shifted care for the seriously ill from stand-alone psychiatric institutions to prisons. The rate of mental illness amongst inmates is unacceptably high. Further, while beds in public stand-alone psychiatric hospitals have shrunk, private ones have expanded, albeit offering services to people with much less debilitating illnesses than those now being admitted to the public system. The committee received little evidence to suggest that the incomplete form of deinstitutionalisation practised in Australia had improved health or welfare outcomes. Low levels of employment and high rates of homelessness are just two of the indicators of failure, not of deinstitutionalisation but of what was supposed to be the provision of at least comparable mental health services in the community to which seriously ill people had been released.

2.17   To be clear, the committee does not doubt the necessity to end the century-old practice of locking people with mental illness away with little expectation of recovery or reintegration into society.

2.18   **Mainstreaming has its limitations.** Most acute care beds are now provided in psychiatric wards of general hospitals. However the environments of these wards can be less than therapeutic for seriously ill people in disturbed states.

2.19   Mobile crisis teams set up in some states now typically attend fewer crises, for under-resourcing and security related reasons, and are more likely to be found in over-stretched accident and emergency departments of general hospitals. The committee heard alarming accounts of the physical and chemical restraint of patients due to lack of expertise in treating people with mental illness, lack of acute psychiatric beds and the inappropriateness of emergency department settings for those experiencing serious and psychotic episodes.

2.20   Community-based mental health centres in NSW, along with their resources, are being mainstreamed onto sites in hospital grounds despite the difficulty of accessing them and a reluctance to visit those facilities by the many people whose previous experience in hospitals was negative. The committee received little evidence that stigma was reduced through this kind of mainstreaming.

2.21   There is **inadequate community-based care**. Expansion of community-based services is supposed to be part of mental health policy, but there has been a lack of funding and commitment to this objective.

2.22   The National Mental Health Strategy was developed in response to clear evidence that community-based treatment has better health outcomes and less life

disruption for the majority of individuals with acute and long-term mental illness. The evidence also suggests that brief admissions to acute psychiatric wards within general hospitals backed up by ready access to 24 hour clinical services and a well-staffed range of supported residential facilities in the community, including in the person's home, is superior to hospital-centred care, particularly that provided in stand-alone psychiatric facilities. The committee notes that this approach is in line with the Australian National Mental Health Service Standards but that no state or territory has yet provided local community-based care in any comprehensive way.

2.23   The National Mental Health Strategy aimed to not only shift services from institutions to local communities but to recognise the right of people to live in the 'least restrictive' circumstances and to develop strong links with groups of consumers, families, GPs, the non-government sector and local services like housing, general disability services, social security and employment.

2.24   People with mental illness are treated in some states as outpatients in public area mental health services but, as with inpatient beds, services are stretched and available only to the most unwell. Others, it is expected, will be treated as private patients by GPs and psychiatrists. However, shortages of doctors, particularly those willing and able to deal with often complex psychiatric conditions and to bulk bill for their services, make this an inadequate response. The ideal of publicly funded, integrated teams of psychiatrists, psychologists and psychiatric nurses who can respond in a timely fashion with accurate assessment and effective treatment of a wide range of mental health conditions is missing. Lack of respite and rehabilitation beds, discharge planning from hospital and clinical support in short and medium term supported accommodation and work opportunities contribute to the expensive, revolving door syndrome of repeat acute care admissions.

2.25   For the not-insignificant minority who are severely disabled by their illness and need ongoing secure care, it is considered by the committee that there should be adequate, spacious secure sites in the environment of general hospitals where patients have access to a range of rehabilitative services and general physical health care. These are in addition to secure forensic facilities, which while different in some respects, should also provide rehabilitative services and have the ability to ensure general physical health care needs are met.

2.26   **Prevention is definitely better than cure**. Everyone seems agreed on the value of raising awareness of mental illness, of reducing stigma, and of prevention and early intervention programs. Such initiatives are frequently cited as being both clinically effective and less costly. However, it is not clear that funding is following this clinical consensus. This type of program is being trialled, but there is room for further expansion. However, data has already shown that many people currently do not seek treatment for their illness, and there is little point striving for reduction in the stigma and increased awareness, if people find there is no support available when they take the first step toward getting help. Stigma reduction and education campaigns will need to be matched with growth in resources for treatment.

2.27   Quality of care appears to **vary greatly from place to place**. The availability of health care professionals, particularly those other than GPs, plummets outside the capital cities. Each state and territory has its services organised differently, and the range in quality of treatment between jurisdictions surprised and at times disturbed the committee. Some health care institutions have unacceptable standards of care. The National Mental Health Strategy appears not to have made any difference to marked differences in care and treatment across a patchy and fragmented system. It was said that many states had still not implemented the first National Mental Health Plan and were years behind leaders such as Victoria in service delivery. The response to criticisms and mental health crises by many governments has been to fund pilot projects and offer short-term grants for worthwhile programs. This work is rarely evaluated or funded more universally.

2.28   **Some mental illnesses receive more attention than others**, in part as a result of the focus on 'serious mental illness' in the National Mental Health Strategy.[21] Across the country, the Committee heard about people with borderline personality disorder experiencing discrimination and lack of effective treatment. Particular conditions such as obsessive compulsive disorder, self harming, post-natal depression and often fatal eating disorders lack specialised treatment support and get lost in the current attention on psychotic mental illnesses.

2.29   **Service silos are preventing effective care**. This problem is most serious in the areas of dual diagnosis and the justice system. People with drug or alcohol problems as well as mental illness are shuffled between services unable and sometimes unwilling to treat both conditions. Dual diagnosis is still not effectively addressed, despite it being the expectation rather than the exception amongst people with mental illness, particularly those ending up in the criminal justice system. Police cells, courts and jails are filling with those experiencing mental illness, who are getting inadequate treatment or none at all in environments that are anything but therapeutic. Those in jail are frequently discharged with little or no transitional support, increasing the chances of recidivism, not to mention the cost of what is often a high level of seclusion and surveillance afforded them in prison.

2.30   **Some people get more mental health care than others**. The complex needs of asylum seekers, particularly if they are in immigration detention, have not been adequately catered for, although the committee is pleased by recent reforms in this area. Cases such as that of Cornelia Rau highlight how some people, whether suspected illegal immigrants or the homeless, are less likely to be considered as potentially having a mentally illness, and less likely to receive proper diagnosis and treatment. Spending on mental health in children and youth is not commensurate with prevalence or opportunities for early intervention. There is also a significant divide between rich and poor. People who are poor and/or do not have private health insurance have fewer treatment options, and appear particularly unlikely to be able to

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21   See for example, Australian Health Ministers, *National Mental Health Plan 1992*, April 1992, Section 2.

afford ongoing treatment for anxiety disorders or depression. Nowhere is this more evident than in Indigenous communities.

2.31   The **dominant medical model is hampering improvement** in mental health care. Psychiatry, while central to the treatment of mental illness, by its own admission is not always able to explain many of the causes and pathways of mental illness. The Committee discerned much frustration among consumers and carers that, despite the persistence of the mysteries of the mind, psychiatric responses often seem rigid and unaccommodating of alternative approaches. Pharmaceutical treatments are certainly improving but their use is also growing at extremely rapid rates, as is Commonwealth expenditure under the Pharmaceutical Benefits Schedule yet psychologists qualified to deliver evidence-based 'talking therapies' are significantly under-utilised in publicly-funded mental health care. Australia has very few psychotherapists and alternative therapies get short shrift, despite some evidence of success. As in other fields of medicine, there must be a move toward more multidisciplinary care approaches to health, and a move away from the narrow medical model. There is a need to counter the effects of stigma due to poor knowledge of appropriate interventions for mental illness among health professionals, as well as among the public. Consumers are often marginalised in the design and conduct of research and the evaluation of treatments.

2.32   These are some of the recurrent themes expressed by many different groups and individuals as the committee travelled around the country The experiences related to the committee, and the facts set out for it, were depressingly similar to those presented in the Burdekin Report ten years earlier. However, there has been progress as well.

Recent initiatives around the country

2.33   The harsh criticisms made by HREOC, the Mental Health Council of Australia and others, and the limited progress documented in reports on mental health services, are well founded. Nevertheless, there have also been successful and substantial initiatives taken by NGOs and by state, territory and federal governments in recent years.

2.34   The non-government sector has been responsible for putting forward many good programs and ideas for combating mental illness. It has been at the forefront of seeking to make the goals of the National Mental Health Strategy a reality. Examples brought to the committee's attention include:

- Partnerships in community-based care, bringing clinical care together with accommodation and other services[22]

- Programs aimed at addressing interactions between mental illness, drug dependency and homelessness[23]

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22   An example visited by the committee was the partnership between the Mental Illness Fellowship Victoria and the Goulburn Valley Area Health Service, at Shepparton.

- Mental illness awareness and education programs[24]

- Online support services for consumers or carers[25]

- A range of services in which consumers are playing key roles[26]

- Training programs, such as mental health first aid.[27]

2.35   There are many government initiatives in the area of mental health, discussed below, and in later chapters. Overall, the great breadth of the goals in National Mental Health Plans makes it difficult to assess the extent to which government initiatives systematically address priority needs. New proposals seem patchy, not consistent between jurisdictions, and sometimes lack sustainable funding (discussed further in Chapter 4). With inadequate funding in the system as a whole, and an overemphasis being placed on acute care, established programs may well be valuable but limit expenditure in other worthy areas.

2.36   The Australian Government expressed its role in addressing and managing mental health in Australia as providing leadership on mental health issues at the national level and to fund programs.[28] This includes medical and pharmaceutical benefits funding, the delivery of primary care services through GPs, the provision of funding through the Australian Health Care Agreements, and programs to support special needs groups. The Australian Government also provides a range of other programs such as income support, social services and housing assistance programs.

2.37   Since the launch of the National Mental Health Strategy, recurrent government expenditure on mental health from 1992-93 to 2002-03 has increased by 73 per cent (real terms).[29] The largest item of Commonwealth expenditure and area of fastest growth has been the subsidising of medicines under the Pharmaceutical Benefits Scheme. Commonwealth initiatives have included:

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23   Examples include the Homeless and Drug Dependency Trial initiated in Melbourne by Hanover Welfare Services, the Salvation Army and St Vincent de Paul. Hanover Welfare Services, *Submission 403*, pp. 9–10.

24   Mental Illness Education ACT, *Submission 354*; Dr Simon Bridge, *Submission 500*.

25   depressioNet, *Submission 475*; ANU Centre for Mental Health Research, *Submission 186*; beyondblue, *Submission 363*; beyondblue, http://www.beyondblue.org.au/index.aspx (accessed March 2006).

26   Many of the NGO programs included consumers as consumer researchers, consultants and advocates.

27   Professor Anthony Jorm and Ms Betty Kitchener, *Submission 47*.

28   Australian Government, *Submission 476,* p. 1.

29   Department of Health and Ageing, *National Mental Health Report 2005*, p. 21.

- National standards for mental health services, with a review of almost 50 per cent of all public service mental health services completed and 40 per cent currently under review.[30]

- A national system of reporting on mental health resources and services.[31]

- Introduction of new Medicare items through the *Better Outcomes in Mental Health* program and mental health training funding for participating GPs.[32]

- Funding for consumers and carers to attend key mental health conferences and forums.[33]

- A review of State and Territory-based legislation to ensure consistency with United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care.[34]

2.38   State and Territory Governments essentially deliver and manage mental health services within their respective jurisdictions.[35] Since the launch of the National Mental Health Strategy, each jurisdiction has implemented reforms and recent initiatives include:

2.39   **Victoria**

- Primary Mental Health and Early Intervention Teams to assist primary health providers in the recognition of mental illness at an early stage and provide specialist consultation.[36]

- $3.5 million provided on an annual basis to *beyondblue*, the NGO promoting community awareness of depression, its treatment and prevention.[37]

- Funding for projects tracking population attitudes (anti-discrimination, promotion of economic participation and social inclusion for particular groups including refugees, young people, rural, indigenous and older people) and research assessing the effectiveness of mental health care initiatives.[38]

- Funding some newer pharmaceuticals not covered under the Pharmaceutical Benefits Scheme.[39]

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30   *Submission 476,* p. 18.

31   Australian Government, *Submission 476,* p. 52.

32   *Submission 476,* pp.10–11, 33.

33   *Submission 476,* p. 3.

34   *Submission 476,* p. 3.

35   *Submission 476,* p. 1.

36   Victorian Minister for Health – Victorian Government, *Submission 445,* pp. [6,] [11].

37   *Submission 445,* p. [6].

38   *Submission 445,* p. [12].

39   *Submission 445,* p. [9].

- $5 million to deliver psychiatric disability rehabilitation and support services to assist people with mental illness, their families and carers.[40]

2.40 Queensland

- Development of the Queensland State Forensic Mental Health Plan and Standards[41] and the creation of new mental health positions in associated areas.[42]

- 'Implementation of the Voluntary Referral Program for mental health.'[43]

- Launch of *Project 300,* to assist in rehabilitating people undergoing extended psychiatric treatment.[44]

- Inpatient beds redistributed into regional centres[45] and the Queensland Centre for Rural and Remote Mental Health established to deliver programs to people in regional areas.[46]

- Establishment of Crisis Intervention Teams between the Queensland Police Service and health service agencies[47] and Mental Health Child Safety Support Teams.[48]

- Funding a post-graduate psychiatry program to increase the number of specialist trainees across the State.[49]

2.41 Western Australia

- Enhanced interactions between mental health service providers, consumers, carers and funding groups.[50]

- Significant capital works undertaken to reform community services.[51]

- Implementation of 'routine collection of consumer outcome measures' and training of mental health workers in using the system.[52]

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40   *Submission 445A,* p. [3].

41   Queensland Government, *Submission 377A,* p. 74.

42   Queensland Government, *Submission 377,* pp.24–25, 29.

43   *Submission 377A,* p. 74.

44   *Submission 377A,* pp. 23–5, 74.

45   *Submission 377A,* p. 4; *Submission 377,* p. 13.

46   *Submission 377A,* p. 65.

47   *Submission 377A,* pp. 12, 74.

48   *Submission 377A,* p. 10.

49   *Submission 377,* p. 33.

50   Department of Health – Government of Western Australia, *Submission 376,* p. 6.

51   *Submission 376,* p. 6.

52   *Submission 376,* p. 8.

2.42 **Northern Territory**

- The *Northern Territory Criminal Code (Mental Impairment and Unfitness to be Tried) Act 2002* amended to ensure offenders with a mental health illness are assessed and treatment is available in the 'least restrictive' environment.[53]

- The Mental Health and Substance Misuse Project commenced in 2004, bringing together mental health providers with organisations treating substance abuse.[54]

- The new Primary Health Care Service was established in Darwin to link mental health consumers with GPs in the community.[55]

- Revised policies and procedures have been implemented for risk assessment, complaints management and provision of information to consumers and carers.[56]

- Modifications to address safety issues in inpatient facilities are complete, or nearing completion.[57]

2.43 **ACT**

- As part of the ACT's comprehensive forensic mental health model, the *Criminal Code (Mental Impairment) Amendment Bill 2006* was introduced on 16 February 2006, clarifying definitions of mental impairment for offenders and alleged offenders.[58]

- $20 million to NGOs for mental health services and non-clinical support, such as education, supported accommodation and respite, and counselling.[59]

- Discharge planners in inpatient units to assist in the transition of inpatients back into the community.[60]

- Additional mental health officer positions across mental health care services.[61]

- Mobile Intensive Treatment Teams to support consumers living in the community who have high level needs.[62]

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53   Northern Territory Government, *Submission 393,* p. 25.

54   *Submission 393,* pp. 31–32.

55   *Submission 393,* p. 32.

56   *Submission 393,* p. 31.

57   *Submission 393,* p. 31.

58   Mr Jon Stanhope, Chief Minister Australian Capital Territory, *Forensic Mental Health Model Takes Step Forward,* 16 February 2006. http://www.chiefminister.act.gov.au/

59   Minister for Health – ACT Government, *Submission 165,* pp. 2–3; Minister for Health – ACT Government, *Submission 165A,* p. 5.

60   *Submission 165,* p. 3.

61   *Submission 165,* p. 4.

- The MindMatters School Project to increase awareness and understanding of mental health issues in schools and other educational institutions.[63]

- From 1 July 2005, a system to monitor the use of seclusion and restraint of people with a mental illness.[64]

- New campaigns to increase the recruitment and retention of specialist mental health staff.[65]

2.44   **NSW**

- The Integrated Services Project for Clients with Challenging Behaviour pilot program to assist people with a mental illness with long term housing support and care.[66]

- Mental Health – Clinical Care and Prevention model released, estimating the number of people in age groups with mental illness and linking the varying levels of severity with treatments required from mental health care providers.[67]

- Funding to NGOs to deliver community services.[68]

- A range of initiatives addressing the needs of people with both a mental illness and a substance abuse disorder.[69]

- Pilot programs specially targeting people with a mental illness who are from culturally and linguistically diverse backgrounds.[70]

- Skilling the mental health care workforce through training programs, including a Graduate Certificate in Mental Health for General Practitioners.[71]

- Community Forensic Mental Health Service established to provide consultation and case management.[72]

- An exposure draft of a new Mental Health Bill for NSW (which was to be tabled in late 2005,[73] but now expected in the first half of 2006).

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62   Minister for Health – ACT Government, *Submission 165,* p. 4.

63   *Submission 165,* p. 5.

64   Minister for Health – ACT Government, *Submission 165A,* p. 15.

65   *Submission 165,* pp. 5–6.

66   NSW Health – NSW Government, *Submission 470*, p. 6.

67   *Submission 470*, p. 18.

68   *Submission 470*, p. 31.

69   *Submission 470*, p. 41.

70   *Submission 470*, p. 42.

71   *Submission 470*, p. 32.

72   *Submission 470*, p. 50.

73   *Submission 470*, p. 7.

2.45   **South Australia**

- 'an Australian-first pilot program between mental health services and ambulance services of specially trained crews of mental health staff and ambulance paramedics who are available (initially only in the northern and southern metropolitan areas) to attend call-outs to crisis situations throughout the night'.[74]

- $25 million extra in grant monies for non-government community health services in 2004/2005'.[75]

- A pilot project on 'Perinatal and Infant Mental Health in the Community'.[76]

- Reforms in the area of supported accommodation.[77]

- A Memorandum of Understanding between the Commonwealth (Department of Immigration and Multicultural Affairs) and the State Government of SA (Department of Health) for health services to immigration detainees.[78]

- A Magistrates Court Diversion Program and planning for new forensic mental health facilities.[79]

2.46   **Tasmania**

- 62 packages of care to support clients to live in the community.

- A 12 bed high support community facility in Launceston.

- 12 bed cluster houses for supported accommodation in the South and the North West Coast.

- A total of 48 new clinical positions across a range of mental health care settings.

- $3.78m to drive quality and safety improvements, assist with the application of the Mental Health Act and develop a mother and baby service.

- $4.52m to upgrade existing mental health and NGOs' facilities and services.[80]

- Acceptance of recommendations and action to be taken to reform Ward 1E at Launceston General Hospital, which had been the subject of complaints.[81]

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74   Department of Health – South Australia Government, *Submission 506*, p. 3.

75   *Submission 506*, p. 4. More details were given in Department of Health – South Australia Government, *Submission 506A*.

76   *Submission 506*, p. 4.

77   *Submission 506*, p. 6.

78   *Submission 506*, p. 10.

79   *Submission 506*, p. 16. See Magistrates Court of South Australia *Submission 175* for more detail on this initiative.

80   Tasmanian Government, *Submission 502*, p. 7.

81   *Submission 502*, pp. 7–8.

2.47 The committee thus recognises that efforts are being made in the area of mental health, indeed it sought examples of good practice that are expanded upon elsewhere. It recognises, too, that there are some signs that the pace of improvement is increasing. As Professor Ian Hickie recently remarked, the ground is shifting rapidly, and 'finally…the situation has some hope of genuinely changing'.[82]

2.48 Nevertheless, the committee encountered a widespread dissatisfaction with the state of service, and a strong consensus for the need for further change. The view is widespread that more resources are needed in mental health, but also that the way resources are used needs to change. Chapter 4 outlines how mental health is resourced and discusses how it might be reformed. Later chapters tackle many questions surrounding how resources need to be directed and what services need to be expanded. The conclusion to this report discusses future directions for mental health in the context of the National Mental Health Strategy.

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[82] Ruth Pollard, 'Out of the wilderness for mental health', *Sydney Morning Herald*, 26 January 2006, p. 2.

CHAPTER 3

MENTAL HEALTH AND HUMAN RIGHTS

Introduction

3.1   Mental illness raises many human rights issues. People with mental illness experience discrimination within society, and even within the health care system; mental illness can cause significant social disadvantage that under-resourced services may fail to adequately address; during episodes of acute illness, a person with mental illness may be unable to assert their rights at the very time when those rights may be most vulnerable to being breached; people experiencing acute mental illness may be treated against their will, or confined against their will, which can be a serious threat to their rights.

3.2   Human rights have been central to discussion about mental health care reform in Australia and overseas. Australia's 1991 *Mental Health statements of rights and responsibilities* focused on consumers' and carers' human rights. The intention was 'to promote social justice, equity, access and a compassionate society with metal health as a primary goal'.[1]

3.3   In the early 1990s, the National Inquiry into the Human Rights of People with Mental Illness sought to assess how well the human rights of the mentally ill in Australia were being honoured. The findings were not encouraging. That inquiry was conducted by reference to human rights instruments developed through the United Nations system and to which Australian governments are committed either as a matter of legal obligation or as a matter of policy.[2]

3.4   The Human Rights and Equal Opportunity Commission (HREOC) summarised the findings of the Burdekin Report:

> … people affected by mental illness suffered from widespread systemic discrimination and were consistently denied the rights and services to which they are entitled.

> Families and carers were found to be badly overstretched and insufficiently supported. As well as improved crisis facilities and other community mental health services the Burdekin Inquiry recommended better information for carers and greater provision for involvement in decisions.

> … recommended consistent accountability mechanisms and service standards.[3]

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1   The Mental Health Consumers Outcomes Task Force, *Mental Health statements of rights and responsibilities*. AGPS, 2000, Foreword.

2   Human Rights and Equal Opportunities Commission, *Submission 368*, p. 1.

3   *Submission 368*, pp. 2–3.

3.5 The National Mental Health Strategy (NMHS) has been significantly influenced by the Burdekin Report and the *Statements of rights and responsibilities*. This has included the development of national standards for services. In 1996 the Australian Health Ministers' Advisory Council's National Mental Health Working group endorsed *National Standards for Mental Health Services* (the *Standards*) which signified 'an important milestone in the achievement of the 1992 agreement by Australian Health Ministers to the development of national standards for mental health services under the Mental Health Strategy'.[5]

3.6 The *Standards* demand that the rights of people affected by mental disorders or mental health problems be upheld by mental health services. They include twelve criteria regarding consumers' and carers' rights. The criteria state, among other things, that: mental health services staff should comply with relevant legislation and instruments protecting the rights of people with a mental illness; consumers should be informed of their rights and responsibilities; consumers should have access to independent advocates and to accredited interpreters; and consumers and carers should have easy access to a responsive and fair complaints procedure.[6]

Consumers' rights

3.7 The Burdekin Report made the obvious points that people with mental illness are human beings with human rights, and that they are entitled without discrimination to the full range of human rights.[7] The report concluded that:

> … our current neglect in terms of violations of the most fundamental rights of Australians affected by mental illness … demand an urgent, concerned and effective response.[8]

3.8 People with mental health issues are protected by the anti-discrimination provisions of the *Disability Discrimination Act 1992*:

> The DDA was enacted to eliminate, as far as possible, discrimination against people on the grounds of disability, and to ensure that people with

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5   *National Standards for Mental Health Services,* Commonwealth of Australia, January 1997, Foreword.

6   *National Standards for Mental Health Services*, Commonwealth of Australia, January 1997, pp 7–8.

7   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, p. 15.

8   Human Rights and Equal opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, p. 15.

disability have the same rights to equality before the law as the rest of the community.[9]

3.9   HREOC informed the committee that all states and territories, except for South Australia, now also cover disabilities from mental illness with their equal opportunity or anti-discrimination laws in broadly similar terms to those contained in the Commonwealth Act.[10]

3.10   HREOC also submitted that a 2000 evaluation of Australian mental health legislation found that there had been significant progress in reform of that legislation since the adoption of the NMHS:

> Every state and territory has amended or is amending its mental health legislation to move away from an emphasis on detention to a model based more properly on human rights – although the same evaluation showed that no Australian jurisdiction had achieved full compliance with the UN Mental Health Principles.[11]

3.11   Reforms made under the NMHS have been beneficial for consumers:

> We acknowledge the extent to which some of the changes driven by the National Mental Health Strategy have influenced mental health services. Apparent among these is the consumer involvement in auditing services and the development of the National Mental Health Practice Standards and the National Mental Health Service Standards.[12]

3.12   Not all consumers do believe, however, that current policies adequately reflect their human rights:

> There is a growing worldwide social movement of mental health consumer-survivors that sees itself in the tradition of the civil rights movements, women's liberation and feminism, Gay Pride movement, and also the physical disabilities movements that are now recognised as communities with their own cultures, needs and rights. The rights of these other movements to speak – and be heard – in their own voices, from their own direct experience, and from within their own communities and cultures, is now generally recognised, accepted and respected in Australian society. This is not yet the case for mental health consumers and survivors.[13]

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9   Australian Government, *Submission 476,* p. 6.

10   Human Rights and Equal Opportunities Commission, *Submission 368*, pp. 4–5.

11   *Submission 368*, p. 4.

12   Mental Health Legal Centre, *Submission 314*, pp. 6–7. (The Australian Government stated that by June 2003 the National Standards for Mental Health Services were being used by 90 percent of all public sector mental health services. See Australian Government, *Submission 476*, p. 2.)

13   insane australia, *Submission 2*, p.2.

15   *Submission 2*, pp. 3–4. The submission lists a third category – discharge from services – which, while not discussed further here, is addressed in Chapter 8.

3.13   Consumers' rights may be compromised in other ways. Two of the most critical are denial of services and abuses within services.[15]

Denial of services

3.14   The *Statements of rights and responsibilities* states that 'the consumer has the right to a co-ordinated and ongoing range of adequately resourced …treatment'.[16] Many consumers, however, are denied proper treatment because insufficient resources are allocated to mental health services. In the words of the HREOC submission, 'Governments have not matched their words with resources'.[17]

3.15   According to insane australia:

> The current, limited public debate on mental health in Australia today focuses largely on the appalling lack of resources for mental health services. At insane we agree that mental health services are grossly neglected in this country and that many people are dying, mostly through suicide, from this neglect. This neglect needs to be seen as not just a failure to resource an essential service but as a violation of our fundamental human rights.[18]

3.16   However, insane australia submitted that lack of resources is a second-order issue. It argued that people in desperate need are denied access to services not only because of lack of resources but also because they do not meet diagnostic criteria.[19] It also argued that the real cause of human rights violations is the stigma surrounding mental health. This stigma results in discriminatory practices which are intrinsic to the system. Insane australia claimed that without a changed approach the allocation of more resources would only entrench the current human rights abuses of mental health consumers and survivors.[20]

3.17   The committee has discussed issues surrounding the allocation of resources to mental health services, stigma attaching to mental illness and problems regarding diagnosis. These matters are examined in Chapter 4, Chapter 7 and Chapter 5, respectively.

Abuses within services

3.18   Abuses within services are said to include hostile environments, mental health staff ignoring or dismissing consumers' personal feelings, physical abuse and forced treatment. Graphic examples are included in Chapter 8. The evidence suggests that if

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16   The Mental Health Consumers Outcomes Task Force, *Mental Health statements of rights and responsibilities*. AGPS, 2000, p. 7.

17   Human Rights and Equal Opportunities Commission, *Submission 368*, p. 5.

18   insane australia, *Submission 2*, pp. 2–3.

19   *Submission 2*, p. 3.

20   *Submission 2*, p. 3.

there were greater levels of consumer participation in their own treatment and in the provision of mental heath services this might alleviate at least some of those concerns.

Consumer participation

3.19   The Burdekin Report and the various documents that comprise the NMHS endorse consumers' participation in the mental health system. One consumer commented on the findings contained in the Burdekin Report:

> For the first time in the history of mental health policy in this country we were perceived outside the sick role. This was a very significant change in policy direction and one of the key platforms of the First National Mental Health Strategy. There was a new vision for consumers to start playing vital roles in 'the system'; as peer supporters, educators of the mental health workforce, as consultants to the system, advocates and other paid roles in service delivery; consumer evaluators and decision makers; service auditors; researchers; orators and visionaries.[21]

3.20   A number of witnesses stated, however, that the promise of substantial consumer participation in the delivery of mental health care had not been met:

> Although National and State Mental Health Plans emphasise the importance of consumer participation, particularly in the planning, monitoring and review of mental health services, there is little evidence that consumers are meaningfully and substantially involved in the development of the methods and procedures used in the monitoring and review of services.[22]

3.21   Another witness submitted that:

> Consumer involvement in mental health programs and services is largely tokenistic, minimal and inadequate. Consumers need to be involved in their own treatment and in remaining well, and in the design of appropriate services and programs. There is currently very little funding and support for consumer driven services and recovery focussed services.[23]

3.22   The National Mental Health Plan 2003-2008 has identified the need for greater consumer participation at all levels, including the development of policy, planning, implementation and evaluation of services, and research.[24]

Extent of participation

3.23   The Australian Government submitted that at the national level consumers are now integral participants in policy forums and committees and are members of project

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21   Ms Merinda Epstein, *Submission 207*, p. 6.

22   Centre for Psychiatric Nursing and Practice, *Submission 217*, p. 4.

23   South Australian Division of General Practice Inc., *Submission 88*, p. 11.

24   Australian Government, *Submission 476*, p. 72.

reference groups.[25] Consumers and carers account for 25 percent of the membership of the Mental Health Council of Australia (MHCA), the peak body representing groups and individuals concerned with mental health.[26]

3.24   A witness who has been a consumer representative on a number of government advisory boards argued that the representation of consumer organisations on MHCA, on which other interested parties were also represented, was not sufficient for the views of consumers to influence decision making:

> Having responsibility for drafting a constitution [for the MHCA] we tried to build in clauses that would ensure that the consumer voice did not get swamped by all the professional and other voices which we knew would now demand to be part of this new and potentially influential body. It was obvious right from the beginning however that the MHCA could not be for the consumer voice the strong articulation that NCAG[27] had been. Put simply, we would never have the numbers … Having the numbers is essential because we don't have the power derived from professional authority.[28]

3.25   The Australian Mental Health Consumer Network made a similar point:

> Because of differences in assumed and real power between consumers and other players in the mental health industry the Australian Mental Health Consumer Network policy is that consumers should work together in at least pairs.[29]

3.26   The MHCA agreed that consumers are not sufficiently involved in mental health services:

> The [National Mental Health] Strategy has established consumer and carer participation in service planning and delivery as a desirable goal, though there is little evidence it has progressed into a practical reality. It has established consumer rights as an accepted part of service delivery, though again there is considerable evidence that the exercise of such rights is weakened by a lack of support for consumers and carers. There is inadequate and patchy funding to train and support carers and consumers to enable them to participate fully in this role, and what is available often does not address mental health issues specifically. As importantly, a change in service culture and practice by the mental health workforce is required so that they recognise the rights of and work effectively with consumers and

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25   *Submission 476*, p. 2.

26   Australian Government, *Submission 476*, p. 19.

27   The National Community Advisory Group on Mental Health (NCAG), comprising consumers and carers, was established under the first National Mental Health Plan and reported directly to the Minister for Health.

28   Ms Merinda Epstein, *Submission 207*, p. 8.

29   Australian Mental Health Consumer Network, *Submission 322*, p. 33.

carers. This is a fundamental and urgently needed element of workforce training and service.[30]

3.27   The involvement of consumers needs to respect the diversity of mental illnesses, but also the diversity of treatment outcomes and experiences. The unpaid nature of many consumer advocacy roles, the stigma that still attaches to having experienced mental illness, and the organisation of consultative meetings during the working day are factors that work against consumer representatives being people who have fully recovered from an illness or are successfully managing it while engaged in full-time work.

3.28   If people with a mental illness who are living and working in the community are involved as consumer representatives, this would provide a greater range of viewpoints, with several advantages:

> (a) they are an excellent resource that comes into play; and (b) the community begins to understand that good outcomes are highly possible. To do that we need to think about when we hold meetings and have funding to cover costs.[31]

3.29   The National Mental Health Reports (NMHRs) compiled by the Commonwealth Department of Health and Ageing contain data on the progress of mental health reform under the NMHS.[32] The latest report found that:

> Overall, the results suggest that the involvement of consumers and carers in mental health service development is increasing when assessed against these 'coarse' criteria.[33]

3.30   These 'coarse' criteria relate to the structural arrangements made by service delivery organisations for involving consumers and carers, with the data being assigned to one of four levels. A Level 1 arrangement is one in which consumers and carers are given a formal place in the local decision making structures or a specific consumer and carer group is established to advise on all aspects of service delivery. A Level 4 arrangement is one in which agencies have made no specific arrangements for consumer and carer participation.[34]

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30   Mental Health Council of Australia, *Submission 262*, p. 10.

31   Dr Simon Bridge, *Committee Hansard*, 5 August 2005, p. 76.

32   Department of Health and Ageing, *National Mental Health Report 2005: Summary of Ten Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2003*, Commonwealth of Australia, Canberra, 2005, p. i.

33   Department of Health and Ageing, *National Mental Health Report 2005: Summary of Ten Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2003*, Commonwealth of Australia, Canberra, 2005, p. 60.

34   Department of Health and Ageing, *National Mental Health Report 2005: Summary of Ten Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2003*, Commonwealth of Australia, Canberra, 2005, pp. 59–60.

3.31   The 2005 NMHR found that the proportion of organisations with some type of formal mechanism for consumer participation had increased from a 53 percent 'baseline' in 1994 to 82 percent in 2003. Ten years into national mental health reform, however, 18 percent of mental health service organisations remained without a basic structural arrangement for consumer and carer participation.[35]

3.32   Taken at face value, these data indicate that, throughout Australia, arrangements have been made by most organisations to enable consumers to have input to the delivery of mental health services. The 2005 NMHR states, however, that consumers and carer representatives had suggested that the progress reported by the states and territories in the previous NMHRs did not match consumers' and carers' perceptions. In particular, consumers and carers considered that the measures used in the survey did not provide information on the extent of the commitment of an organisation to employing consultants.

3.33   In the 2003 National Survey, on which the 2005 NMHR was based, additional data were sought on the employment of consumers and carers as an indication of the commitment of organisations to consumer participation. These data showed what was described in the 2005 NMHR as 'a more realistic picture':

> Nationally, a total of only 53.6 fulltime equivalent consumer consultants and 8.6 carer consultants were employed across the 251 mental health service organisations funded by state and territory governments. Total expenditure on consumer and carer consultants in 2002-03 was $2.5 million, or 0.2 per cent of total spending on salaries and wages.
>
> Consumer and carer consultants are not employed in all states and territories. Three jurisdictions (Western Australia, Tasmania and the Northern Territory) reported neither category within their 2002-03 workforces.[36]

Rationale for consumer participation

3.34   There was no real dissent from the widely-held view that consumers have a major role to play in mental health care. One witness summarised that role:

> Consumers can and should play a core role in monitoring service quality and ensuring that services are responsive to consumer needs. This includes employing consumers as consultants within services as well as ensuring they contribute to pre-service and in-service training for mental health professionals. Statewide consumer advocacy organisations are another important component as they can identify and seek redress for systemic

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35   Department of Health and Ageing, *National Mental Health Report 2005: Summary of Ten Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2003*, Commonwealth of Australia, Canberra, 2005, pp. 59–60.

36   Department of Health and Ageing, *National Mental Health Report 2005: Summary of Ten Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2003*, Commonwealth of Australia, Canberra, 2005, p. 61.

problems as well as resourcing and supporting consumers taking on consultancy roles in services.[37]

3.35   The Victorian Mental Illness Awareness Council informed the committee that:

> It has been our observation and experience that the knowledge and skill gained through the "lived experience" is invaluable with regard to assisting other consumers not only when people are quite unwell, but also in the recovery and rehabilitation phases of their illness.[38]

3.36   Consumers play a useful role in the treatment even of forensic patients.[39] At the Thomas Embling Hospital in Melbourne, which treats forensic patients, consumers perform valuable functions:

> One of the things that has been a remarkable success—to me, at least—has been the development of consumer representatives within the hospital and within the community service … when this started seven or eight years ago I was somewhat sceptical about whether this could work, given the nature of our system and the nature of our patient population. In fact, it has been an extraordinary success. Every unit has its own consumer rep. We employ consumer representatives who have been patients in the hospital and are now in the community. They make a very important contribution to the running of the hospital and to the whole way in which we manage treatment.[40]

3.37   While there is clear support for consumer participation, its extent seems still to be too limited. This limited role afforded to consumers is even more clear when it comes to the absence of consumer-run services.

Services delivered by consumers

3.38   The committee heard evidence suggesting that twelve years after the adoption of first *National Mental Health Plan* there are no consumer-run mental health services in Australia, and that resources have not been put into exploring successful consumer-run services despite ample evidence from overseas that these work:[41]

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37   Public Health Association of Australia Inc., *Submission 212*, p. 5.

38   Victorian Mental Illness Awareness Council, *Submission 267*, p. 8.

39   Forensic patients are persons charged with an indictable offence who have been found not fit for trial or who have been acquitted on grounds of mental impairment. People in mainstream mental health services who are a significant danger to others and who require the involvement of a specialist mental health service may also be considered forensic patients.

40   Professor Paul Mullen, Clinical Director, Victorian Institute of Forensic Mental Health, *Committee Hansard*, 6 July 2005, p. 44.

41   Ms Merinda Epstein, *Submission 207*, p. 10.

> Where is the money to investigate whether consumer-run crisis services are less damaging than professionally run ones, or peer counselling is more effective than drugs once every two weeks and so on.[42]

3.39   The Australian Mental Health Consumer Network submitted examples of publicly-funded, consumer-run services that had apparently achieved success in other countries. These were: safe houses that provide 24 hour crisis respite; sub-acute 'peaceful places'; and 'warm lines' that consumers can ring to speak to people who have experienced mental health issues first hand.[43] The SOAR Consumer Case Management in Madison, Wisconsin, and the employment of consumer case workers in Hawaii were also cited as examples of successful consumer-run services.[44] AMHCN pointed out that the only consumer-run recovery service in Sydney was achieving success but completely lacked government support:

> Pitane Recovery Centre is the only consumer run recovery centre for consumers in metropolitan Sydney. This centre has no funding whatsoever from mental health services and relies on small community grants, membership fees, and fundraising efforts of consumers. Yet this centre is gaining an international reputation due to providing a unique range of recovery activities which consumers not only enjoy but have given very positive feedback.[45]

3.40   Not everyone was supportive of consumer-run services. As regards the provision of treatment by consumers, one professional service provider observed:

> That consumers feel they could do better is important and is another indictment of service failure. … During the sixties we had consumer groups taking responsibility for the treatment of early psychosis. This experiment failed – people with psychosis do need medication. There is professional knowledge, and for all disorders evidence-based care is better than compassionate care…[46]

3.41   A community-based, volunteer, non-profit support and advocacy organisation submitted that:

> In theory the provision of services for consumers by consumers is laudable. However, to what extent this is feasible given the level of debilitation is unknown.
>
> Having said that, only consumers can give a consumer perspective on what is and is not perceived by them to be a positive approach. However, because of the many different illnesses that make up mental illness, the vast variation in levels of severity of episodes from time to time for the

42   *Submission 207*, p. 17.

43   Australian Mental Health Consumer Network, *Submission 322*, p. 21.

44   Mental Health Association NSW Inc., *Submission 230,* p. 10.

45   *Submission 322*, p. 56.

46   Professor Gavin Andrews, *Submission 176*, p. 11.

individual, and the vast differences between people it has to be recognised that this is a very complex question with no straightforward answer.[47]

Involuntary treatment

3.42   In an environment in which human rights are clearly tenuously maintained and sometimes breached, the forced treatment of individuals is a difficult and controversial practice. Involuntary admissions and treatment are common, and can be the norm in acute inpatient settings. For example, 83 per cent of patients admitted to St Vincents Acute Inpatient Unit in Sydney are involuntary admissions.[48] The actual level of people being treated against their will is probably higher than figures alone suggest. In addition to involuntary admissions, some patients are threatened with being made involuntary if they attempt to leave hospital.[49] In practical terms, these too might be considered 'involuntary' patients.

3.43   Involuntary and coerced 'voluntary' treatment give rise to questions regarding human rights, especially when the person being treated has not been charged with a crime:

> …for 5 months I was imprisoned in Mental Institutions and injected and forced to swallow tranquilisers against my will, without any proven wrong doing or transgression. I am completely innocent and seek full justice...[50]

3.44   Some took the view that the philosophical and practical problems with involuntary treatment were so great that it should never occur.[51] Most people with a mental illness are entitled to refuse treatment. In the words of one carer:

> Frustrating as it may seem to bystanders, especially families, individuals who are ill do have a right to refuse treatment. Some do so through lack of insight or misinformation; some for very sound reasons and good understanding of the effects of treatments.[52]

3.45   Some persons, however, do not have the legal right to refuse treatment. Mental health laws in all Australian jurisdictions make provision, in certain circumstances, for the detention of people with mental illness and for involuntary treatment. The relevant provisions in the different Mental Health Acts vary among the different jurisdictions, but generally they provide that if persons appear to suffer from a mental illness, if their health or safety is at risk, or if they pose a threat to members of the public, they may be 'scheduled' or 'sectioned' as involuntary patients.

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47   Canberra Schizophrenia Fellowship, *Submission 103*, p. 10.

48   St Vincents & Mater Health, *Submission 390*, p. 2.

49   Australian Mental Health Consumer Network, *Submission 322,* p. 41.

50   Mr Glen Minahan, *Submission 477*, p. 1.

51   Ms Catherine Roper, Mr David Webb, *Committee Hansard*, 5 July 2005, pp. 24–30.

52   Name withheld, *Submission 113*, p. 4.

3.46   The Mental Health Commission of New Zealand recently published a paper, *No-Force Advocacy by Users and Survivors of Psychiatry*, prepared by Tina Minkowitz, an American human rights lawyer and a self-described survivor of psychiatry. Also published in the document are commentaries on the paper from lawyers and consultant psychiatrists.[53] The introduction to that paper states:

> Minkowitz advocates for psychiatry without compulsion. Two principal grounds underlie her advocacy: force is a breach of human rights, and secondly that force is counter-productive, doing more harm than good. She examines a range of relevant human rights and human rights instruments, including the UN Convention Against Torture.[54]

3.47   The lawyers' commentaries on the Minkowitz paper focus on the limits of a human rights approach, especially when the courts are unwilling to uphold those rights, and on difficulties involved in relying on the UN Convention Against Torture. It is argued that allegations of mistreatment may provide a more effective route for challenging forced incarceration and compulsory treatment than reliance on the Convention.[55]

3.48   Two consultant psychiatrists who commented on the Minkowitz paper and the Mental Health Commission itself did not entirely agree with the 'no force' proposal. They considered that, in the words of Dr Codyre, an Auckland-based psychiatrist, the use of compulsion needs to become the rare and temporary exception rather than the rule for engaging people with serious mental illness in care and treatment.[56] There was agreement also that compulsion was overused. Dr Curtis, an Australian psychiatrist, stated that not all involuntary examinations are necessary,[57] and the Mental health Commission considered:

> … we believe that those emergencies [occasions when compulsion is necessary to protect people from immediate danger to themselves or others] are far less frequent for people who have not committed a crime than New Zealand's compulsory treatment rates suggest.[58]

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53   Minkowitz, T. (2006) *No-Force Advocacy by Users and Survivors of Psychiatry.* Wellington: Mental Health Commission.

54   Minkowitz, T. (2006) *No-Force Advocacy by Users and Survivors of Psychiatry.* Wellington: Mental Health Commission, pp 7-8.

55   Minkowitz, T. (2006) *No-Force Advocacy by Users and Survivors of Psychiatry.* Wellington: Mental Health Commission, p. 8.

56   Minkowitz, T. (2006) *No-Force Advocacy by Users and Survivors of Psychiatry.* Wellington: Mental Health Commission, p. 43.

57   Minkowitz, T. (2006) *No-Force Advocacy by Users and Survivors of Psychiatry.* Wellington: Mental Health Commission, p. 38.

58   Minkowitz, T. (2006) *No-Force Advocacy by Users and Survivors of Psychiatry.* Wellington: Mental Health Commission, p. 7.

3.49   Involuntary treatment, usually administered in the form of drugs, may be provided in an institution or in the community. Insane australia submitted that outside of the hospital setting forced treatments and coercion are found in the widespread and growing use of Community Treatment Orders.[59] Insane australia submitted that voluntary patients are often coerced into treatment by the threat of being made involuntary patients, or are deceived, tricked or bullied into taking potent psychotropic drugs with harmful side effects.[60] At the same time, the Committee heard from families who had tried to ensure that someone was admitted to or kept in hospital, and who felt that discharge was often neglectful, and sometimes tragic in its consequences.[61]

Consumers versus carers

3.50   Involuntary treatment also raises issues for carers, and is an area in the treatment of mental illness where there is at least the potential for tensions between the rights of carers and those of consumers. The *Statements of rights and responsibilities* states that:

> Carers and advocates have a right to comprehensive information, education, training and support to facilitate the understanding, advocacy and care of those consumers they care for.[62]

3.51   However, some consumers and their advocates consider that consumers and medical personnel should have absolute discretion not to provide information to carers:

> Crucially also, governments and service providers must resist the ongoing pressure from carers to facilitate greater access to confidential information about consumers. Privacy of information concerning mental health is a fundamental right protected at every level - from the International Covenant on Civil and Political Rights down to domestic legislative regimes and professional codes of ethics. And it has vital therapeutic importance. It is essential for consumers' trust and rapport with therapists that they are confident their privacy will be respected. Periodically in Victoria there is pressure to broaden the capacity of services to disclose information to carers beyond the provision of the Mental Health Act 1986. As it is that provision discriminates against consumers in that the comparable provision which applies to users of general health services under the Health Services Act 1988 contain no such exception. Facilitating greater access to personal information for carers than already exists is likely to lead to further distrust of and disengagement and alienation from mental health services.[63]

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59   insane australia, *Submission 2*, p. 4.

60   *Submission 2*, p. 4.

61   Names withheld, Submissions 27, 31, 49, 367; Sharon Ponder, Submission 84.

62   The Mental Health Consumers Outcomes Task Force, *Mental Health statements of rights and responsibilities*. AGPS, 2000, p. 17.

63   The Mental Health Legal Centre, *Submission 314*, p. 19.

3.52   Some carers see things in a different light. A father of a son who experienced mental illness and who committed suicide and husband of a wife who requires care, including occasional hospitalisation, for bi-polar disorder, informed the committee that:

> In the case of my son, no information was ever provided to those who were expected to care for him after each of his 3 discharges. Family were not even informed that he was to be discharged despite the assumption that they would care for him. He was in effect discharged onto the street.
>
> I now have a much more aggressive approach and will demand, with whatever threats are necessary, information about my wife and how to care for her. This should not be necessary, but all too often is.[64]

3.53   Parents who lost a daughter to suicide submitted:

> We would rather have our daughter alive with some of her rights set aside than dead with her rights (uselessly) preserved intact.
>
> The most important 'right' that a mentally ill person (or an outside person coming into contact with a violent patient) has is the right to life…[65]

3.54   The committee is concerned that consumer rights, including the right to privacy, should be respected, but this should not become an excuse for failure to engage with the families of those with mental illness, inadequate discharge planning or failure to implement appropriate community care.

Accountability issues

3.55   Providers of mental health services, in common with providers of all public services, should be accountable to the people for the efficiency and effectiveness of those services. This requires that:

> Accountability mechanisms should be developed and implemented across the mental health system at both a Federal and state level to ensure that the progressive policies and philosophies contained in plans such as the National Mental Health Plan (NMHP) 2003-08 are actually delivered in practice.[66]

3.56   One measure of effectiveness is whether every person with a mental illness who requires care receives care. In the absence of an accurate assessment of needs, it is not possible to know if this has been the case. An indication of needs is provided by an Australian Bureau of Statistics study that found that in 1997 approximately 18 percent of Australian adults (2.4 million) had experienced a mental disorder at some

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64   Mr Graeme Bond, *Submission 484*, p. 4.

65   Name withheld, *Submission 28*, p. 4.

66   Office of the Public Advocate Victoria, *Submission 172*, p. 3.

time during the previous 12 months.[67] The committee heard estimates that perhaps only 40 percent of people who should be treated are treated,[68] and that:

> Mental health consumers are less likely to be diagnosed with health problems, less likely to complete treatment, and less likely to receive state of the art treatment.[69]

3.57   There were concerns expressed about the level of accountability at a systemic level:

> … blaming the victim and shooting the messenger is very much alive and well in the mental health care system. Thus, accountability is only limited to the few things governments, organisations, managements and staff cannot get away with.[70]

3.58   Another witness contended that:

> … one of the reasons there are gaps in services generally and why certain groups continue to fall through the cracks is because both levels of government are not really held accountable for the mental health status of their communities. Governments should be aiming towards marked percentage improvements in the health status and quality of life in the population generally and in particular for vulnerable groups.[71]

Accountability to consumers

3.59   For the individual who does receive treatment the most significant measure of the effectiveness of mental health services is the outcome for that individual. Some consumers and service providers hold different views about what constitutes a successful outcome. According to the Victorian Mental Illness Awareness Council:

> The failure to either understand or respect the principles of consumer participation is perhaps best demonstrated by the introduction of consumer outcomes.
>
> Consumer outcomes have been introduced in some clinical and non-clinical services. Consumers in the psychiatric and disability rehabilitation sector were given a choice of measures. What the services failed to do was provide consumers with the education necessary to make an informed decision. Thus, services got the measure they preferred.[72]

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67   Australian Bureau of Statistics, *Mental Health and Wellbeing: Profile of Adults, Australia*, 1997, AGPS, Canberra, p. 5.

68   See for example, Professor Gavin Andrews, *Submission 176*, p. 11.

69   The Richmond Fellowships of Australia, *Submission 234*, p. 7.

70   Victorian Mental Illness Awareness Council, *Submission 267*, p. 12.

71   Catholic Health Australia, *Submission 276*, p. 16.

72   *Submission 267*, pp. 13–14.

3.60   Successful outcomes include the concept of recovery from illness, but recovery from mental illness may not have the same connotation as recovery from a physical ailment:

> Recovery is a myth; promulgated by over-optimistic therapists … Recovery is a very positive and uplifting word. It has been linked into a limited medical model where it does not fit. 'Personal recovery' may be a better term as it stresses the individual …[73]

3.61   The Centre for Psychiatric Nursing and Practice submitted that consumers should define recovery and what approaches should be used to facilitate recovery.[74] Desirable outcomes therefore may have a significant element of subjectivity:

> Outcome measures need to be consumer driven, if they aren't then their validity and reliability is highly questionable. We need to stop the pretence that experts know best and it is they who know what indicates a good outcome. The person receiving the service can only determine what constitutes a good outcome. Therefore measures need to be developed in collaboration with them.[75]

Advance directives – A way forward?

3.62   Consumers are likely to achieve successful outcomes if they participate in their own treatment, but this may not be possible at those times when they are extremely unwell. This has led to suggestions that when consumers are experiencing good health they could give advance directives (also known as 'living wills') about matters that may affect them later, during episodes of illness, including directives about their treatment.

3.63   HREOC produced a discussion paper on 'living wills' ten years ago. The Commission defined a 'living will' as:

> … a voluntary statement outlining the types and conditions of medical care that a person would prefer in a given situation prior to requiring care. A person may also nominate one or a number of substitute decision-makers (Power of Attorney) to make decisions of their own behalf. A living will sets out a consumer's wishes in relation to treatment decisions in advance … A living will may also cover financial, personal and medical decisions concurrently.[76]

3.64   The discussion paper addressed several issues surrounding the making and implementation of advance directives, including their legal status, invocation and

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73   The Richmond Fellowships of Australia, *Submission 234*, p. 2.

74   Centre for Psychiatric Nursing Research and Practice, *Submission 217*, p. 6.

75   Dr Barbara Tooth, *Submission 453*, p. 7.

76   Human Rights and Equal Opportunity Commission, *Discussion Paper: Living Wills*, http://www.hreoc.gov.au/disability_rights/hr_disab/Wills_DP/wills_dp.html (accessed March 2006).

advocacy implications. HREOC invited comment from interested parties, and received several submissions in response, but appears not to have proceeded to making a report.[77]

3.65   The submissions made in response to HREOC's invitation canvassed many matters of a legal, medical and practical nature. The committee has noted these matters, but has not been able to consider them in detail. It is of interest, however, that provision has already been made in Canada for agreements similar to the proposed advance directives.

3.66   The committee was told that if consumers with episodic illnesses were able to prepare advance directives regarding their treatment and other matters of importance this could somewhat alleviate their situation if they are involuntarily detained. A witness gave the following example of what might be included in an advance directive on treatment:

> 'I do not want ECT unless' or, 'I have been tried on Mellaril and I have really bad side effects from it. Please don't put me on Mellaril, but I have had this other drug before and that has been okay.'[78]

3.67   The committee was also given an example of another important matter that could be included in an advance directive:

> … one woman was taken by the police from her flat. They left two children under 10 in the flat. This woman became very upset. They saw that as part of her psychotic illness so they just kept medicating her more and more. It turned into a crescendo in the acute setting. This woman said to us that she wanted to have an advance directive that said: 'If I get taken away by the police, this is my sister's number. Please ring her. She needs to come straightaway and look after the kids.' That does not seem to be too difficult a request. If it is all written down beforehand, it is very empowering for people to have.[79]

3.68   Other witnesses similarly advocated the making of advance directives. The Mental Health Legal Centre (MHLC) informed the committee that it considered the introduction of 'living wills':

> … is crucial for people who know there is some likelihood that they might be involuntarily detained against their wishes. They can include areas such as treatment eg. what drugs to avoid, views on ECT, activities or therapies of preference, nominated contacts and people to be consulted or not; employment and study, role of family; what will happen to the children, this is especially important if the consumer is a single mother – no medical

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77   HREOC submitted that in the time since the release of the *Burdekin Report* it has not had sufficient resources to continue a detailed monitoring role on mental health issues. See Human Rights and Equal Opportunity Commission, *Submission 368*, p. 4.

78   Ms Merinda Epstein, *Committee Hansard*, 6 July 2005, p. 28.

79   Ms Merinda Epstein, *Committee Hansard*, 6 July 2005, p. 28.

intervention will have any salutary effect unless mothers know their children are safe; the bills are paid etc. [80]

3.69   Dr Meg Smith OAM, speaking at a national conference on mental health services at the University of Newcastle in 1997, discussed what could be included in advance directives, making similar points to those of Ms Epstein and others. She identified 'treatments to which one objects' as being appropriate for inclusion in an advance directive. She reported that in her case haloperidol had dreadful side effects, while another medication, clonazepam, was much more pleasant, had fewer side effects and worked just as quickly as haloperidol.[81]

3.70   From her experience as a member of the New South Wales Guardianship Board Dr Smith suggested that guardianship legislation, or the principles of guardianship, may be an appropriate vehicle for the making of advance directives.[82] She also offered practical advice to people thinking of making a living will:

- Research the current service system. Choose a couple of hospitals, asylums or places where you can be cared for.

- Pick some good friends or carers to carry out your wishes; who do you know who is strong, determined, articulate, persistent? …

- Find out about new treatments and services. Talk to other consumers. Ask your health care workers…

- Educate your health care workers. What are their attitudes and values?[83]

3.71   According to Dr Smith:

Living wills and, more importantly, the process of making one, can be a powerful way of accepting disability in your life and putting it into some context. I don't think very much now about impending illness or worry about what is going to happen if or when I become ill. Like my other will it is tucked away to be activated when necessary.[84]

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80   The Mental Health Legal Centre, *Submission 314*, p. 11.

81   Dr M Smith, *Living Wills for People with a Psychiatric Disability*, Proceedings of the Conference, *Mental Health for All: What's the Vision*, the University of Newcastle, 13-15 February 1997, p. 127.

82   Dr M Smith, *Living Wills for People with a Psychiatric Disability*, Proceedings of the Conference, *Mental Health for All: What's the Vision*, the University of Newcastle, 13-15 February 1997, pp 127-128.

83   Dr M Smith, *Living Wills for People with a Psychiatric Disability*, Proceedings of the Conference, *Mental Health for All: What's the Vision*, the University of Newcastle, 13-15 February 1997, p. 128.

84   Dr M Smith, *Living Wills for People with a Psychiatric Disability*, Proceedings of the Conference, *Mental Health for All: What's the Vision*, the University of Newcastle, 13-15 February 1997, p. 127.

3.72   However, Dr Peter Bartlett, Nottinghamshire Healthcare NHS Trust Professor of Mental Health Law at the University of Nottingham, UK, observed that, based on the judgements of British courts, there may be difficulties in the application of advance directives:

> The courts have no stomach for taking rights seriously in this area, [involuntary treatment] particularly when the contest is between a psychiatric patient and doctors or other well-intentioned professionals. The precisely similar problem occurs, by the way, for advance directives: the experience is that the courts will bend over backwards to find reasons why they don't apply.[85]

3.73   Despite some possible legal problems, MHLC stated that the development of 'living wills' is 'an essential tool to protect the human rights of people with episodic illness'.[86] It recommended to the committee that there should be a national approach to pursue the initiative.[87]

Conclusion

3.74   Since the release of the *Burdekin Report* there have been significant advances in the official acknowledgment of consumers' human rights and the incorporation of those rights in legislation. Nevertheless, there is evidence that, in practice, the rights of consumers may be denied by a lack of adequate services, and there is anecdotal evidence that consumers have sometimes suffered abuse within services.

3.75   Consumers also do not participate in their treatment to the extent that the NMHS demands that they should. Witnesses made many suggestions as to how consumer participation could be increased. These suggestions may be found in the submissions made to the committee, and should be explored further by service providers.

3.76   A suggestion of particular interest, which should be explored as a matter of priority, is that people who have episodic illness should have the right to make advance directives regarding their treatment and other matters of importance. If these directives were followed by service providers, there could be many advantages. Consumers would have a greater voice regarding their own treatment, within a legally recognised framework, however sick they might occasionally be. Service providers could be more efficiently guided toward successful treatment strategies, which would reduce the time consumers spend in care, reduce the pain and suffering they endure, and reduce the costs. Transitions into and out of acute care could be smoother, and less traumatic for family members. Finally, many of the serious concerns surrounding

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85   Dr P Bartlett, *Human Rights? Of course ... but what does that mean?* in *No-Force Advocacy by Users and Survivors of Psychiatry*, Wellington: Mental Health Commission, p. 26.

86   *Submission 314*, p. 11.

87   *Submission 314*, p. 11.

inappropriate treatment and unnecessary curtailment of consumers' rights could be addressed.

CHAPTER 4

RESOURCING

4.1   There is no doubt that more resources need to be devoted to mental health services. Time and again the committee heard from every stakeholder in mental health, from individual consumers to federal and state governments, saying that more money needs to be spent on services.

4.2   This message is not new. It was clearly articulated in the Burdekin Report of the early 1990s:

> Lack of resources has bedevilled community-based care in much the same way that inappropriately allocated resources contributed to the ineptly executed demise of the large institutions. Clearly, resources and effective coordination are imperative if mainstreaming is going to work.[1]

4.3   The committee heard that mainstreaming, despite the rhetoric, has not been successful; that a 'silo' mentality continues to exist within government departments, both state and federal; and that the integration of services to provide resources where they are most needed has, to a large extent, simply not occurred. It was suggested that nothing has changed since the Burdekin Report and that the quote above is as relevant today as it was in 1993.[2]

4.4   Calls for greater resources certainly appear to have been met with relatively little action. This is not to say, however, that resources for mental health have been static for the last ten years. Funding for mental health has increased steadily (Figure 4.1):

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1   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness – Report of the National Inquiry into the Human Rights of People with Mental Illness*, vol 1, Canberra 1993, p. 137.

2   Mental Health Association of Queensland, *Submission 312*, p. 2.

Figure 4.1 Growth in health expenditure and mental health expenditure.[3]
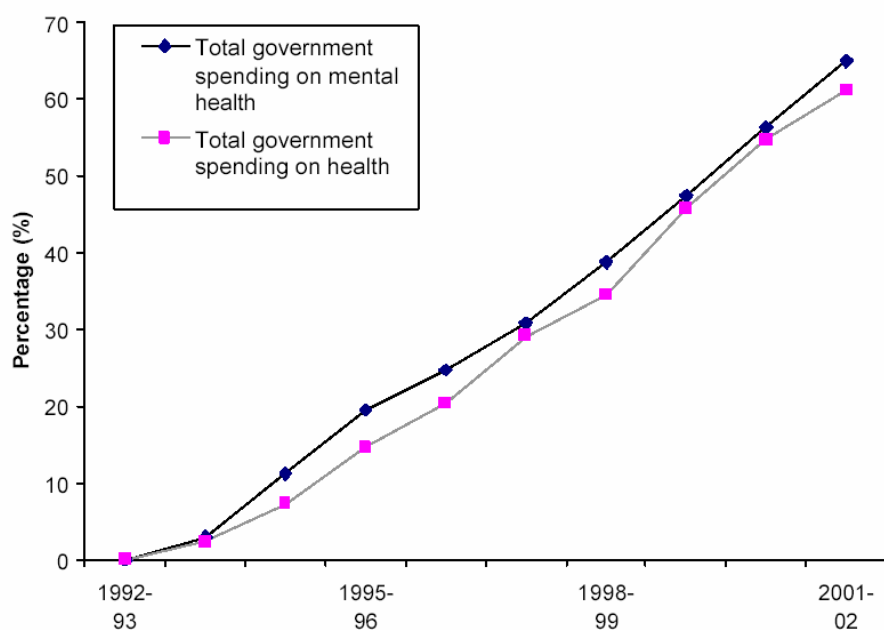
4.5   The graph shows that mental health expenditure rose by about 65 per cent from 1992–93 to 2001–02. It also reveals the reason why resources for mental health remain a prominent issue. Ten years ago, mental health was a neglected field of health care. Since that time, expenditure on mental health has risen no faster than health expenditure in general. This suggests that mental health is not being given the priority it needs. Throughout this report evidence is presented of capacity constraints and neglect across the sector indicating that resource levels need to rise.

4.6   This chapter outlines the cost of mental health problems, demonstrates the need for more resources, and outlines debate about where those resources should go.

The Costs of Mental Illness

4.7   Mental illness costs the country a great deal in many different ways. There are the human costs in terms of time lost to disability or death, and the stresses that mental illnesses place upon consumers, carers, and the community generally. There are financial costs to the economy which results from the loss of productivity brought on by illness. Then there is the expenditure by governments, health funds, and individuals associated with combating mental illness and facilitating mental health.

4.8   It is well established, but not well enough understood, that mental illness is the number one health problem causing years lost to disability (YLD) in the

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3   I. Hickie, G. Groom and T. Davenport. *Investing in Australia's future: Summary*, December 2004, p. 9. See also DoHA, *National Mental Health Report 2005: Summary of Ten Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2003*, Commonwealth of Australia, 2005.

Australian community.[4] Other diseases like heart disease and cancer may take more lives, but nothing causes as much ongoing suffering and disablement as does mental illness. The level of health burden caused by a disease can be measures in terms of disability-adjusted life years (DALYs), and Figure 4.2 compares these figures for major types of illness:

Figure 4.2 The burden of mental illness compared.[5]
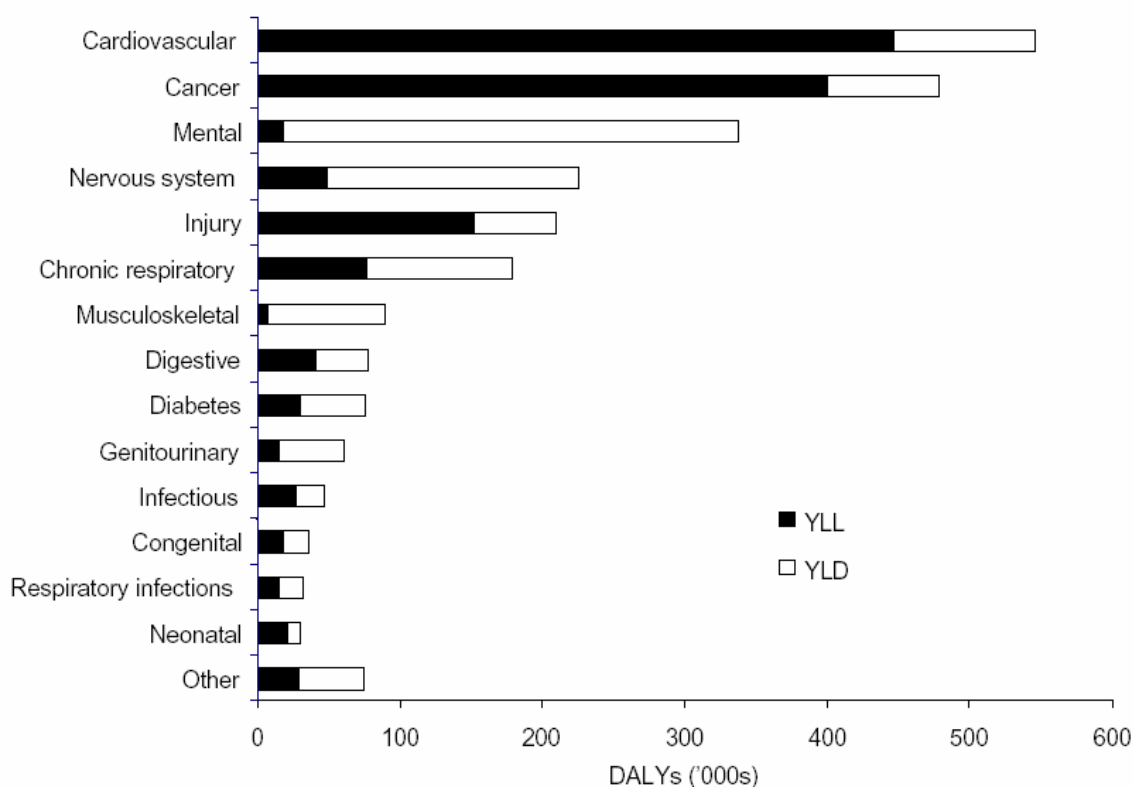
4.9   Behind the figures showing the very high level of disability due to mental illness lie two stories, one about health and one about human suffering. In health terms, mental illnesses are different to most other illnesses. The overwhelming burden of mental illnesses falls upon the young, while most other conditions are more likely to affect the old. Thankfully most mental illness is not fatal. However, the early onset of much mental illness can mean that sufferers, particularly of acute conditions, can face varying degrees of disability for many years of their lives. As shown below, this means mental illnesses can create enormous costs for our health system and our society – costs that are exacerbated if effective treatment and care are not provided.

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4   C. Mathers, T. Vos & C. Stevenson, *The Burden of Disease and Injury in Australia*. AIHW Cat. No. PHE 17, Australian Institute of Health and Welfare, Canberra, 1999.

5   C. Mathers, T. Vos & C. Stevenson, *The Burden of Disease and Injury in Australia*. AIHW Cat. No. PHE 17, Australian Institute of Health and Welfare, Canberra, 1999, p. 63. YLL: years of life lost (to death). YLD: years lost due to disability.

4.10 The human story behind the high level of disability caused by mental illness is the story of considerable hardship faced by people experiencing mental illness as well as those who care for them. These hardships are documented throughout this report, but are borne particularly by the families of, and other carers for, those experiencing mental illness, and this is a focus of Chapter 11.

4.11 With so many people who experience mental illnesses becoming ill at relatively early ages, it should be no surprise that these conditions have major economic impacts. No comprehensive estimates are available, but research on three conditions – depression, bipolar disorder and schizophrenia – gives some indication of the issues. *Beyondblue* commented that the economic impact of depression was large:

> Apart from the social impact of depression, we know that over $3 billion is lost to our economy each year by not addressing the illness. These costs are not just to the health sector but include indirect costs that impact on other portfolio areas, for example welfare and disability support costs.[6]

4.12 SANE Australia commissioned research on the costs of two particular mental illnesses. That research showed for bipolar disorder:

> The direct and indirect costs of bipolar disorder and associated suicides are substantial. Real financial costs total $1.59 billion in 2003, 0.2 per cent of GDP and over $16,000 on average for each of nearly 100,000 Australians with the illness. Around half of this cost is borne by people with the illness and their carers.
>
> – Direct health system costs are estimated at $298 million in 2003, with two-thirds being hospital expenditure, 13 per cent medical expenditure (GPs and specialists), 11 per cent residential care, 2 per cent pharmaceuticals and the remainder on allied health, pathology, research and administration.
>
> – This represents only $3007 per person with bipolar disorder, even less than spending on the average Australian's health care and 0.43 per cent of national health spending.
>
> – 42 per cent of costs relate to depression, 36 per cent to mania or hypomania and 22 per cent to prophylaxis.
>
> – Real indirect costs are estimated at $833 million, including $464 million of lost earnings from people unable to work due to the illness, $145 million due to premature death (the net present value of the mortality burden), $199 million of carer costs and $25 million of prison, police and legal costs.
>
> – Transfer payments are estimated at $224 million of lost tax revenue (patients and carers) and $233 million in welfare and care payments, primarily comprising disability support pensions.[7]

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6   beyondblue, *Submission 363*, p. 2.

7   Access Economics, *Bipolar Disorder Costs: An analysis of the burden of bipolar disorder and related suicide in Australia*, Report for SANE Australia, 2003.

The results for an analysis of the economic impact of schizophrenia reveal even larger costs:

> The direct and indirect costs of schizophrenia and associated suicides are enormous. Real financial costs of illness totalled $1.85 billion in 2001, about 0.3 per cent of GDP and nearly $50 000 on average for each of more than 37 000 Australians with the illness. Over one third of this cost is borne by people with the illness and their carers.
>
> – Direct health system costs were $661 million in 2001, including 60 per cent hospital costs, 22 per cent community mental health services, 6 per cent medical costs (GPs and specialists), 4 per cent nursing homes and 2 per cent pharmaceuticals.
>
> – This represents nearly $18 000 per person with schizophrenia, over six times the spending on the average Australian's health care and 1.2 per cent of national health spending. Even so, it is clear that public health spending in Australia is at the low end of the international spectrum (1.2 per cent of health spending compared to 1.6 per cent to 2.6 per cent in other comparable countries)
>
> – Real indirect costs were $722 million, including $488 million of lost earnings from people unable to work due to the illness, $94 million due to premature death (the net present value of the mortality burden), $88 million of carer costs and $52 million of prison, police and legal costs.
>
> – Transfer costs were $190 million of lost tax revenue (patients and carers) and $274 million in welfare payments, primarily comprising disability support pensions.[8]

4.13   As these studies have noted, a considerable proportion of the economic costs of mental illness are borne by consumers and carers. However, there is obviously also major government expenditure on mental illness. For many years now, expenditure on mental health by governments and private health funds has been outlined in the National Mental Health Reports.

Expenditure on mental health

4.14   The different levels of government have different roles in funding the mental health care system:

> State and territory governments are primarily responsible for the management and delivery of public specialised mental health services while the Australian government, as well as providing leadership on mental health issues of national significance, also subsidises the cost of primary mental health services, principally through the Medicare and Pharmaceutical

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8   Access Economics, *Schizophrenia Costs: An analysis of the burden of schizophrenia and related suicide in Australia*, Report for SANE Australia, 2003.

Benefits Schemes. The Australian government also subsidises private
health insurance and directly funds a number of other initiatives…[9]

4.15 Total expenditure on mental health services by federal, state and territory
governments and private health funds was $3.3 billion in 2002–03.[10] Detailed
description of historical trends and breakdowns of how the sector is resourced are
covered by the National Mental Health Reports, and are not reproduced here. More
detail is included in Appendix 2 to this report. Mental health funding has risen in real
terms, but it has risen no faster than health funding generally.

4.16 In addition to this direct spending on mental health, there is significant
indirect expenditure by governments. Indirect expenditure 'refers to the estimated
costs…of providing other social, support and income security programs for people
affected by mental illness'. The Commonwealth indicated it spent $3,648.6 million
across the following items:

- Income support payments.
- Workforce participation programs.
- Department of Veterans' Affairs disability compensation payments.
- Housing and accommodation programs.
- Aged care residential and community services.
- Home and Community Care programs.
- National Suicide Prevention Strategy (NSPS).[11]

4.17 Government expenditure due to mental illness is even broader, however.
As Chapter 13 will show, a significant number of people who come into contact with
the justice system, do so as a result of mental illness, and this is an economic cost of
caring for the mentally ill that is 'hidden' in the budgets of state and territory
correctional services authorities.

4.18 The private sector plays a significant role in mental health care:

The private sector contribution towards hospital admission that relate to
MDC 19 Mental Disease and Disorders is substantial and it has increased.
In the last 12 months the proportion of all mental disease and disorders
treatments performed in the private sector increased by 5.7 per cent, from
37.5 per cent to 43.2 per cent (2001-02 compared with 2002-03, Data
source AIHW).

9   Mr Philip Davies, Acting Secretary, Department of Health and Ageing, *Committee Hansard*, 7
October 2005, p. 2.

10   Department of Health and Ageing, *National Mental Health Report 2005: Summary of Ten
Years of Reform in Australia's Mental Health Services under the National Mental Health
Strategy 1993-2003*, Commonwealth of Australia, Canberra, 2005, p. 20.

11   Australian Government, *Submission 476, Attachment 2*, p. 3.

> The private sector provided 95,672 in-hospital treatments for mental diseases and disorders in 2002-03. This included 73,137 same day separations and 22,535 overnight admissions. ON average each overnight admission had an average length of stay of 16.4 days. The private sector provided 443,210 patient days in private hospitals.
>
> In 2002-03 the private sector contributed at minimum $135 million toward the funding of in-hospital treatments for mental diseases and disorders.[12]

4.19   There are many non-government organisations that provide care and assistance for people experiencing mental illness. Some of these do so under government funding arrangements. Many others, such as Lifeline and GROW, do so largely on the basis of volunteer time, and donations. Lifeline Australia informed the committee that approximately 80 000 (or 27 per cent) of its counselling calls in 2002 were known to be about mental health and that a study conducted of Sydney callers found that 69.5 percent of those callers suffered from high levels of psychological distress.[13] Except in Victoria, Lifeline does not receive any recurrent government funding 'to manage increasing demand of mental callers'. It is interesting, however, that government agencies refer clients to Lifeline, if they are in crisis.[14]

4.20   A great part of the cost of care of many people experiencing mental illness is carried by their families and carers. Individual carers on average contribute 104 hours per week caring, or being on call to care, for people with mental illnesses.[15] Without the sustained efforts of carers and family members, the current mental health system would not function.

4.21   The costs to these families and carers are substantial. As well as direct and indirect financial costs, families bear the social and emotional costs of their family members' illnesses. Direct and indirect financial costs borne by families include:

- Ongoing expenses of health professionals, medication and health programs;

- Costs of travel whether public transport or personal petrol costs of car & parking fees;

- Replacing everyday items destroyed from loved ones inability to use or care for items (saucepans; washing machines; vacuum cleaners to personal items of clothing etc.);

- Payment of abnormal expenditure and debts incurred by loved ones;

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12   Australian Health Insurance Association, *Submission 292*, p. 4.

13   Lifeline Australia Inc., *Lifeline in Mental Health: A Perspective on the Mental Health Needs of the Australian Community 2002*, p. 9.

14   Lifeline Australia Inc., *Submission 329*, p. 3.

15   Mental Health Council of Australia in partnership with the Carers Association of Australia Inc, June 2000, *Carers of People with Mental Illness Project Final Report*, pp. 4, 12, 54.

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- Loss of incomes with the need to give 24-hour care to loved ones;

- Loss of housing opportunities, living with ageing parents, substandard housing, homeless shelters; and

- Loss of careers – carers and family members' inability to fully commit to study and/or careers.[16]

4.22   Social and emotional costs include:

- Significant health and psychological distress experienced as a result of caring;

- Breakdown in relationships due to the burden of caring;

- Reduced quality of life – handling the myriad of issues from ongoing crises and/or relapses; and

- Loss of self worth because of the stigma of mental illness.[17]

4.23   Carers described the sacrifices they had made in their own lives in order to carry out their caring role. One major impact of providing ongoing care was the inability of carers to maintain full-time employment. Having to give up jobs, or reduce working hours, not only affected carers' financial wellbeing, but also their own sense of self and achievement.

> I have had to leave my position as a senior social worker…after 20 years in ICU/CCU hospital settings…[18]

> I was a very good teacher of maths and science, and, what is more, enjoyed doing it very much – all my education and experience has been lost to both myself, and the community, and my role as a carer has ensured that I enjoy an old age of certain poverty – no superannuation for me![19]

4.24   For some families, lack of employment combined with the additional costs of providing care leads to poverty.

> We just become poorer and poorer. I cannot get dental care; I'm on the waiting list for that. You name it; I'm on the waiting list for a number of things ranging from health care through to accommodation. I probably won't be able to keep the car going after this year. The payment I get is just not enough to live on. I can't remember our last holiday. I shop at St Vinnies, haven't had new clothes for ages. It is just so tiring trying to make

16   Mental Health Carers Network Inc, *Submission 286*, p. 4.

17   Mental Health Carers Network Inc, *Submission 286*, p. 5.

18   Name withheld, *Submission 144*, p. 2.

19   Name withheld, *Submission 518*, p. 2.

ends meet. It can come down to, do I buy milk and food or go to the doctors.[20]

4.25   This wide range of sources of funding and support does not hide two fundamental problems: not enough is spent on mental health services; and it is not clear the resources are being applied wisely.

Not enough is spent on mental health

4.26   Just about every witness, whether government or non-government, peak group or special interest group, health care professional or consumer, indicated that the level of resources is inadequate.

4.27   The Mental Health Council of Australia's (MHCA) first point about resources for mental health is that there aren't enough:

> The burden of mental illness and associated disability within the community is not matched by the funding allocated to prevent, relieve and rehabilitate people experiencing mental health illness.[21]

4.28   This message was explored in detail in their report *Not for Service*. The Australian Medical Association (AMA), in response to the release of the MHCA report stated:

> The 'Not for Service' report into Australia's mental health care system reveals a sad story of inactivity, poor planning, under-funding and under-resourcing by all Australian governments in the face of one of the biggest health challenges facing the nation in the 21st century – mental health care.

> At a time when demand for quality mental health services is at its highest, our national commitment to the mental health sector is frighteningly inadequate and fragmented.[22]

4.29   Other witnesses agreed including the Victorian Mental Illness Awareness Council, the Mental Illness Fellowship Australia, and RANZCP:

> the greatest impediment to policy implementing has been the failure of government to provide adequate funding so that what is written as policy actually can happen in practice.[23]

> Federal government needs to lead states and territories in the implementation of reforms and increase the funding allocation for mental

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20   Carer quoted in Mental Health Community Coalition of the ACT Consumer Caucus, *Submission 214*, pp. 6–7.

21   Mental Health Council of Australia, *Submission 262*, p. 1.

22   Dr Choong-Siew Yong, AMA, 'Mental Health Care in Australia in the 21st Century – 'Out of Sight, Out of Mind'', Press Release, 19 October 2005.

23   Victorian Mental Illness Awareness Council (VMIAC), *Submission 267*, p. 2. See also evidence from VMIAC, *Committee Hansard*, 5 July 2005, p. 72.

health and allied services. Australia spends less than 7 per cent of the health budget on mental health. This sum places Australia well down on comparable amounts spent by OECD countries. Despite the low funding allocated to mental health, it is the leading cause of disability.[24]

RANZCP believes that the mental health system in Australia has all the right fundamentals but requires additional recurrent funding. Ideally one billion dollars per year is required to reform existing mental health service systems, ensure a sustainable workforce, address equity issues and ensure the provision of an agreed level of service delivery in all geographic areas.[25]

4.30   Medicines Australia considered that 'More resources need to be devoted to treat mental illness, given the disease burden placed on the Australian community'.[26] *Beyondblue* broadly concurred:

One billion dollars is required as an injection for mental health, with the Federal Health Minister taking on portfolio responsibility to lead a reform agenda. The wider costs associated without a social coalition approach cannot be underestimated.[27]

4.31   This need reflects widespread public perceptions, reflected in the 70 letters sent as part of one write-in campaign to the committee's inquiry,[28] as well as many individual submissions by carers and consumers:

One of my adult daughters, who lives in NSW, has suffered from schizophrenia for over ten years. During that time it has become more and more apparent to me and other family members that there are many inadequacies and gaps in the provision of adequate mental health care and community support services for someone with her condition. I think that the majority of these matters are a direct result of inadequate funds and resources being available to mental health services.[29]

4.32   While there was a strong consensus on the general lack of funding for mental health, there were also specific areas where that lack of resources was perceived to create particular problems. The most prominent concern was the lack of support for counselling, psychological services and talk therapies:

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24   Mental Illness Fellowship of Australian Inc., *Submission 402*, p. 2.

25   The Royal Australian and New Zealand College of Psychiatrists, *Submission 323*, p. 3.

26   Medicines Australia, *Submission 389*, p. 3.

27   beyondblue, *Submission 363*, p. 2.

28   Standard letter, *Submission 154*.

29   Name withheld, *Submission 55*, p. 1. See also *Submissions 251, 375*.

Patient out-of-pocket costs are probably a key reason why few people with depression or anxiety currently receive CBT, despite considerable evidence for its cost effectiveness.[30]

4.33   Dr Gil Anaf agreed, saying:

I am most interested to reverse an ill-informed push that aims to reduce access to long term therapy services, and that aims to only promote medication and quick-fix therapies as the main rebatable treatments.[31]

4.34   This position was also supported by the National Association of Practising Psychiatrists, which indicated:

Psychiatrists are placed in an untenable ethical situation of having to refuse appropriate treatment, where no other treatment would be efficacious, because most patients do not fulfil the criteria of Item 319, and because they cannot afford to treat more than one or two, or no, patients at half the fee. Most patients cannot afford to pay half of the schedule fee if they receive intensive treatment because many psychiatric patients are vocationally and thereby financially disadvantaged. This legislation contravenes the mandate of Medicare of equity of access.[32]

4.35   Psychologists Rudd and Jackson agreed:

Cost of services is a major barrier for many in need, and not just at the individual client level. For example, in Victoria, it has been reported that teachers with special needs students (including mental health difficulties) often find it difficult to access specialist Psychologist services because of lack of funding.[33]

4.36   More generally, there was concern that the high level of copayments was an issue, particularly for those without private health insurance:

Co-payments are preventing people access to quality health service. Without measures to reduce copayments, the Commonwealth Fund will continue to document financial barriers to access for a significant percentage of Australians. Those with mental illnesses will be amongst the most likely to suffer.[34]

I can't afford psychological counselling even with the $50 refund provided by my private health fund. My annual net medical expenses are already about $7000. Medicare Plus also provides reimbursement of $50 for up to

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30   C. Mihalopoulos, L. Kiropoulos, S. T-F Shih, J. Gunn, G. Blashki and G. Meadows, 'Exploratory economic analyses of two primary care mental health projects: implications for sustainability', *Medical Journal of Australia*, vol. 183, no. 10, p. S75.

31   Dr Gil Anaf, *Submission 265*, p. 2.

32   National Association of Practising Psychiatrists, *Submission 202*, p. 34.

33   Raymond Rudd and Professor Henry Jackson, *Submission 401*, p. 6.

34   Doctors Reform Society, *Submission 220*, p. 2.

five counselling sessions in a year but five sessions is not enough and it is still expensive.[35]

4.37   The Australian Council of Social Services (ACOSS) and others were concerned about equity of access, citing as an example:

psychological counselling services, [which] are highly restricted within the public system but available to those with sufficient private means and/or private health insurance.[36]

4.38   Australian College of Psychological Medicine noted:

Many sufferers from significant mental health disorders require a multi-disciplinary approach, with the majority of them too socially disadvantaged to afford private health insurance.[37]

4.39   BlueVoices reported a consumer saying 'I cannot afford private health insurance so my only option for treatment is medication'.[38] This seems a recurrent and disturbing complaint. BlueVoices also indicated that:

many consumers report to us that unless they have private health insurance they are unable to afford the recommended fee of the Australian Psychological Society for cognitive behaviour therapy from a Registered Psychologist.[39]

Inappropriate targeting of spending on mental health

4.40   While the dominant theme in the inquiry was the inadequacy of spending on mental health, issues were also raised around how that spending was being prioritised and administered. A question repeatedly raised about the allocation of funding for mental health, is why mental health does not receive a greater proportion of the health budget:

In Australia, the provision of mental health services receives an inappropriately low priority having regard to the large number of people affected, the high burden of disability, the untoward impact on service-deprived sub-groups within the community and the missed potential for the cost-effective achievement of better health outcomes. International comparisons of mental health spending are dated (circa 1993) but suggest a spending shortfall in Australia compared to Canada, the US and the Netherlands. A decade or so after the deinstitutionalisation of mental health,

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35   Name withheld, *Submission 251*, p. 1.

36   ACOSS, *Submission 457*, p. 11.

37   Australian College of Psychological Medicine, *Submission 411*, p. 6.

38   bluevoices, *Submission 259*, p. 22.

39   *Submission 259*, p. 22.

> it is now obvious that governments did not ensure enough resources for the new community-based care structures to operate effectively.[40]
>
> …
>
> The *Sane Mental Health Report 2004; 'Dare to Care'* states that Australia spends less than 8 per cent of its national Health Budget on mental health. The same report asserts that comparable OECD countries spend upward of 12 per cent of their health budget on mental health.[41]
>
> …
>
> While total health funding has grown over the life of the National Mental Health Strategy, spending on mental health has remained static in comparison with overall health spending; yet mental health has grown as a component of the overall health burden.[42]

4.41   Another recurrent theme was the contrast between the mechanisms for Commonwealth funds allocation and those of the states and territories. Victoria argued:

> The Commonwealth funded health care system also constrains and provides barriers to improving services to people with serious mental illness. For example, newer atypical pharmaceuticals used to treat psychosis are not always funded by the Pharmaceutical Benefits Scheme so the states must find this funding. Additionally, the Medicare Scheme does not impose significant restrictions on the number of visits to private psychiatrists. Neither are there adequate controls over the distribution of private psychiatrists, nor on priority of access for those people most in need. Few incentives exist for psychiatrists to take on new clients or to work in a public sector with capped funding and more complex clients…

4.42   The South Australian Government described the problems of coordinating services 'when enhancement monies from the Australian Government may promote particular or specific aspects of a service only'.[43] The Queensland Government noted the difficulties faced by the states and territories in 'invest[ing] new monies each year on a recurrent basis, representing real growth in monetary terms', which results in them having to 'fully fund reform'.[44] The Victorian Government argued:

> More weight should be given to the constraints the states and territories operate under that impact on the rate and extent of change. These constraints include capped budgets and high levels of non-discretionary expenditure related to meeting statutory obligations to involuntary clients.[45]

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40   AMA, *Submission 167*, p. 1.

41   Standard Letter, *Submission 154,* p. 1.

42   Mental Health Council of Australia, *Submission 262,* p. 2.

43   Department of Health – South Australia Government, *Submission 506,* p. 4.

44   Queensland Government, *Submission 377A,* p. 13.

45   Victorian Minister for Health – Victorian Government, *Submission 445,* p. [5].

4.43   There was particular concern about the direction of funds to medication and away from other therapies. Over the nine-year period of the mental health strategy:

> the Australian Government's contribution increased 127 per cent, though 66 per cent of this increase was accounted for simply by the increase in expenditure on medications through the Pharmaceutical Benefits Scheme. While new medications play an important role in improving mental health outcomes, to achieve value for money they need to be backed by complementary psychological, social, informational and self-management strategies. To date, significant developments in these other areas have been promising but limited in scope or reach (Hickie et al. 2004) and now require more overt long-term support by the Australian Government.[46]

> Psychotherapy (such as Cognitive Behavioural Therapy) has proved to be a cost effective treatment for some mental disorders, especially anxiety and depression. However, under the current Medicare arrangements, Medicare only funds psychotherapy costs where the provider is either a psychiatrist or a general practitioner with some welcome, but limited provision, for psychology services through new initiatives such as Better outcomes in Mental Health. This effectively restricts longer term psychotherapy access to those people who either have ancillary private health insurance (for a psychologist only) or can afford to pay the costs themselves, or to seek treatment from a psychiatrist or general practitioner, or public mental health services.[47]

4.44   The Western Australian Government also commented on the true basis for the increase in expenditure on mental health by the Australian Government since 1993:

> When this increase (65 per cent in real terms) is further examined it is found that in constant prices the major area of growth is in Pharmaceuticals provided under the PBS. The increase in expenditure for psychiatric drugs is nearly 600 per cent during this time period and accounts for nearly two thirds of all the growth in Federal mental health expenditure.[48]

4.45   Other concerns have also been raised about the allocation of resources, including that research on mental illness is under-resourced:

> At present, Australia spends 3 per cent of funding on mental health research, compared to 9 per cent for cancer research. The 8.9 per cent of NHMRC funds spent on mental health is small when compared to the 19.1 per cent contribution of mental disorders to disease burden in Australia. Compared to other OECD countries, Australia spends relatively little on research.[49]

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46   I. Hickie, G. Groom and T. Davenport, *Investing in Australia's future,* December 2004, p. 32.

47   Victorian Minister for Health – Victorian Government, *Submission 445*, pp. 6, 11.

48   Department of Health – Government of Western Australia, *Submission 376,* p. 16.

49   Centre for Mental Health Research, *Submission 186*, p. 2.

4.46   The Commonwealth was critical of the argument that money should be allocated directly according to percentage of disease burden. Pointing out that costs of treatment vary from illness to illness, Mr Davies of the Department of Health and Ageing said:

> to argue that the spending should be proportionate to the burden of disease is not a safe line of argument to pursue, because obviously the costs of treating different types of conditions vary. Just because something is 10 per cent of our burden of disease, to argue we should spend 10 per cent of our health budget on it is not really a logical line of argument.
>
> CHAIR—What is the argument? What is the line of establishing what the level of spending is for particular burdens of disease?
>
> Mr Davies—Spending in health care and the allocation of resources between different conditions is essentially a social, political, societal decision. In terms of the services we fund, as the Australian government, all that Medicare spending, the PBS spending, is ultimately determined by people's propensity to seek out services and doctors' propensity to prescribe. There is no cap on the total MBS or PBS budget, nor is there an allocation of that as between mental health and other services. It is very much demand driven for the Australian government funding.[50]

4.47   The committee formed a clear impression that while Mr Davies may be correct, the prevailing 'social, political, societal' view is that resources for mental health are deficient.

4.48   Consumer groups are concerned about whether consumers have an adequate role within the funded health care system:

> Consumer self advocacy groups, organisations and individuals have insufficient funding to provide the overwhelming support needs of consumers whose rights have been abused. Nor do we have funding to provide the kinds of alternative supports that we know will work for many of us. Nor do we have funding to allow us to hold forums, conferences, communicate with each other. Without funding we remain voiceless and disconnected. Without funding we cannot participate in any of the ways that our mental health policies tell us we should be participating.[51]

4.49   It was also argued that funds provided to advocacy groups have not been targeted appropriately:

> Current funding to consumer groups hosted and controlled by groups such as MHCA and 'beyondblue' is a misuse of these limited funds and needs to be redirected to genuine consumer-survivor organisations.[52]

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50   Mr Philip Davies, Acting Secretary, Department of Health and Ageing, *Committee Hansard*, 7 October 2005, p. 53.

51   insane australia, *Submission 2*, p. 1.

52   insane australia, *Submission 2*, p. 8.

4.50   Non-government organisations (NGO) are an integral component of the mental healthcare workforce, providing much-needed services to the community that are either not available – or in short supply – through the public or private systems. Federal, state and territory funding to NGOs, particularly funding allocated on a recurrent basis, is severely limited, reducing the ability of NGOs to provide an optimal level of service. NGOs reported that the shortage of funding has resulted in having to turn away people who are in need of help. These matters are examined in Chapter 9. Instead of funding NGOs, including consumer-run organisations, the vast majority of resources continue to be channelled to the public and private for-profit organisations.

The problem of the pilot

4.51   As the committee travelled across Australia, it kept hearing about promising pilot schemes, project trials and new program proposals that were not receiving funding support. There were recurrent complaints that pilots were not rolled out to a broader public, regardless of their success; that projects were not placed on a sustainable budget basis; and that groups applying for grants could not effectively plan for the future of their operations.

4.52   The MHCA submitted:

> Australia is often known as "the land of pilots", and with good reason. The mental health sector is littered with project and pilots that are funded for a short period and then abandoned.[53]

4.53   The NT Mental Health Coalition submitted that:

> … over the past few years the federal government has funded some very innovative and effective 'pilot projects'. However, the lack of ongoing funding for these projects from either the federal or NT governments has resulted in the loss of good services and clients having expectations being raised only to be disappointed.[54]

4.54   St Luke's Anglicare Limited, which offers Psychiatric Disability Rehabilitation and Support programs stated:

> Our agency has been able to provide some pilot recovery programs for young people who experience psychosis but we have no recurrent funding to support these early intervention recovery and rehabilitation programs in the longer term. Philanthropic sources of funding are very limited for this group of consumers.[55]

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53   Mental Health Council of Australia, *Submission 262A*, p. 1.

54   NT Mental Health Coalition, *Submission 409*, p. 4.

55   St. Luke's Anglicare Limited, *Submission 345*, p. 1.

They recommended that recurrent funding be provided for such services so that target programs for young adults could be offered.[56]

4.55   The SA Divisions of Private Practice also raised concerns about the current practice of providing short-term funds for pilot programs:

> … Divisions of General Practice have a history of episodic, short-term project, and pilot funding by government. This is also evident in other parts of the health system, especially for work that seeks to bring about system change. By the time one project nears completion, the funding agenda has moved on and hence the opportunity to capitalise on the learnings and apply them more broadly is lost. SADI recently had the experience of a successful pilot project which aimed to re-align private psychiatrist practice. … This project was terminated by the Commonwealth Government Department of Health and Ageing at the completion of the pilot phase … The termination occurred before the planned (and paid for) evaluation had been completed or submitted. No evidence was provided as to why this decision was made. It was clearly not based on objective analysis of the comparative evaluation data. Short term episodic funding often makes the whole system worse, as clinicians, consumers and carers become cynical. … Pilot projects need to be a part of an overall strategy, and if they show benefit, need to be rolled out more broadly.[57]

4.56   Concern about insecure funding and a preponderance of pilot projects was shared by other groups.[58] The committee heard about a dieting disorder pilot program that was neither continued nor expanded, despite no evidence to suggest it had produced poor results.[59] It heard about the lack of recurrent funding to indigenous community-controlled health organisations being linked to service delivery inefficiencies.[60] Similar stories were recounted by many organisations, particularly those in the non-government sector involved in advocacy, support and service delivery.

4.57   MHCA identified a number of difficulties for organisations and programs that receive short-term funding, including that: consumers, their carers and families become distressed, with adverse effects on their mental health, when a successful program is cancelled; uncertainty regarding tenure acts as a barrier to recruiting and retaining quality staff; organisations suffer a loss of corporate knowledge; and organisations can be prevented from engaging in long-term planning.[61] The St.

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56   *Submission 345*, p. 2.

57   SA Divisions of General Practice, *Submission 88*, p. 4.

58   See for example, Council to Homeless Persons, *Submission 315*, p. 6; Mental Health Council of Tasmania Inc, *Submission 455*, p. 1; Anglicare Tasmania, *Submission 464*, p. 18.

59   Centre for Eating & Dieting Disorders, *Submission 307*.

60   Central Australian Aboriginal Congress, *Submission 486*, p. 2.

61   Mental Health Council of Australia, *Submission 262A*, p. 1.

Vincent de Paul Society also identified those difficulties for organisations and recommended a return to recurrent funding to guarantee continuity of programs.[62]

What more is needed?

4.58   More funding is needed for mental health care, but attention needs to be paid to more than just the amount. The committee heard that other areas of concern are that mental health care be extended to more people; that enhanced resourcing must go hand in hand with continuing reform; that there be better integration of services; and there be more accountability for and evaluation of mental health expenditure.

Greater resources

4.59   Witnesses made suggestions about how much extra funding was needed. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) believes that:

> … the mental health system in Australia has all the right fundamentals but requires additional recurrent funding. Ideally one billion dollars per year is required to reform existing mental health service systems, ensure a sustainable workforce, address equity issues and ensure the provision of an agreed level of service delivery in all geographic areas.[63]

4.60   In an answer to a question from the committee about the application of those funds, RANZCP responded as follows:

> … the RANZCP seeks a level of funding for mental health care commensurate with the burden of the disease. We provide below a breakdown of the major targets for increased funding.
>
> - An additional $500 million a year is required for primary mental health care, including access to allied health professionals, the Better Outcomes in Mental Health Care Initiative, and reform of the Medicare Benefits Schedule rebate for psychiatrists to encourage better delivery of consultancy services.
>
> - Youth mental health requires an additional $50 million per year.
>
> - Funding for mental health research should be increased from $15 million to $50 million per year.
>
> - The remaining funding we envisage would be spent on the following components, although these components are not all individually costed.
>
> - Employment participation, including:
>
>   - Specialised schemes for people on a Disability Support Pension to resume work;

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62   St Vincent de Paul Society, National Mental Health and Homelessness Advisory Committee, *Submission 478*, p. 12.

63   Royal Australian and New Zealand College of Psychiatrists, *Submission 323*, p. 3.

- Trials of workplace mental health awareness, screening and implementation programs.

- Population measures (such as destigmatisation programs, community education, prevention, and early intervention).

- Assistance for consumers and carers.

- Annual and independent reporting on progress in national mental health reform ($300,000 per year).[64]

4.61 The RANZCP expected that the money would come from the states and territories, as well as the Commonwealth and did not consider that funds should be transferred from other areas of the health budget.[65]

4.62 As stated earlier Medicines Australia recommended a similar increase in funding, as did the MHCA:

Increase expenditure on mental health by $1.1 billion per year over the next ten years, refocus funding on the full spectrum of service provision system and adjust existing funding mechanisms to bring them into line with the new funding (not the other way around as is more usual).[66]

4.63 The MHCA also submitted that the recommended increased funding should be applied differently from current funding:

We submit that, while significantly more funds are needed to deliver acceptable mental health care, on their own they will not fix the problems, merely deliver the same sort of services more widely. The Strategy has got the broad policy right but continuation of its present approach will waste money and lives. What is needed is:

- leadership,

- accountability,

- governance, and

- investment in research and innovation.[67]

4.64 ORYGEN provide specialised mental health services for youth aged 12-25 years, and have advocated a roll out of their services to youths nationwide. This involves the establishment of 30 new services units across Australia to serve an equivalent number of young people as is currently occurring through ORYGEN's Victoria-based model. It is estimated that eight specialised mental health services for youth would be required in NSW, seven in Victoria, five in Queensland, three each in

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64 Royal Australian and New Zealand College of Psychiatrists, *Submission 323A*, pp. 1–2.

65 *Submission 323A*, p. 2.

66 Mental Health Council of Australia, *Submission 262*, p. 2.

67 *Submission 262*, p. 11.

Western Australia and South Australia, two in Tasmania and one each in the Northern Territory and Australian Capital Territory.

4.65   ORYGEN have estimated the annual operating costs for each service at $17.5 million, with a total recurrent cost of $525 million per annum.[68] Some of these costs would be offset by the re-distribution of existing resources within Child Adolescent Mental Health Services and Adult Mental Health Services. However, capital costs would also be required to establish the new services.[69]

4.66   ACOSS expressed concern about where extra resources should go:

> Calls for major increases in the mental health budget must be weighed carefully against other options, which may help lower the incidence and severity of mental illness and its impact at the individual and community level.[70]

More coverage

4.67   Only approximately 40 per cent of people with mental health disorders access professional help. As the MHCA asked:

> What other health sector would accept a non-response rate of 62 per cent in any 12 month period.[71]

4.68   Families, carers and community groups are left to deal with the majority of untreated cases. Yet:

> Nobody suggest that we restrict funding for osteoarthritis so that we only treat half the sufferers and require the community groups to provide exercise and weight loss programs to the remainder. Nor do people suggest we restrict the supply of statins to reduce cholesterol levels to half the people with high cholesterol and require community groups to encourage lifestyle modifications for the remainder of people at risk of cardiovascular disease. Why do we accept low coverage levels and inadequate treatment for people with mental disorder? It is one of the enduring puzzles that is not unique to Australia.[72]

4.69   Professor Gavin Andrews argued that the necessity for greater funding is not to improve existing care, but to meet this significant unmet need:

> We do not need additional funds to provide care to the 40 per cent of the people currently consulting, we just need good management to ensure that the appropriate care is supplied in the least restrictive environment. We

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68   ORYGEN Research Centre, *Submission 284b*, p. 10.

69   ORYGEN Research Centre, *Submission 284b*, p. 10.

70   Australian Council of Social Service, *Submission 457*, p.2.

71   MHCA, *Submission 262*, p. 4.

72   Dr Gavin Andrews, *Submission 176*, p. 11.

will need to double the funds if we are to double the proportion of people in need who are seeking care, to the level of people with physical disorders who seek care. I cannot think of any justification for the under-treatment of people with mental disorders.[73]

4.70   There are thus at least two drivers of increasing expenditure: the need for better services; and the need to serve more people.

More reform

4.71   As Chapters 8 and 9 will reveal, the transition from the old psychiatric institutions to mainstream hospitals and community-based care is incomplete, and some believe it is a reform agenda that has stalled. One of the key consequences of the slowness of reforms is that funds fail to be freed up for new initiatives and high priority needs. Failure to close stand-alone institutions, a phenomenon most marked in NSW and South Australia, creates budget pressures that prevent the transformation of the mental health care system.[74] This is because without the closures, savings are not available to be reallocated to other services. This is consistent with the experience of reform in Italy, in which the closure of institutions helped force the development of effective community care.[75]

4.72   While the closure of institutions may have forced Australian governments to develop community care, this can hardly be said to be adequate. Anglicare Tasmania quoted from a study of the effects that the closure of institutions has had on homelessness, in which it is suggested that authorities failed to recognise the range of services that institutions provided, including the provision of housing, and to fully cost and transfer those functions to community programs.[76]

4.73   Boystown identified a number of areas for reform:

> Review costs associated with the delivery of integrated mental health care. Special attention should be paid to decision making processes for listing psychotropic medications under the Public Benefits Scheme and the availability of comparable generic alternatives; access to bulk billing services; and the criteria for accessing the Disability Support Pension.[77]

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73   Dr Gavin Andrews, *Submission 176*, p. 11.

74   V. Gerrand, 'Can Deinstitutionalisation Work? Mental health Reform from 1993 to 1998 in Victoria, Australia', *Health Sociology Review*, vol. 14, no. 3, 2005, p. 267; Commonwealth Department of Health and Ageing, *National Mental Health Report 2000: Sixth Annual Report*, Department of Health and Ageing, Canberra, 2000.

75   M. Hazelton, 'Mental Health Reform, Citizenship and human Rights in Four Countries', *Health Sociology Review*, vol. 14, no. 3, p. 235.

76   Anglicare Tasmania, *Submission 464*, p. 10.

77   Boystown, *Submission 107*, p. 2.

4.74   Many areas for further reform are discussed in more detail in subsequent chapters of the report.

More integration

4.75   A more collaborative approach between all levels of government is required to address the current 'crisis' in service delivery. The Parliamentary Secretary to the Minister for Health and Ageing, the Hon Christopher Pyne MP, outlined his view of the importance of addressing mental health issues in the National Mental Health Report 2004:

> I…am aware that improving the mental health of the community requires coordination across diverse areas of public policy, both within and external to the health portfolio. Coordination with action taken under the National Drug Strategy and the National Suicide Prevention Strategy is especially critical, but the need for linked initiatives extends to areas such as housing, employment, social security, crime prevention and justice. Mental health can no longer be treated as an isolated issue.[78]

4.76   The Parliamentary Secretary went further on a subsequent occasion, saying that

> Australia's states and territories stand condemned for their failure to deliver adequate mental health services . . . perhaps it is time for them to cede their responsibility for mental health to the Commonwealth.[79]

4.77   Professor Andrews argued that these comments reflect concern both about the effects of federalism, and the effects of poorly coordinated services:

> Part of [Pyne's] rhetoric should be viewed in the light of federal–state relationships. However, part does reflect the uncoordinated way we fund our health systems — Medicare and Pharmaceutical Benefits at the federal level, private health insurance, the state and territory provision of public-sector services, and rising out-of-pocket expenses at the individual level. A coordinated funding system would be preferable.
>
> There are six contributors to Australia's mental health service — general practitioners, private psychiatrists, private psychologists, private hospitals, state inpatient and community services, and non-government charitable

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78   Department of Health and Ageing, *National Mental Health Report 2004: Eighth Report – Summary of changes in Australia's Mental Health services under the National Mental Health Strategy 1993-2002*. Commonwealth of Australia, Canberra, 2003, p. i.

79   C. Pyne, States stand condemned over their failure to deliver on mental health care [media release], Canberra: Australian Government Department of Health and Ageing, 24 February 2005, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2005-cp-pyn006.htm, (accessed March 2006).

organisations. The work of these contributors is poorly coordinated. It is like a six-horse chariot with six horsemen who seldom communicate.[80]

4.78   Others expressed similar concerns, complaining that both governments and some individual agencies were 'passing the buck' for providing better services:

There needs to be more resources as well as a better use of existing resources and an acknowledgement that all Australian governments must work together to provide adequate services for the mentally ill…

The statement by Christopher Pyne, Australian Government Parliamentary Secretary for Health: "Australia's States and Territories stand condemned for their failure to deliver adequate mental health services" indicates a buck-passing mentality that is part of the problem.[81]

A whole-of government approach to mental health policy and funding should emerge from the Commonwealth, in order to see the same level of integration in the States' delivery of services. …resources could be better utilised if various silos of government were to develop more effective collaborative arrangements…

The prerequisite to achieving this is that the policy dialogue moves away from what have become traditional notions of 'core business' beyond which an agency will accept no responsibility, towards a 'without prejudice' discussion of those issues which no single agency can hope to resolve and which are therefore 'everybody's business'[82]

4.79   The patchwork of federal and state funding, coupled with the provision of direct and indirect government funding to non-government organisations, and a growing and changing role for the private sector, means that integration, while vital, is a constant challenge.

4.80   The AMA was also critical of the way in which funds are utilised within the mental health service sector:

Existing funding mechanisms favour defined episodes of care. However the mental health conditions that generate the highest burden of disease are chronic conditions and they require longitudinal care. The Commonwealth/State funding arrangements are dysfunctional, funds are wasted in duplication of administration and policy formulation while a silo mentality detracts from the continuum of care.[83]

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80   G. Andrews, *The crisis in mental health: the chariot needs one horseman*, Medical Journal of Australia, vol. 182, no. 8, 2005, p. 372.

81   St Vincent de Paul Society, National Mental Health and Homelessness Advisory Committee, *Submission 478*, p. 7.

82   Office of the Public Advocate – Queensland, *Submission 303*, p. 9.

83   AMA, *Submission 167*, p. 1.

4.81   A consumer group said:

> One of the biggest sticking points for mental health services, including community non-government organisations, is that the co-ordination of funding between commonwealth and state governments via the CSDA agreement is an absolute bureaucratic nightmare, full of gaps, centres more on "let's try and short change this government or that health service provider" than actually adequate[ly] funding in 'real' terms the 'real' costs of mental health service delivery that meets the needs of people with a mental illness.[84]

4.82   RANZCP submitted that care must extend beyond mental health care to all other relevant services needed by patients (general health care, financial support, housing, substance abuse, rehabilitation etc.) and that the development of a single integrated health system would require the removal of structural barriers at state and Commonwealth levels, and substantial reform in both sectors.[85]

4.83   RANZCP suggested the following strategies to achieve better coordination:

- the re-integration of drug and alcohol and dementia services with mental health services;

- inclusion of developmental disability services as an essential component of the service matrix;

- funding of nursing and allied health professionals in private psychiatric outpatient practices such as More Allied Health Services (MAHS);

- development of "stepped care" systems linking GPs and state mental health services in the care of common and severe disorders, including prioritisation of GP referrals over self-referrals in state services; and

- encouragement of integrated staffing models, with more flexible arrangements for public and private psychiatrists to work together will also strengthen system effectiveness.[86]

More accountability and evaluation

4.84   As already outlined, funding for mental health is a complex patchwork of direct and indirect expenditure, by different levels of government, with spending based on numerous different policies, formulae and guidelines. The National Mental health Strategy is meant to place the resourcing of mental health in a coherent strategic framework, but it lacks a sharp focus and was widely condemned for having few measurable performance benchmarks:

> Unfortunately, what has been lost in this complex model of funding and evaluation is effective service provision to the consumers, the people at the

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84   Northern Beaches Mental Health Consumer Network, *Submission 60*, p. 6.

85   Royal Australian and New Zealand College of Psychiatrists, *Submission 323*, p. 5.

86   *Submission 323*, p. 5.

heart of the issue. The National Mental Health Strategy is not delivering mental health services effectively or efficiently because it focuses on the process of managing funds and statutory relationships, not on providing services to those people who desperately need them.87

4.85   The regular publication of National Mental Health Reports provides a mechanism for accounting for expenditure on and provision of mental health services at an aggregated level. However, dollar figures and trends alone do not provide a complete picture on whether expenditure has had any meaningful impact on service provision and better mental health outcomes:

Whilst there have been eight National mental health reports since 1994, there is still no accounting in them for the number of people that are actually seen and treated in mental health services and whether they are seen face-to-face, or merely by telephone contact. This contrasts with very specific details of the number of Australians treated and even the number of hours spent treating consumers by private psychiatrists in the private mental health sector. While the private mental health sector has been collecting outcome measures of consumers treated in private psychiatric hospitals over the last three years, the public mental health system is only just starting to approach such a project. There are also rumblings from public sector clinicians that unless there is a very significant increase in funding for such data collection, the outcome measurement process is likely to further undermine the management of consumers in the public mental health system.[88]

4.86   Additionally, it is not clear that the data that is contained in the National Mental Health Reports findings necessarily reflect the real position. The Australian Psychological Society (APS) submitted:

Although financial reports support the conclusion that funding for mental health services has kept pace with that provided to other areas of health, there is a strong sense from workers in mental health facilities that positions have been lost, budgets reduced and less and less services are able to be provided. Repeated reports from APS members working in institutions or under specific programs have raised concerns regarding this reduced level of funding for mental health services by state and local instrumentalities. Although these situations are clearly anecdotal, they are indicators of a crisis which we believe currently exists in public mental health services.[89]

4.87   The MHCA also criticised the lack of accountability for the provision of mental health services:

Over half of all public mental health services had not even reviewed their performance against these standards [National Standards for Mental Health

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87   Mental Health Council of Australia, *Submission 262*, p. 4.

88   AMA, *Submission 167*, p. 19.

89   The Australian Psychological Society Ltd, *Submission 50A*, p. 11.

Services] by June 2003, some seven years after they were agreed to by all governments. This is a very clear example of the lack of accountability and commitment to mental health by all Australian governments. The reality of the reports of consumers, carers and providers is that they put flesh on the difficulties of a system struggling to cope with the human cost of the huge gap between policy and its implementation.[90]

4.88   The National Mental Health Centre submitted:

Crucial to addressing underlying impediments to realization of these rights, such as disproportionately low mental health service funding and priority from a whole-of-government perspective is the development of a mechanism to ensure transparent service delivery and proper accountability of mental health providers. Lack of accountability and secrecy systemically undermine the legitimacy of complaints of people who have mental illness and the confidence the community can have in the complaints systems and services themselves.[91]

4.89   Part of the dysfunction of current funding arrangements may well be attributable to the lack of discernable population health monitoring. Professor Anthony Jorm of the ORYGEN Research Centre advised:

It is amazing that we know so little about whether mental health in Australia is improving, worsening or stable. The only routinely collected indicator of population mental health is the suicide rate…. We need to have other population indicators which will monitor how we are doing as a nation and allow resources to be focussed on sub-groups that are not doing well.[92]

4.90   Professor Jorm further posits the question:

Why doesn't Australia already have population monitoring? The Australian Bureau of Statistics has been collecting national data on mental health since the 1980s. However, they have changed the measure they have used several times, making comparison over time impossible. Even when a consistent measure has been used, other aspects of the methodology have been changed. There is a need for consistent measures collected at regular intervals using the same methodology.[93]

4.91   Catholic Health Australia stated that governments should be aiming towards marked percentage improvements in the health status and quality of life in the population generally and in particular for vulnerable groups and recommended that:

Commonwealth and State/Territory Governments … set targets for improvements in mental health outcomes across the community and for

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90   Mental Health Council of Australia, *Submission 262*, p. 14.

91   The Mental Health Legal Centre, *Submission 314*, p. 6.

92   Professor Anthony Jorm, *Submission 178*, p. 3.

93   *Submission 178*, p. 3.

specific groups in greatest need and be held accountable for meeting these targets. [94]

4.92 The AMA suggested that the following themes should be included in accountability mechanisms:

The importance of a proper econometric analysis of the need, including the unmet need, for mental health services in Australia with this analysis incorporated into future National Mental Health reports.

- The desirability of mandatory reporting by State and Territory jurisdictions of the number of people treated and whether those people are treated face-to-face or by telephone.

- The need for a significant increase in the resources for outcome measurement in the public mental health system.[95]

4.93 It was widely argued that the establishment of a national mental health commission would be a major step towards ensuring proper accountability for mental health provision. A group of Australia's most prominent mental health experts made a compelling case for the establishment of an independent Mental Health Commission to fill the role of anti-discrimination campaigner, information repository and leader of coordinated mental health reform.[96] The authors cited the successful New Zealand Commission as particularly suggestive for Australia, but also referred to similar bodies in the United States and the United Kingdom.[97] The New Zealand Commission has widespread powers encompassing:

- human rights and anti discrimination agendas without being restricted to these agendas (as would a commission set up under the HREOC);

- a formal mandate to monitor and identify service gaps, oversee training and performance management and conduct evidence based reviews and consultations;

- an ability to provide continuity through government change; and

- the capacity to pursue a positive political agenda, avoiding sequential and often unproductive inquiries.[98]

4.94 The model is distinctive in that the Commission is established by legislation for a defined period, to perform specified tasks to a set time frame, with the options of

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94   Catholic Health Australia, *Submission 276*, p. 16.

95   AMA, *Submission 167*, p. 28.

96   A. Rosen, P. McGorry, G. Groom, I. Hickie, R. Gurr, B. Hocking, M. Leggatt, A. Deveson, K. Wilson, D. Holmes, V. Miller, L. Dunbar and F. Stanley, 'Australia Needs a Mental Health Commission', *Additional Information: item 11*.

97   'Australia Needs a Mental Health Commission', *Additional Information: item 11*, p. 217.

98   'Australia Needs a Mental Health Commission', *Additional Information: item 11*, p. 217.

extensions until its work is assessed to be completed:[99] 'ultimately, doing itself out of a job becomes the measure of its success'.[100]

4.95   Particularly promising is the potential to override federal, and state and territory tensions with their resulting 'buck passing' and compartmentalisation of services. Despite concerns that the NZ Commission would act as an unconstructive critic of Government, the NZ Ministry of Health, Directorate of Mental Health, has found it has been a most effective partner 'walking alongside us' in the reform process.[101]

4.96   Under the auspices of the New Zealand Commission, mental health reform has replicated or adapted several Australian mental health initiatives.[102] However, in New Zealand these reforms were embedded after wide consultation and appraisal of the international evidence base; service gaps were then identified and resources accurately costed to fill these gaps.[103]

4.97   Many others were supportive of a commission. The Mental Health Legal Centre, for example, submitted:

> … the establishment of an adequately empowered and independent national complaints and accountability mechanism may well be the only way to address the serious deficiencies in terms of both 'civil libertarian' and service access and quality rights which endure, Burdekin Report and National Mental Health Strategy notwithstanding.[104]

4.98   The MHCA suggested:

> That the Commonwealth Government establish regular, frequent and formal reporting mechanisms to the Prime Minister and Heads of Governments on specific key indicators including an annual public report to the Prime minister, 'The State of our Mental Health', with data which reflects user and carer experience, not just system measuring indicators. Leadership of this process should be vested in an independent, empowered national office or person with direct access to the Prime Minister.

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99   The Commission became a separate Crown entity with the enactment of the *Mental Heath Commission Act 1998*, which was amended to extend it from 2001 to 2004. It was recently further extended until 2007. 'Australia Needs a Mental Health Commission', Additional Information: item 11, p. 214.

100   'Australia Needs a Mental Health Commission', *Additional Information: item 11*, p. 217.

101   'Australia Needs a Mental Health Commission', *Additional Information: item 11*, p. 217.

102   'Australia Needs a Mental Health Commission', *Additional Information: item 11*, p. 218.

103   Resulting an increase of funding to 250 percent of the average per capita expenditure in Australia and considerably more than public and private mental heath per capita expenditure combining public and private expenditure. 'Australia Needs a Mental Health Commission', *Additional Information: item 11*, p. 216 and see table in *Additional Information: item 11*, p. 214.

104   The Mental Health Legal Centre, *Submission 314*, p. 6.

> That the day-to-day responsibility for the National Mental Health Strategy within the Commonwealth Government rests with the Cabinet level Minister.[105]

4.99   The Centre for Psychiatric Nursing Research and Practice and many others argued for a commission that would provide independent monitoring and recommendations to guide performance of mental health services.[106]

Conclusion

4.100   This chapter has given a broad picture of how mental health services are resourced, and a brief sample of the barrage of criticism levelled at the system. It is not often that a committee hears such a united chorus of criticism from such a diverse array of organisations and individuals, and the concerns obviously raise serious questions about the adequacy of mental health care in Australia.

4.101   Later chapters look in more depth at specific areas of mental health care. First, however, the committee considered the diversity of mental illnesses, and some of the fundamental assumptions that underpin their treatment.

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105   Mental Health Council of Australia, *Submission 262*, pp. 37–38.

106   Including Centre for Psychiatric Nursing Research and Practice, *Submission 217*, p. 5; insane australia, *Submission 2*, p. 1.

CHAPTER 5

ADDRESSING THE DIVERSITY OF MENTAL ILLNESS AND TREATMENTS

Introduction

5.1   'Mental illness' is a label that covers a wide variety of conditions. These conditions are as different from each other as are physical illnesses. Because they are so diverse, they can have very different treatments. And just as with many physical illnesses, a treatment that works for one person can be ineffective for another. Some physical illnesses are easily and effectively treated, such as minor bacterial infections, or appendicitis. Others are difficult to do anything for, such as the common cold, or some types of cancer. So it is with mental illness: treatment is more successful with some than others, and more is understood about some than others.

5.2   However, this diversity of illness and diversity of treatments both present some special challenges. Some mental illnesses get more resources than others, and some are taken more seriously than others. This inquiry, like others, heard accounts of people being refused effective treatment, or being unable to locate a service that could assist them. It should be a source of concern when some diagnoses lead to poorer quality care than others, and not just because there are fewer known treatments for particular conditions.

5.3   Of course, the seriousness of a medical condition should be a factor in prioritising treatment. Faced with a choice between treating someone with acute schizophrenia who has recently tried to take their own life, and someone with a moderate anxiety disorder who is unable to leave their home, but is living relatively safely within its confines, the person with schizophrenia gets priority. However, other factors appear also to be at work. In a system with limited resources, and which is dominated by a medical model of illness, there are hierarchies of care. Often only the most severe conditions get treatment at all, most of that treatment is pharmaceutical, and little effort is directed toward prevention. This chapter looks at how some illnesses, and some treatments, are being marginalised by a health system that has determined that some illnesses are more worthy of attention than others.

Diversity of Mental Illness

5.4   What mainstream Australian society refers to as 'mental illness' or 'mental disorder' has not always been, and is not universally regarded as, a medical matter.[1] Mental illness has also been defined from a variety of cultural, social and legal points

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1   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, p. 38.

of view. Similarly, the tendency to distinguish between the mental, physical and spiritual dimensions of mental health is not, and has not always been, shared by other societies.[2] Further, in recent years, psychiatry and psychology have sought to move away from the distinction between mental and physical aspects of mental illness. For example, the DSM-IV notes that the term 'mental disorder' in its title 'unfortunately implies a distinction between "mental" disorders and "physical" disorders that is a reductionist anachronism of mind/body dualism':

> A compelling literature documents that there is much "physical" in "mental" disorders and much "mental" in "physical" disorders. The problem raised by the term "mental" disorders has been much clearer than its solution, and, unfortunately, the term persists in the title of DSM-IV because we have not found an appropriate substitute.[3]

5.5   The National Mental Health Plan 2003-08 (NMHP) explains that: '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'.[4] Mental illness specifically is 'a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities'.[5]

5.6   The diagnosis of mental illness is typically made with reference to the classification systems of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-IVR), and, the International Classification of diseases, Tenth Edition (ICD-10). The DSM-IVR covers a wide range of mental disorders and the ICD-10 makes reference to mental and physical disorders.[6]

5.7   The DSM-IVR classifies the following disorders:[7]

- Adjustment Disorders

- Anxiety Disorders

- Dissociative Disorders

- Eating Disorders

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2   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, p. 38.

3   American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders—DSM-IV-TM*, Fourth Edition Revised, Washington, 1997, p. xxi.

4   Australian Health Ministers, National Mental Health Plan 2003-2008: Australian Government, 2003, p. 5.

5   Australian Health Ministers, National Mental Health Plan 2003-2008: Australian Government, 2003, p. 5.

6   Australian Health Ministers, National Mental Health Plan 2003-2008: Australian Government, 2003, p. 5.

7   http://allpsych.com/disorders/disorders_alpha.html, (accessed April 2005).

- Impulse-Control Disorders

- Mood Disorders

- Sexual Disorders

- Sleep Disorders

- Psychotic Disorders

- Sexual Dysfunctions

- Somatoform Disorders

- Substance Disorders

- Personality Disorders

5.8   In terms of mental disorders the ICD-10 covers:[8]

- Organic, including symptomatic, mental disorders

- Mental and behavioural disorders due to psychoactive substance use

- Schizophrenia, schizotypal and delusional disorders

- Mood [affective] disorders

- Neurotic, stress-related and somatoform disorders

- Behavioural syndromes associated with physiological disturbances and physical factors

- Disorders of adult personality and behaviour

- Mental retardation

- Disorders of psychological development

- Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

- Unspecified mental disorder

5.9   A broad description of the above disorders can be located at Appendix 1 to this report.

5.10   The committee heard evidence that not all disorders receive equal or sufficient attention in the current mental health system. The focus of the National Mental Health Strategy on 'serious' mental illness and stigma surrounding certain disorders were highlighted as the key drivers. The following sections discuss these concerns.

Mental illness – a homogeneous group?

5.11   The use of the expression 'mental illness' in public policy and popular discussion is in stark contrast to the term 'physical illness'. Typically, in the realm of

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8   http://allpsych.com/disorders/disorders_alpha.html, (accessed April 2005).

'physical illness', attention is paid to the specific illness or subset of illnesses and this is reflected in care settings – the oncology ward, the cardiology unit, the ear, throat and nose specialist, for example.

5.12   While emphasis on the umbrella term 'mental illness' has been driven by the need to raise the profile of a neglected area of health policy, bringing a range of marginalised mental health problems on to the policy agenda, grouping the diverse range of mental illnesses in this way is problematic. Professor Gavin Andrews noted:

> It is difficult to think about 'mental illnesses' as a homogeneous group and any discussion of a generic mental disorder is obscuring important information, just as discussion of a generic physical disorder would do.[9]

5.13   Conceptualising 'mental illness' as one category of care, compared with the many recognised specialist epidemiologies of physical health, fails to recognise the breadth of service responses required:

> Through our experience we have found the Mental Health System to be seriously flawed, not so much by any persons in particular but rather by serious systemic failures. Furthermore, we have found that these systemic failures basically stem from the incorrect assumption that "one hat fits all." Prima facie, the policies and protocols in relation to the delivery of mental health services may appear to be adequate but in reality they fall far short. They simply do not take into account the enormous depth, breadth and variances in mental illness. Nor do they take into account the individuality and complexities of the sufferers of mental illness.[10]

5.14   Not only is there a diverse range of mental illness groups, but illnesses and people's experience of illness vary within the broad illness groupings. For example, the Black Dog Institute argued that while the prevailing simple conceptualisation of 'depression' is useful for countering stigma and for encouraging people to seek assistance, it is limited in practice:

> In reality, there are multiple depressive conditions, each with differing principal causes and benefiting from differing treatment priorities. However, there has been a general tendency to homogenize myriad depressive conditions into non-specific single diagnoses such as 'major depression' or 'clinical depression', and then initiating non-specific treatment.[11]

5.15   Focussing on 'mental illness' as one single area of health need, rather than a diverse range of needs requiring diverse responses, also supports the under-resourcing of mental health services. Distinct differences are evident in the services available for mental illnesses compared with specific physical illnesses:

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9   Professor Gavin Andrews, *Submission 176*, p. 1.

10   Break the Psycle, *Submission 183*, p. 1

11   Black Dog Institute, *Submission 170*, p. 1.

> Visit both the psychiatric acute care unit and the cancer care unit of your local area health service. Compare the adequacy and quality of buildings, staffing, service levels, furniture and fittings, culture and attitude. You will find chalk and cheese.[12]

5.16   Evidence to the inquiry shows that overall mental health services need increased resources to meet the needs of the community. However, the use of the broad term 'mental illness' masks the reality that service response for some illnesses is far less than for others.

The diversity of need

5.17   Certain disorders do not receive adequate coverage within the current framework for mental health services. Two factors underling this are:

- a two-tiered system that fails to equally recognise or accommodate different illnesses; and

- certain disorders are not considered within the ambit of national and/or state mental health plans, for example, dementia is primarily dealt with under aged care.

Hierarchies of care—the acute focus

5.18   One of the greatest obstacles to addressing the diversity of mental health need is the incapacity of the present health system to deal with anything other than the most acute levels of need. Dr Ruth Vine, Director of Mental Health, Department of Human Services of Victoria, told the committee:

> Public funding is directed towards those most vulnerable, those most in need, those who may require treatment under the protection of the Mental Health Act. The recognition that this area has been under increasing demand and does require expanding services is shown in the growth of the mental health budget that has occurred.[13]

5.19   The mental health legislation sets out certain priorities:

> One of the challenges for public mental health policy is to strike a balance, and we have to strike lots of balances. One balance is between the issues of safety and autonomy, another is between the interests of the community and the interests of the individual, and another is between the individual's immediate safety and their longer term safety. That is why we have mental health legislation—to try to strike that balance and to try to take into account the different interests.[14]

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12   Mr Brian Haisman, *Submission* 114 , p. 3.

13   Dr Ruth Vine, Director of Mental Health, Department of Human Services of Victoria, *Committee Hansard,* 7 July 2006, p. 37.

14   Dr Ruth Vine, Director of Mental Health, Department of Human Services of Victoria, *Committee Hansard* 7 July 2006, p. 35.

5.20   The NMHP interprets this to suggest that the right 'balance' involves prioritisation of care for people with severe mental health problems but also ensures that 'appropriate services are readily accessible to all Australians with menta health problems'. This means that implementation of early intervention and prevention strategies and other health and community services, such as housing, employment and income support, are also necessary.[15]

5.21   Under current funding levels, however, most jurisdictions have adopted the Mental Health-Clinical Care and Prevention (MH-CCP) model, where state and territory funds aim to address high need, severe illnesses, leaving the high prevalence disorders, such as anxiety and depression, to be carried by federal government initiatives. The NSW Government reported:

> In broad terms the MH-CCP model accepts the current division in which specialist public mental health services operated by States and Territories provide the vast majority of care for people with severe illness, and especially those who currently consume 50per cent of state resources, namely people who are so ill that they must be treated under the involuntary care provisions of mental health legislation. The other 50 per cent of State services extend as far towards moderate and mild levels of illness as resources permit. The "care packages" in the model assume an increasing role for non-specialist clinical services, especially in primary care, for the high prevalence by lower severity illnesses. Most of these would be expected to be provided under Medicare, though generalist community health services would also be involved, especially in rural and regional areas where – for example – private psychiatry is either non-existent or extremely scarce.[16]

5.22   In Victoria the result is that, as Dr Vine stated, 'the most in your face' level of need is prioritised, hence in Victoria the majority of funding goes to adult and youth services, at 60 to 70 per cent, aged care gets 20 per cent, and child and adolescent services only nine per cent.[17]

5.23   Medical health professionals argued that the focus needs revision; delivery models should be front end and preventative, and address the continuum of need across both high and low-prevalence disorders:

> …greater focus on early intervention and illness prevention is needed across the board, in both low prevalence severe mental health disorders such as schizophrenia and other psychoses, and in the high prevalence problems of anxiety and depression.[18]

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15   NSW Health – NSW Government, *Submission 470,* pp. 13–14.

16   *Submission 470,* pp. 13–14.

17   Dr Ruth Vine, Director of Mental Health, Department of Human Services of Victoria, *Committee Hansard* 7 July 2006, p. 38.

18   SA Divisions of General Practice, *Submission 88*, p. 3; see also, Western Australia Section of the College of Clinical Psychologists – Australian Psychological Society, *Submission 101*, p. 1.

5.24   Professor Patrick McGorry of ORYGEN Research Centre agreed:

> I am sure you have heard this from a number of submissions but what we see in mental health care in Australia is too little, too late. The services that are provided at the state level are tightly targeted at people with end stage illnesses, severe chronic illnesses or in very acute, high-risk situations—they may be acutely suicidal, aggressive or behaviourally disturbed. So the care is reserved, in a sense, at a state level for that group of patients. The whole concept is to intervene early and prevent people from getting to that high-conflict stage—where they almost have to force their way into care—which can be avoided, but the current model of care and resource levels at a state level are impeding that. There is a resistance to this mind-set.[19]

5.25   Given the substantial pressures of competing need within the system, it was argued that the onus is on the federal government to set up support and funding structures which will train service provision towards the goal of early intervention and preventative care across the spectrum of need:

> …the failure to specify the priority populations for care has led to a debate in which the needs of those who were to be given priority under the National Mental Health Policy have been combined with the much larger number of people in need of primary care and relatively low levels of specialist care. This is a long-standing issue in mental health, and for the same reason: all mental illnesses that warrant a diagnosis are "serious", but they are not all equally acute, disabling, or in need of the same kind of treatment.[20]

Caring for the most vulnerable

5.26   At present the NMHP not only fails to articulate priorities, it also excludes a number of significant areas of urgent mental health need from its purview. In the main, those disorders neglected are complex conditions combining features which fall into disputed territories between mental health and other health treatment regimes. These people are arguably the most vulnerable consumers in the community. Failed by demarcated service regimes, they are falling through the cracks in the mental health framework.

5.27   As discussed above, psychiatry and psychology have sought to move away from the distinction between mental and physical aspects of mental illness, and this is reflected in the definition of mental illness applied within the NMHP. Unfortunately, the traditional service divisions between physical, mental and intellectual disability services are not so easily overcome. This is reflected in the way the NMHP ascribes responsibility for significant mental health problems to other service systems.

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19   Professor Patrick McGorry, Director, ORYGEN Research Centre, *Committee Hansard*, 7 July 2006, p. 2.

20   NSW Health – NSW Government, *Submission 470,* p. 21.

5.28   In particular, dual diagnosis, a growing problem among youth, is the domain of the drug and alcohol service system, and dementia, on the rise as the population ages, is primarily the responsibility of aged care services.[21] The fragmentation of service delivery for the people with dementia and for those with dual diagnosis, as discussed here and in other chapters of this report, is therefore underpinned by this approach, which establishes them as 'non core' responsibilities for mental health; related, but separate to the mainstream mental health agenda.

5.29   At the other end of the spectrum, people with comparatively rare but complex high need disorders, such as intellectual and developmental disabilities like autism are left outside any identifiable care framework. The mental health system does not own responsibility for oversight of targeted assistance, and nor does mainstream health services.[22] In this way there is a lack of impetus and a lack of flexibility in the system to address the diversity of need in the holistic way intended by the NMHS. Dementia, dual diagnosis, and autism as cases in point, are discussed in more detail below.

Dementia and mental illness

5.30   As discussed in Chapter 15, the mental health of older Australians is not adequately catered for compared with other groups in the community. Although some developments in psychogeriatric services are occurring at state level,[23] there is a need for a comprehensive national plan:

> Mental health policy is largely focused upon the needs of relatively robust adults, with more recent attention given to the needs of children and adolescents. The third National Mental Health Plan acknowledges the elderly as a priority group, which is welcomed. However, there needs to be an insertion of the effort and resources required to develop this recognition into a coherent plan for comprehensive mental health service provision to older people across the nation.[24]

5.31   The key policy document for older people, the Public Health Action Plan for an Ageing Australia (2003), is implemented by the Department of Health and Ageing, with some assistance from the Department of Families, Community Services and Indigenous Affairs.[25] However, the partnership with mental health services needed to produce the comprehensive approach required is poorly developed:

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21   Australian Health Ministers, *National Mental Health Plan 2003-2008*: 2003, p. 36.

22   See for example, Autism Aspergers Advocacy Australia, *Submission 92*.

23   See for example, Queensland Government, *Submission 377*, pp. 17–18; Victorian Minister for Health – Victorian Government, *Submission 445*, p. 1; Professor Henry Brodaty, *Committee Hansard*, 2 August 2004, p. 72.

24   Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard* 2 August 2006, p. 73.

25   Australian Government, *Submission 476*, p. 65.

There appears to be disagreement at National, State and Area Health Service levels regarding the respective responsibilities of Mental Health versus Aged Care departments. This is then further exacerbated by disagreement regarding the respective responsibilities of different levels of government. The consequence of this is that, even when the need for such services is acknowledged, at all levels the funding of mental health services to older people appears to always be something that should be sought 'from someone else'. This problem is particularly evident in attempting to develop services for people with mental health disorders in Residential Aged Care Facilities; or who have Behavioural and Psychological Symptoms of Dementia (BPSD). BPSD is a term that has been developed to describe those people with dementia who develop associated mental health and behavioural disorders.[26]

5.32   The Australian Government acknowledged that people with dementia and their carers are experiencing serious access problems.[27] Significant government funding was committed to health care in this area:

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.[28]

5.33   However, without a coherent plan to integrate approaches across the distinct silos of aged care and mental health services, people with complex presentations of dementia and mental illness are unlikely to receive the comprehensive assistance they need:

…if an older Australian develops mental illness this becomes an impediment to obtaining access to appropriate support services (ongoing or respite) in the community or within Residential Aged Care. This can be because services consider (officially or unofficially) that the presence of a mental illness makes the person 'outside their scope'; fear that the presence of mental illness (even depression) may make the person dangerous or inappropriate for the service; or because no services have been developed

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26   Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard,* 2 August 2006, p. 73.

27   Australian Government, *Submission 476*, p. 66.

28   *Submission 476*, p. 66.

for those who do require services with able to refocus upon people with ongoing mental illness.[29]

5.34   The Office of the Public Advocate Victoria concluded:

> There is little evidence that the projected dramatic increase in the incidence of dementia …is matched with preparedness in the mental health system in terms of infrastructure and expertise. There is potential for a considerable negative impact upon services already over-stretched and supported accommodation already in critical under-supply.[30]

Dual diagnosis

5.35   Dual diagnosis is the combination of mental health disorders with substance abuse. Dual diagnosis has increased most markedly among young people.[31] At the same time, self medication among all people with mental health disorders has increased to the degree that dual diagnosis has become more like the rule, rather than the exception, among consumers.[32] As noted above, the NMHP ascribes responsibility for people with dual diagnosis to drug and alcohol services and the National Drug Strategy provides the framework of care. In relation to illicit drugs, the overall focus is on control and regulation of supply, demand reduction strategies, including abstinence-focussed treatments and harm reduction strategies.[33]

5.36   In recent years the rising incidence of co-mordity, as it is also termed, has supported a substantial increase in the number of people with mental illness in gaol. Predominating among these are young men[34] and Indigenous people, a disproportionate number being women.[35] Submissions to this inquiry took the view that this trend is a direct consequence of the failure to adequately respond to the mental health needs of people with dual diagnosis, combined with an increased focus on law and order models to control perceived behavioural problems.[36]

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29   Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, p. [3].

30   Office of the Public Advocate, *Submission 172*, p. 11.

31   Australian Division of General Practice, *Submission 308,* p. 38.

32   Eastern Hume Dual Diagnosis Service, Statement in support of *Submission 374*, tabled Melbourne Public Hearing, 6 July 2005, p. 2.

33   Australian Government, *Submission 476*, Part 1

34   Probation and Community Corrections Officers' Association Incorporated, *Submission 503*, quoting NSW Health, 2000b, pp. 4, 15.

35   See for example, Department of Psychiatric Medicine, Children's Hospital Westmead and Tamworth (CAMHS), *Submission 99*, p. 1.

36   Fr Peter Norden, Policy Director, Jesuit Social Services, 'Prison Is Not A Healthy Place': ANEX Harm Reduction Conference, July 2004, quoted in Catholic Health Australia, *Submission* 276, p. 14.

5.37   The increased prevalence of dual diagnosis has highlighted a service gap for this group which has been growing for over twenty years:

> At one time psychiatric illness and the problems of dependence (inebriation) were regarded as closely related and care was provided in the same institutions and through similar sets of services. Australian health care saw these two areas separate several decades ago. That was a positive change at the time, however, with the increasing recognition of the coexistence of mental health and substance use problems, this separation needs to be rethought, and new organisational and professional approaches devised to respond to this area of serious unmet need more appropriately.[37]

5.38   The Australian Medical Association judged the failure to integrate services for people with dual diagnosis as an exemplar of the inefficiencies of the mental health system overall, with its reactive focus on episodic and acute need:

> The separation of some services results in significant inefficiency eg between mental health, drug and alcohol services, and there is scope to improve patient outcomes by integrating these services. Existing funding mechanisms favour defined episodes of care. However the mental health conditions that generate the highest burden of disease are chronic conditions and they require longitudinal care. The Commonwealth/State funding arrangements are dysfunctional, funds are wasted in duplication of administration and policy formulation while a silo mentality detracts from the continuum of care.[38]

5.39   The committee received evidence from stakeholders and many personal stories illustrating the limited access that people with dual diagnosis have to services which can provide assistance. Some state and territory governments have responded to the extent of unmet need, attempting to bridge the gaps. The Mental Health Legal Centre – Victoria reported:

> Complex and co-morbid conditions and drug and alcohol dependence, affects many of our clients. Like many people with multiple needs this may mean being on the waiting list for a number of different specialist services, though never being a priority for any, each service expecting another 'more appropriate' service to act. These clients fall between the gaps between service silos. The Victorian Department of Human Services was perplexed by the plight of such clients and established new legislation for some such complex clients. It is envisaged that the complex care list will provide a range of services to those people deemed to be some of Victoria's most difficult clients.[39]

5.40   The extent of the problem of dual diagnosis, and proposals for a 'whole-of-government' response are discussed in Chapter 14.

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37   Dr Ian Webster, *Submission 458*, p. 17

38   AMA , *Submission 167*, p. 1.

39   Mental Health Legal Centre – Victoria, *Submission 314*, p. 17.

Autism—intellectual and developmental disorders

5.41   Between one and three per cent of people in the community have a developmental or intellectual impairment.[40] Many have coexisting mental health problems consequent to their disabilities, such as stress, anxiety, depression and sometimes psychosis.[41] Their situation exemplifies the very considerable diagnostic and service access problems for people with complex disorders:

> They require constant support and assistance across the lifespan....yet they are a very diverse group— their needs are often very individualistic...in the UK and parts of the USA psychiatrists specialise in the treatment of this group – in Australia, they fall through the gaps in service provision because they don't neatly fit into eligibility criteria...they dont "fit" because of their cross agency, cross-professional needs....in Australia few psychiatrists have the inclination, the skills or the expertise to be involved, this is a huge unmet need, clinicians don't know how to help this group—how to serve their best interests.[42]

5.42   As the Burdekin Report noted, there is 'a huge number of intellectually disabled people who receive no treatment for their psychiatric disorder because there is none available'.[43] At the extreme end of the spectrum, is the situation of those with severe developmental or intellectual disability; in June 2005, the Senate Community Affairs Reference Committee reported on the distressing circumstance of affected young people relegated to aged care facilities.[44] The gravity of their situation and those of people with intellectual disability and mental health problems more generally, requires more specialised attention, and should perhaps the focus in a separate inquiry.

5.43   Autism Spectrum Disorder (ASD), including high functioning Autisms or Aspergers syndrome, is a developmental disability, although it is also classified as a mental illness under the diagnostic treatment manual.[45]. Termed Pervasive Developmental Disorder by the mental health sector, ASD is not regarded as a treatable condition. Accordingly:

> Policy in the mental health sector does not provide the resources or funding for the clinical treatment that people with autism need. Nor does any other section of government…existing policy excludes people with autism from the effects of the National Mental Health Strategy.[46]

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40   Queensland Centre for Intellectual and Developmental Disability Mater Hospital, *Submission 463*, p. 1, and see attachments.

41   Autism Aspersers Advocacy Australia, *Submission 92*, pp. 3–4.

42   *Submission 463,* p. 1, and see attachments.

43   *Submission 92*, p. 3.

44   See Chapter 4, *Quality and Equity in Aged Care,* Senate Community Affairs Reference Committee, June 2005.

45   *Submission 92*, p. 9.

46   *Submission 92*, p. 9.

5.44   Rather cruelly this exclusion extends to access of services under the Better Outcomes Initiative. A parent was advised by a mental health department official:

> Can I explain at the outset that the Better Outcomes Initiative is designed to support GPs in the management of their patients with mental health conditions. The Initiative was mentioned in the correspondence to you as being one of the mainstream programs we have in the health portfolio which may be of interest to families of children with autism. The program itself does not extend to developmental disabilities and provides treatment which specifically targets mental health conditions.[47]

5.45   This has serious consequences for the up to one percent of children who will be diagnosed with (ASD) before leaving school.[48] Effectively, children with Autism cannot access early intervention and preventative treatments available to other children with mental health problems. This is despite recognition of the effectiveness of these for ASD in the diagnosis reference manual:

> The DSM-IV [1], first published in 1994, formally recognised PDD (or ASD) as a family of clinical conditions, categorising them on Axis I with the other mental disorders. Internationally, recognition that ASD requires treatment resulted in improved early intervention and treatment regimes being provided for people with ASD.[49]

5.46   Autism Aspergers Advocacy Australia asked for urgent recognition of the validity of recovery-based models of care for children with autism and for implementation of affordable and evidence-based early intervention approaches by public health services.[50] A key mechanism is early identification by screening. Under identification of autism can have profoundly negative outcomes in adult life. Studies have found, for example, that a significant number of people diagnosed with schizophrenia or psychosis and unresponsive to treatment have undiagnosed ASD.[51]

Marginalisation of some disorders – Borderline Personality Disorder

5.47   Borderline Personality Disorder seems to be as much a recipe for marginalisation as it is a diagnosis:

> My daughter is now thirty years old and still no closer to getting the help or support she as a human being deserves and should be able to expect.
>
> A few of the diagnoses mentioned by the government authorities are: psychiatrically ill, post traumatic stress disorder; self harmer; suicidal; major depression and borderline personality disorder. The most recent

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47   Autism Aspersers Advocacy Australia, *Submission* 92, p. 8.

48   *Submission 92,* pp. 8–9.

49   *Submission* 9*2*, pp. 8–9.

50   The key feature is the requirement for more one to one intensive interaction. See *Submission 92*, pp. 10–11.

51   *Submission 92*, p.5.

diagnosis I have was that there is nothing wrong with her. Is it any wonder one can not cope with life? ...

As a mother it has been and is a heart wrenching exercise to see a loved one go through what my daughter has been through and to hear and see the cries for help go unnoticed or dismissed as being 'attention seeking'. There is barely a patch of unmarked skin on her arms or neck where she has slashed herself or attempted hanging. …

Borderline Personality Disorder (BPD) is as I understand, a difficult thing to diagnose, but it can be done and it can be treated according to a Psychiatrist in Victoria. He recommends psycho-therapy and a mild medication for depression and anxiety which is part of BPD. He also states that many mental health clinicians dismiss people with BPD as being 'trouble makers'. What a sad indictment on our society.[52]

5.48   The evaluation of the second National Mental Health Plan noted that the role of the mental health system in the treatment of personality disorders was a particularly poorly understood issue.[53] This remains the case. While personality disorders clearly fall within the domain of mental illness, as defined in the DSM-IVR and ICD-10, those experiencing these disorders find it particularly difficult to access services. The Victorian Office of the Public Advocate assessed that '[p]eople with personality disorders are often excluded from the system through clinical judgements'[54] and recommended that there be '[g]reater acceptance of responsibility by the mental health sector for the provision of services for people with diagnoses of personality disorder'.[55]

5.49   Submissions to this inquiry particularly highlighted the plight of those experiencing Borderline Personality Disorder (BPD).[56] A diagnosis of BPD closes the doors to already limited mental health services. It leads to social rejection and isolation. Sufferers are blamed for their illness, regarded as 'attention seekers' and 'trouble makers'. BPD is the diagnosis every patient wants to avoid.

5.50   The ICD-10 classifies BPD under 'Emotionally unstable personality disorders', which are characterised by:

…a definite tendency to act impulsively and without consideration of the consequences; the mood is unpredictable and capricious. There is a liability

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52   Name withheld, *Submission 418,* pp. 1-2.

53   Steering Committee for the Evaluation of the Second National Mental health Plan 1998-2003, *Evaluation of the Second National Mental Health Plan,* p. 17.

54   Victorian Office of the Public Advocate, *Submission 172*, p. 11.

55   *Submission 172*, p. 11.

56   See for example, Mental Health Community Coalition of the ACT Consumer and Carer Caucus, *Submission 214,* p. 7; Council to Homeless Persons, *Submission 315,* p. 20; Mental Illness Fellowship of Victoria, *Submission 388*, p 12; Ms Merinda Epstein, *Submission 207*; Australian Mental Health Consumer Network , Submission 322, p. 18.

to outbursts of emotion and an incapacity to control the behavioural explosions. There is a tendency to quarrelsome behaviour and to conflicts with others, especially when impulsive acts are thwarted or censored.[57]

5.51   ICD-10 further notes that BPD is particularly characterised by 'disturbances in self-image, aims, and internal preferences, by chronic feelings of emptiness, by intense and unstable interpersonal relationships, and by a tendency to self-destructive behaviour, including suicide gestures and attempts'.[58]

5.52   There is a strong link between BPD and experiences of childhood abuse,[59] but this is too often ignored in the targeting of service responses:

> Many of our clients have childhood abuse and neglect histories. There appears to be a political blind spot in relation to childhood abuse in terms both of State policy and everyday practice, the National Mental Health Strategies are silent about it. People who have early experiences of child abuse and neglect often end up in the mental health system particularly but not exclusively with diagnosis of dissociative identity disorder, borderline personality disorder and other forms of personality disorders; there are many people who have the diagnosis of psychotic illness who have early experiences of abuse and neglect.[60]

5.53   The AMA report data that, although a decade old, put the prevalence of borderline personality disorder at 0.3 per cent of the population, around the same as schizophrenia (0.4 per cent).[61] However, the likelihood of obtaining appropriate treatment for BPD is markedly different:

> For example, we know that if you have Borderline Personality Disorder (BPD) somewhere in your history you've probably got a very limited chance of attracting a service regardless of the seriousness of your pain or functioning. Alternatively, if you've managed to attract a diagnosis of Schizophrenia your chances improve markedly.[62]

5.54   BPD is marginalised within the community and within the mental health sector. There is a lack of recognition of the disorder as a mental illness and a lack of service response, let alone specialised treatment response. Discrimination is evident

57   World Health Organisation, *International Statistical Classification of Diseases and Related Health Problems, 10th Revision*, http://www3.who.int/icd/vol1htm2003/fr-icd.htm, (accessed March 2006).

58   World Health Organisation, *International Statistical Classification of Diseases and Related Health Problems, 10th Revision*, http://www3.who.int/icd/vol1htm2003/fr-icd.htm, (accessed March 2006).

59   Women and Mental Health Inc, *Submission 310*, p. 3; Australian Mental Health Consumer Network, *Submission 322*, p. 18.

60   Mental Health Care Legal Centre, *Submission 314*, pp. 7–8.

61   Australian Medical Association, *Submission 167*, p. 7.

62   Ms Merinda Epstein, *Submission 207*, p. 13.

and studies have reported negative attitudes and a perceived lack of training amongst clinical staff toward patients with BPD.[63]

> Certain diagnoses seem to have greater and lesser status in the community and in mental health systems. This status is often contradictory. It seems that "proper mental illness" (psychosis) brings some status within mental health systems but is perhaps most vilified in the community. Alternatively, 'nasty behaviour traits' (e.g., Borderline Personality Disorder) does not carry the same burden as Schizophrenia in society but is a dreaded diagnosis within mental health services and often leads to clinical neglect and gross and unfair judgments by many clinicians.[64]

5.55   The marginalisation of BPD has it roots, at least partly, in the early focus of the Mental Health Strategy on 'serious' mental illness, without a clear concept of how this emphasis would be interpreted for service delivery:

> …since the emergence of the First National Mental Health Strategy some groups (and I have referred specifically to people labelled as having Borderline Personality Disorder and people too often not recognised as having Dissociative Identity Disorder) have been so badly marginalised that it will take a reversal of policy and a radical retraining and reorientation of clinicians to overcome the systemic neglect at the State policy and local level.[65]

5.56   Even the labelling of the disorder is marginalising:

> Derogatory labels such as Borderline Personality Disorder must be examined and new, more respectful, and more accurate terms such as Complex Post Traumatic Stress Disorder be considered. Consumers must decide how they would like their distress to be described.[66]

5.57   Clinicians too encounter the mental health sector's routine discrimination against people with BPD and are unable to secure appropriate treatment responses for their patients:

> My patient had rapid, severe mood swings and a tendency to self-harm. She met the criteria for borderline personality disorder. There is increasing evidence that, rather than a wicked soul, dysfunction of the brain's limbic system underlies this condition. This dysfunction is often associated with past emotional trauma. Among my female patients, a history of childhood sexual abuse is common.

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63   C. Deans and E. Meocevic, 'Attitudes of Registered Psychiatric Nurses Towards Patients Diagnosed with Borderline Personality Disorder', *Contemporary Nurse*, 2006, vol. 21, no. 1, pp 43–49.

64   Australian Mental Health Consumer Network, *Submission 322,* p. 13.

65   Ms Merinda Epstein, *Submission 207*, p. 4.

66   *Submission 207,* p. 4.

This already disturbed young woman had problems dealing with the murder of a friend and I sought psychiatric help for her.

She told me that the community mental health service said she didn't have a mental illness. She was also assessed at a public hospital psychiatric unit and apparently told that she didn't need a psychiatrist. None of this surprised me, and I'm not blaming the clinicians who assessed her. Like most health care problems, the fault does not lie with individuals. They were merely following their training and, of course, to a degree restrained by the resources allocated to the public system. There was certainly nothing unique about the failure to achieve psychiatric support for this woman and I have been down this same path many times with many patients in many locations.[67]

5.58   There is a clear need for a change in service response for those experiencing BPD, including the provision of treatments appropriate for this disorder. As noted elsewhere, a 'one size fits all' response is inappropriate for 'mental illness', and this is exemplified by the experience of BPD. For example:

It has been known for many years now that inpatient settings are terrible places for people with who have Borderline Personality Disorders. Many get "*'re-triggered' into reliving their abuse experiences and sometimes self harm as a consequence.*" More than any other category of patient these women (usually) do really badly in hospital. Because of this most services now have a system where people with Borderline Personality Disorder are told they will only be admitted very briefly (no more than four days) and only once every two months for example. However, the triage system is often too clumsy to pick up people who have not been hospitalized with psychotic illness as being needy of case management. Unfortunately many people with this Borderline diagnosis (for example) lead a terrible life on the streets, cutting themselves regularly, perhaps picked up for a few days in an acute setting, told that what is happening to them isn't serious and sent out to deal with their lives themselves. This happens even when it is demonstrably shown that they can't do this on their own.[68]

5.59   Some of the most appropriate treatment responses for BPD are not available:[69]

Many people who have been diagnosed as having 'syndromes' like BPD or DID which need long term psychotherapy or Dialectical Behavioural Therapy (DBT) and more intensive interpersonal relationships with therapists over a longer period of time (rather than medical drugs) are now 'out of policy fashion'. Consumers recognise and are very concerned that since the publication of the First National Mental Health Strategy **public**

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67   Dr Andrew Gunn, *Submission 52*, p. 1.

68   Australian Mental Health Consumer Network, Submission 322, p. 18.

69   Ms Merinda Epstein, *Committee Hansard*, 5 July 2005, p. 36.

systems throughout Australia have lost a whole generation of psychotherapists.[70] [emphasis in original]

5.60   Ms Merinda Epstein pointed out that the private sector is providing some of the best services for people with this disorder:

> The irony is that some consumers who have been literally ejected from the public system have found very special private psychiatrists with an interest in BPD and DID and who use psychotherapeutic tools and 'talking therapies' either instead of or as an adjunct to drug therapy. Often, these clinicians are also refugees from the State system where they found their skills were no longer wanted.[71]

5.61   However, access to the private sector is an issue for many with mental illness, with few private psychiatrists' bulk billing for their services. Accessible, appropriate treatments for those experiencing BPD, and an end to marginalisation of the disorder within the community and the mental health sector, are urgently needed.

Need for specialist services for some disorders

5.62   Given the diversity of mental illness, there is a need for specialist services that allow response to distinctive features of conditions.   Whilst not an exhaustive exploration of the spectrum of mental illnesses, this section examines: eating disorders; anxiety; obsessive-compulsive disorder; and, post-traumatic stress disorder.

Eating Disorders

5.63   Eating disorders – grouped into three broad categories in the DSM-IV; anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified (eg binge eating disorder) – are a common group of psychiatric disorders with a spectrum of severity, and can include significant levels of medical complications.[72] Anorexia nervosa has the highest rate of mortality of any psychiatric disorder.[73]

5.64   There are many obstacles to obtaining help for the treatment of eating disorders. The Centre for Eating and Dieting Disorders reported that generalist and mental health professionals have expressed 'a lack of knowledge and skills' on eating disorders, which leads to reluctance in their willingness to work with people presenting with such disorders. The Centre also highlighted the stigma that results from the misguided and damaging notion that eating disorders are 'self-induced' and that the consumer is in some way to blame for their illness, so treatment is denied.[74]

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70   Ms Merinda Epstein, *Submission 207*, p. 17.

71   *Submission 207*, p. 17.

72   Centre for Eating and Dieting Disorders, *Submission 307,* p. 1.

73   E. Harris, B. Barraclough, 'Excess mortality of mental disorder', *British Journal of Psychiatry,* 173, 1998.

74   Centre for Eating and Dieting Disorders, *Submission 307,* pp. 8–9.

5.65   The inadequacy of services for people with eating disorders was highlighted in a submission by a person with recurring bouts of anorexia nervosa. The submitter explained that the only long-term support available was through a private practitioner. Paying for this support required the selling of personal assets.[75]

5.66   The Centre for Eating and Dieting Disorders stated that recovery from eating disorders requires intervention from multiple health care providers, such as dieticians, psychologists and psychiatrists, as well as from organisations delivering social support and family therapy.[76] There is a need for more research into effective treatments for the specific nature of eating disorders and risk factors, and strategies for better targeting the needs of groups with a high risk of developing eating disorders, such as children, adolescents and young women.

5.67   Promoting heightened awareness of the medical management of eating disorders and treatment is also needed to assist health care workers to facilitate the diagnosis and referral of patients with eating disorders. However, this also relies upon an adequate level of specialised health care services for people with eating disorders in the community, including an increase in the number of dedicated eating disorder hospital beds for the management of acute stages of illness.

Anxiety

5.68   Anxiety Disorders – or disorders of fear and stress show predominantly in the teenage years or earlier. It is estimated that 12.6 percent of the population suffers from an anxiety disorder,[77] yet it is very difficult to access help until the person is in such a poor state of mental health that they may be suicide.

5.69   A person with an anxiety disorder commented on the enormous difficulties in accessing help for this category of mental illness:

> My search for help has been in four states of Australia, as well as living in London for three and a half years. It's only since arriving in Perth in 1985 I've finally managed to obtain proper help.[78]

5.70   A support group for people with anxiety recommended that a 'mood disorders clinic(s)' be established, offering services that address the specialised needs of people with anxiety disorders and depression:

> … shorten treatment delays and reduce misunderstandings by practitioners, negative labelling and poor referral systems. This would offer an alternative service to acute psychiatric services and an opportunity for early

75   Name withheld, *Submission 13*, p. 1.

76   Centre for Eating and Dieting Disorders, *Submission 307,* p. 10.

77   Anxiety and Depression Support Group – Albury-Wodonga, *Submission 151,* p. 10.

78   Name withheld, *Submission 499,* p. 4.

intervention. The service focus should also consider wellness with less emphasis on purely medical treatment.[79]

Obsessive-Compulsive Disorder (OCD)

5.71   The diversity of mental illness and the suffering faced when the true nature of the illness is misdiagnosis, was recalled by a submitter living with OCD which produced obsessions with food and dieting:

> At age 19 I was diagnosed by a local GP with anorexia and began treatment. A specialist physician confirmed the diagnosis and admitted me to hospital. Whilst in hospital a psychiatrist appeared once and prescribed pills. For the next 29 years I was misdiagnosed by nine psychiatrists who did no more than give me medication which often left me in a zombie state. In and out of various hospitals and not once given any program or recovery of indeed any hope of recovery, How could there be – none of them knew what was wrong with me.[80]

5.72   Submitters pointed out the inadequacy of the public mental health system in providing specialised care for people with a diversity of mental illnesses, such as OCD:

> There is an attitudinal problem from the public mental health professionals. I was told, **"Beggars can't be Choosers"**.[81]

> It is essential that people with OCD and people with other anxiety disorders and depression are able to access psychological and medical treatments that are evidence-based and can be tailored to their particular symptoms and experienced.[82]

5.73   The Brisbane Obsessive Compulsive Disorder Support Group has called for vocational, rehabilitation and employment programmes targeting the specific needs of people with OCD, so as to 'keep (people with OCD) on track' and better support living in the community.[83]

Post-Traumatic Stress Disorder

5.74   Post-traumatic stress disorder (PTSD) is a common disorder where a person has experienced abuse or trauma in their life. In evidence submitted to the inquiry, groups commonly reported to suffer from PTSD include women subjected to abuse throughout their lives,[84] and care leavers who endured childhoods of terrible abuse

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79   Anxiety & Depression Support Group – Albury Wodonga, *Submission 151, Attachment 1,* p. 7.

80   Name withheld, *Submission 162,* p. 4.

81   Name withheld, *Submission 196,* p. 1.

82   *Submission 162*, p. 5.

83   Brisbane Obsessive Compulsive Disorder Support Group, *Submission 197,* p. 2.

84   Women and Mental Health Inc, *Submission 310,* p. 3.

and neglect growing up in institutional care[85]. The committee also heard evidence of the high incidence of PTSD that occurs following the release from involuntary treatment for a mental illness of a different nature.

Responding to the diversity of mental illness

5.75   The committee thus heard about an enormous range of conditions, and about distinct needs for many of them: needs that are not adequately being met. Generalist and specialist health care providers must recognise and respond to the full range of mental illnesses, just as we do to the range of physical illnesses. The key to achieving this outcome is recognition of the diversity of health professionals in the management of mental illness, discussed in Chapter 6, acknowledging the broad-based biopsychosocial model of illness and diversity of treatment responses required.

Diversity of treatments

A dominant medical model

5.76   The section above focused attention on two aspects of the mental health framework that impact on the way in which certain illnesses are responded to in the current system: the priority given to low-prevalence disorders and the boundaries of the mental health framework, which precludes certain disorders. This section introduces a third feature, which limits the kinds of treatments available within the public health system, in turn limiting consumer access to different and, in some cases, more appropriate forms of treatment: the dominance of the medical model.

5.77   As the dominant paradigm governing the care and treatment of mental illness, the medical model emphasises pharmacological approaches that aim to cure mental disorders that find their genesis in bio-chemical disturbances. Less attention is given to the prevention of mental illness, to non-pharmacological treatments and to the psycho-social causes of mental health disorders:

> [The medical model] stresses: individual rather than collective health; functional fitness rather than welfare; and cure rather than prevention. The central beliefs of this model saw physiological factors ('genes and germs') not psychosocial factors as the main causes of illness. It is a model, which, in policy terms, translates into a prime concern with the treatment and cure of individuals' ill health, especially in acute sector settings.[86]

5.78   The medical model underpins the division between high and low prevalence disorders and, to an extent, the stigma attached to certain disorders – for example, the idea that depression is 'all in the mind' or that borderline personality disorder reflects bad behaviour. The psychological and the behavioural fit less easily into a model that

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85   Broken Rites (Australia) Collective Inc, *Submission 340,* p. 5.

86   B. Hardy and R. Rhodes, 'Beliefs and Institutional Change: The UK National Health Service', in I. Holland and J. Fleming (eds.), *Government Reformed: Values and New Political Institutions*, 2003, Ashgate Publishing, England and USA, p. 71.

emphasises biological and specifically, bio-chemical disturbance. This is not to suggest that there is no bio-chemical basis to some forms of depression and other high-prevalence disorders, or that there are no psychological or behavioural dimensions to low-prevalence disorders. Rather, how certain disorders are culturally characterised and how they are attended to is, in part, influenced by the dominant paradigm of thought. Those disorders most responsive to medication are embraced by the model. Other disorders are, to varying degrees, marginalised.

5.79   While the National Mental Health Plan 2003-08 reports a shift in emphasis from a 'focus only on treatment to consideration of prevention, early intervention, rehabilitation and recovery'[87] and presents a vision of a 'holistic approach to improving mental health and well-being',[88] evidence suggests that in practice this vision is yet to be realised. The Office of the Public Advocate, Victoria, submitted that:

> Proposed new directions in mental health policy reflect a departure from the dominant medical paradigm, within which mental health care has hitherto been situated, to a more individualistic and social model of mental health care. The Public Advocate observes that despite this clear direction of the previous two NMHPs, and the current NMHP 2003-2008, this policy is not reflected in the services provided. For example, people in non-acute phases of mental illness and people with high prevalence disorders continue to have difficulty accessing the public mental health system.[89]

5.80   This echoed a 2004 report jointly prepared by the Brain and Mind Research Institute and the Mental Health Council of Australia:

> The Australian system is over-reliant on cost-inefficient specialist care systems and does not support its investment in effective medications with effective non-pharmacological treatments and recovery strategies.[90]

5.81   Insane australia summarised consumer needs for a more diverse set of treatments:

> a very common call from consumers is for greater attention on and access to counselling services, psychotherapies, psychosocial services, peer support groups, nutritional and so called 'alternative' approaches such as natural therapies, yoga and meditation etc. Resources are unavailable to these much sought after services because the vast bulk of publicly funding

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87   Australian Health Ministers, National Mental Health Plan 2003-2008: 2003, p. 3.

88   Australian Health Ministers, National Mental Health Plan 2003-2008: 2003, p. 4.

89   Office of the Public Advocate, *Submission 172*, p. 7.

90   I. Hickie, G. Groom and T. Davenport, *Investing in Australia's Future: the personal, social and economic benefits of good mental health*, December 2004, Brain & Mind Research Institute and Mental Health Council of Australia, p. 69.

for mental health is consumed by services based on the medical model – hospital wards, subsidies for doctors fees and the drugs they prescribe etc.[91]

5.82   Several submitters noted the dominance of the medical model and raised concerns about its limitations. These limits include: an over-reliance on pharmacological treatments and correspondingly, limited investment in, or access to, non-pharmacological treatments; an inadequate mix of mental health professionals accessible to consumers; and limited support for research into alternative/complementary forms of treatment.

A poor mix of pharmacological and non-pharmacological treatments

5.83   The dominance of the medical model results in 'a poor mix of pharmacological *vs* non-pharmacological treatments',[92] with an over-reliance on pharmacological responses to mental health disorders. The Office of the Public Advocate, Victoria, drew attention to the dominance of drug treatments noting their 'concern about the pharmacological focus of the system and the lack of psychosocial interventions accessible to people in the public mental health system'.[93]

5.84   Dr Horton-Hausknecht outlined recent research, which argues that medical and biological models are too frequently applied to psychological disorders, in part influenced by the interests of powerful pharmaceutical companies:

> Dr. John Read, Director of Clinical Psychology at the University of Auckland in NZ, co-authored a book titled "Models of Madness" (2004). This excellent book, which mostly focuses on schizophrenia but produces research and argument which apply to all areas of mental health, outlines the problems which occur when medical and biological psychiatry illness models are applied to psychological disorders. The book also focuses on the power of the pharmaceutical companies to manipulate research to promote the biological models of mental ill health and to promote their medications. He provides good evidence that the medical model of psychological disorders is not supported in research and argues for greater use of psychological therapies in the treatment of mental health problems.[94]

5.85   Dr Horton-Hausknecht argued that the situation needs to be redressed with non-drug therapies being used as the 'first line' of treatment – particularly for high

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91   insane australia, *Submission 2*, p.5.

92   I. Hickie, G. Groom and T. Davenport, *Investing in Australia's Future: the personal, social and economic benefits of good mental health*, Brain & Mind Research Institute and Mental Health Council of Australia, December 2004, p. 69.

93   Victoria, Office of the Public Advocate, *Mental Health Services Community Visitors Annual Report 2003/04*, Office of the Public Advocate, October 2004, p. 3.

94   Dr Jillian Horton-Hausknecht, *Submission 337*, p. 16.

prevalence disorders such as depression and anxiety - and drug treatments being used as a 'last resort'.[95]

5.86   The Western Australia Section of the College of Clinical Psychologists – Australian Psychological Society pointed to research that argues that medications are over-prescribed by GPs for 'less-serious' mental illnesses, which adds to the costs of medical care. It was claimed that other forms of treatment could be as effective, or more effective.[96]

5.87   The Professional Psychotherapy Centre stated that:

> A common consequence of the dominance of the medical approach to mental disorders is the encouragement of the sick role with its emphasis on medication as the treatment of choice.[97]

5.88   The Mental Health Foundation (ACT) highlighted the importance of using a range of treatments and services to enable consumers to manage their illnesses, arguing that a pharmacological response alone was not enough:

> Consumers need access to interventions which are proven to be effective such as cognitive behavioural therapy not just crisis management.
>
> It is widely acknowledged that it is not good enough, morally or ethically to solely prescribe medication and hand over a few jargon written pamphlets. People need to be educated, and guided to seek ways of managing their own mental health that works for them. We need to empower these individuals to take control over their own lives, and access a range of relevant services to heighten their quality of life.[98]

5.89   Controversy around the treatment of attention-deficit/hyperactivity disorder (ADHD) highlights some of the concerns regarding the balance of pharmacological and other treatments. The committee heard evidence on this in Western Australia, where prescription rates for ADHD medications are higher than in other parts of the country. The committee does not want to weigh into a clinical debate about the treatment of ADHD, and it also acknowledges the work of others in this area,

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95   Dr Jillian Horton-Hausknecht, *Submission 337*, p. 16.

96   Western Australia Section of the College of Clinical Psychologists – Australian Psychological Society, *Submission* 101, p. 3.

97   Professional Psychotherapy Centre, *Submission 30*, p. 2.

98   Mental Health Foundation (ACT) Inc, *Submission 112*, p. 4.

including the NHMRC,[99] the Western Australian Legislative Council[100] and the federal parliamentary Library.[101]

5.90   Concern centres on the dominant use of pharmaceutical treatments for a behavioural disorder, rather than 'simultaneous medication use, behaviour management, family counselling and support, educational management, and specific developmental issues.'[102]

5.91   Drug-Free Attention Deficit Support Inc (DFADS) argued…

> Medicare payments are structured to encourage quick diagnosis and treatment after brief consultations. This pressure for quick diagnosis and treatment results in ADHD being diagnosed as a catchall condition with the underlying cause ignored…
>
> Dexamphetamine is the only treatment option supported by the Commonwealth Government for ADHD. Dexamphetamine in low doses has an almost universal effect of temporarily sharpening focus and concentration.
>
> The combined effect is that the pressure for quick diagnosis encourages the diagnosis of ADHD that is then treated with subsidised Dexamphetamine…[103]

5.92   The Learning & Attentional Disorders Society of WA (LADS) had a different view from DFADS, arguing that ADHD was if anything under-diagnosed and that medication was an important part of an effective treatment strategy. The two groups appeared to differ about the extent to which ADHD was a primary medical condition as well as the number of cases in which it should be thought to be a medical condition at all.

5.93   However, the committee notes that the most obvious point the groups had in common was a consensus around a lack of effective non-pharmacological treatment options. LADS supported a multi-faceted approach to treatment including medication as just one element. However, as they themselves pointed out, 'due to a lack of funding and resources, the multi-modal treatment stipulated in [WA Department of Health] policy is seldom accessible to families with AD/HD'.[104] These concerns,

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99   National Health and Medical Research Council, *Attention Deficit Hyperactivity Disorder*, NH&MRC, Canberra, 1997.

100   Western Australian Legislative Council, Education and health Standing Committee, *Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder in Western Australia*, 2004.

101   L. Buckmaster, 'Medication for Attention Deficit/Hyperactivity Disorder (ADHD): an analysis by Federal Electorate', *Research Brief*, no. 2, 2004–05, Parliament House, Canberra.

102   National Health and Medical Research Council, *Attention Deficit Hyperactivity Disorder*, 1997, NH&MRC, Canberra.

103   DFADS, *Submission 334*, p. [2].

104   LADS, *Submission 202*, p. 3.

together with evidence of high and rising rates of prescription, strongly suggest that medication is becoming a dominant treatment option at the expense of other approaches.

An inadequate mix of mental health professionals

5.94   The dominance of the medical model manifests in the limited range of mental health professionals financially accessible to consumers. Unsurprisingly, with their ability to prescribe medications, GPs and psychiatrists are heavily represented in financially-accessible services. Psychologists, counsellors and psychotherapists play a distinctly secondary role. Submitters argued that a greater mix of health professionals and, correspondingly, a greater mix of treatments are required to adequately meet the needs of consumers. At the heart of these concerns is ongoing anxiety about the practice of psychiatry.

The practice of psychiatry

5.95   The Royal Australian and New Zealand College of Psychiatrists (RANZCP) submitted that psychiatrists are trained to bring an integrated biopsychosocial approach to mental health problems, which includes treatment with medication (the biological component), psychological therapies, and social interventions:

> Psychiatrists are medical practitioners with a recognised specialist qualification in psychiatry. By virtue of their specialist training they bring a comprehensive and integrated biopsychosocial and cultural approach to the diagnosis, assessment, treatment and prevention of psychiatric disorder and mental health problems. Psychiatrists are uniquely placed to integrate aspects of biological health and illness, psychological issues and the individual's social context.[105]

5.96   However, this holistic approach was not the prevailing experience of consumers or of other organisations. The practice of psychiatry came in for criticism during the course of the inquiry, primarily in relation to its reliance on a medical model of treatment of mental illness.[106] Some witnesses indicated that psychiatrists took an approach where they made an assessment of a patient, formed a diagnosis, and decided on a treatment. This process often happened too quickly, and the treatment determined was often medication and/or confinement. This approach was taken without treating the patient with respect and without taking into account the patient's perspective or broader needs.[107]

5.97   Mrs Pearl Bruhn, a submitter with personal experience of the mental health system, expressed frustration with the perfunctory treatment sometimes received:

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105   RANZCP, *Submission 323*, p. 2.

106   See for example, insane australia, *Submission 2* and attachments.

107   Dr Julie Johnstone, *Committee Hansard*, 5 August 2005, p. 18.

> Psychiatrists, if you are lucky enough to see one, and not just a medical officer, spend only 15 minutes with each patient, with time only to discuss medication. There is no time to deal with the many other worries a patient is likely to have.[108]

5.98   Other personal experiences provided to the committee were similar:

> …psychiatrists knew that mania was a possible side effect of many anti-depressant drugs but they weren't apparently on the alert for it, and they apparently did not know how to recognise it, or what questions to ask. Even after I crashed, they had no idea how to deal with the aftermath, or how to deal with the devastation caused except to write more prescriptions.[109]

5.99   Evidence of negative consumer experience echoed the findings of the Mental Health Council of Australia's *Not for Service* report:

> In short, the available evidence suggests that persons with mental illness still struggle on a daily basis to access appropriate health care or be treated with respect or dignity when they do enter our health care systems.[110]

5.100   The Mental Health Foundation ACT was also critical, noting the propensity towards pharmacological solutions with little attention to the therapist-client interface:

> Professionals, especially medical people, still hold power and authority in our society. Psychiatrists are mainly educated in the medical model of prescribing medication, but are not necessarily clued into the importance of the relationship between themselves and their client, although this is changing.[111]

5.101   Even some doctors found that aspects of the organisation of the health system could be contributing to these kinds of problems and argued that there was a focus on 'biological therapies'. The committee frequently heard how the pressure in public hospitals, and emergency departments in particular, contributed to what was seen as unsatisfactory psychiatric treatment:

> Many trainees are now forced to work on crowded, busy acute adult inpatient units, where the disorders are generally restricted to three or four diagnoses. The patients are chronic and almost impossible to treat and the focus is mainly on the biological therapies.[112]

5.102   Obviously not all consumer experiences with psychiatric treatment are negative. The committee heard from a consumer advocate, Mr John Olsen, a person

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108   Ms Pearl Bruhn, *Submission* 147, p. 2.

109   Name withheld, *Submission 449*, p. 4.

110   Mental Health Council of Australia, *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia – Summary*, 2005, p. 13.

111   Mental Health Foundation ACT Inc., *Submission* 112, p. 4.

112   Health Services Union, *Submission 223*, p. 36

with schizophrenia, who described himself as 'one of the lucky ones' for whom medication worked. He told the committee of his gratitude to a psychiatrist (in a prison setting) who coerced him into taking medication, and established him on the road to a stable life.[113] Others referred to the positive experience of finding a 'wonderful psychiatrist' whose care greatly assisted them or family for whom they cared.[114] Nevertheless, rapidly rising levels of pharmaceutical prescriptions and persistent, widespread complaints about a lack of other therapy options suggest that such positive experiences are not as common as they should be.

5.103   The RANZCP responded to criticisms of psychiatry by saying that they were supportive of consumer and carer involvement when planning treatment. Dr Freidin of the RANZCP stated that:

> In the clinical setting, the more information you can get about someone's social circumstances and social network and the involvement of their carers and their families and their own views, quite simply the better able you are to plan with them what needs to be done and then to implement a plan that will be successful and acceptable to them.[115]

5.104   Dr Freidin went on to say that in some stressful circumstances, involvement of the consumer was difficult:

> We are also aware, though, that practically, in stressed, under-resourced services, when people do start having to act fast to make decisions more quickly than ideally they should—for a host of reasons—one of the things that slips by the wayside is the time that should be taken to consult in detail with family and with the patient before deciding on an ongoing management plan. It is a little easier in private practice because one is a bit more able to control the pace of things.[116]

5.105   The committee recognises that the stresses under which psychiatrists are working, particularly in settings such as public hospital emergency departments, can contribute to poor care outcomes, such as the use of medication ahead of other therapeutic options. These stresses have been outlined in Chapter 4, and are discussed further in Chapter 8. However, these stresses do not account for the under-use of psychologists in the health care system (particularly public health care) compared to psychiatrists.

A greater role for psychologists

5.106   As discussed in Chapter 6, psychologists are under-employed in both the public and private sectors of the mental health system. The Australian Psychological Society submitted:

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113   Mr John Olsen, *Committee Hansard*, 27 July 2005, pp. 59–60.

114   Name withheld, *Submission 131*, p.2.

115   Dr Julian Freidin, President, RANZCP, *Committee Hansard*, 6 July 2005, p. 90.

116   Dr Julian Freidin, *Committee Hansard*, 6 July 2005, p. 90.

> Psychologists are significantly under-utilised in the provision of mental health services due to limited federal/state funding for allied health in the public sector, and by affordable, government-supported access in the private sector.[117]

5.107   At the same time, evidence to this inquiry also suggests there is an unmet need for the kinds of treatments that psychologists can offer. The Australian Psychological Society argued that there is currently only limited use of evidence-based[118] psychological interventions despite their effectiveness in treating a range of mental health disorders. Cognitive behavioural therapy (CBT) was highlighted as a 'best practice' treatment for depression, anxiety, panic disorder and alcohol/drug use, and as a contributing therapy for schizophrenia:

> CBT is a more effective (and cost-efficient) treatment for Major Depressive Disorder than anti-depressant medication (Selective Serotonin Reuptake Inhibitors [SSRIs]) in most cases, especially for youth. In anxiety, CBT is the most cost-effective treatment available for panic disorder and generalised anxiety disorder when compared with pharmacological interventions. Significant developments have occurred in the use of cognitive behavioural strategies for patients with schizophrenia. These interventions have been shown to have a significant impact on symptoms, behavioural responses and relapse incidence.[119]

5.108   An increased role for psychologists could achieve a greater balance between pharmacological and non-pharmacological therapies. For example, *beyondblue* argued that treatments such as cognitive behaviour therapy should be more accessible to consumers.[120] The failure of the health care system to respond to such evidence or to facilitate a diversity of treatment options reflects a narrow medical model which marginalises psychologists and the therapies they offer.

Psychotherapists and Counsellors

5.109   A number of submissions expressed support for greater consumer access to counselling and psychotherapy services and highlighted the benefits of talking therapies.

5.110   The Psychotherapy and Counselling Federation of Australia (PACFA) outlined the form of treatment offered by psychotherapists and counsellors explaining that:

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117   The Australian Psychological Society, *Submission 50A*, p. 6.

118   'Evidence-based' practice refers to psychological interventions that have been identified through research evidence as the most effective for different conditions across a range of patient groups. Australian Psychological Society, *Submission 50A*, p. 15.

119   The Australian Psychological Society, *Submission 50A*, p. 15.

120   beyondblue, *Submission 363*, p. 2.

> Counsellors and psychotherapists work within a clearly contracted, principled and collaborative relationship to enable their clients to explore and resolve a wide range of personal and relational issues.[121]

5.111   In distinction to psychiatrists and psychologists, the training of psychotherapists and counsellors places a far greater emphasis on interpersonal communication, clinical skills and experiential learning, with the therapeutic relationship forming the core of the clinical encounter. In turn, distinctions can be drawn between counselling, which tends to focus on 'specific problems' or 'changes in life adjustment', and psychotherapy, which generally involves intensive, long-term work on 'deeper issues' and/or with more 'deeply disturbed clients'. Both psychotherapists and counsellors receive clinical supervision, which supports the health professional and provides a quality assurance mechanism for consumers by ensuring 'competent and ethical practice'. [122]

5.112   PACFA submitted that counsellors and psychotherapists are under-utilised in current models of care. They argued that government resources need to be allocated across a broad range of services and a wider mix of health professionals.[123]

5.113   PACFA explained that the existing policy framework also limits the role of counsellors and psychotherapists in the non-government sector and consumer access to private services:

> Current government policy provides barriers to employment of well trained counsellors and psychotherapists within the non-government sector and access of clients to private providers. The most important barrier is that the current GST legislation does not recognise counsellors and psychotherapists as approved providers of counselling services. The GST legislation provides for GST-exemption on counselling services provided by several other health professions such as psychiatry, psychology and social work, many of whom would not meet the minimum requirements for specialist training in counselling or psychotherapy, as defined by PACFA. This situation is inequitable. Government policy should provide the same funding to the various health professional groups who can provide counselling services.[124]

5.114   PACFA made a specific recommendation:

> We recommend that Psychotherapists and Counsellors who are eligible for registration on the PACFA national Register for Psychotherapists and Counsellors be recognised in the GST legislation as a recognised provider of counselling services.[125]

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121   The Psychotherapy and Counselling Federation of Australia, *Submission 383*, p. 5.

122   *Submission 383*, p. 5.

123   *Submission 383*, p. 2.

124   *Submission 383*, pp 2-3.

125   *Submission 383*, p. 3.

5.115　The Australian Mental Health Consumer Network (AMHCN) argued in favour of bolstering resources for therapeutic 'talking therapies'. In particular, the AMHCN expressed concern that mental health problems arising from childhood abuse and neglect required early intervention, but that resources in the public health system for providing psychotherapeutic treatment were inadequate:

> AMHCN hears frequently from members with histories of child abuse and neglect. Many consumers come from childhood backgrounds that were psychologically dangerous and damaging. This calls not only on interventions to protect children but also on supporting psychotherapeutic interventions early – before harmful adult mental health patterns are fully established. At the present time there is almost no psychotherapy available in public mental health systems in this country. Since the First National Mental Health Plan 1993-1998 pushed priorities away from 'talking therapies' there has been no investment in developing the capacity of mental health services to respond to people with abuse and neglect histories.[126]

Other forms of care and treatment

5.116　While more and more resources are poured into pharmacological treatments and pharmaceutical research, talk therapies remain relatively hard to access, while other possible approaches to care are largely neglected.

Support groups and consumer-driven recovery approaches

5.117　Several submitters highlighted the importance of support groups in the management of mental illness. The evidence presented by the community-based organisation, GROW, exemplified these views.

5.118　GROW is a voluntary, non-government mental health organisation that operates 'mutual support groups' and provides training and social activities. GROW explained that at the support groups:

> individuals who are experiencing the trauma of mental illness or seek to prevent mental illness, come together to support each other with the aid of GROW's 12 step Program (referred to by some Psychologists as " lay person's cognitive behavioural therapy"). Here members are able to share their difficulties, find commonality and learn to recover from their illnesses with the sustained assistance of a caring and sharing community environment.[127]

5.119　GROW argued that mutual support groups provide a valuable, complementary role in the prevention and recovery stages of mental illness. Based on self-conducted and independent research, GROW submitted that the support groups:

126　AMHCN, *Submission 322*, p. 12.

127　GROW, *Submission 224*, p. 2.

- Significantly reduce the need for hospitalisation

- Decreased the incidence of suicidal thoughts

- Improve quality of life for consumers

- Facilitate development of life management and social skills[128]

5.120   A recent study on GROW support groups undertaken by Lizzie Finn and Dr Brian Bishop, School of Psychology, Curtin University, Western Australia, confirmed GROW's claims. The researchers argued for the recognition of the value of mutual help groups:

> It is important for health professionals to realise the very real benefits which mutual help groups can offer, and to see them as being complementary to mainstream mental health services. Mutual help groups can be integrated with therapy where relevant. For some people, particularly those with the more severe diagnoses, mutual help can be a vital ingredient for maintenance within community and reduction of the risk of relapse.[129]

5.121   In a study undertaken by the Albury-Wodonga Anxiety and Depression Support Group, La Trobe University and the Anxiety Recovery Centre, Victoria, the need for 'more support to support groups' was identified. This included increased funding and improved referral sources – for example, through educating GPs about referral to the support group.[130]

5.122   The need for more support of support groups was reiterated by Patricia Minnar, Coordinator of the Brisbane Obsessive Compulsive Disorder Support Group (BOCDSG). She argued that the lack of substantial recurrent funding was inhibiting the capacity of this state-wide support group.[131]

5.123   The Centre for Psychiatric Nursing Research and Practice (CPNRP) highlighted the importance of recovery centres outside of acute hospital care settings, and consumer driven recovery approaches:

> The Soteria houses set up by Dr Loren Mosher are an example of a recovery centre without forced treatments. There are other recovery centres in Europe and The US, where outcomes are at the least comparable, usually better, than for standard acute hospital care. As the current rhetoric moves toward the language of recovery, it is critical that it is consumers who define this most individual and personal journey. We need the resources to develop and articulate our own deepening and sophisticated thinking about

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128   GROW, *Submission 224*, pp. 13–14.

129   L. Finn and B. Bishop, *Mutual help: An important gateway to wellbeing and mental health*, http://www.vicserv.org.au/publications/new_para/pdf/mhelp.htm (accessed 23 March 2006).

130   Albury-Wodonga Anxiety and Depression Support Group, *Submission 151*, Attachment A, p. 13.

131   BOCD, *Submission 197*, p. 2.

what works best for us, in terms of service provision, and in terms of our own well being and self care. Nobody else can do that for us, and no service or government can be confident of success without that knowledge, and without then directing resources to it. [132]

5.124   The CPNRP noted that consumer support services in Australia are significantly under-resourced and therefore under-developed in contrast to services in New Zealand, the United Kingdom, Europe and the United States:

We know that peer support and peer operated services work. … Australia lags far behind New Zealand, the United Kingdom, Europe and the United States when it comes to resourcing consumer operated peer support and recovery services, so that it is not surprising to find there are almost **no such services** in the whole of the country, and therefore almost no current evaluative data. In fact, the money spent on consumer initiated projects and services is negligible. This is a serious gap, when we already know that these types of services work. If our National mental health plans are to be more than mere rhetoric, proper resources must be devoted to consumer initiated projects and services. [133]

5.125   The Centre recommended:

That funding be allocated to develop peer support programs, and consumer operated services in each state and territory, and that consumers define recovery and what approaches/resources should be used to facilitate recovery. [134]

5.126   Noting that support groups should be encouraged, Professor Gavin Andrews argued that these services should complement rather than stand in for professional treatment. In particular, he emphasised that consumer groups should not be expected to fill the current service-gap. Rather, this should be met by evidence-based therapies. [135] He explained:

During the sixties we had consumer groups taking responsibility for the treatment of people with early psychosis. This experiment failed – people with psychosis did need medication. There is professional knowledge, and for all disorders evidenced-based care is better than compassionate care. The age of moral treatment of the insane as the only therapy is past. Treatment should be expert and moral. [136]

5.127   It was clear from evidence received that support groups play a vital role in the management and recovery of mental illness. If adequately resourced and managed, support groups can contribute significantly to improving the quality of life of

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132   Centre for Psychiatric Nursing Research and Practice, *Submission 217*, p. 16.

133   *Submission 217*, p. 16.

134   *Submission 217*, p. 6.

135   Professor Gavin Andrews, *Submission 176*, p. 11.

136   *Submission 176*, p. 11.

consumers. In this way, they play an important, complementary role to professional therapies. Further, support groups can also ease the pressure on the broader public health system by reducing consumer need for hospitalisation. The committee encourages increased Government investment in support groups. At the same time, the committee believes that improved consumer access to appropriate forms of professional treatment is also vital. Support groups should operate as a complementary and not replacement form of care.

Nutrition-based approaches

5.128   The committee received evidence on other, dietary-based approaches to the treatment of mental illnesses.

5.129   Bio-Balance Health Association argued that 'the focus on biological causes and pharmaceutical solutions' has inhibited the development of 'more refined approaches' that draw on recent scientific advances in the understanding of the biochemistry of brain functioning.[137]

5.130   Bio-Balance was set up in 1998 to:

> promote, support and assist recovery from mental, behavioural and learning disorders through the identification of biochemical imbalances and treatment of such imbalances by complementary nutritional techniques.[138]

5.131   Bio-Balance submitted that there are limits to medication therapy, which they described as a 'blunt instrument':

> The powerful antipsychotic, antidepressant and other psychoactive pharmaceutical medications currently used to treat mental illnesses produce some beneficial effects in most cases, but these benefits are usually partial in nature and the medications can often result in unwanted changes in behaviour and various other 'side-effects' which can be so intolerable as to undermine patient compliance with the prescribed medication.[139]

5.132   Bio-Balance put forward a complementary form of treatment: biochemical treatment. They explained that:

> It is now clearly understood that schizophrenia, bipolar disorder, depression and other mental disorders are primarily caused by imbalances in brain neurotransmitters, the raw materials of which are amino acids, vitamins, minerals and other nutrients. The step-by-step processes by which these neurotransmitters are produced in the brain and how neurotransmitters function are also well understood.

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137   Bio-Balance Health Association, *Submission 378*, p. 1.

138   *Submission 378*, p. 3.

139   *Submission 378*, p. 2.

5.133   In order to remedy these biochemical imbalances Bio-Balance explained that the prescription of 'appropriate nutrients in appropriate dosages' can complement, and in some cases reduce the need for, psychiatric medication therapy.[140]

5.134   Bio-Balance concluded:

> Given the limited effectiveness of present 'mainstream' psychiatric medications and the serious and widespread implications of these limitations for patient, family and community outlined above, any treatment which offers the potential for improvement towards recovery for a significant proportion of people with mental illness warrants serious consideration.[141]

5.135   Mr Douglas McIver, a consumer, submitted a personal account of his success with an alternative treatment – orthomolecular medicine - which enabled him to manage schizophrenia without the use of medication:

> I was diagnosed with schizophrenia in early 1973 and prescribed psychiatric medication for 10 and half years. I had various side effects from my medication. Following research by my wife, Jan, I decided to use an intervention strategy which was a biochemical model endeavouring to reduce the symptoms of mental illness. It involved the effects of foods and chemicals on my health, and required fasting, single food challenges, allergy and sensitivity testing, dietary control, the use of micronutrients, and minimising exposure to toxic chemicals. And, certainly, exercise! The intervention was more than, but included, 'megavitamin therapy'.[142]

5.136   Mr McIver argued that the current paradigm, with its focus on pharmacological treatments, inhibits a full examination of other measures:

> Medical research is stuck in the biochemical approach of the drug treatment paradigm. While this continues, safe and effective treatment regimes using nutrient and food and chemical avoidance regimes are not being fully investigated. The present system seems more interested in proving such treatments do not work than finding out how they do work when they work.[143]

5.137   He envisaged a much greater role for medical accrediting bodies and government in seriously investigating orthomolecular medicine and other alternative/complementary treatments:

> I believe that medical accrediting bodies have a responsibility to give more priority to examining the positive claims that are made about the nutritional and environmental medicine issues in conjunction with advocates. And I feel that Governments can assist the process in various ways and that it is

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140   Bio-Balance Health Association, *Submission 378*, p. 3.

141   *Submission 378*, p. 4.

142   Mr Douglas McIver, *Submission 317*, p. 1.

143   *Submission 317*, p. 4.

their interests to do so. … All that can be done should be done to encourage the medical accrediting bodies, medical researchers and Governments to more proactively assess its inclusion within the Medicare protocols and the NMHS.[144]

5.138   The committee is not advocating any particular approach to treatment of mental illness. It is aware that different treatments have their advocates and their detractors. Some treatments may only work for some people. Some complementary treatments may be effective on their own, while others may assist when used in conjunction with conventional therapies.[145] Some may not be effective at all.

5.139   The committee agrees with the general sentiment expressed by Mr McIver that more attention may need to be paid to researching and disseminating a broad range of therapeutic approaches to different mental illnesses. The committee shares the opinion of the Senate Standing Committee on Community Affairs, in its inquiry into services and treatment options for persons with cancer, that this may involve some broadening of research in the field of medicine. That committee recommended:

> the National Health and Medical Research Council provide a dedicated funding stream for research into complementary therapies and medicines, to be allocated on a competitive basis.[146]

5.140   The Mental Health Committee notes that the NHMRC essentially rejected this recommendation, arguing that

> funding of research into complementary therapies and medicines, like the funding of other health and medical research, must be on the basis of excellence as assessed by peer review. Any funding for research outside of existing schemes, such as Project Grants, would need to be based on identified need and met from external sources.[147]

5.141   While there can be debate about what mechanisms are best to fund a broader research base, the underlying concern remains that research is currently not as broad as it could be, and this appears to marginalised those therapies that do not fit easily with the dominant medical model. The committee hopes that the current dominance of both pharmacological treatment and pharmacological research will be corrected through a range of measures, including some recommended in other chapters of this report. It can also see a case for a broad-based review of the current state of research

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144   Mr Douglas McIver, *Submission 317*, pp 7-8.

145   V. Kotsirilos, 'Psychotic illness: Does complementary medicine have a role in management?', *Australian Family Physician*, vol. 35, no. 3, pp. 115–116, 2006.

146   Senate Standing Committee on Community Affairs, *Inquiry into services and treatment options for persons with cancer*, June 2005, Recommendation 22.

147   Senate Standing Committee on Community Affairs, Response to the recommendations directed to the National Health and Medical Research Council (NHMRC), http://www.aph.gov.au/Senate/committee/clac_ctte/cancer/response.htm, (accessed March 2006).

in the area of mental health. This will help a transition toward a more balanced approach to care.

A balanced approach to care

5.142   Dr Di Nicolantonio argued that the medical model was fundamentally flawed and suggested a 'new paradigm' of care:

> Set up a completely new paradigm for the treatment of so called mental illness. There are just too many competing ideologies at the moment. This is understandable given that mental illness and its treatment is a relatively new academic construct. Organic brain diseases such as dementia, mental retardation and schizophrenia will probably always remain within the province of the medical profession. Psychosis is in a bit of grey area. However, for states such as depression, anxiety, eating disorders, borderline personality disorders and addictions, the "patient" should be placed in the primary care of a psychologist or (better still) a psychoanalyst. A consultant psychiatrist would also be assigned to act in a liaison capacity only.[148]

5.143   Similarly the Australian Mental Health Consumer Network (AMHCN) submitted that the range of services available to consumers can no longer afford to be constrained by the medical model:

> [T]he variety and scope of available services [should] no longer be limited by institutional traditions or medical model understandings of what constitutes a health intervention.[149]

5.144   These views were reaffirmed by GROW:

> The belief that assumes the majority of problems experienced by mental health consumers are solved solely via medication and/or hospitalization needs to be challenged. In nearly all forms of mental illness medication/hospitalisation is not sufficient for recovery.[150]

5.145   Dr Horton-Hausknecht recommended that:

> Non-drug therapies should be supported and promoted as the first line of therapy for mental health problems such as depression and anxiety, with medications used as a last resort – not the other way around. [151]

5.146   Research shows that non-pharmacological interventions can be effective across a range of illnesses. While it is clear that a pharmacological approach is appropriate and, indeed, imperative for certain illnesses under certain conditions, the dominance of pharmacological intervention does not appear to be justified. In

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148   Dr Robert Di Nicolantonio, *Submission 526a*, p. 7.

149   AMHCN, *Submission 322*, p. 5.

150   GROW, *Submission 224*, p. 13.

151   Dr Jillian Horton-Hausknecht, *Submission 337*, p. 2.

economic terms, it has been argued that the efficiency of the system could be greatly enhanced through a mix of therapies and models of care:

> [I]t has been estimated that the efficiency of the system (specifically when dealing with persons with common disorders such as depression or anxiety) could be doubled by improving the balance between primary and specialist care providers and the use of medications or psychological therapies.[152]

5.147   The research highlights an over-reliance on medications for immediate and long-term care and inadequate attention to early intervention, the use of non-pharmacological treatments and specialised recovery programs. The flow-on effects are great. For example, the research states that the numbers of people with enduring mental illness able to return to work or other forms of social participation in Australia is half that of people in other OECD countries.[153] As a result, it is argued that increased expenditure should be directed towards remedying this situation.[154]

5.148   The committee is concerned that the dominance of the medical model may colour assessments of alternative/complementary forms of treatment and inhibit research into these areas. As discussed in Chapter 8, it is clear that the system still emphasises cure and crisis management and not prevention and early intervention, with care concentrated in the hospital system.

5.149   Evidence to the inquiry suggests there would be both economic and therapeutic benefits to diversifying treatments. The form this would take is two-fold:

- supporting consumer access to psychologists and other non-medical practitioners through the public health system, and Medicare access to private sector health professionals

- investment in research on other treatments

Conclusion

5.150   The committee was disappointed to hear that there is a considerable disjunction between the aspirations of the National Mental Health Plan to provide a 'holistic approach' to mental health care in Australia and the actual range of treatments available to consumers. The committee recognises the necessity of pharmacological interventions and supports ongoing research to improve and refine pharmacological

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152   I. Hickie, G. Groom and T. Davenport, *Investing in Australia's Future: the personal, social and economic benefits of good mental health*, December 2004, Brain & Mind Research Institute and Mental Health Council of Australia, p. 69.

153   I. Hickie, G. Groom and T. Davenport, *Investing in Australia's Future: the personal, social and economic benefits of good mental health*, December 2004, Brain & Mind Research Institute and Mental Health Council of Australia, p. 69.

154   I. Hickie, G. Groom and T. Davenport, *Investing in Australia's Future: the personal, social and economic benefits of good mental health*, December 2004, Brain & Mind Research Institute and Mental Health Council of Australia, p. 73.

options available to consumers. However, it is clear that a better balance between pharmacological and non-pharmacological treatments is urgently required.

5.151   Within the current paradigm consumers have limited choice in the kinds of treatments available to them – unless they can afford the luxury of choice. The form of treatment offered is determined by the prevailing approach rather than the treatment being tailored to meet the specific needs of the consumer. This problem is exacerbated by the tendency to view mental illnesses as a homogeneous group.

5.152   In some cases, access to treatment is extremely restricted. The current (inadequately resourced) system concentrates on low-prevalence disorders and acute and crisis cases. At the same time, the system and many health professionals appear to be ill-equipped to manage certain illnesses such as obsessive-compulsive disorder and some of the personality disorders.

5.153   The dominance of the medical model and the consequent dominance of psychiatric treatment have resulted in these limits. While the committee recognises that consumer experience of psychiatric treatment has in many cases been positive, evidence to this inquiry suggests an unacceptable level of dissatisfaction with the current paradigm of care. Further, positive experiences conveyed to the committee highlight the expertise, compassion and receptiveness of *individual* psychiatrists rather reflecting a systemic attitude or approach to psychiatric treatment.

5.154   The committee believes that all consumers should receive appropriate forms of support in a timely manner. To this end, the committee supports the diversifications of treatments available in the mental health system. This will require:

- An increased role for psychologists, psychotherapists and counsellors in the mental health system

- Improved access of consumers to these health professionals through a) more positions for these health professionals in the public sector and b) Medicare funded access to these health professionals

- Investment in research of alternative treatments

5.155   Whilst the committee appreciates that public resources are invariably limited and must be targeted accordingly, the under-resourcing of mental health in Australia and the resulting focus on low-prevalence disorders and crisis intervention produces false economies. This is compounded by the dominance of the medical model and an over-reliance on pharmacological approaches. Evidence suggests that the diversification and appropriate targeting of treatments could, in fact, produce savings as well as enhancing the mental health and well-being of consumers.

CHAPTER 6

ACCESS TO MENTAL HEALTH SERVICES

6.1   Access to mental health services was a key issue for the inquiry. This chapter deals with the role of mental health professionals, workforce training and shortages and their uneven geographical distribution, government initiatives intended to overcome these problems, barriers to utilising allied mental health workers and alternative models of primary health care.

Workforce issues

Psychiatrists

6.2   Psychiatrists are medical practitioners with a recognised specialist qualification in psychiatry.[1] They work in public hospitals, community mental health services, private hospitals, and in private practice. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) stressed the importance of their leadership role:

> Psychiatrists are uniquely placed to integrate aspects of biological health and illness, psychological issues and the individual's social context. They provide clinical leadership with many working in multidisciplinary team settings. Psychiatrists treat patients and work with the patient's general practitioner, other health care providers, families and carers of patients, and the general community.[2]

6.3   Access to psychiatrists is however very limited. The Australian College of Psychological Medicine (ACPM) submitted that private psychiatrists were largely inaccessible because few bulk-billed, most are located in metropolitan areas and too few psychiatrists are employed in the public sector. ACPM pointed out:

> Most [public psychiatrists] are too busy coping with acute crises to be able to become pro-active in prevention and early intervention. Most have no time to deal with the high prevalence disorders such as anxiety, depression, personality disorders and drug abuse, in the main treating the individually very demanding schizo-affective range of disorders.[3]

6.4   The RANZCP itself said; 'There is clearly a discrepancy between the available psychiatric workforce and the mental health needs of the population'[4]. Dr Martin Nothling, a psychiatrist representing the Australian Medical Association (AMA), said this shortage translated into long waits for patients to see psychiatrists:

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1   Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Submission 323*, p. 2.

2   *Submission 323*, p. 2.

3   Australian College of Psychological Medicine (ACPM), *Submission 411*, pp. 6–7.

4   *Submission 323*, p. 3.

> ...in many cases there can be delays of weeks or months before someone can be seen because psychiatrists are literally so busy. It is common talk at any psychiatry meeting you go to where you talk to colleagues—everyone is booked out. How can you keep seeing patients? You cannot. ... You just cannot keep adding on patients and working on into the night.[5]

6.5   Several witnesses commented that not many private psychiatrists bulk-billed, putting access beyond the financial reach of many.[6] Psychiatrist Professor Ian Hickie told the committee that the out-of-pocket costs of seeing a psychiatrist had risen by 49 percent since 1998.[7]

6.6   Difficulty in attracting young doctors to train as psychiatrists was identified as a serious problem. The AMA indicated that many psychiatric registrar training positions across the country are not filled by trainees:

> Psychiatrists are among the poorest paid of all medical specialties and it is not attracting sufficient new entrants which will show up in serious workforce shortages in later years.[8]

6.7   The Australian Medical Workforce Advisory Committee found that psychiatry was one of a minority of specialisations in which fewer people were training than had been recommended, and the only one showing a decline in numbers.[9] Dr Nothling told the committee how potential trainee psychiatrists were put off pursuing a career in the field:

> They go into these emergency rooms and they see how dysfunctional they are. If you have a patient who is psychotic, what do you do? It is extremely difficult. You spend a lot of time on telephones trying to find a bed somewhere. You cannot get them in. The treatment they need is in-patient facilities. They are not available. The emergency rooms get clogged up. The young doctors see all that and they start thinking, 'Would you want to be in this area?' That is a big problem. Many doctors who have said to me: 'Look, I wanted to be a psychiatrist,' said that once they started to see how the system was not working decided they would go elsewhere.[10]

6.8   Compounding the shortage of psychiatrists is their poor distribution geographically, with the majority concentrated in urban areas. The National Rural Health Alliance (NRHA) observed that at the general hospitals outside of major urban centres that must deal with mental health in-patients, there are few or no psychiatrists, and that less than 3 percent of psychiatrists or psychiatrists in training work outside

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5   Dr Martin Nothling, Federal Councillor, Australian Medical Association (AMA), *Committee Hansard*, 19 May 2005, p. 68.

6   See, for example, Dr Georgina Phillips, *Committee Hansard*, 6 July 2005, p. 10.

7   Professor Ian Hickie, *Committee Hansard*, 19 May 2005, p. 28.

8   AMA, *Submission 167*, p. 2.

9   Australian Medical Workforce Advisory Committee, *Annual Report 2002–03*, AMWAC Report 2003.4, September 2003, pp. 15–19, http://www.health.nsw.gov.au/amwac/amwac/pdf/amwannual_20034.pdf, (accessed March 2006).

10   *Committee Hansard*, 19 May 2005, p. 64.

major cities and inner regional centres.[11] Data from the Australian Institute of Health and Welfare (AIHW) indicates that whereas there are 7.1 private psychiatrists per 100 000 population practising in major cities, the equivalent figure for non-major city areas is far less, with only 1.8 per 100 000 in inner regional areas, and less than 0.1 per 100 000 for outer regional and remote areas. (Figure 5.1)[12] Even within urban areas, psychiatrists are more likely to be located in more affluent neighbourhoods.[13]

Figure 5.1   Number of psychiatrists per 100 000 population
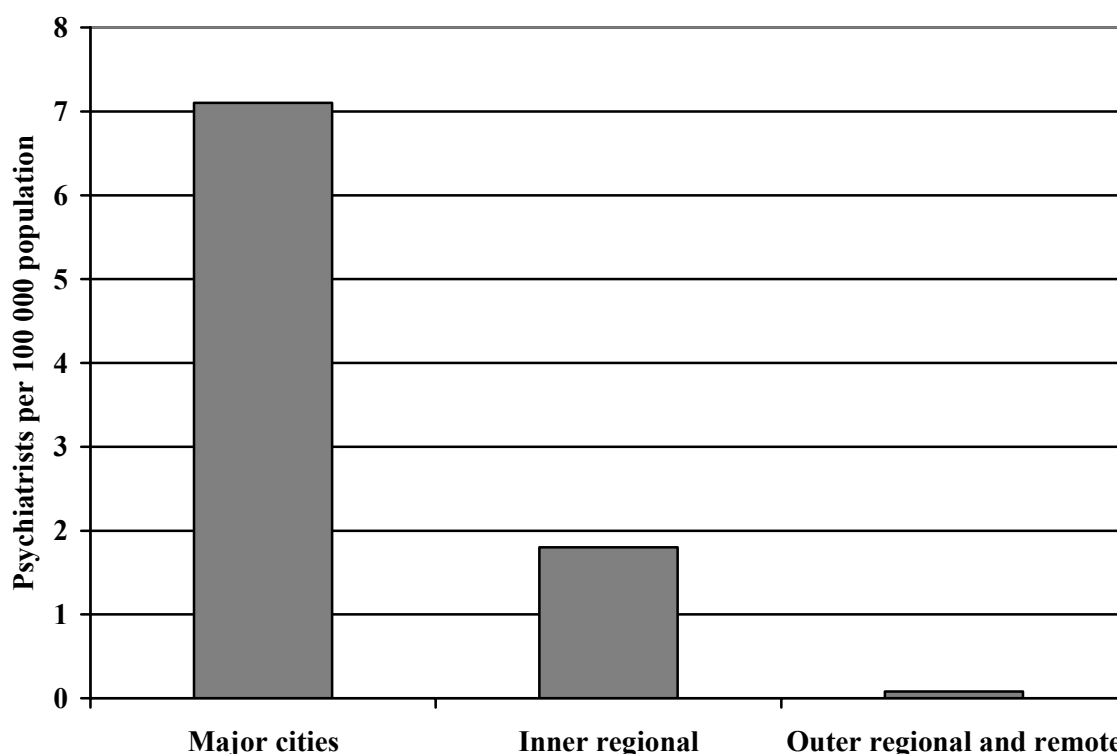
6.9   Lifestyle appears to be a factor in the maldistribution of psychiatrists. The RANZCP commented that psychiatrists liked to be close to fellow psychiatrists to share information and for continuing education programs.[14] Other evidence pointed to problems with practising in small communities:

> Unless you have a critical mass of psychiatrists on call ... you are going to meet most of your patients in Coles and your kids are going to be playing on the football team with some of your chronic patients et cetera. So there

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11   National Rural Health Alliance (NRHA), *Submission 181*, p. 19.

12   Australian Institute of Health and Welfare (AIHW) 2005, *Mental Health Services in Australia 2002-03*, Canberra, AIHW (Mental Health Series No. 6), p. 199.

13   Ms Jane Halton, Secretary of the Department of Health and Ageing has indicated that ' there is a particularly high concentration of psychiatrists on the north shore of Sydney and east Melbourne.' *Estimates Hansard*, Senate Community Affairs Legislation Committee, 2 November 2005, p. 62.

14   Dr Julian Freidin, President, RANZCP, *Committee Hansard* 6 July 2005, p. 87.

are issues about living in rural communities for mental health professionals generally that are tricky.[15]

6.10   Initiatives are being taken to address the lack of psychiatrists in rural and regional areas. These are discussed further in Chapter 16 in the context of the needs of rural and regional Australians.

6.11   The practice of psychiatry came in for criticism for its reliance on a medical model of treatment.[16] Some witnesses said psychiatrists assessed patients and formed a diagnosis too quickly and prescribed treatment that was all too often medication and/or confinement, They were also criticised for not treating the patient with respect and without taking into account the patient's perspective or broader needs.[17]

6.12   Mrs Pearl Bruhn, with personal experience of the mental health system, expressed frustration with the perfunctory treatment sometimes received:

> Psychiatrists, if you are lucky enough to see one, and not just a medical officer, spend only 15 minutes with each patient, with time only to discuss medication. There is no time to deal with the many other worries a patient is likely to have.[18]

6.13   Others complained:

> …psychiatrists knew that mania was a possible side effect of many anti-depressant drugs but they weren't apparently on the alert for it, and they apparently did not know how to recognise it, or what questions to ask. Even after I crashed, they had no idea how to deal with the aftermath, or how to deal with the devastation caused except to write more prescriptions.[19]

6.14   The Mental Health Foundation ACT was also critical:

> Professionals, especially medical people, still hold power and authority in our society. Psychiatrists are mainly educated in the medical model of prescribing medication, but are not necessarily clued into the importance of the relationship between themselves and their client, although this is changing.[20]

6.15   The pressure in public hospitals, and emergency departments in particular, contributed to what was seen as unsatisfactory psychiatric treatment:

> Many trainees are now forced to work on crowded, busy acute adult inpatient units, where the disorders are generally restricted to three or four diagnoses. The patients are chronic and almost impossible to treat and the focus is mainly on the biological therapies.[21]

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15   Dr Jennifer May, Secretary, NRHA, *Committee Hansard* 4 July 2005, p. 80.

16   See, for example, insane australia, *Submission 2* and attachments.

17   Dr Julie Johnstone, *Committee Hansard*, 5 August 2005, p. 18.

18   Mrs Pearl Bruhn, *Submission 147*, p. 2.

19   Name withheld, *Submission 449*, p. 4.

20   Mental Health Foundation ACT, *Submission 112*, p. 4.

21   Dr Anthony Llewellyn, in Health Services Union, *Submission 223*, p. 36.

6.16   Obviously not all consumer experiences with psychiatric treatment are negative. Consumer advocate, Mr John Olsen, a person with schizophrenia, described himself as 'one of the lucky ones' for whom medication worked. He told the committee of his gratitude to a psychiatrist (in a prison setting) who coerced him into taking medication, and established him on the road to a stable life.[22] Others referred to the positive experience of finding a 'wonderful psychiatrist' whose care greatly assisted them or family for whom they cared.[23]

6.17   The RANZCP responded to criticisms of psychiatry by saying that psychiatrists were working with a biopsychosocial model of care that was consumer-centred:

> In the clinical setting, the more information you can get about someone's social circumstances and social network and the involvement of their carers and their families and their own views, quite simply the better able you are to plan with them what needs to be done and then to implement a plan that will be successful and acceptable to them.[24]

6.18   Dr Freidin argued that inadequacies in psychiatric assessment and treatment are often the result of factors beyond the clinician's control, agreeing that sometimes this resulted in consumers and carers being marginalised:

> We are also aware, though, that practically, in stressed, under-resourced services, when people do start having to act fast to make decisions more quickly than ideally they should—for a host of reasons—one of the things that slips by the wayside is the time that should be taken to consult in detail with family and with the patient before deciding on an ongoing management plan. It is a little easier in private practice because one is a bit more able to control the pace of things.[25]

Mental health nurses

6.19   Mental health nurses work in public and private hospitals, community mental health centres and teams, prison mental health services, and in private medical practices. They are a significant part of the mental health workforce: in 2001 there were 62.2 mental health nurses per 100,000 population.[26]

6.20   A joint submission by peak nursing representative bodies, the Association for Australian Rural Nurses (AARN), the Australian and New Zealand College of Mental Health Nurses (ANZCMHN) and Royal College of Nursing Australia (RCNA), identified the current nation-wide shortage of psychiatric nurses as critical, and affected the ability of nurses to do their jobs properly:

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22   Mr John Olsen, *Committee Hansard*, 27 July 2005, pp. 59-60.

23   Name withheld, *Submission 131*, p.2.

24   Dr Julian Freidin, *Committee Hansard*, 6 July 2005, p. 90.

25   *Committee Hansard*, 6 July 2005, p. 90.

26   Australian Institute of Health and Welfare (AIHW) 2005, *Mental Health Services in Australia 2002-03*, Canberra, AIHW (Mental Health Series No. 6), p. 199.

The mental health nurse may be so overburdened by their workload that they are unable to perform their roles to its fullest potential, and are themselves being exposed to stress and anxiety. Staff going on leave, especially in community services, are usually not replaced resulting in the remaining staff not having the time to follow up all of their clients.[27]

6.21   This joint submission from nursing peak bodies also pointed out that the workforce shortage is more marked in rural, regional and remote areas:

There are a higher proportion of mental health nurses in the capital cities and very low numbers in smaller regional and remote areas (Australian Institute of Health and Welfare 2001). The shortage further compounds the under-servicing of rural and remote locations.[28]

6.22   The numbers of mental health nurses in major cities, inner and outer regional areas and remote and very remote are shown in Figure 5.2.[29]

Figure 5.2   Number of mental health nurses per 100 000 population
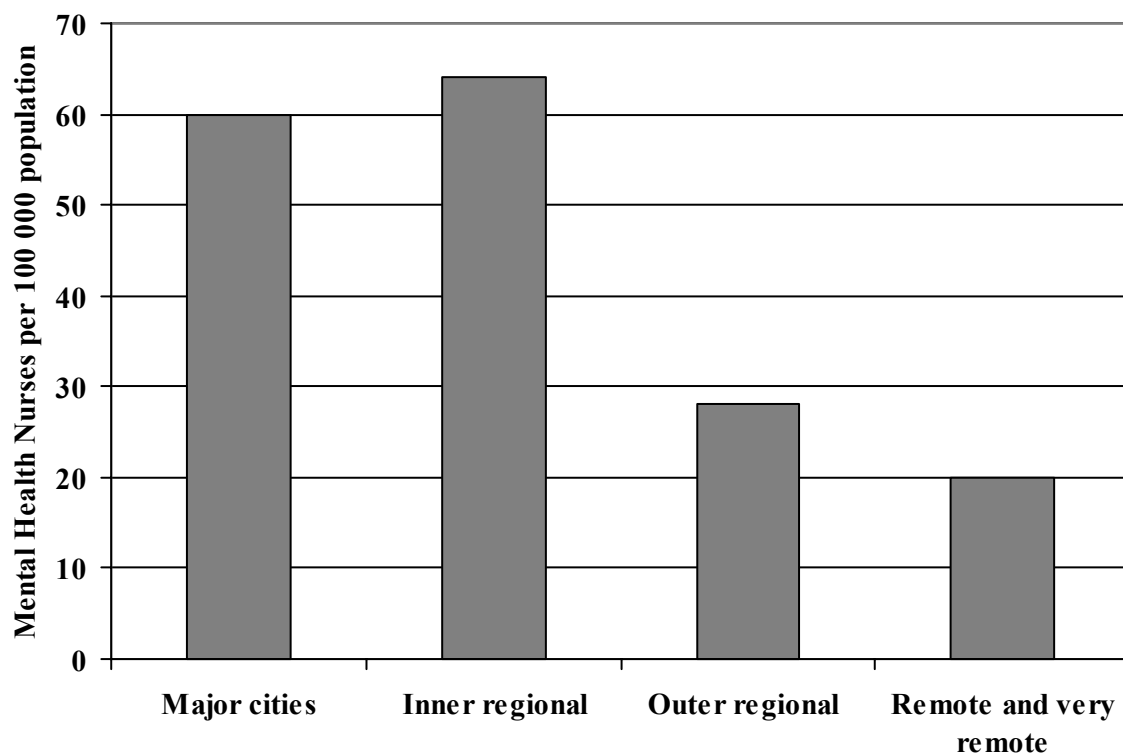
6.23   Submissions referred to the difficulty in recruiting and retaining nurses in the field of mental health. The ageing of this workforce was noted as a significant problem, with mental health nurse Mr Jon Chesterson observing that:

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27   Australian Rural Nurses (AARN), the Australian and New Zealand College of Mental Health Nurses (ANZCMHN) and Royal College of Nursing Australia (RCNA), *Submission 321*, p. 5.

28   AARN, ANZCMHN and RCNA, *Submission 321*, p. 6.

29   Australian Institute of Health and Welfare (AIHW) 2005, *Mental Health Services in Australia 2002-03*, Canberra, AIHW (Mental Health Series No. 6), p. 11.

...the average age of the mental health nursing workforce is 47+, and more than half of the existing workforce is expected to retire within the next 15 years. The pitifully small trickle of new graduates into mental health today compared with the late nineteen seventies and early eighties has already resulted in a workforce crisis.[30]

6.24   The Health Services Union pointed out that the bulk of older nurses are graduates of the former direct entry psychiatric nursing courses.[31] Unlike their older colleagues, nurse trainees today must first undertake a three-year generalist nursing degree (with very limited content on mental health theory and clinical practice)[32], followed by post-graduate studies in mental health nursing. Thus there is a reliance on generalist graduates being attracted to pursuing further studies in mental health. The committee heard that this was not happening to a sufficient extent. The NSW Nurses' Association commented that 'the appeal of the sector to new graduates is diminishing.'[33] Stressful working conditions and significant levels of violence in the mental health workplace were mentioned in several submissions as negative factors.[34] The AMA commented:

> ...nurses are not being attracted to work in psychiatry because the system is dysfunctional and because of security problems. It is a common theme across the nation that nurses and doctors attending severely disturbed patients are being assaulted at a rate which is causing concern and public discussion amongst these groups.[35]

6.25   A study of a psychiatric unit at one hospital in NSW revealed high levels of violence and aggression, and pointed to the heavy toll on mental health nurses:

> [Psychiatric] Units where high levels of aggression and violent behaviour are experienced in the workplace on a daily basis must be acknowledged as dangerous workplaces. Staff work continuously under elevated stress levels (physical, mental and emotional). Staff locked in [these] units for eight hours per day for five shifts per week with aggressive patients must pay a toll in some way. [36]

6.26   To address the problems of recruitment, the joint submission from peak nursing bodies argued that mentoring in mental health nursing needed to be provided to encourage already practicing nurses into the field, and that funding incentives were also required:

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30   Mr Jon Chesterson, *Submission 177*, p. 3.

31   Dr Anthony Llewellyn, in Health Services Union, *Submission 223*, p. 14.

32   AARN, ANZCMHN and RCNA, *Submission 321*, p. 5.

33   NSW Nurses' Association, *Submission 391*, p. 7.

34   See, for example, *Submission 321*, p. 15; Mr Jon Chesterson, *Submission 177*, p. 6; AMA, *Submission 167*, p. 21.

35   *Submission 167*, p. 21.

36   James Fletcher Hospital Psychiatric Emergency Centre and Psychiatric Intensive Care Unit, *Overt Aggression Survey*, Mr M Witkowycz (RN), *Submission 349* (Attachment 1), p. 24.

> It is ... important that appropriate funding be made available for transition programs specifically for mental health ... for newly graduating nurses coming into the workforce, to attract them into this specialty field.[37]

6.27   The shortage of mental health nurses has been the subject of many reviews and studies. Submissions made reference to the 2003 report of the Australian Health Workforce Advisory Committee, *Australia Mental Health Nurse Supply, Recruitment and Retention*.[38] This report made a number of recommendations to address workforce shortage issues, including that an agreed framework for mental health content in undergraduate general nursing degrees be developed.[39] The committee notes the recent Victorian State Government *Victorian Taskforce on Nurses Preparation for Mental Health Work Report* (September 2005), which recommends, amongst other things, the trial of a specialist university degree with a major in mental health.[40]

Psychologists

6.28   The greater role that could be played by psychologists, particularly clinical psychologists, in Australia's mental health workforce was a strong theme in the inquiry.

6.29   Psychologists, as defined by the Australian Institute of Health and Welfare, consult with individuals and groups, assess psychological disorders, and administer programs of treatment.[41] They do not prescribe medication, and according to the Australian Psychological Society (APS), have spearheaded the development of non-pharmacological treatments.[42] There are several different specialisations within psychology, all requiring additional post-graduate study and training. The APS advised of a number of specialist affiliated colleges covering the fields of clinical, community, counselling, educational and developmental, organisational, neuropsychology, and health psychology.[43] The committee received evidence that psychologists can play an important role in the assessment and treatment of mental disorders.[44]

6.30   The public sector is a major employer of psychologists, particularly in community mental health teams. Yet evidence from representative psychologist bodies suggests that psychologists in these teams are increasingly employed in generic

37   *Submission 321*, p. 5.

38   Australian Health Workforce Advisory Committee (2003), *Australian Mental Health Nurse Supply, Recruitment and Retention*, AHWAC Report 2003.2, Sydney.

39   Australian Health Workforce Advisory Committee (2003), *Australian Mental Health Nurse Supply, Recruitment and Retention*, AHWAC Report 2003.2, Sydney, p. 19.

40   Victorian Government Department of Human Services, *Victorian Taskforce on Nurses Preparation for Mental Health Work Report*, Melbourne, September 2005.

41   Australian Institute of Health and Welfare (AIHW), *Mental Health Services in Australia 2002-03*, Canberra, AIHW (Mental Health Series No. 6), 2005, p. 200.

42   Australian Psychological Society (APS), *Submission 50A*, p. 4.

43   *Submission 50A*, p. 4

44   Mr Raymond Rudd and Professor Henry Jackson, *Submission 401*, p. 4.

positions as 'case managers' or 'allied health workers', and not providing psychological assessment and treatment for which they are trained.[45] Many are too busy dealing with clients with serious mental illness to be able to provide effective early intervention 'upstream' treatment, or to provide treatment to those with high prevalence disorders such as depression. The Victorian Section of the APS explained:

> Mental health services are currently only available to those with the most severe mental health disorders. Many people suffering from complex and disabling psychological problems, including disorders of high prevalence, are unable to access psychological treatments in the public mental health sector, despite evidence of their effectiveness. In addition, the long waitlists and increasing caseloads present in continuing care mental health teams mean that little or no opportunity is available for clinical psychologists to provide early intervention and relapse prevention.[46]

6.31   Clinical Psychologist Dr Jillian Horton argued that public mental health services should maintain the capacity to provide psychological treatments by making more positions available for clinical psychologists:

> There needs to be many more positions available to six year trained Psychologists in Community Health Centres and public mental health services so that consumers can access these services. Psychological therapy positions should not be down graded into generic mental health worker positions or to other professions with short training in a limited number of psychological therapy skills.[47]

6.32   Better access to psychologists was not only supported for its potential to increase the scope of mental health services but also for helping to provide a better balance between 'drug-therapy' and 'talk therapy'. Some submissions expressed a view that medication as a treatment was sometimes overused by both psychiatrists and GPs, and that non-pharmacological treatment was often effective as an alternative or in combination with medication. The Western Australia Section of the College of Clinical Psychologists – APS - submitted that:

> Research from overseas indicates that most consumers with less serious mental health problems do not receive adequate care for their mental health problems from GPs and this can lead to a worsening of their mental health problems. Research also indicates that GPs tend to prescribe medication for less serious mental health problems which adds to the high cost of medical care, yet these individuals could be treated as effectively (and sometimes more effectively) by psychological interventions provided by clinical psychologists.[48]

6.33   Beyondblue argued:

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45   Victorian Section, APS, *Submission 479*, p. 4.

46   *Submission 479*, p. 3.

47   Dr Jillian Horton, *Submission 337*, p. 16.

48   Western Australia Section of the College of Clinical Psychologists – APS, *Submission 101*, p. 3.

> Non-pharmacological treatments, such as cognitive behaviour therapy, are effective and therefore need to be more accessible to the general community through improved access to psychologists and allied health.[49]

6.34   Access to psychological services was perhaps the single biggest issue about which the committee heard evidence. In the private sector, many psychologists registered to practise offer a range of psychological treatment for mental health problems. However, as many submissions pointed out, access to these private-sector services was beyond the financial reach of many. The cost of a one hour sessions with a psychologist usually ranges from $100 to $175[50] for which there is no Medicare rebate, unlike consultations with private GPs and psychiatrists. The Mental Health Association of NSW pointed out that 'people with depression often want a choice between medication and counselling, but find that their only access to counselling is through private practitioners, and Medicare does not cover these services'.[51] The Public Health Association of Australia commented that:

> ...for most people with mental disorders, clinical psychologists in private practice are only accessible to those with the ability to pay. This is therefore a greatly under-utilised resource, particularly as many of the newer psychological treatments are provided by this group of mental health professionals.[52]

6.35   This issue of whether or not governments should fund or subsidise access to psychological treatment in the private sector, either through Medicare or in some other way, was a recurrent theme of the inquiry. This matter is discussed in more detail in a later section of this chapter.

6.36   The committee notes that private health insurance (ancillaries cover) can provide some reimbursement of costs for psychological services, but the benefits paid cover only a small portion of the cost paid for the service[53] and many people needing mental health services are socially and financially disadvantaged, and cannot afford private health insurance.[54]

General practitioners

6.37   GPs are the first point of professional contact for a great majority of people seeking help with mental health problems.[55] Although research suggests that only 38

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49   Beyondblue, *Submission 363*, p. 2.

50   Black Dog Institute; Black Dog Institute fact sheets, available at http://www.blackdogInstitute.org.au/gettInghelp/consultprof/psychologIsts.cfm , (accessed December 2005). See also Anxiety and Depression Support Group Albury Wodonga, *Submission 151*.

51   Mental Health Association NSW, *Submission 230*, p. 12.

52   Public Health Association of Australia, *Submission 212*, p. 3.

53   Victorian Section, APS, *Submission 479*, p. 4.

54   Private health Insurance for Psychiatric Services is discussed in more detail in Chapter 12.

55   See, for example, General Practice Mental Health Standards Collaboration (GPMHSC), *Submission 320*, p. 3; Australian Divisions of General Practice (ADGP), *Submission 308*, p. 10.

per cent of those with mental health problems seek help, of those that do, 75 per cent do so in the first instance from a GP.[56] Many with chronic physical conditions visiting GPs frequently also have comorbid mental health conditions such as depression and anxiety.[57] The role of GPs in mental health is especially significant in rural and remote areas, where there are often no other health workers.[58]

6.38   Dr Rob Walters of the Australian Divisions of General Practice (ADGP) told the committee that 'it is general practice and not the specialist mental health system that delivers the greater majority of mental health care in this country', with over 10 million general practice visits in 2003-04 related to mental health.[59] Most people with high prevalence disorders such as depression and anxiety are seen by GPs.

6.39   The role of GPs as a 'gateway' to other services was mentioned in a number of submissions.[60] The AMA submitted that:

> General Practitioners (GPs) are the most accessible medical resource in the community and are the gatekeepers to other community resources such as specialist psychiatric care and acute care.[61]

6.40   The ACPM argued that, because of the limited access to psychiatrists and psychologists, GPs were significant providers of mental health care, especially to the financially disadvantaged:

> General practitioners ... have to provide a large proportion of mental health services in this country. It cannot be overemphasised that the mental health services general practitioners provide are to the most financially needy, those who cannot access the private sector, and those with the most difficult diagnoses in terms of their social impact – those with chronic as opposed to acute problems who therefore cannot access the crisis-focussed public system either.[62]

6.41   GPs should not be regarded as the last resort in service provision. The AMA argued:

> [It is necessary to] Recognise that GPs will not be able to 'pick up the pieces' when other mental health services, public specialist mental health services in particular, are not able to provide sufficient services to their consumers, particularly those with supposedly less serious mental illnesses and those in extreme disadvantage, including financial disadvantage.[63]

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56   AMA, *Submission 167*, p. 9.

57   *Submission 308*, p. 10.

58   SA Divisions of General Practice, *Submission 88*, p. 1.

59   Dr Rob Walters, Chairman, ADGP, *Committee Hansard*, 4 July 2005, pp. 82–83.

60   See, for example, Royal Australian College of General Practitioners (RACGP), *Submission 311*, p. 5.

61   AMA, *Submission 167*, p. 9.

62   ACPM, *Submission 411*, p. 7.

63   *Submission 167*, p. 41.

6.42   In recognition of the reliance on GPs for the provision of primary mental health care, the Australian Government in 2001 introduced and funded the Better Outcomes in Mental Health Care initiative (Better Outcomes). Better Outcomes provided education and training for GPs in mental health, improved access to psychiatrist support for GPs, and funded referrals to psychological services in private practice. Evidence to the inquiry indicates that Better Outcomes has been a useful initiative, though take-up by GPs and caps have limited its distribution. Better Outcomes is discussed in more detail later in this chapter.

6.43   The Inquiry into the Human Rights of People with Mental Illness in 1993 (the Burdekin Inquiry) had found that the training of GPs in mental health was inadequate, and that they often failed to identify mental illness.[64] The inquiry recommended that GPs receive more comprehensive mental health education.[65] One of the results of Better Outcomes has been an improvement in the mental health care skills amongst the approximately 20 per cent of GPs who have undertaken training. Several submissions argued that curricula at the undergraduate level and in GP registrar training were deficient in mental health assessment skills and care.[66] The ADGP suggested that the training provided in Better Outcomes should be incorporated into GP registrar training.[67]

6.44   It was argued that the general practice fee structure for Medicare rebates discouraged the long consultations often required when dealing with patients with mental health problems.[68] The Royal Australian College of General Practitioners (RACGP) submitted that more effective and comprehensive care was achieved within longer consultations, yet the GP consultation item structure encourages shorter consultations.[69] Evidence from the ACPM indicated that a GP dealing with usual medical problems could normally see four or more patients in the same time that they could consult with one patient with a mental health problem.[70]

Other professional groups

6.45   Social workers and occupational therapists are often members of community mental health teams, performing case-worker and other roles. However, the committee received little evidence regarding these professional groups. Training courses for a

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64   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry Into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, pp. 194–195.

65   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry Into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, pp. 194–195.

66   See, for example, see GPMHS, *Submission 320*, p. 6.

67   ADGP, *Submission 308*, p. 3.

68   See, for example, AMA, *Submission 167*, p. 41; RACGP, *Submission 311*, p. 5; ACPM, *Submission 411*, p. 7.

69   *Submission 311*, p. 5.

70   *Submission 411*, p. 7.

relatively new group – Aboriginal mental health workers – is addressed in Chapter 16 in discussion of the needs of Indigenous people.

6.46   A submission from Psychotherapy and Counselling Federation of Australia (PACFA) argued that the counsellors and psychotherapists they represented (different from psychologists) were under-utilised in the mental health field:[71]

> Counsellors and psychotherapists are unique within the mental health field with respect to undertaking in-depth training, usually at a post-graduate level, in counselling and psychotherapeutic theory and skills, as well as their mandatory requirements for ongoing clinical supervision for the duration of the therapist's career.[72]

6.47   PACFA argued that PACFA-registered practitioners should be granted the GST-exempt status applied to psychologists and GPs, and should be included in Better Outcomes. Such inclusion, PACFA argued, would 'provide a much needed addition to the severely stretched mental health system and provide greater consumer choice, and better mental health outcomes.'[73]

6.48   There are also non-health professionals who, in the course of their work regularly encounter people with mental health problems. Teachers are often the first to identify mental health problems in young people; police officers are often relied upon to transport people with mental illness to hospital; government agency employees deal with people affected by mental illness; and family members are usually integral in care arrangements.

6.49   The Burdekin Report in 1993 recommended mental health training for a broad range of professionals in the community and Mental Health First Aid training is now available, increasing knowledge, reducing stigma, encouraging supportive responses and assisting with early intervention and the ongoing support of people with mental illnesses.[74]

6.50   Professor Tony Jorm and Ms Betty Kitchener (the originator of the Mental Health First Aid course), put the case that the course has been proved to be effective, and recommended Australian Government funding to support and train a national cohort of instructors:

> Once these are trained, the program can be self-supporting just like conventional first aid courses. For example, to train 100 additional instructors and to provide seeding support for them would cost around $400,000. These instructors would then train people who are outside the mental health sector, but have an increased probability of contact with mental health issues. These groups include teachers, nurses, welfare workers and family carers.[75]

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71   Psychotherapy and Counselling Federation of Australia (PACFA), *Submission 383*, p. 3.

72   *Submission 383*, p. 5.

73   *Submission 383*, p. 4.

74   Professor Anthony Jorm and Ms Betty Kitchener, *Submission 47*, p. 1.

75   *Submission 47*, p. 6.

6.51   The committee supports the idea of training in mental health for the wider community, and notes that Mental Health First Aid training can not only assist professionals such as teachers and police, but can also reduce stigma in the community, as a result of the greater general awareness of mental health issues in the community that results. The committee heard, for example, about the provision of mental health support training for hairdressers in Horsham, Victoria[76] – an excellent example of a group who talk to a lot people in their community and who could thus benefit from mental health first aid knowledge.

Initiatives that can improve access to better mental health care

6.52   In recognition of the need to increase the mental health skills of the existing GP workforce, and the need to improve access to mental health and allied health professionals, a number of initiatives have been developed in recent years. This section of the chapter looks at these initiatives, and discusses their achievements as well as some criticisms that have been levelled. In particular, this section examines the following initiatives:

- Better Outcomes in Mental Health;
- Chronic Disease Management Medicare items; and
- More Allied Health Services program.

Better Outcomes in Mental Health

6.53   The stated aim of the Better Outcomes initiative was '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.'[77] The initiative has been funded by the Australian government since 2001-2002 and 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.[78]

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76   Mr Gordon Gregory, Executive Director, NRHA, *Committee Hansard*, 4 July 2005, p. 71; Ms Brianna Casey, Senior Policy Manager, NSW Farmers Association, *Committee Hansard*, 2 August 2005, p. 16.

77   Australian Government, *Submission 476*, p. 33.

78   *Submission 476*, p. 33.

6.54   The training component involves two levels:

- Level One skills based training in managing mental health disorders in general practice (six hours of training), and
- Level Two training in extending skills in psychological treatment such as counselling and therapy (20 hours of training). These psychological treatments are known as Focussed Psychological Strategies (FPS) under the Better Outcomes, and include treatments which are evidence-based. That is, there is evidence to prove their effectiveness. Specific psychological treatments included are cognitive behaviour therapy, interpersonal therapy, and psycho-social education.

6.55   Once trained and credentialed, a GP can deliver these treatments as claimable items under the Medical Benefits Schedule (MBS). The specific MBS item numbers allow greater remuneration for the longer time spent in consultation, such as for consultations over 40 minutes that are used to provide focussed psychological strategies.[79]

6.56   In the 3-step Mental Health Process GPs make a patient assessment, devise a care plan, and review progress. On completion, GPs are entitled to a Service Incentive Payment (SIP) of $150. The GP Psych Support service operates 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'.[80] Also under this component, psychiatrists are remunerated for case conferencing with GPs.

6.57   The component of Better Outcomes which attracted the most comment during the course of the inquiry was Access to Allied Health Services, which allows GPs who have completed Level One training to refer a patient to allied health professionals under arrangements whereby the out-of-pocket cost to the patient is nil or is a small co-payment, usually less than $10. The great majority of referrals have been to psychologists, although the eligible professional groups include social workers, mental health nurses, and occupational therapists.[81] Referrals in the first instance are for six visits, with an additional six visits allowed subject to a review by the GP.

6.58   The Australian Government funds the Access to Allied Health Services through Divisions of General Practice around Australia, who then make their own funding arrangements with allied health services. Most commonly this is either by individual contract, or by direct employment.[82] In Round 1 of the pilot stage of the program, 15 Divisions received funding for Access to Allied Health Services projects.

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79   Medicare Benefits Schedule Item 2725.

80   *Submission 476*, p. 34.

81   *Evaluating the Access to Allied Health Services component of the Better Outcomes in Mental Health Initiative; Fourth Interim Evaluation Report*, Program Evaluation Unit, The University of Melbourne, April 2005, p. 11.

82   *Evaluating the Access to Allied Health Services component of the Better Outcomes in Mental Health Initiative; Fourth Interim Evaluation Report*, Program Evaluation Unit, The University of Melbourne, April 2005, p. 10.

In 2005 over 100 of Australia's 118 Divisions took up the initiative and receive funding.[83]

6.59   Uptake by GPs in the three years since the program began has, according to the ADGP, far exceeded initial predictions of GP interest,[84] if not government projections. Data indicates that 20 percent (one in five) GPs had completed training and registered.[85]

6.60   The ADGP submitted that:

> The allied health component has been a particular drawcard for GPs who have found that better access to allied health support has resulted in improved clinical outcomes for patients and improved management in the primary care setting.[86]

> Of all the measures funded by the federal government under recent national mental health plans, Better Outcomes has been a relative policy success, a success that has been consistently supported by all national mental health stakeholders...[87]

6.61   Local evaluation reports compiled through ADGP showed that participating GPs, allied health professionals and consumers were 'very satisfied' with the evolution of services through Better Outcomes.[88] ADGP commented that the nation-wide Divisions of Practice have been instrumental in driving reforms and encouraging GPs to take up the initiative, and they have called for the capacity of the Divisions Network to be expanded to improve the delivery of mental health care to better meet community needs, including access to health care by key groups:[89]

> The network, which is already in place and funded, is a unique infrastructure and agent of change that can build and support GP led sustainable primary mental health care teams, support primary mental health care work force development, promote coordinated and integrated care by linking general practice with other systems, deliver quality primary mental health care services, deliver models of service delivery tailored to local contexts and reach rural and regional Australia.[90]

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83   *Evaluating the Access to Allied Health Services component of the Better Outcomes in Mental Health Initiative; Fourth Interim Evaluation Report*, Program Evaluation Unit, The University of Melbourne, April 2005, p. 2.

84   ADGP, *Submission 308*, p. 19.

85   Australian Government, *Submission 476*, p. 34; ADGP, *Submission 308*, p. 19; GPMHSC, *Submission 320*, p. 3.

86   *Submission 308*, p. 19.

87   *Submission 308*, p. 41.

88   *Submission 308,* p. 42.

89   ADGP, *Submission 308,* p. 45.

90   Dr Rob Walters, *Committee Hansard,* 4 July 2005, p. 84.

6.62   Concerns have been expressed about the limitations of Better Outcomes, including:

- Insufficient take-up by GPs;
- Difficulties for rural GPs in undertaking Better Outcomes training;
- The need for GP practices to be accredited;
- Adequacy of 20 hours training in psychological treatment;
- Lack of access to psychologists in rural and remote areas;
- Limits placed on the number of patients GPs can treat and refer;
- Conflict of interest in pharmaceutical companies funding training; and
- The need to remove disincentives for longer consultations by GPs.

Insufficient take-up by GPs

6.63   Despite the positive reaction by GPs, it is nevertheless the case that only one in five GPs has undertaken at least Level One training. Thus four in five GPs – often including those with the least expertise in mental health - are not eligible to refer patients to a psychologist under Better Outcomes.

6.64   It was suggested that the take-up so far was largely by those GPs who already had an interest in mental health, and saw registering with Better Outcomes as part of their continuing interest and professional development and that GPs whose interests lay outside of mental health would be unlikely to undertake the training.[91]

6.65   It certainly appears that the proportion of GPs credentialed under Better Outcomes is unlikely to rise. The Department of Health and Ageing indicated that 'the number of additional general practitioners (GPs) who will complete Level One training under the Better Outcomes in Mental Health Care Program is about 150 each quarter and the number of GPs who will complete Level Two training is about 50 per quarter'.[92] While 600 GPs are completing Level One training each year, this seems no higher than the annual rate of turnover in the profession. In 2004, 557 places were filled in the General Practice Training Program,[93] and in addition to these new entrants, some doctors are recruited directly into the system as general practitioners from overseas. Thus the rate at which doctors are being credentialed for Better Outcomes Level One is no greater than the rate at which new doctors are entering the system, while the rate of training at Level Two may mean that the proportion of doctors accessing this option will actually fall.

6.66   The paperwork in the 3-step process was cited as a disincentive to take-up and, in particular, GPs were frustrated with the 'red tape' and paperwork required to claim the Service Incentive Payment (SIP) of $150. In recognition of these concerns, changes were made by the government in May 2005, allowing the process to be completed in two consultations rather than three. Nevertheless, take-up by GPs has been less than expected, resulting in a reduction in the forward estimates for funds

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91   Dr Carole Castles, *Committee Hansard*, 28 October 2005, p. 46.

92   Department of Health and Ageing, answer to question on notice, 2 November 2005.

93   Department of Health and Ageing, *General Practice in Australia 2004*, p. 292.

earmarked for SIPs of $85.4 million over four years.[94] The Department of Health and Ageing told estimates hearings that in addition to the revised 3-step process, other changes were being contemplated to try to improve the take-up and make the process easier to use[95] and said in its submission to this inquiry:

> ...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.[96]

Difficulties for rural GPs in undertaking Better Outcomes training

6.67   A further barrier to take-up by GPs according to some submissions was the fact that it was difficult for GPs in rural and remote areas to take time away from their practices to attend training, often conducted in a city, as it could leave a town without any medical care. The South Australian Divisions of General Practice submitted that:

> The more remote Divisions report considerable difficulty accessing the required training for their GPs to participate in the [Better Outcomes] scheme... Training of GPs to do counselling themselves (Level 2 under [Better Outcomes]) is likewise difficult as it requires the GP to do 20 hours of training – not available in the country thereby necessitating the GP to leave their practice unattended for a number of days. With the lack of available locum coverage to backfill, and rural doctors required to provide after-hours emergency care, this may leave entire towns and regions without any medical care.[97]

6.68   The associated costs of travel, and of finding a locum, were also a disincentive for rural GPs:

> At present, there is no alternative for a rural or remotely located GP but to travel to a regional or major centre in order to undertake the entry point training for the Better Outcomes initiative (Level One or Two accredited training). The travel requirements impose a significantly greater burden on rural and remote GPs who often have difficulties finding and funding a locum GP to service their area during their absence, and of course incur substantial travel, accommodation and loss of income costs.[98]

6.69   The GPMHSC suggested that some accredited Level One Better Outcomes training packages could be adapted for online or distance delivery, but also recognised that face-to-face training was preferable. The GPMHSC recommended that there be

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94   Mr David Learmonth, First Assistant Secretary, Primary Care Division, Department of Health and Ageing, *Committee Hansard*, 7 October 2005, p. 69.

95   Mr D Learmonth, *Estimates Hansard*, Senate Community Affairs Legislation Committee, 2 November 2005, p. 55.

96   Australian Government, *Submission 476*, p. 34.

97   SA Divisions of General Practice, *Submission 88*, p. 9.

98   GPMHSC, *Submission 320*, p. 4.

financial support provided for rural GPs needing to travel to undertake training, and incentives for training providers to deliver training in non metropolitan areas.[99]

The need for GP practices to be accredited

6.70   Another barrier to GP take-up of Better Outcomes is the requirement that for a GP to be eligible for the Service Incentive Payment, the 3-step mental health process consultations must be provided from a practice participating in the Practice Improvement Program (PIP) or an accredited practice.[100] The ACPM pointed out that this requirement excludes qualified medical practitioners who for various reasons do not see patients at an accredited practice – for example they may work at a university medical centre. The requirement can also lead to anomalies:

> [The requirement can result] in the absurd situation where some practitioners are registered in one site and not in another. As an example the College can cite a member ... who works in two accredited practices. In one, he uses a room which is part of the accredited practice. In the other, the consulting room which he rents is not physically part of the accredited practice - it is in the same building but in a part designated as the Specialist Centre. In that practice he cannot be registered for [Better Outcomes] despite doing the same work and having the same qualifications (namely a Masters degree in Psychological Medicine and additional qualifications) in each setting![101]

6.71   The costs and resources associated with achieving accredited status were also a barrier for some practices. Fundamental reorganisation of practice structure could be necessary, which was a disincentive for many.[102] The Northern Territory Government said this was a particular issue for practices in the Northern Territory:

> While the Australian Government's 'Better Outcomes in Mental Health Care' initiative attempts to increase the capacity of GPs to provide mental health care, the success of this initiative in rural and remote areas of the NT has been marginal. Although a number of GP practices and Aboriginal controlled health services in the NT were initially accredited and accessed training, fewer practices are now making that commitment due to the costs associated with achieving the expected standards and the relative benefits for individual practices. The uptake rate in the NT has been confined to a small group of Darwin based GPs.[103]

6.72   The AMA and the ADGP pointed out that the practice accreditation requirement excluded many Aboriginal Medical Services and youth-specific services[104] yet these were some of the highest need populations in the community.[105]

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99   *Submission 320*, p. 4.

100   General Practice Mental Health Standards Collaboration, Level One General Practitioner Registration Form: Better Outcomes in Mental Health Care.

101   ACPM, *Submission 411*, p. 9.

102   Professor Ian Hickie, *Committee Hansard*, 28 October 2005, p. 86.

103   Northern Territory Government, *Submission 393*, p. 16.

104   AMA, *Submission 167*, p. 24.

The ADGP recommended exception criteria for GPs working outside accredited practices, particularly those working with these high need groups.[106]

6.73   It was also pointed out that Better Outcomes accreditation operates independently of other accreditation and professional development for GPs. RACGP suggested:

> At the moment the accreditation processes for mental health training are separate from the RACGP quality assurance and continuing professional development program. In the future it would make good sense to roll these into one so that GPs do not have separate accreditation for mental health and all their other areas of education. It makes sense to roll these into the one QA and CPD program.

6.74   The committee agrees, and hopes that such streamlining might encourage some more GPs to take up Better Outcomes accreditation.

Adequacy of 20 hours training in psychological treatment

6.75   A view strongly expressed to the committee was that the 20 hours of training comprising Level Two training was inadequate to equip GPs with the necessary skills to provide effective psychological treatment (Level Two training covers specific psychological treatments including cognitive behaviour therapy). Organisations representing psychologists were adamant that 20 hours of training could not be considered the equivalent of the many years of study and clinical supervision undertaken by psychologists in order to register to practise. The APS submitted that:

> The techniques that GPs are expected to master in 20 hours are components of those required of psychologists to be registered to practise. Psychologist's training for registration involves a four-year university degree in psychology, two years post-graduate study (usually a Masters degree) and at least one subsequent year of clinical supervision (at least six years training). We believe that twenty hours of instruction in psychological therapy techniques is not adequate training and does not meet appropriate professional standards for mastering the skills for effective psychological intervention.[107]

6.76   The Association for Counselling Psychologists commented that the 20-hour Level Two training for GPs has been seen by psychologists as the equivalent of allowing psychologists to undertake brief training in medicine in order to prescribe drugs,[108] and argued that the delivery of psychological interventions should be reserved to appropriately qualified licensed and experienced mental health specialists.[109]

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105   ADGP, *Submission 308*, p. 43.

106   *Submission 308*, p. 8.

107   APS, *Submission 50A*, p. 9.

108   Association for Counselling Psychologists, *Submission 452*, p. [5].

109   *Submission 452*, p. [1].

6.77   There was some evidence that GPs were not necessarily using the psychological treatment skills they had obtained under Level Two training, but preferred to refer patients on to psychologists. Professor Ian Hickie told the committee that the training often had the effect of making a GP more likely to refer on, rather than deliver the service him or herself:

> What you see is that those GPs who have undertaken further training actually make more referrals, not fewer referrals. There is a belief system, which I think is quite wrong, that if GPs get more access to these items themselves or further training they will not refer. All the research evidence shows the opposite. The better trained people are, the more aware they are of what they cannot do and the more aware they are of options and of what others can do.[110]

6.78   At December 2004, almost 2000 GPs had referred almost 13 000 consumers for focussed psychological care by allied health professionals, and almost 50 000 sessions of therapy had been received by consumers.[111] GP-provided focussed psychological strategies totalled over 33 500 for the period January 2003 to December 2004.[112]

6.79   A number of submissions commented that, with a shortage of GPs in Australia, it made sense to utilise the workforce of psychologists, rather than further burden the already overstretched GP workforce.[113] Dr Jillian Horton commented that the long consultations required to deliver psychological treatments were time-consuming for GPs, and encroached on their medical practice:

> There is already a shortage of GP hours for medical care, and consumers often complain about the difficulty in getting medical appointments. Why would the Federal Government wish to burden this sector further and make the hours for medical care even less available to the public, when there are clear alternatives? Wouldn't supporting a way to ease and re-direct the mental health burden from GPs make more sense?[114]

6.80   Psychologists argued that the Medicare item numbers used by GPs to deliver psychological treatments should also be available to six-year trained psychologists:

> Enabling psychologist access to the Medicare items for Focussed Psychological Strategies ... would ease the mental health burden through mobilisation of a significantly under-utilised trained psychology workforce.[115]

6.81   Whilst there appears to be general support across the health professions for the idea of making better use of psychologists in the provision of mental health care, there is some debate over how best to achieve this, whether it should be through direct

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110   Professor Ian Hickie, *Committee Hansard* 28 October 2005, p. 94.

111   ADGP, *Submission 308*, p. 41.

112   *Submission 308*, p. 41.

113   See, for example, Association for Counselling Psychologists, *Submission 452*, p. [4].

114   Dr Jillian Horton, *Submission 337*, p. 13.

115   APS, *Submission 50A*, p. 10.

or indirect access to Medicare items by psychologists, or through some other method. This matter is discussed further in a later section of this chapter.

Lack of access to psychologists in rural and remote areas

6.82   A number of submissions pointed out that although GPs welcomed the Access to Allied Health, the program fell down when no suitable professionals were available. This problem was most pronounced in rural and remote areas.

6.83   The South Australian Divisions indicated that their more remote Divisions had considerable difficulty in attracting appropriately qualified and experienced personnel.[116] The ADGP observed:

> ...regional and rural Divisions face challenges such as attracting suitably credentialed allied health workers to their communities. This is often due to the availability of relatively short term (annual) employment contracts. Recruitment and retention challenges are compounded by Better Outcomes' current status as a lapsing program which means it is difficult for divisions to offer ongoing positions to allied health professionals and facilitate recruiting and retaining them in rural and regional centres.[117]

6.84   The South Australian Divisions suggested:

> Some requirement or enticement for allied health workers to do some rural service, either as a fly-in model, or for a limited period of time, would also be welcome to address the workforce difficulties.[118]

Limits placed on the number of patients GPs can treat and refer

6.85   The Better Outcomes framework imposes a cap on GPs and their use of the Medicare items, presumably to control the budgetary implications of the program. The cap limits GP's claims for individual services (completed 3-step processes) to $10 000 per year per GP, which is the equivalent of 67 mental health plans.[119]

6.86   Professor Hickie argued that the cap discouraged GP practices from undertaking the practice reorganisation needed to participate in the program:

> The biggest disappointment from a GP point of view is what we see as the cap on the number of services. The Commonwealth rejects this as an issue, but what you want here is fundamental practice reorganisation, for GPs to alter the way they work. In fact, if you say there will be a limit to the number of people whom any individual or practice can service then you get a fundamental disincentive. So there has not been the degree of GP practice reorganisation that we would have hoped for...[120]

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116   SA Divisions of General Practice, *Submission 88*, p. 9.

117   ADGP, *Submission 308*, p. 44.

118   *Submission 88*, p. 9.

119   'Money's too tight to mention', *Australian Doctor*, 19 October 2005, http://www.Australiandoctor.com.au/articles/46/0c037346.asp , (accessed November 2005).

120   Professor Ian Hickie, *Committee Hansard*, 28 October 2005, p. 86.

6.87   The government indicated that in 2004-05 only 17 GPs out of over 4 000 who are trained had reached the cap.[121]

6.88   This was however not the only cap within Better Outcomes that attracted criticism. Another cap limits the number of referrals GPs can make under Access to Allied Health Services by limiting funding within individual Divisions. The AMA submission expressed this concern:

> [The] counselling component is subject to capped funding and GPs are very limited in the numbers of services that they may refer patients to, some Divisions reporting that they can only refer 5 patients per annum.[122]

6.89   The ADGP argued that allied health services are popular with GPs, allied health providers and consumers, but that demand is far outstripping supply. The ADGP called for an increase in funding for allied health,[123] and pointed out the inconsistency:

> It is perverse that GPs belonging to Divisions who have worked hard to enrol a large number of GPs in the program are then penalised when the available allied health services are 'rationed' due to capped funds.[124]

Conflict of interest in pharmaceutical companies funding training

6.90   The committee was told that pharmaceutical companies are involved in funding for training in Focussed Psychological Strategies (FPS). The appropriateness of this was questioned:[125]

> The financial involvement of pharmaceutical companies in FPS training is also a matter of serious concern. ... Such involvement represents a grave conflict of interest that undermines the focus of FPS training.[126]

6.91   The concern originates in part from the tension that currently exists between professional groups and their different approaches to treatment, as well as an understandable concern about the motives of pharmaceutical companies in funding training in non-pharmaceutical treatment options.

The need to remove disincentives for longer consultations by GPs

6.92   While Better Outcomes attempted to address the financial disincentives to GPs for conducting the long consultations often necessary when caring for people with mental health problems, the ACPM argued that:

> While the [Better Outcomes] item numbers redress [the disincentive problem] to some extent their use is limited and not always applicable...

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121   Mr David Learmonth, *Committee Hansard*, 7 October 2005, p. 70.

122   AMA, *Submission 167*, p. 25.

123   *Submission 308*, p. 7; see also APS, *Submission 50A*, p. 10.

124   ADGP, *Submission 308*, pp. 43–44.

125   Dr Leanne Rowe, Councillor, RACGP, *Committee Hansard*, 28 October 2005, p. 51.

126   Association for Counselling Psychologists, *Submission 452*, p. [5].

> The College recommends that an extension of item numbers to recognise and reward those performing more complex services should be introduced as a matter of urgency. This should include item numbers for longer consultations, preferably up to two hours in duration, as exist for psychiatrists and for ongoing psychological care of patients with complex problems.[127]

6.93   The submission from bluevoices (the consumer body of beyondblue) recommended a further increase in the rebate for longer consultations:

> Beyondblue/blueVoices acknowledges the advances made in General Practice in the Better Outcomes in Mental Health Care Initiative, and recommends that in subsequent budget cycles, the level of rebate offered to General Practitioners offering high quality mental health services to consumers was increased even further. There must be a reduction in the incentive to reward doctors for the number of patients they see each hour, when it is widely accepted that the volume of patients seen does not equate to good health care.[128]

Multidisciplinary care planning, and Medicare items for chronic disease management

6.94   Historically, Medicare has only provided rebates for services delivered by doctors.[129] In recent years, however, the Australian Government has experimented (in a limited way) with broadening the rebate to services delivered by allied health professionals, such as psychologists, practice nurses, physiotherapists and podiatrists.

6.95   Under Chronic Disease Management (CDM) Medicare items, GPs can involve allied health professionals in the care planning of patients with chronic and complex care needs, including patients with mental health problems. The CDM items replaced (in July 2005) Medicare items for Enhanced Primary Care (EPC). Medicare rebates are available for a maximum of five allied health services per patient in a 12-month period, following referral from a GP. Allied health professionals eligible include psychologists, Aboriginal health workers, occupational therapists, physiotherapists, and podiatrists. An allied health professional must be registered with Medicare Australia to provide Medicare rebateable services. The allowable five visits per 12-month period can be to different allied health professionals, for example, two visits to a physiotherapist, and three visits to a psychologist. The Medicare rebate for any of these services is $44.85.

6.96   The Central Australian Aboriginal Congress, which provides health services to Indigenous Australians in Alice Springs, was positive about this initiative:

> The advent of ... multidisciplinary care plans have also enabled better coordination of team care arrangements for [patients with complex and comorbid conditions], especially the coordination of GP involvement with

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127   ACPM, *Submission 411*, pp. 8–9.

128   Bluevoices, *Submission 259*, pp 22–23.

129   Mr Phillip Davies, Acting Secretary, Department of Health and Ageing, *Committee Hansard* 7 October 2005, p. 34.

the necessary allied health professionals such as psychologists and other counsellors who provide holistic care to these patients.[130]

6.97 The NSW Nurses' Association also welcomed the initiative:

The introduction of the new allied health items under Medicare is a great initiative which the Association supports and we look forward to working with the Government to ensure that people with mental illness benefit from greater access to skilled nursing interventions. We recommend that the Government examine more closely the role of the mental health nurse practitioner with a view to making the benefits and advantages of wider implementation more widely available to the public.[131]

6.98 However, the Medicare items for CDM are limited to patients with complex and chronic conditions. Further, although visits to allied health professionals are subsided through Medicare, the level of rebate is just $44.85, leaving a patient with high out-of-pocket costs after visiting, say, a psychologist, whose session can cost $100 - $175 per hour.[132] Mr Keith Wilson, Chair of the Mental Health Council of Australia, expressed this concern:

The recently introduced mechanisms under the chronic disease management items ... cost a person up to an additional $50 or $60 out of pocket to see a psychologist. You might get a $45 rebate, but it will cost you over $100. ... I think that, worryingly, [this initiative] has still left a very large burden of out-of-pocket expenses on those who wish to access [psychology] services.[133]

6.99 For a person receiving care under a CDM care plan, the $44.85 Medicare rebate applies regardless of the type or cost of service provided. A session with a physiotherapist or podiatrist, for example, attracts the same $44.85 rebate, despite the fact that these sessions may take less time and cost less than that with a psychologist. The Department of Health and Ageing indicated that:

[There has been] debate ... about the structure of the rebates in relation to how services are provided for; for example, something like psychology versus physiotherapy and the amount of time that is taken and the rebates which are available. Where that structure might go in the future is a matter that is being considered.[134]

6.100 Mr Wilson indicated a preference for psychologists to be, in the main, contracted directly and for out-of-pocket cost for consumers to be nil or very small:

[The Chronic Disease Management Medicare items arrangement] is quite different to the system that the Council and most other professional groups

130 Central Australian Aboriginal Congress, *Submission 486*, p. [7].

131 NSW Nurses' Association, *Submission 391*, p. 9.

132 Black Dog Institute; Black Dog Institute fact sheets, available at http://www.blackdoginstitute.org.au/gettinghelp/consultprof/psychologists.cfm , (accessed December 2005).

133 Mr Keith Wilson, Chair, MHCA, *Committee Hansard*, 28 October 2005, p. 93.

134 Mr David Learmonth, *Committee Hansard*, 7 October 2005, p. 35.

have championed under Better Outcomes, which essentially involved no additional out-of-pocket expenses or a small co-payment.[135]

6.101   It is important to note that, unlike arrangements under Better Outcomes, GPs do not require any particular training to make referrals to psychologists under CDM arrangements.

6.102   Departmental officials advised that CDM items have been funded by transfer of a projected underspend against, primarily, the Service Incentive Payment (SIP):

> There was, going back over the history of the mental health Service Incentive Payments as part of the Better Outcomes program, an underspend against what we had anticipated the level of expenditure to be, without the capacity for particular precision in that process. Some of that projected underspend going forward ... has been transferred to the [Medical Benefits Scheme] to create the new chronic disease management items.[136]

6.103   Concern was expressed that this transfer shifted funds from mental health to the more general area of chronic disease. In response, departmental officials argued that chronic disease management comprised a strong element of mental health, including in all the major chronic disease categories of cancer, heart disease and strokes. Chief Medical Officer Professor John Horvath told the committee that 'mental health is ... an important component of the entire chronic disease spectrum'.[137]

More Allied Health Services

6.104   The More Allied Health Services (MAHS) program aims to 'improve the health of people living in rural areas through allied health care and local linkages between allied health care and general practice'.[138] As with Better Outcomes, the federal government funds Divisions of General Practice, which then administer and fund allied health services. Unlike Better Outcomes, MAHS can fund a range of allied health professionals, such as dieticians and audiologists, and not just mental health professionals.

6.105   The MAHS program funds 66 Divisions - those with at least five percent of their population living in rural areas - to provide clinical care by allied health providers.[139] Divisions can use direct employment by the Division, or engage allied health service professionals under contract. The guidelines indicate that services should be provided free of charge.[140]

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135   Mr Keith Wilson, *Committee Hansard*, 28 October 2005, p. 93.

136   Mr David Learmonth, *Committee Hansard*, 7 October 2005, p. 68.

137   Professor John Horvath, Chief Medical Officer, Department of Health and Ageing, *Committee Hansard*, 7 October 2005, p. 69.

138   Australian Government, Department of Health and Ageing, Guidelines for the *More Allied Health Services Program*, Divisions of General Practice Program, update as at July 2004, p. 8.

139   Australian Government, *Submission 476*, p. 36.

140   Australian Government, Department of Health and Ageing, Guidelines for the *More Allied Health Services Program*, Divisions of General Practice Program, update as at July 2004, p. 13.

6.106   The ADGP commented:

> While MAHS was not a mental health initiative, a great proportion of the eligible rural Divisions elected to devote it to the establishment of allied psychological services in their community.[141]

6.107   In 2003-2004, the MAHS program engaged 45.7 psychologists, 23.2 mental health nurses, 8.6 counsellors and 12.5 aboriginal mental health workers (full-time equivalents).[142] The Top End Division of General Practice in the Northern Territory has used MAHS funding to employ Aboriginal mental health workers.[143]

6.108   The Government guidelines for MAHS however discourage its use where Better Outcomes is available:

> If Divisions receive funding from multiple sources, they should use this funding effectively. For example, a Division could seek to consolidate their mental health services using Better Outcomes in Mental Health, leaving MAHS for other allied health professionals.[144]

6.109   However, not all GPs are registered with Better Outcomes and therefore cannot refer to psychologists. The Limestone Coast Division in South Australia (covering an area around Mount Gambier) found MAHS to be an important component of the mental health services available to GPs in that area[145] and MAHS, like CDM, allows GPs to refer patients to psychologists or other mental allied health professionals, without needing to have undertaken particular training, as is the case with Better Outcomes.

What is the best model for increasing access to cost-supported psychologists?

6.110   There was broad agreement that psychologists and other allied mental health professionals play an important role in primary mental health care, but that they are currently an under-utilised resource. Psychiatrist Professor Ian Hickie said:

> ...there is agreement across the whole medical and psychological health work force. All we need is an integrated work force. We need people to be working in partnership with each other, particularly at the primary care level and at the specialist level. We are different in Australia, in that we do

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141   ADGP, *Submission 308*, p. 20.

142   Australian Government, *Submission 476*, Attachment 8.

143   Top End Division of General Practice website, http://www.tedgp.asn.au/resdoc/31stDecProgressReport.doc, (accessed December 2005).

144   Australian Government, Department of Health and Ageing, Guidelines for the *More Allied Health Services Program*, Divisions of General Practice Program, update as at July 2004, p. 5.

145   *Evaluation of the Better Outcomes in Mental Health and More Allied Health Services Initiatives*; Final Report; Limestone Coast Division of General Practice (LCDGP), June 2005, p. 1. Available at http://www.sesadgp.org.au/fIles/links/Mental_Health_Final_Report.pdf , (accessed December 2005).

not recognise psychologists as mental health specialists in the way they are recognised in other systems, and we do not use them effectively.[146]

6.111   In the United Kingdom, the National Health Service (NHS) funds psychological therapy services, and patients can receive treatment on GP referral at no cost. Services are provided at GP's surgeries, hospitals, or local community mental health teams.[147] The committee also notes reports that the UK system has waiting lists of nine months to access counsellors. Nevertheless, there is significant recognition of the importance of psychological counselling services.

6.112   Mental health teams in Australia often include psychologists, but these staff are often have high work loads acting as case managers for people with serious mental illness, and do not have the time to provide psychological treatment, early intervention or relapse prevention strategies. Dr Georgina Phillips commented that in her experience on a community mental health team there were not enough counselling or therapy services available, and that it was difficult to find affordable alternatives:

> My experience was that we were constantly swamped with referrals for young people who had long-term issues that needed long-term therapies and we really struggled to appropriately refer them to something that was not going to be quite financially difficult for that person.[148]

6.113   Affordable access remains limited and many submissions supported expansion of the current Government initiatives. The following section discusses the issues involved.

Should GPs need particular training in order to refer patients to allied health professionals?

6.114   As previously discussed, GPs must have completed Level One training and stay registered with Better Outcomes in order to refer patients for low-cost psychological treatment through the Better Outcomes program. This requirement seems inconsistent with the other Government initiatives discussed above, which allow GPs to refer patients to cost-supported mental health allied professionals without any additional training or registration requirement.

6.115   More broadly, there also seems to be an inconsistency in the fact that, in the case of referrals to medical specialists such as cardiologists or psychiatrists, GPs do not require special additional post-graduate training. Presumably this is based on recognition that GPs receive enough basic training (in cardiology or psychiatry, say) in their undergraduate degree or GP registrar training to equip them to recognise a need for additional specialist care. It could be argued that the training received at the undergraduate level in psychiatry and psychology should similarly allow a GP to refer a patient to a psychologist, without a requirement for further training. It would appear that arrangements under the CDM care plans and also under the MAHS program

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146   Professor Ian Hickie, *Committee Hansard* 28 October 2005, pp 91–92.

147   Cambridgeshire Mental Health Info factsheet, available at http://www.cambsmentalhealthinfo.nhs.uk/support/talking_therapies.html, (accessed 1December 2005).

148   Dr Georgina Phillips, *Committee Hansard*, 6 July 2005, p. 10.

already accept this proposition; yet a GP referring under Better Outcomes needs additional training to make the same referral.

6.116   It was suggested to the committee that the Level One training requirement (which allows a GP to refer to a cost-supported psychologist) reflected the incentive nature of the Better Outcomes program, which aimed to reward GPs for undertaking training and up-skilling.[149] However, a result of this limitation on GPs is that patients are affected by their GP's willingness and ability to undertake the Better Outcomes training. The training requirement precludes the four out of five GPs who have not undertaken Better Outcomes training from referring patients. The patients of these GPs are clearly disadvantaged by this requirement.

6.117   Professor Harvey Whiteford, Clinical Mental Health Advisor to the Department of Health and Ageing, acknowledged this as an issue:

> You could take the position ... that the GPs who have less interest in mental health—do not bother to do the training—should be the ones who get better access to the psychologists who have the skills. I think the view that has prevailed is that we want to encourage all GPs to upskill and the quality of the referral to the psychologist is greater than the knowledge base of the GP. ... I have sympathy with [the] view that the patients of GPs who are not interested in mental health should in some way get support if they have mental health problems. As Mr Davies [Acting Departmental Secretary] said, there are some GPs who will not ever be interested in mental health. It is not their area and they do not like it particularly, but they may well have patients with those issues. I do not think this strategy necessarily helps them as much as those GPs who are more interested in mental health, so we needed to broaden the strategy as we work it through.[150]

6.118   The question thus arises of whether it is sound and reasonable to allow referral to cost-supported psychologists by *all* GPs. Professor Ian Hickie thought that the medical profession would be willing to allow referral to cost-supported psychologists by *all* GPs, not just those who had undertaken particular training. The problem, Professor Hickie suggested, was there not being sufficient government funding to cover that increased degree of psychological service and support.[151]

6.119   Professor Hickie further suggested that allowing GP referrals to appropriately qualified and recognised practising psychologists would quickly boost the mental health workforce:

> Fundamentally, this is an issue for the psychological profession itself. But if those who agreed to reach a certain standard of training behaved as mental health specialists, just the way that psychiatrists do, and then saw people essentially on GP referral then I think you would have absolute agreement between psychology and psychiatry.

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149   Professor Ian Hickie, *Committee Hansard*, 28 October 2005, p. 95.

150   Professor Harvey Whiteford, Clinical Mental Health Advisor, Department of Health and Ageing, *Committee Hansard*, 7 October 2005, p. 67.

151   Professor Ian Hickie, *Committee Hansard*, 28 October 2005, p. 95.

> ...
> If the Commonwealth were to immediately recognise the number of psychologists who would automatically meet that [standard of training]—there is some debate about that number but there would be somewhere around 2,000 psychologists—and they were to behave like the 2,000 psychiatrists we are working in practice, we would immediately double the mental health specialist work force, and it would not kill the Treasury.[152]

6.120　On the question of requiring a recognised system of qualifications and registration for practising psychologists, the committee notes that there is already government recognition of psychologists providing services through the CDM care planning Medicare items. These psychologists must be registered with Medicare Australia for their services to be rebateable.

If a system of referrals to cost-supported psychologists by ALL GPs is supported, should this be done through a Better Outcomes-type arrangement, or through Medicare?

6.121　As mentioned earlier, GPs currently have the ability to refer *some* patients for Medicare-rebateable treatment by a psychologist (under CDM Medicare items). This arrangement leaves patients with significant out-of-pocket costs, however, as the rebate of $44.85 falls short of the cost of a session with a psychologist, which usually exceeds $100. It is this concern about out-of-pocket costs which causes the MHCA to favour a system such as Better Outcomes, where consumers receive psychological treatment at no cost, or for a small co-payment.[153]

6.122　The APS supports an expansion of the arrangements under Better Outcomes for Access to Allied Health Services, to allow more GP referral for psychological services. At the same time, the Society also supports a Medicare-based arrangement, allowing psychologists access to the same Medicare item numbers for Focussed Psychological Strategies available to GPs who provide this service after having completed Level Two Better Outcomes training.[154]

6.123　The issue of expanding access to allied health professionals through Medicare has been raised in other forums. In 2003 the Senate Select Committee on Medicare considered suggestions of extending Medicare to cover allied health services, and acknowledged in its majority report that such action would have considerable and complex economic and financial consequences. A concern of that committee was that an extension of Medicare would raise the issue of which services would receive priority for Medicare funding and which would not qualify. It was also pointed out that decisions about extending coverage could arbitrarily create a financial windfall for certain professions while excluding others.[155]

152　Professor Ian Hickie, *Committee Hansard*, 28 October 2005, pp. 94–95.

153　Mr Keith Wilson, *Committee Hansard*, 28 October 2005, p. 93.

154　APS, *Submission 50A*, p. 10.

155　Senate Select Committee on Medicare, First report, *Inquiry into Medicare: Medicare - healthcare or welfare*, October 2003, pp. 143–144.

6.124   The Select Committee on Medicare concluded that rather than extending Medicare coverage, it would be preferable instead to utilise more targeted and effective mechanisms to increase access to allied health professionals. The committee suggested building on existing initiatives such as the MAHS program, and providing funding for shared access to resources via groups such as the Divisions of General Practice.[156]

6.125   The issue of extending Medicare coverage to allied health professionals was also considered by the Productivity Commission in its position paper on 'Australia's Health Workforce', released in September 2005. The Productivity Commission expressed the view that existing mechanisms for assessing requests for changes to Medicare coverage lack transparency. It proposed the establishment of a single, broadly-based and independent body to make recommendations to government about extending Medicare coverage to new services.[157]

Should GPs remain the gateway for access to cost-supported psychological treatment, or should consumers have access without a GP referral?

6.126   A possibility raised with the committee was not only for the government to fund or subsidise psychological services (through Medicare or by some other method), but to allow consumers direct access to psychologists, without the need for a referral from a GP. It was argued that GPs are not necessarily appropriate to perform the role of 'gatekeeper':

> [The requirement for GP referral] ... means that GPs become solely responsible for the identification of psychological health problems, acting as gate keepers for psychological referrals, something which, for a range of reasons, GPs have a poor track record with.[158]

6.127   Professor Ian Hickie indicated that such a proposal had been contentious:

> ...some areas of psychology have argued that it should be the same as general practice, that somebody should be able to walk in off the street and see someone in a primary care role and receive their psychological care independently of any other aspect of the medical system. It is that model which has created much more contentious discussion, because it would be a more divided model, where psychological care and medical care would not necessarily come together. You would essentially have another primary care work force separated from the other work forces. So the issues of working together and immediately recognising those who obviously have the expertise—and the numbers vary, but there are 2,000 to 3,000 psychologists in Australia—would be a very effective, immediate solution to the specialist side of the problem.[159]

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156   Senate Select Committee on Medicare, First report, *Inquiry into Medicare: Medicare - healthcare or welfare*, October 2003, p. 144.

157   Productivity Commission 2005, *Australia's Health Workforce*, Position Paper, Canberra.

158   Dr Jillian Horton, *Submission 337*, p. 14.

159   Professor Ian Hickie, *Committee Hansard*, 28 October 2005, p. 94.

Concluding remarks

6.128   The committee considers that most people with mental illness do not currently have access to an integrated, specialised mental health service that meets their needs and that fixing the problems identified in this chapter is essential.

6.129   At the heart of the problems in primary care are three related issues:

- limited effective access to mental health workers;
- limited numbers of mental health professionals; and
- inadequate training of mental health professionals.

6.130   There are many ways in which each of these three things could be tackled. More direct involvement of psychologists in publicly-funded health care is one. More university places and more funded positions is a second. Stand-alone specialist degrees for mental health nurses is a third. Many of these solutions will take time and resources.

6.131   It is also clear that the current reliance on GPs for the bulk of those using primary mental health care and for prevention and early intervention is ineffective. Initiatives aimed at supporting GPs in this role have made some progress but relatively minor adjustments, such as removing the need for GPs to have undertaken Better Outcomes training as a pre-requisite for referring to allied health professionals or direct access to Medicare rebates for psychologists, fall well short of providing comprehensive, expert and timely care.

6.132   For greatest effectiveness, psychiatrists, psychologists, psychiatric nurses, social workers and GPs should work together in integrated teams. This does not seem possible under the current arrangements.

6.133   The committee is of the view that publicly funded community-based mental health centres should be established as the primary mental health equivalents of the tertiary area mental health services that currently operate in many states for the most seriously ill. These centres should be multi-disciplinary and treat the broadest range of disorders. GPs and psychiatrists in private practice who are interested and have expertise in mental health would continue to practise in this area but would have the support of the centre in doing so. Whilst funding the infrastructure and the training would require considerable investment, the committee considers that over time that investment would be rewarded with far less demand on acute care and our prison system and greater participation of people with mental illness in society.

6.134   A comprehensive shift toward multi-disciplinary community based mental health centres would help complete a shift away from acute hospital care, away from the old institutions (many of which continue to operate, particularly in South Australia and New South Wales), and toward the agreed goal of the National Mental Health Strategy: an emphasis on community based care. The need for this shift to be given a new impetus is starkly underlined by the findings in later chapters on inpatient, crisis and community care.

6.135   The committee believes that this shift can ably be supported by Divisions of General Practice, with their increased focus on multidisciplinary teams and the broader emphasis on primary care generally rather than just traditional general practice, as recommended by the Review of the Role of Divisions of General Practice, and endorsed in the Commonwealth's response to that review.[160]

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160   Review of the Role of Divisions of General Practice, *The Future Role of the Divisions Network*, June 2003, http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pcd-programs-Divisions-divfuture.htm, (accessed March 2006); Commonwealth Government, *Divisions of General Practice: Future Directions. Government Response to the Report of the review of the role of Divisions of General Practice*, April 2004, http://www.health.gov.au/internet/wcms/publishIng.nsf/Content/health-pcd-programs-divisions-index.htm/$FILE/fut_dir.pdf, (accessed March 2006).

CHAPTER 7

PROMOTION, PREVENTION AND EARLY INTERVENTION

Introduction

7.1   There is indisputable evidence that the bulk of mental health care resources are allocated to acute care and the treatment of mental illness through hospital-based services.   Whilst the importance of treating mental illnesses and their symptoms should not be understated, the question remains as to how much pain – experienced by the consumer, the health care system and the community – could be avoided if preventative measures had been taken to reduce the potential for developing a mental illness, or there had been early intervention?

7.2   Mass media campaigns over the years have targeted community-wide issues, such as the prevention of AIDS, skin cancer and damage caused by smoking. Yet given the social impact and often devastating consequences of mental illness, there has been relatively little effort to raise awareness of a range of mental health issues on a national scale, and to break down the damaging stereotypes and misconceptions surrounding mental illness that create strong barriers to the seeking of help.

7.3   A number of community organisations are implementing valuable prevention, promotion and early intervention programs. However, the short term funding outlook of governments at the federal, state and territory levels in supporting the future development and continued delivery of such programs was criticised, as was the lack of back-up mental health care services to handle referrals and provide continuity of care, and the absence of a national effort to coordinate successful local programs or support their roll-out on a broader scale.

7.4   This chapter reviews: the stigma associated with mental illness and the need to realign the public's perception of mental illness; the prevention of mental illness by targeting the young and other high risk groups; the role of early intervention programs; and examines a number of community programs that are delivering positive results.

Setting the context of prevention, promotion and early intervention in mental health care

What are prevention, promotion and early intervention?

7.5   Promotion, prevention, and early intervention approaches are relevant across the entire spectrum of mental health problems and disorders, from behavioural disorders and depressive and anxiety disorders, through to psychotic disorders. Anxiety disorders in children, for example, can be prevented through school-based

programs designed to promote resilience.[1] Research also shows the positive effects of early intervention in reducing the impact of psychotic illness.[2]

7.6   Mental health **promotion** is any action taken to maximise mental health and wellbeing among populations and individuals. An example is programs that support and strengthen family functioning.[3]

7.7   **Prevention** is defined as 'interventions that occur before the initial onset of a disorder' to prevent the development of disorder. Prevention relies on reducing the risk factors for mental disorder, as well as enhancing the protective factors that promote mental health.[4] *Selective* prevention interventions target at-risk populations: an example is school-based programs specifically targeting young people at risk of depression. *Universal* prevention interventions are aimed at improving the overall mental health of a population: an example would be programs aimed at building connectedness and a sense of belonging in school students.

7.8   **Early intervention** refers to interventions targeting people displaying the early signs and symptoms of a mental health problem or disorder, and people developing or experiencing a first episode of mental disorder. Early intervention aims to prevent progression into a diagnosable disorder, and for those experiencing a first episode of mental disorder, it aims to reduce the impact of the disorder.[5]

The national approach

7.9   The National Mental Health Strategy of 1992 and subsequent National Mental Health Plans recognised the importance of promotion, prevention, and early intervention. The Second National Mental Health Plan 1998-2003 identified promotion and prevention as one of three priorities for future activity. The current (third) National Mental Health Plan 2003-2008 identifies 'promoting mental health and preventing mental health problems' as one of four priority themes.

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1   Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p. 99.

2   Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p. 104.

3   Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p. 29.

4   Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p. 30.

5   Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – a Monograph*, Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, pp. 32–33.

7.10   The need for national direction in promotion and prevention was identified in a 1997 evaluation of the National Mental Health Strategy. A Mental Health Promotion and Prevention Working Party was set up to develop a plan of action to provide this national direction.[6] Subsequently, a *National Action Plan for Promotion, Prevention, and Early Intervention for Mental Health 2000* (PPEI Action Plan) was published.[7] PPEI Action Plan is a joint initiative of federal and state governments. It is accompanied by a second document – a monograph providing the theoretical and conceptual framework and background (*Monograph 2000*).[8]

7.11   Working in parallel with PPEI Action Plan is the Australian Network for Promotion, Prevention, and Early Intervention (Auseinet), funded by the federal Department of Health and Ageing, which collects and disseminates information, and works collaboratively with government and non-government sectors.[9]

Why are prevention, promotion and early intervention important?

7.12   There is strong support for a prevention and early intervention approach, as it has the significant potential to reduce future adverse outcomes[10] and:

> It is widely recognised and understood that treatment interventions alone cannot significantly reduce the burden of mental disorder and that there is compelling evidence that implementation of promotion, prevention and early intervention approaches will significantly reduce the burden of mental illness and mental disorder. Given the current limitations in effectiveness of treatment interventions for decreasing disability due to mental disorders, the only sustainable method for reducing the burden caused by these disorders is prevention.[11]

7.13   The NSW Children's Commissioner similarly argued:

> The Commission supports the establishment and maintenance of prevention and early intervention programs rather than a single focus on the tertiary treatment of people with mental health issues. International research suggests that mental health outcomes are improved by effective prevention

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6   Commonwealth Department of Health and Aged Care 2000, *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health,* Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra, p. 4.

7   Commonwealth Department of Health and Aged Care 2000, *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health,* Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

8   Commonwealth Department of Health and Aged Care 2000, *Promotion, Prevention and Early Intervention for Mental Health – a Monograph,* Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

9   Auseinet, *Submission 441*, pp. 3–4.

10   See for example, Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMA), *Submission 83*, p. 5.

11   Auseinet, *Submission 441*, p. 5.

programs and that early identification and treatment of problems is a priority for reducing the potentially disruptive influence of mental health problems on social engagement and functioning.[12]

7.14   The proportion of people with a mental disorder who access care is half that of comparable physical disorders. Almost all those with schizophrenia receive services but only 60 percent with depression, 35 percent with anxiety disorders and 11 percent with substance use disorders consult for their disorder.[13]

7.15   Savings can be made through prevention and early intervention:

> The emphasis on treatment is extremely costly. Planned and systematic prevention could save costs, time, suffering and much community and workplace dislocation.[14]

7.16   The need for prevention is not disputed by governments. The PPEI Action Plan states:

> treatment interventions alone cannot significantly reduce the enormous... burdens associated with mental health problems and...disorders…
>
> There is a compelling need to make promotion, prevention and early intervention priorities in global, national and regional policy, and to develop a clear plan for progressing activities in these areas.[15]

Promoting a healthier attitude to mental illness in the community

Stigma as a barrier to health care and services

7.17   Ignorance of and fear about mental illness exists in the general community, in organisations, and even in some cases amongst health care professionals. Stigma leads to discrimination, which compounds the disadvantage experienced by people already battling with difficult diseases. It results in low self-referral, under-reporting of illness and under-use of support services.

7.18   The stigma attached to mental illness is evident in many ways. It can be seen in the terminology often used relating to mental illness:

> …we are not "the Mentally Ill", we are "people with mental illness", we are not "beds", we are not "schizophrenics" we are people with Schizophrenia. Imagine what it would be like if a patient who had cancer was called "a cancer", what would that do to their self image and illness, to the attitudes of others to the patient called "the cancer".[16]

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12   NSW Commission for Children and Young People, *Submission 399*, p. 1.

13   Professor Gavin Andrews, *Submission 176,* pp. 8–9.

14   The Cairnmillar Institute, *Submission 204*, p. 1.

15   PPEI Action Plan, p. 1.

16   Ms Fay Jackson, *Submission 534,* p. [4].

7.19   The language used in mental health legislation, which conventionally refers to detainment and control, may underpin or promote the association of mental illness with criminality:

> The [NSW Mental Health] Act promotes social stigma. The words in the Act alone promote stigma: 'Control', 'detention', 'to apprehend', 'the court', 'the magistrate', 'police', 'forensic patients', the association of the Act with the Mental Health (Criminal Procedure) Act (NSW) 1990 that leads to a perception that people with mental illness are criminals or likely to be criminals. And if the Act were better known by the community (I am glad that it is not), it would promote the association with criminality by a community always sensitive to aberrant behaviour and ready to lay blame on that disadvantaged group.[17]

7.20   Lumping all mental illnesses together does not help people understand them, or help them understand that there are different issues associated with different illnesses:

> The current practice of using the generic term 'mental illness' rather than specifically addressing the issues contributing to stigma for different mental illnesses is a major barrier to destigmatisation of ANY mental illness. As such, current education programs are totally inappropriate and inadequate in de-stigmatising mental illness and disorders.[18]

7.21   DepressioNet suggested:

> The term 'mental health' should only be applied in the same situations that the term 'physical health' would also be used and deemed essential to differentiate from 'mental health' or 'spiritual health' etc. In fact if we use common practices in physical health as a guide when communicating about all health and specifically when referring to mental health, significant steps forward will be made.[19]

7.22   Ms Merinda Epstein reported:

> I have often been on the podium with Barbara Hocking from SANE. Usually I go first, which is one of the things about being a consumer—they ask you to speak first. We need to reclaim this language. We need to call ourselves 'batty'; Cath has a wonderful T-shirt about 'batty' and 'nut case'. We need to reclaim that language and make it not scary. Then Barbara gets on to speak and from a non-consumer perspective says, 'We need to get rid of all these horrible words like 'nut case'. Both of us are trying to do the same thing in totally opposite ways. That is where the consumer perspective is so vital. If we just rely on people who read it from a non-consumer perspective, I think that we will not make inroads into discrimination as

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17   Mr Peter Hutton, *Submission 185*, p. 11.

18   depressioNet, *Submission 475*, p. 11.

19   depressioNet, *Submission 475*, p. 7.

> quickly as we will if consumers start to challenge it in unorthodox ways through such things as cartoons and language.[20]

7.23   Stigma associated with mental illness is also inhibiting people from seeking much-needed treatment. Submitters suggested that stigma is a major reason people attempt to 'self manage' their illnesses, with a consequent delay in treatment:

> My personal experience agrees with that, as my son took about 3 years to agree to assessment and treatment, despite support from university football colleagues and administrators including a doctor associated, and other friends. His fear was about future relationships, jobs etc., which was realistic. Alas lack of family unity due to ignorance did not help, and has taken some years to overcome, as we all learned how best to cope.[21]

7.24   If people are afraid to speak about their illness in their workplace, it can prevent them making use of support services that employers may have available. The committee was contacted by people who wanted to make submissions to its inquiry, but were not prepared to be identified in case their employers found out their identity. Employers are often ill informed about the nature of mental illnesses, and unsure how to make the best of employees affected. One consumer reported:

> I haven't disclosed anything about my illness to my employer, though I'm sure they know there is something going on. Initially, I had a shared office, which was really hard—I avoided going in to the office whenever I could (I work part time and have a fair bit of flexibility). We just didn't get on very well—but my employer was accommodating and found me another place where I could be by myself. But they have gone to the extreme—I have a whole level to myself and there is no one else around. I don't get to see anyone—it's weird but I get a sense that I'm there because they think I'm weird. Work is now very lonely.[22]

7.25   However, many consumers have no access to employment. The Catholic Welfare Australia Member Organisations reported that the negative perception attached to mental health problems and disorders is a significant factor inhibiting people's access to employment and other services within the community:

> Our Member Organisations report that owing to negative community attitudes, people with a mental health problem face difficulty finding private accommodation, achieving employment through accessing generic employment services, and other education and training programs. And it is often the case, that until these basic needs are met, further assistance for the client is ineffective.[23]

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20   Ms Merinda Epstein, *Committee Hansard*, 5 July 2005, p. 39.

21   Name withheld, *Submission 76*, p. 5.

22   Brotherhood of St Laurence, *Submission 97*, p. 8.

23   Catholic Welfare Australia, *Submission 302*, p. 17.

Damaging misconceptions of mental illness in the media

7.26   Negative stereotypes of people with mental illness are reinforced through representations of mental illness in the media:

> As a society, we are bombarded with negative images of people with mental illnesses. The media and entertainment industries overwhelmingly present people with mental illnesses as dangerous, violent and unpredictable individuals. These inaccurate and unfair portrayals shape the public's perception of people with mental illness as people to be feared and avoided.[24]

7.27   Sensational reportage of the most appalling outcomes, such as the recent case of child murder and sexual assault by a 23 year old with acute psychosis and substance abuse disorder,[25] draws attention to serious flaws in the health care system but also engenders the highest degree of misunderstanding and fear:

> stories of 'psycho killers' and 'feral psychotics' which are splashed in the tabloid press harm all people with mental illness and hamper the rehabilitation of offenders with mental illness.[26]

7.28   The Brotherhood of St Laurence commented:

> At a public level, the association of violence and aggression with mental illness must be challenged whenever it appears. The public must be made aware that such violence is an exception, and that people who do have a psychiatric illness are much more likely to be on the receiving end of it rather than to be the perpetrators. All people with a mental illness suffer at some level by them is the conception that is created by sensationalist media reporting.[27]

7.29   Consumers asked that, instead of the stigmatising portrayal of the mentally ill as 'crazy', the media should focus on educating the community about the experiences of people with mental illness.[28] A number of submitters commented on the 'silencing' of the real impacts of neglected mental health needs, especially in relation to the high number of suicides that are consequent to untreated depression:

> Anecdotal information given to NCOSS shows that not reporting on suicide marginalises and stigmatises mental illness even further, as it suggests that

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24   Richmond Fellowship of NSW, *Submission 266*, p. 7.

25   Probation and Community Corrections Officers (PACCOA), *Submission 503*, p. 4, and see 'NSW: Judge Criticises Health System for Releasing Schizophrenic', 24 March 2005; *Australian General News*; Story No. 9081.

26   Mental Health Legal Centre, *Submission 314*, p. 23.

27   Brotherhood of St Laurence, *Submission 97*, p. 6.

28   Name withheld, *Submission 20*, p. [1].

suicide is shameful and should not be publicly discussed – yet it is an issue that the whole of the community needs to consider.[29]

Damaging misconceptions of mental illness in the health care system

7.30   Experiences of discrimination and ignorance within health care services appear widespread, with potentially serious consequences. Some of this is specific to particular illnesses, a topic referred to again in Chapter 5.[30] A common complaint was that people with mental illness felt dehumanised by a system which took little account of their individuality. Consumers felt as they were seen through the lens of their illness, so that outside of their diagnosis they ceased to exist. A young consumer reported:

> I have been lucky I have not experienced stigma in the broader community. Everyone that I know and have met since my first episode has accepted and embraced my openness about it. Where I have felt like less of a person is within the adult mental health system…One thing that drives me to maintain my health is that I refuse to be part of a service that can't see me as a person, and believes that I am only a schizophrenic that speaks "schizophrenise". There are services out there that adopt a caring and responsive philosophy, if these places do it, why can't they all?[31]

7.31   A number of submitters maintained that mental health reform has exacerbated stigma by placing pressure on the mainstream health system to absorb care responsibilities for people with mental health problems when it is ill-prepared, and not sufficiently funded, to do so. The Public Advocate, South Australia, identified the following systemic features as drivers of this response:

- many non-mental health personnel still appear to be reluctant participants in service responses for the mentally ill and their families;

- the occupational health and safety issues and responses to protect staff seem to drive considerations of service responses (at times appropriately) which may serve to further traumatise and alienate already severely disturbed people (eg the use of security guards to guard detained patients in general hospitals); and

- there are conflicting beliefs from site to site about the nature, scope and service responsibilities and ethos that mental health services should be providing.[32]

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29   NCOSS, *Submission 274*, p. 9.

30   Dr Julie Johnson, *Submission* 4, Attachment 2, p. 14, and see Women and Mental Health Inc (WAMH), *Submission 310*, pp. 8–9.

31   Youth Mental Health Coalition, *Submission 284*, case study: JOLAN'S STORY, pp. 14–15.

32   Public Advocate South Australia, *Submission 268*, p. 13.

Promoting better mental health at the national level

7.32   The stigma described above creates a barrier to mental health promotion. Many submissions argued for a sustained national education campaign to inform Australians about the true nature and extent of mental illness. However, it was equally strenuously argued that such a campaign must be grounded in community-based education programs that promote good mental health and attack stigma in schools and in the workplace at the local level:

> AICAFMHA believes that the concept of mental health literacy should not be confined to a sole focus on mental health problems and disorders but should include knowledge and awareness of what constitutes positive mental health and strategies that promote good mental health. Multiple education and community awareness strategies that promote knowledge and skill development are required to improve mental health literacy and need to be specifically designed within a developmental framework for target populations and settings.[33]

7.33   A focus on reform of media commentary was just one aspect of this agenda:

> Currently there appears to be no standard to address the inaccurate statements that occur in many of the media reporting of mental health incidents. The complexity of the problems experienced by the mentally ill and the staff who provide support to them appear to exceed the capacity of the media to present a balanced report. This has implications if one is to encourage people to seek treatment. It is also a disincentive in recruiting people to the area. Considered, resourced educational programs for the press, for emergency services such as the police and the ambulance, and the public generally, are priorities. Resource allocation to the non-government sector and professional organisations could facilitate the development of de-stigmatising programs, which would then be able to offer education through effective targeted professional development strategies.[34]

7.34   A number of individual projects have been undertaken by non-government organisations to raise awareness of mental illnesses (discussed later in this chapter). However, Mr Jeff Kennett, Chairman of beyondblue, stated the importance of addressing mental health in the context of a government campaign on well being:

> …every day in the media we hear, see or read about deaths on our roads around the country. We do not hear about the injuries, only the deaths. But every day about eight or nine Australians take their life—suicide—as a result of depressive illnesses. The number of those who die by their own hand is almost more than double those who die in a motor vehicle accident, yet we hear nothing on our radio or see on our television screen or in the press nothing to try to prevent that. In other words, we get this media concentration on deaths and then we have governments responding to

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33   AICAFMHA, *Submission 83*, p. 6.

34   Association of Australian Rural Nurses Australian and New Zealand College of Nursing, *Submission 321*, p. 16.

deaths, but in the area of mental illness we do not have the same concentration on promoting good health and wellbeing as an ongoing program.[35]

7.35   However, for any such promotional activity or campaign to be truly effective, it must capture the authentic and diverse voices of consumers, and their images.[36] The effect of this empowerment would be profoundly remedial for both consumers and for the community in general. Insane australia wrote:

> The consumer-survivor movement is as culturally diverse as any, again, with parallels to the feminist and gay movements. *insane* welcomes, endorses and encourages this diversity of voices. One of the primary aims of *insane* is to promote the awareness of Mad Culture as a community with a culture and a unique voice of its own. We seek to promote this both among consumers and survivors as well as in the general community. With this awareness, we seek to encourage consumer-survivors to speak of their experience, in their own language, with pride rather than shame and for the general community to hear our voices with open minds and open hearts rather than with fear and judgement. We believe this will promote a much healthier dialogue and understanding of the many complex issues around mental health than is currently the situation in Australia.[37]

7.36   An enormous amount of evidence to the inquiry outlined how mental illness and the community in general suffer through an inadequate understanding of mental illness. It is the opinion of the committee that effective media campaigns are needed o raise community awareness. This will provide an important step in better managing mental health care in Australia, particularly given the community-based care focus that resulted from deinstitutionalisation.

Minimising the impact of mental illness through prevention and early intervention

7.37   The importance of prevention and early intervention was a particularly strong theme in evidence to the inquiry. The significance of applying prevention and early intervention approaches from an early age, and throughout childhood and youth are recognised to be of vital importance, while people of any age that are exposed to adverse environmental conditions (such as poverty or unemployment) also benefit from early intervention and prevention.

Early influences on the young

7.38   The literature on mental health refers to risk and protective factors as influences in the development of mental health problems. Experiences in infancy,

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35   Mr Jeff Kennett, Chairman, beyondblue, *Committee Hansard,* 5 July 2005, pp. 3–4.

36   For comments on actors see Nicci Wall, *Submission 44*, p. 2.

37   insane australia, *Submission 2*, p. 2.

childhood and youth have an influence on the development of future mental health problems, and also there is a continuity of disorders between childhood, adolescence and into the adult years.[38]

7.39   Risk factors that increase the likelihood that a mental disorder will develop include insecure attachment in infancy, family disharmony, and harsh discipline style by a parent. Protective factors include a secure and stable family, a sense of belonging at school and adequate nutrition.[39]

7.40   A number of submissions argued that many risk and protective factors came into play even before birth, and that prevention and early intervention strategies need to begin in the antenatal and infancy periods.[40] Parental mental disorder has been identified as a risk factor for the development of mental health problems.[41]

7.41   The Australian Association for Infant Mental Health and NIFTeY referred to research indicating that infants as young as 3 months old can detect depression in their mothers.[42]

7.42   According to the Post and Antenatal Depression Association (PANDA):

> [PND] can interfere with the behavioural and emotional interactions that are now recognised as being necessary for a successful mother-infant relationship. Mothers with depression tend to be less sensitive to the needs of their babies and can be less responsive to their communications

7.43   PANDA say:

> Many women and their partners are not aware that mood changes are common after childbirth and can vary from mild to severe. In fact in the year after childbirth a woman is more likely to need psychiatric help than at any time in her life'.[43]

7.44   Studies show that 17 per cent of women giving birth in any year are likely to have postnatal depression, 10 per cent antenatal depression and 0.2 per cent postnatal psychosis and that 10 per cent of male partners of women giving birth may also have postnatal depression.[44] Children whose parents have untreated perinatal mental illness

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38   See,for example, Australian Divisions of General Practice, *Submission 308,* p. 29.

39   Monograph 2000, pp. 14–16.

40   Australian Association for Infant Mental Health and NIFTeY, *Submission 301*, p. 1; Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMA), *Submission 83*, p. 7.

41   Monograph 2000, p. 16.

42   *Submission 301*, p. 2.

43   PANDA, Mood changes, http://www.panda.org.au/aboutPndMoodChanges.html, (accessed March 2006).

44   PANDA, *Submission 544, Appendix A,* p. 9.

will demonstrate learning and developmental difficulties, hyperactivity disorders, mental illness and adult criminal behaviour.[45]

7.45   PANDA identified three mood disorders in the postnatal period:

- The 'baby blues', which affect most mothers between the third and tenth days after birth

- Postnatal depression (PND), affecting around 15 to 20 percent of mothers, and

- Postpartum psychosis, which affects about 1 in 500 mothers, usually in the first 3 to 4 weeks after delivery.[46]

7.46   PND is not always well understood or diagnosed. One mother recounted attempts to get help:

> I finally decided to tell my GP how I felt. He would help me, I thought. I tried to tell him how I felt, but it was too hard. Instead I complained that my baby was not feeding and sleeping well. I went back every week worried about my baby's health. Each week he reassured me that my baby was fine. Maybe, if he had asked about me, I would have told him that something was wrong and that I was scared, but he never did. I kept trying to tell him how I felt but the words just wouldn't come out. Each week I left his office and cried all the way home.[47]

7.47   Risk factors for PND include poor support from partner, family and or staff during labour, unplanned pregnancy, previous stillbirth, childhood sexual abuse, high trait anxiety, perceptions of not being in control, inadequate pain relief and fear for the wellbeing of the baby.[48]

7.48   Helpful in dealing with childbirth disorders were: early identification of the symptoms of PND; provision of accurate information and interventions; emotional support from family, friends and services; practical help with housework and childcare; psychological help with counselling and cognitive therapy; support groups; medical assessment and monitoring by GPs or psychiatrists; antidepressant medication; hospitalisation, ideally in a mother-baby unit and lifestyle changes – diet, exercise, rest.[49]

7.49   Beyondblue says there has been a lack of national focus and insufficient attention paid to improving women's mental health before they give birth:

> Left untreated, the impact on the mother and her child can be profound…

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45   PANDA, *Submission 544*, p. 2.

46   *Submission 544, Attachment 1*, p. 4.

47   *Submission 544, Attachment 1,* p. 3.

48   *Submission 544*, Attachment 1, p. 11.

49   *Submission 544*, Attachment 1, p. 9.

> If women at risk of postnatal depression are identified during pregnancy and effective psychological and social interventions are provided, then it is possible that postnatal depression may be reduced in severity or prevented altogether.[50]

7.50   Beyondblue conducted a four year National Postnatal Depression Program of research across six states to determine the scope for prevention through screening, information packages and psychological and social interventions. The findings show that new mothers were unlikely to identify their own depression and unlikely to seek treatment. Their beliefs about PND were often at odds with those of GPs over pharmacological treatment for depression. New mothers were also reluctant to use psychological or psychiatric therapies favoured by maternal and child health nurses.[51]

7.51   PANDA conducts a helpline in Victoria for PND but its limited state government funds allow it to operate only 4 days a week. The only two other states with PND help lines are WA and the ACT, neither of which receives public funds.

7.52   The organisation reported that many women calling their helpline admit to supplying deliberately false positive answers to a self-report scale used by health professionals working with mothers in the first postnatal year, for fear of being seen as bad mothers, insane, or that their child/ren will be placed in protective care.[52] This highlights both the stigma that can attach to mental illness and the need to ensure effective support is provided to women who feel they are experiencing, or at risk of, PND.

7.53   PANDA made a range of recommendations regarding perinatal mental health, including that there be a national strategy to support perinatal health services for 'the early identification, intervention, prevention and education of perinatal mental illness for men and women having children', arguing that it would be highly cost effective.[53]

7.54   The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) pointed to the negative effects of domestic violence:

> Of particular significance relating to infant mental health is the presence and effect of domestic violence - "a stressful life event" - experienced by women ante-natally and post-natally and her risk of developing post-natal depression. A mother's emotional availability and ability to respond sensitively to her infant are severely compromised and are influential in

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50   beyondblue, *About the PND Program: About PND,* http://www.beyondblue.org.au/postnataldepression/index.aspx?link_id=31.164, (accessed March 2006).

51   beyondBlue, *About the PND Program: PND Program Outcomes,* http://www.beyondblue.org.au/postnataldepression/index.aspx?link_id=31.168, (accessed March 2006).

52   PANDA, *Submission 544, Attachment 1,* p. 37.

53   *Submission 544,* p. 4.

limiting the infant's secure attachment leading to early development of poor mental health.[54]

7.55 Professor Jorm supported the use of information campaigns as part of a prevention and early intervention strategy, and suggested parenting was an area in which education for parents could be valuable:

there is a lot of research showing that, if children grow up in an environment where there is a lot of conflict in the home from the parents, they are at greater risk of developing anxiety disorders and depressive disorders when they grow up. The critical thing seems to be that the children are involved in or witness the conflict. If all parents knew not to involve the children in arguments, not to argue in front of the children and not to involve them—it is a very simple thing—they could then take the personal action that is going to reduce risk. That is a preventive action.[55]

7.56 AICAFMHA also pointed to the consequences for a child when the parent has a mental illness, and the need for health professionals to recognise that families needed support. AICAFMHA advised the committee of its successful collaboration with psychiatrists:

AICAFMHA, through its Children of Parents with a Mental Illness (COPMI) Project, has been successful in working with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) in developing a Position Statement (Position Statement #56) which acknowledges the effects of parental mental illness on family and also recommends that any assessment of an adult psychiatric patient must take into account the impact of the parental mental illness on any children within the family and ensure that appropriate supports are available for the family.[56]

7.57 Suggested early intervention strategies for children included a specific Medicare item number for GPs for health checks for children and adolescents. The ADGP submitted a recommendation to:

Develop, fund and implement an infant and early childhood promotion, prevention and early intervention program for primary care under the National Agenda for Early Childhood that includes... a child and adolescent health check item number into the Medicare Benefits Schedule.[57]

7.58 Strategies to identify children at risk were not well received by all. The Australian Mental Health Consumer Network recognised the benefits of a diagnosis for a young person in distress, but expressed concern at the negative consequences of the ensuing labelling:

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54   AICAFMHA, *Submission 83*, p. 19.

55   Professor Anthony Jorm, *Committee Hansard*, 1 February 2006, pp. 56–57.

56   *Submission 83*, p. 12.

57   ADGP, *Submission 308*, p. 4.

> The AMHCN is anxious about the attempts that have been made to intervene early in people's lives. We are not convinced that giving people medical diagnoses (labels) when they are young does anything to help their self esteem and generate the strengths that are necessary to deal with the ...real life issues...[58]

7.59   The identification of potentially unstable parents prior to birth of a child also was met with criticism. The Mental Health Legal Centre in Melbourne submitted that such identification was not backed up by practical initiatives such as support for those parents identified:

> A range of negative and discriminatory consequences can flow from labelling by government agencies which is not matched by appropriate service provision. In Victoria we have a push for antenatal notifications against parents the Department of Human Services perceive may have trouble parenting, there is nothing more offered, no parenting support or guidance, these parents continue with a pregnancy under surveillance, knowing that the child may be whipped away upon delivery.[59]

7.60   These circumstances seem likely to place additional stress in the parents, and this could potentially exacerbate the mental health risk factors for the child. There is an obvious need for antenatal identifications to be matched with support programs.

Adolescents and Young Adults

7.61   Mental disorders are most prevalent during adolescence and young adulthood, and account for 55 per cent of the total disease burden of those aged 15 to 24 years.[60]

7.62   According to ORYGEN Research Centre, over 75 per cent of all serious mental health and related substance use disorders commence before age 25 years and approximately 14 per cent of 12-17 year olds and 27 per cent of 18-27 year olds experience such problems in any given year. Effective, early intervention is necessary to reduce the burden of disease in this age group.[61]

7.63   Yet young people are particularly reluctant to get help. The ADGP advised on major barriers to young people:

> …14 percent of adolescents reported being worried about what other people would think of them if they sought help. 38 percent report that they preferred to manage their own problems, and other major barriers include thinking nothing would help (18 percent) and not knowing where to get help (17 percent).[62]

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58   AMHCN, *Submission 322*, p. 13

59   Mental Health Legal Centre, *Submission 314*, p. 8.

60   Australian Government, *Submission 476, Attachment 4,* p. 1.

61   ORYGEN Research Centre, *Submission 284*.

62   ADGP, *Submission 308*, p. 32.

7.64   Young males suffer the additional barrier conferred by the Australian stereotype of masculinity. Evidence suggested that rural males are even more affected, as the 'tougher than John Wayne' image supported the high incidence of suicide in the bush.[63] A submission stated:

> Unless they have lost a limb it is hard to get any young Australian male to a doctor. It is viewed as a sign of weakness to seek help and the fact that there are few physical symptoms with mental illness, the adage of 'It's all in your head', couldn't be any more relevant.[64]

7.65   The Victorian Task Force report on Suicide Prevention found that

> …young people living in family environments that display disharmony, inconsistent discipline, violence, neglect and abuse are at significantly increased risk of suicide and require particular support. Some young people living in such circumstances subsequently become homeless, and their risk of engaging in self-harming behaviours then may escalate.[65]

Targeting Australia's youth population through school-based programs

7.66   A number of submissions acknowledged the importance of GPs as a primary point of contact for families but many also acknowledged that young people do not necessarily seek help from GPs.[66] This was especially so for young people who are marginalised and disconnected from family and school.[67] A child and adolescent mental health service in Perth indicated that 35 percent of referrals came from schools.[68]

7.67   The Australian Guidance and Counselling Association (AGCA) representing school counsellors and school psychologists argued that schools are an obvious location in the community for mental health promotion, prevention and early intervention.[69] The AGCA pointed out that as young people were at school anyway, there was less of a problem associated with the stigma of seeking help, and less of a problem accessing transport when services were not locally available.[70]

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63   Mr Jeff Kennett, *Committee Hansard,* 5 July 2005, pp. 1, 9; and see NSW Farmers Association, *Submission 410*.

64   Mr Kieran Wicks, *Submission 104*, p. 8.

65   Victorian Suicide Prevention Task Force, *Report*, 1997, p. 56, http://www.health.vic.gov.au/mentalhealth/publications/suicide/report.htm, (accessed March 2006).

66   Professor Debra Rickard, *Committee Hansard*, 27 September 2005, p. 57.

67   ADGP, *Submission 308*, p. 32.

68   West Australian Child and Adolescent Mental Health Services Advisory Committee, *Submission 24*, Section (c).

69   AGCA, *Submission 413*, p. 2.

70   *Submission 413*, p. 2.

7.68   Schools currently conduct a number of programs aimed at building students' healthy development and resilience. MindMatters is a mental health promotion initiative in secondary schools, funded by the Federal Department of Health and Ageing and discussed later in this chapter. The AGCA argued that although schools already conducted such programs, there was considerable room for improvement, and for mental health promotion and prevention to be built into the ongoing curriculum in the same way as subjects such as literacy and numeracy:

> Mental health promotion and illness prevention needs to be clearly built into the curriculum for teachers to afford it the same consistent attention they give to literacy and numeracy skills. Literacy and numeracy skills are reinforced year after year in school. All students need to develop resilience, social competence and coping skills. These abilities also need to be reinforced year after year in school.[71]

7.69   AGCA pointed to the importance of linkages between schools, health professionals, and community agencies to ensure effective early intervention. The ADGP argued that GP groups played an important role in bringing together schools, health professionals and family/community support groups for improved collaboration and referral pathways.[72]

Minimising the impact of adverse conditions or disadvantage

7.70   A number of submissions emphasised the importance of social connectedness as a protective factor against the development of mental health problems, and also stressed the importance of minimising risk factors, such as poverty, unemployment, and poor education. The AGCA indicated that children from impoverished backgrounds and disadvantaged population groups are at greater risk of adult mental health concerns.[73] The ADGP submitted that:

> Social connectedness, stable accommodation, employment and relationships are well documented factors that protect against the development of mental health problems and disorders.[74]

7.71   ACOSS argued that there was a strong link between poverty and disadvantage, and poor mental health:

> While there is a clear and strong association between poverty and mental illness, the causal links are more complex. Nevertheless, it is at least as likely that the stresses relating to poverty and disadvantage are as significant in contributing to mental illness as the presence of mental illness is to the likelihood of a person living in poverty. What is indisputable is that poverty and mental illness can combine in a vicious cycle in which the fact

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71   AGCA, *Submission 413*, pp. 2–3.

72   Australian Divisions of General Practice, *Submission 308*, p. 32.

73   *Submission 413*, p. 2.

74   *Submission 308*, p. 26.

of poverty contributes to the manifestation of mental illness, which in turn contributes to the risk of poverty.[75]

7.72   ACOSS argued for greater investment in supports and social services to not only reduce the poverty of people with mental illness, but to ensure that poverty did not contribute to the incidence of mental illness in the first place, or to its severity or persistence.[76]

7.73   In a similar vein, the AMHCN supported a focus on addressing social inequities that are risk factors in the development of mental health problems. Representing people living with mental illness, AMHCN submitted that

> Many of our members believe very strongly that their experiences of mental distress are closely linked to life experiences. Poverty, physical illness, immigration detention, racism, family violence, breakdown of adult relationships, losing substantial amounts of money, gambling etc. etc. lead to mental illness.

> Over the past decade it has been fashionable to attempt to understand mental illness as some sort of a biochemical abnormality acting in isolation from the rest of people's lives. This has meant that the focus has come off searching for ways of preventing the social and cultural inequities and traumas that many consumers believe precedes the development of signs of mental illness.[77]

7.74   Social disadvantage may also be vertically transmitted from one generation to the next in deprived communities, thus perpetuating emotional and behavioural and psychological problems.

Delivering promotion, prevention and early intervention programs to the community

7.75   A variety of community-based services are working to reduce the stigma of mental illness and raise awareness in the community. There is also a number of programs that are assisting to recognise the onset of mental illness and prevent the escalation of harm. Some concentrate on particular modes of service delivery; others concentrate on addressing specific issues. The following provides an overview of some of the services available in the areas of telephone counselling, online services, child and youth-focussed services, and other national initiatives.

Telephone counselling

7.76   A number of telephone counselling services exist that have an important place in the spectrum of prevention and early intervention strategies in Australia, providing

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75   ACOSS, *Submission 457*, p. 3.

76   *Submission 457*, p. 2.

77   AMHCN, *Submission 322*, p. 12.

a cost-effective and practical way of responding to the immediate needs of consumers.[78]

Lifeline

7.77   Lifeline Australia runs the longstanding free 24-hour telephone counselling service from 42 centres throughout Australia in around 59 different locations, half of which are in rural and remote areas.[79]   In addition, Lifeline provides information and referral services and has recently developed Just Ask, a mental health information telephone service with a particular focus on rural and regional areas and Just Look, a one-stop national service directory available through a web-based portal or CD-ROM.

7.78   Lifeline answered 489,406 calls in 2004-05, which gives an indication of the scope of assistance provided to the community.[80] The vast majority of Lifeline's workforce is volunteers (estimated at 10,000), providing telephone counselling and administrative support.

7.79   Telstra has committed around $1 million per annum for the next three years to Lifeline. Other sources of funding include corporate sponsors, partners and donors and contributions from community members.[81]   Funding from the Australian Government (Department of Health and Ageing and Department of Family and Community Services) over the past year has enabled Lifeline to develop a range of new initiatives for improving access to care in the community.[82]   However, Lifeline has stated that it does not receive recurrent state government funding to manage the ever increasing demand for telephone counselling services, despite Commonwealth and State Government services advising clients to contact Lifeline for assistance.[83]

Kids Help Line

7.80   Kids Help Line is a free 24-hour national telephone and on-line counselling service for children and young people aged 5 to 18. The service is run by Boystown and adopts a child-centred early intervention approach towards the mental health issues of young people, employing 100 professionally trained, paid counsellors, and as well as 24-hour telephone counselling, provides crisis response, after-hours services, and ongoing support.[84] Many young people who contact Kids Help Line have experienced adverse life events and/or display early warning signs of mental health

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78   Illawarra Institute for Mental Health, *Improving NSW mental health care: evidence got the unique role of Lifeline's 24-hour telephone service,* February 2005, p. 1.

79   Lifeline, *Submission 328, Attachment 1,* p. 3.

80   Lifeline, *Annual Report 2004-05,* p. 10.

81   Lifeline, *Annual Report 2004-05,* p. 21.

82   Lifeline, *Annual Report 2004-05,* pp. 9, 14–15, 19–20.

83   *Submission 329, Attachment 6,* p.3.

84   Boystown, *Submission 107,* p. 4.

problems. In 2004, Kids Help Line answered 447,367 calls and more than half of these calls were from rural and remote areas.[85]

7.81   Kids Help Line is well-recognised by young people. A study conducted by the NSW Commissioner for Children found that it was the only formal service that most children and young people could identify.[86]

7.82   The key sources of revenue for Kids Help Line are Boystown lotteries and special community fund-raising activities, while funding from the Australian Government supports specific programs relating to suicide prevention, supported accommodation and employment assistance.[87] Revenue is also provided through donations from the public and corporate sponsors, with Optus being the major sponsor of Kids Help Line.[88]

Parentline

7.83   Kids Help Line has also developed the Parentline telephone counselling service, which assists parents and carers with behavioural management, parenting skills, and interpersonal relationships. Parentline is a Queensland and Northern Territory service, funded by the respective state governments.[89]

Online services

7.84   The Internet has been used effectively in recent times for various online counselling and therapy initiatives. These services deliver treatment in the form of computer-based therapy, facilitating care that may be otherwise unaffordable to the consumer or very difficult to access based on location.[90] This mode of delivery is also more cost effective than visiting a healthcare professional, yet effectiveness of treatment is reported to be on par.[91]

MoodGYM

7.85   MoodGYM is a free-of-charge interactive software program delivering therapy for depression. It leads the user through a number of modules that explore varying areas of their life, such as learned behaviours, coping skills and relationships,

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85   Kids Help Line, "Kids Help Line 2004", *Kids Help Line Infosheet 2,* *http://www.kidshelp.com.au/upload/12363.pdf* (accessed 10 March 2006).

86   NSW Commission for Children and Young People, *Submission 399*, p. 2.

87   Boystown, *Submission 107,* p. 1.

88   Boystown, *How you can support Kids Help Line,* *http://www.kidshelp.com.au/template/standard.aspx?s=122&p=119&r=2&b=1* (accessed March 2006).

89   Boystown, *Submission 107,* p. 5.

90   Centre for Mental Health Research, *Submission 186,* p. 15.

91   Inspire Foundation, *Submission 491,* p. 6.

and how to better manage some of the difficulties of everyday life. The site currently attracts around 18,000 visits per month, has 80,000 registered users and is accessed in 62 countries. [92] The site is fully funded through the Australian National University.

7.86   Research by the Centre for Mental Health Research has shown that MoodGYM is effective in reducing depression and anxiety symptoms, with the degree of improvement equivalent to that achievable through face-to-face psychotherapy.[93]

Kids Help Line online email and counselling

7.87   Boystown (through Kids Help Line) was funded by the Australian Government to establish real-time web counselling and email services.[94] Boystown reported these services as becoming increasingly popular, and the number of online contacts about mental health issues being 'three times higher than the rate of contacts to Kids Help Line via telephone counselling'. [95]   This is encouraging support for the further development of on-line services.

Reach Out!

7.88   Reach Out! is a web-based mental health service targeting late adolescent and early adults (18-24 year old age group). The service provides self-help information, illustrated by personal stories from people facing challenges, and is focussed on empowering individuals to work through difficulties themselves wherever possible, whilst also providing details of referral services for additional support.[96] Reach Out! is funded by the Inspire Foundation.[97]

depressioNet

7.89   DepressioNet is an on-line service providing information and resources on depression, including 24-hour peer based support. The service emphasises that it is operated by people who live with depression, providing encouragement and support that is tailored to the unique needs of people with depression, their families and

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92   The Australian National University, *The MoodGYM Training Program Mark II,* http://moodgym.anu.edu.au/ (accessed March 2006).

93   Centre for Mental Health Research, *Submission 186,* p. 17.

94   Boystown, *Submission 107,* p. 14.

95   *Submission 107,* p. 14.

96   Reach Out!, *Frequently Asked Questions,* http://www.reachout.com.au/default.asp?ti=926#q1 (accessed March 2006).

97   Inspire Foundation, *Submission 491,* p. 4.

carers.[98] DepressioNet is funded through grants, donations and corporate partnerships.[99]

Child and youth-focussed services

MindMatters

7.90   *MindMatters* supports the development of sound emotional and social development of pupils in Australian secondary schools through delivering education and resources for promotion of mental health, and prevention of and early intervention in mental illness.[100] An evaluation of the project by the Australian Principals Associations Professional Development Council reported very positive results, and this view is supported across other parts of the community.[101] A number of side projects have been created under the *MindMatters* banner, including *MindMatters Plus* (supporting students deemed to be at risk) and *MindMatters Plus GP* (establishing referral pathways between *MindMatters Plus* schools and primary mental health care practitioners).

7.91   *MindMatters* was funded from 2000-2005 through the National Mental Health Strategy, and the committee was informed that future funding requirements were to be sought through the Department of Health and Ageing.[102] The Australian Divisions of General Practice stated its support for federal Government funding to ensure the longevity of the project, as well as to expand *MindMatters Plus GP* initiative nation-wide.[103] Mr Don Zoellner, Chair of the *MindMatters* National Reference Committee, also informed the committee that the *MindMatters* program has not been taken up by all schools, possibly because they already have programs in place.[104] The Mental Health Council of Australia was supportive of *MindMatters*, but also stated that MindMatters is currently 'limited in its scope and application', and cannot be fully effective unless supported by broader community strategies.[105]

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98   depressioNet, *Submission 475,* p. 2.

99   depressioNet, *Partners in health,* http://www.depressionet.com.au/partners.html (accessed March 2006).

100   Mr Ian Webster, *Submission 458,* p. 10.

101   Australian Principals Associations Professional Development Council, *Submission 120,* p. 2; Mr Ian Webster, *Submission 458,* p. 10; *Submission 308,* p. 22.

102   Ms Susan Boucher, Chief Executive Officer, APAPDC, *Committee Hansard,* 27 September 2005, p. 21.

103   Australian Divisions of General Divisions, *Submission 308,* pp. 47, 33.

104   Mr Don Zoellner, Chair of the MindMatters National Reference Committee, *Committee Hansard,* pp. 21–22.

105   Mental Health Council of Australia, *Submission 262,* p. 32.

ORYGEN

7.92   ORYGEN is a youth-focussed (12-25 years old) mental health care and research organisation servicing the western and north-western regions of Melbourne, Victoria. Key services provided by the organisation include operating a youth clinical program, the ORYGEN Research Centre and managing the support and training service for early psychosis in Australia. ORYGEN is the 'only specialist youth mental health service of its type in Australia', and has received international recognition.[106]

7.93   The philosophy of ORYGEN is to acknowledge the special needs of youth and develop promotion, prevention and treatment strategies tailored to their specific requirements. ORYGEN advises:

> Treatments have never been better – if treated appropriately and early, a young person has excellent prospects for a happy and healthy life. Early case identification and intensive treatment of the emerging disorder has been shown to reduce the need for inpatient treatment and is associated with better outcomes and subsequent cost reductions for the health care system.[107]

7.94   Like many community-based organisations, ORYGEN has stated that it is unable to deliver services to all those in need due to a lack of resources. This results in a situation where 'a substantial number of very unwell young people have to be turned away' with longer-term impacts of untreated mental illness felt by both the consumer and society as a whole.[108]

7.95   In December 2005, the Prime Minister announced that a consortium, led by the ORYGEN Research Centre, will establish a Youth Mental Health Foundation.[109] The Foundation will have access to $54 million funding over four years from the Australian Government, and will bring together a number of organisations to improve coordination of mental health services for young people. This model of service delivery could be adopted across other areas of mental health care in Australia. ORYGEN recommended the creation:

> of youth-specific specialist mental health services for young people aged 12-25, which would complement existing state funded child and adolescent, adult and aged persons' services, and would provide access to integrated mental health, substance use, and vocational recovery supports and services.

> Such services would have a special focus on first episode and early stage psychotic disorders and major mood disorders — illnesses which eventually

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106   ORYGEN Research Centre, *Submission 284,* p. 2.

107   ORYGEN Research Centre, *Report 2004 & 2005*, p. 21.

108   *Submission 284,* p. 3.

109   Prime Minister of Australia, *Youth Mental Health Foundation,* http://www.pm.gov.au/news/media_Releases/media_Release1721.html (accessed March 2006).

make up the clientele of the State public mental health system. It is estimated that the roll-out of youth-specific, specialist mental health services across Australia would require a recurrent budget of $525M per annum, although a proportion of this cost may be offset by re-allocation of resources from existing CAMHS and adult public mental health services.[110]

7.96   Under this model, there would be at least three age brackets to which mental health care would be delivered: children; adolescents and/or youth; and adult. There is strong evidence that the onset of many mental health problems occurs during the teenage and early adult years, and that the special needs of this group deserve a targeted response.[111] Mental health amongst young people is also discussed further in Chapter 15.

Other Child and Youth Services

7.97   The committee heard about examples of other child and youth services, in addition to those above, and those discussed earlier such as PANDA. Mental Health Child Safety Support Teams, established by the Queensland Government, provide specialist identification, treatment and long-term therapy for children with severe psychological and behavioural problems. These teams are linked with primary health care providers, as well as non-government organisations to facilitate the continuity of care as the child matures.[112]

7.98   The Intensive Community Youth Service is under development by the Western Australian Government. It aims to strengthen the opportunities for early intervention in young people by linking a spectrum of both community-based and specific mental health services to young people to support them in life.[113]

7.99   The Perinatal and Infant Mental Health In the Community project, funded by the South Australian Government, is working to improve the diagnosis and management of perinatal and maternal health problems by primary health providers and community organisations.[114]

National initiatives

beyondblue

7.100   Beyondblue is a national organisation for raising awareness about depression, anxiety disorders and related substance abuse in Australia. It is a

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110   ORYGEN Research Centre, Submission 284B, pp. [3–4]

111   See AICAFMHA, *Submission 83*, pp. 7–9; beyondblue, *Submission 363*, p. 9; Inspire Foundation, *Submission 491*, pp. 3–4.

112   Queensland Government, *Submission 377A,* p. 10.

113   Department of Health – Government of Western Australia, *Submission 376,* p. 20.

114   Department of Health – South Australia Government, *Submission 506*, p. 4.

bipartisan project of the Commonwealth, State and Territory Governments, and the overwhelming focus to date has been raising awareness of mental illness as a health problem in Australia and reducing the associated stigma.[115] The organisation has conducted extensive research into people affected by depression, their carers and families, and is working to develop new initiatives for early intervention and prevention, destigmatisation of mental illness, and to improve access to training and support services for both the community and health care providers.

7.101   An example of recent work is beyondblue working with a range of health care bodies to ensure those with mental illness receive the same rights when dealing with insurance companies as are those with physical disabilities. This is in response to concerns from consumers that they are less able to access insurance products as compared to people with a physical disability, so are being discriminated against.[116]

Suicide prevention

7.102   Many important projects – at both the national and local level – have been funded through the 'Living is for Everyone' (LIFE) framework of the National Suicide Prevention Strategy.

7.103   The suicide rate is higher for mentally ill people than the general population, particularly for people with disorders such as depression, yet there is strong evidence that many individuals with this illness are not recognised or do not receive adequate treatment.[117] The indigenous population also has a much higher rate of suicide, compared with the general population.[118] A key outcome of the LIFE framework is to reduce known risk factors for suicide and self-harm.

7.104   Suicide Prevention Australia stated that for the 150 local projects funded through the LIFE framework, project areas include:[119]

- Aboriginal and Torres Strait Islander communities, ensuring that programs are culturally appropriate;

- suicide prevention in males, as they are more likely to commit suicide than females;

- families, carers and friends bereaved by an act of suicide;

- alcohol and substance abuse associated with self-harm and the increased risk of suicide;

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115   beyondblue, *Submission 363,* p. 5.

116   *Submission 363,* p. 19.

117   Suicide Prevention Australia, *Submission 425,* p. 3.

118   Auseinet, *Submission 441,* p. 14.

119   Suicide Prevention Australia, *Submission 425,* pp. 13, 15, 16, 17, 19, 20, 22, 27, 27.

- suicide prevention in older people, as international studies demonstrate that people over the age of 65 years have the highest rate of suicide;

- reduction in the impact of adverse social conditions associated with an increased suicide risk, such as a death in the family or domestic violence;

- support to people involved with, or that may potentially become involved with, the criminal justice or juvenile justice system;

- enhancement of community acceptance and support for marginalised groups, people with risk factors for suicide and those affected by suicide; and

- promotion of increased acceptability of help-seeking to respond to mental health problems.

7.105   However, the ORYGEN Research Centre argues that the LIFE suicide prevention strategy takes a public health oriented approach that is too broad to be effective:

> While such a broad population based approach is important if we are to reduce suicide at a population level, it is very hard to measure and implement. To make a measurable difference it is important to tackle populations we know to be at high-risk – the mentally ill (depression is present in 88 per cent of suicides), those in early stages of a mental illness or recently discharged from a mental health service and those with both mental health and substance abuse problems.[120]

The challenges of delivering promotion, prevention and early intervention programs

7.106   A number of key challenges is restricting the long term delivery of programs, or they are not available across the wider community. Challenges examined in this section are: resourcing, short-term funding approach and a lack of back-up services, and the need to embed a prevention approach within health bureaucracies. There is also a need to ensure that programs producing positive outcomes are recognised, funded appropriately, and strategies developed to roll them out on a national scale.

7.107   The effectiveness – and difficulties – of using on-line services as an alternative approach to reaching out to people in need is also examined in this section.

Resourcing

7.108   Despite consensus on the need to give priority to promotion, prevention and early intervention, a number of submissions argued that insufficient resources generally for mental health had the effect of tying up available resources in the treatment end:

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120   ORYGEN Research Centre, *Report 2004 & 2005*, p. 22.

> ... despite the policy directions and the evidence, the mental health service system appears to reflect a sense of competing priorities between treatment and promotion and prevention activities. Mental health expenditure needs to reflect commitment across the spectrum of services, not a focus on treatment services only.[121]

7.109   Whilst expressing praise for PPEI Action Plan, the Australian Health Promotion Association also lamented the competing resources that limited the implementation of the Plan:

> A significant barrier to progress in implementing [PPEI Action Plan] in jurisdictions is created by the need for 'prevention end' interventions to constantly compete with established clinical services for priority in funding.[122]

7.110   Submissions giving the perspective of medical and allied health professionals painted a picture of this competition for resources as it was felt at the coalface in hospitals and community mental health teams. Frustration was expressed at the lack of opportunity to provide prevention and early intervention services, because of the pressing need to deal with acute cases of mental disorder.[123] Auseinet argued strongly for increased expenditure on prevention and early intervention strategies:

> It is very clear that if we are going to stem the tide of increasing prevalence of mental disorders such as depression, anxiety and mood disorders, a greater proportion of the mental health budget needs to be expended on [promotion, prevention and early intervention] initiatives which intervene at a much earlier stage.[124]

Short-term funding approach and a lack of back-up services

7.111   Concerns were raised that many initiatives were funded on only a short-term basis, and did not result in lasting changes to the mental health system. The Mental Health Council of Australia commented that prevention and early intervention services were restricted to demonstration funding rather than ongoing funding.[125] The Australian Divisions of General Practice supported federal government initiatives to build capacity of general practitioners in the area of early intervention for children, but expressed concern at what was seen as 'ad hoc, uncoordinated funding of a series of projects by various levels of government'.[126]

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121   Auseinet, *Submission 441*, p. 5.

122   Australian Health Promotion Association, *Submission 187*, p. 3.

123   Victorian Section, Australian Psychological Society, *Submission 479*, p. 4; Australian College of Psychological Medicine (ACPM), *Submission 411*, p. 6.

124   *Submission 441*, p. 10.

125   Mental Health Council of Australia, *Submission 262*, p. 12.

126   Australian Divisions of General Practice, *Submission 308*, p. 29.

7.112   These comments reflect similar concerns expressed throughout the inquiry regarding the drawbacks of short-term funding and pilot project funding for many mental health initiatives, not just those associated with prevention and early intervention. These concerns are discussed in Chapter 4.

7.113   Suicide Prevention Australia argued that short-term funding of prevention and early intervention projects runs the risk of increasing demand for mental health services, without increasing services to meet that demand:

> The prevention 'push' often has encouraged the funding of short-term projects that risk increasing expectations without interventions being sustainable. Such funding enhancements generally have not generated ongoing new mental health services.[127]

7.114   The problem of creating demand without providing services to meet the demand can also apply to well-supported programs such as beyondblue, the depression awareness initiative, discussed earlier in this chapter. One medical practitioner (from regional NSW) told the committee of her concern that whilst the beyondblue initiative raised awareness of depression and encouraged people to seek help, it could result in frustration when services were not available:

> ... I would articulate the concern that, if we create more need, unless we have more services we can deliver to support these people we are going to have even more disappointed people. There is the difficulty of beyondblue coming to town and identifying and raising awareness but then the system does not have the capacity, or feels like it does not have the capacity, to respond to those needs being generated.[128]

7.115   Ms Jennie Parham of Auseinet echoed these concerns, telling the committee that a major problem in progressing the promotion and prevention agenda was under-funding of the treatment end of services that resulted in long waiting lists to access specialist mental health services. Ms Parham told the committee:

> ... if we are serious about wanting to identify mental illness early and get early intervention on the agenda, we really have to do something about the service system that supports it.[129]

Need to embed a prevention approach within health bureaucracies

7.116   A variable level of commitment to prevention and early intervention strategies across jurisdictions was raised as a concern with the committee. In particular, it was argued that there was a need within health bureaucracies to get past a short-term, project-funding outlook, and move towards firmly embedding a long-term prevention approach. Auseinet described its efforts in assisting jurisdictions to develop

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127   Suicide Prevention Australia, *Submission 425*, p. 5.

128   Dr Jennifer May, NRHAC, *Committee Hansard*, 4 July 2005, p. 80.

129   Ms Jennie Parham, Auseinet, *Committee Hansard*, 27 September 2005, p. 55.

infrastructure to support work in the prevention and early intervention area, and indicated that all jurisdictions now have some level of infrastructure in place to advance implementation. [130] Auseinet argued, however, that 'there is still a way to go in embedding [prevention and early intervention approaches] in sustainable systems and structures'.[131] Ms Jennie Parham of Auseinet told the committee:

> Unless you have things actually bedded down in what I would call bureaucratic capacity, then really they are not sustainable and we are just going to be back to square one. [132]

7.117   Auseinet also indicated that the level of prevention/early intervention infrastructure developed was in some cases determined by the energy and commitment of 'champions' or 'advocates', who made progress through developing collaborative relationships.[133] Unfortunately, as Professor Debra Rickwood told the committee, the collaborative relationships can break down when these key people move on, because the system supports are not there.[134]

7.118   At a more general level, the Australian Divisions of General Practice expressed concern at what it saw as a national lack of effort and commitment to prevention and early intervention:

> The problem is not a lack of evidence, availability of programs, or that these programs lack merit. The issue is quite the opposite. On a national scale, there has been insufficient effort and funding to promote awareness, and coordinated access and uptake of these vital mental health promotion, prevention and early intervention programs.[135]

7.119   To monitor progress of jurisdictions in implementing prevention and early intervention strategies, Auseinet suggested the development of a promotion and prevention scorecard.[136]

On-line services – a new way of targeting mental health problems?

7.120   A number of submissions pointed to the benefits of online resources for mental health. The anonymity of online services was seen as important in encouraging help-seeking by those who would otherwise not wish to reveal their concerns. As the

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130   Auseinet, *Submission 441*, p. 10.

131   *Submission 441*, p. 10.

132   Ms Jennifer Parham, Auseinet, *Committee Hansard*, 27 September 2005, p. 54.

133   *Submission 441*, p. 10.

134   Professor Debra Rickwood, Auseinet, *Committee Hansard*, 27 September 2005, p. 54.

135   Australian Divisions of General Practice, *Submission 308*, p. 30.

136   Professor Debra Rickwood, Auseinet, *Committee Hansard*, 27 September 2005, p. 52.

Australian Health Promotion Association pointed out, 'the advantage of anonymity in accessing online help is likely to prove life-saving in many cases'.[137]

7.121   The Australian Guidance and Counselling Association reported anonymity as being particularly important for young males who are more likely to seek anonymity and avoid closeness.[138] However, preliminary monitoring of gender and web counselling usage by Boystown revealed that males were not accessing this service at a higher rate than females, which was not the expected result.[139]

7.122   Online services also were seen as very positive for increasing access to services for people in rural and remote areas, especially in locations where professional help was not available locally.

7.123   Inspire Foundation, sponsor of the Reach Out! website, argued that online services were more appropriate than telephone services for the late adolescence and early adult group, which generally does not access Lifeline and Kids Help Line.[140] Inspire also argued that online services were much cheaper to provide than telephone services.

7.124   Although many submissions were very positive about the potential of online services in prevention and early intervention, some drawbacks were raised. The Australian Health Promotion Association (AHPA) put forward that online service provisions had further potential, and deserved continued support, but pointed to the problems of access for people on limited incomes.[141] One submitter, a parent of a person with a mental illness, echoed this concern, and suggested that mental health care using e-technology was primarily for benefit to people on middle and upper incomes.[142] The submitter argued that people with mental illness would make more use of such online services if they were more accessible and affordable:

> While people on low incomes and those below the poverty line may be able to obtain some access to the internet through social and other support services ... this access is not regular enough to be of any real help. Although my younger son rejects almost all support services, I believe he would access mental health care over the internet if he had free access to the internet in his home. He is very computer literate, very concerned about his privacy and would like to manage his life by himself (although he is not

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137   Australian Health Promotion Association, *Submission 187,* p. 10.

138   Australian Guidance and Counselling Association, *Submission 413*, p. 3.

139   Boystown, *Males and Help Seeking Behaviour,* *http://www.kidshelp.com.au/template/standard.aspx?s=164&p=162&r=156&b=109* (accessed March 2006).

140   Inspire Foundation, *Submission 491*, p. 4.

141   Australian Health Promotion Association, *Submission 187*, p. 10.

142   Name withheld, *Submission 251*, p. 6.

able to do so). Accessing mental health care by himself in the privacy of his own home would suit him very well.[143]

7.125   This parent suggested that 'people with a mental illness who are interested in accessing mental health care over the internet should be provided with a cheap second-hand computer and a certain amount of free internet access in their own home'.[144]

7.126   AICAFMA raised a further concern with online services provided to young people, suggesting that consideration needed to be given to the ethics of providing counselling to children without the consent of their parents.[145]

Concluding remarks

7.127   Whatever approach is taken to the labelling of mental illness, greater community awareness is widely regarded as an important part in the process of healing and acceptance. Raising community awareness will reduce fear and ignorance. This will allow people with mental illnesses to live and work more successfully in their communities.[146] But it is also a key part of enhancing mental health promotion, prevention and early intervention.

7.128   Prevention and early intervention clearly have a critical role in alleviating the impact of mental illness in the longer term, particularly when targeted at developing members of the community, such as the children, adolescents and young adults. The future benefits of proactive management of mental illness at an early stage and in minimising the social factors that may lead to the onset of mental illness are overwhelming.   This includes a reduction in the social burden associated with supporting people left untreated for so long that they are in very poor health and unable to function independently, lower clinical care costs, reducing the incidence of suicide, and a better quality of life for people with, or at risk of developing, a mental illness.

7.129   However, this is only part of the work that is needed. Much more still needs to be done at the national level to raise community awareness of other disorders with devastating effects, and in promoting the much-needed services that are available across communities, in every state and territory across Australia to deliver health care. Awareness raising is largely ineffective if the back-up services are not available. This

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143   Name withheld, *Submission 251*, p. 6.

144   *Submission 251*, p. 6.

145   AICAFMA, *Submission 83*, p. 6.

146   Other initiatives would be in expansion mental health first aid education programs, see Professor Anthony Jorm and Mrs Betty Kitchener, *Submission 47*, and introduction of work experience programs to improve both consumer and employer confidence. Ms Elizabeth Crowther, *Committee Hansard*, 5 July 2005, p. 97. See discussion of the Flat Bottle initiative, pp. 94, 97.

also extends to ensuring a steady and reliable funding stream to evolve promotion, prevention and early intervention initiatives and ensure their longer term success.

CHAPTER 8

INPATIENT AND CRISIS SERVICES

> One thing I came to understand clearly over these years of dealing with and talking to the crisis teams and the staff of the mental health centres is that the system is so under-resourced that they must deal with the life and death cases first and other cases necessarily come second. This is a brutal reality which should not exist in a civilised society.[1]

8.1   Mental health inpatient and crisis services are under significant strain. Witnesses to the inquiry despaired at the absence of treatment or other interventions in all but the most immediate life-threatening situations. There was a clear call for increased resources to meet current needs, to improve service availability and standards of care.

8.2   The committee received many harrowing personal stories from consumers, carers and others about inpatient treatment experiences and mental health crisis situations, in some instances leading to tragic deaths. Many expressed their frustration and anger. Others expressed despair. Some submitters had seldom told their stories before, feeling alienated and stigmatised because of their circumstances. The committee appreciates the great effort and courage they showed in giving evidence to this inquiry.

8.3   Other contributors had told their stories before, many times. They commented that the same issues have been presented over and again in different forums.[2] The committee appreciates the determination these submitters show by continuing to contribute their experience, knowledge and ideas to help improve mental health services and ultimately the lives of those experiencing mental health problems.

Mental health care in an age of deinstitutionalisation

8.4   Care for people experiencing severe mental illness has undergone a revolutionary transformation over the last few decades. Australia had around 30,000 acute care psychiatric beds in the 1960s. The number of public beds had fallen to around 8,000 at the time of the development of the National Mental Health Strategy (NMHS), and is now around 6,000.[3] This decline was driven by several factors[4]:

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1   Name withheld, *Submission 375,* p. 8.

2   See for example, Ms Isabell Collins, Director, Victorian Mental Illness Awareness Council (VMIAC), *Committee Hansard*, 5 July 2005, p. 72.

3   Australian Government, *National Mental Health Report 2005*, p. 38.

- Changes in views about human rights, treatment and care for people experiencing mental illness

- Improvements in treatment for mental illness, particularly through new pharmaceuticals

- Effective antibiotic treatment of syphilis, avoiding the need for psychiatric hospitalisation in advanced cases of the disease

- Evolution of specialised aged care facilities that could manage geriatric illnesses, particularly dementia

- Creation of specialised institutions for people with intellectual disabilities, and

- Audits and reviews of stand-alone psychiatric institutions that were highly critical of the care they provided.[5]

8.5 The closure of stand-alone psychiatric institutions is often referred to as deinstitutionalisation.[6] Figure 1 shows the change in beds over the last decade, and demonstrates two key trends: the shift in beds from stand-alone facilities to general hospitals; and the decline in the total number of beds, as more care takes place in the community.

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4   Australian Government, *National Mental Health Report 2005*, p. 38; K. Richmond and P. Savy, 'In Sight, In Mind: Mental Health Policy in an Era of Deinstitutionalisation', *Health Sociology Review*, vol. 14, no. 3, 2005, p. 217.

5   See for example, Victoria. Office of Psychiatric Services, *Audit of Standards of Treatment and Care in Psychiatric Hospitals in the State of Victoria*, 1992, Health Department Victoria, Melbourne.

6   The committee recognises that closure of institutions does not occur in isolation, but in conjunction with development of other modes of care.
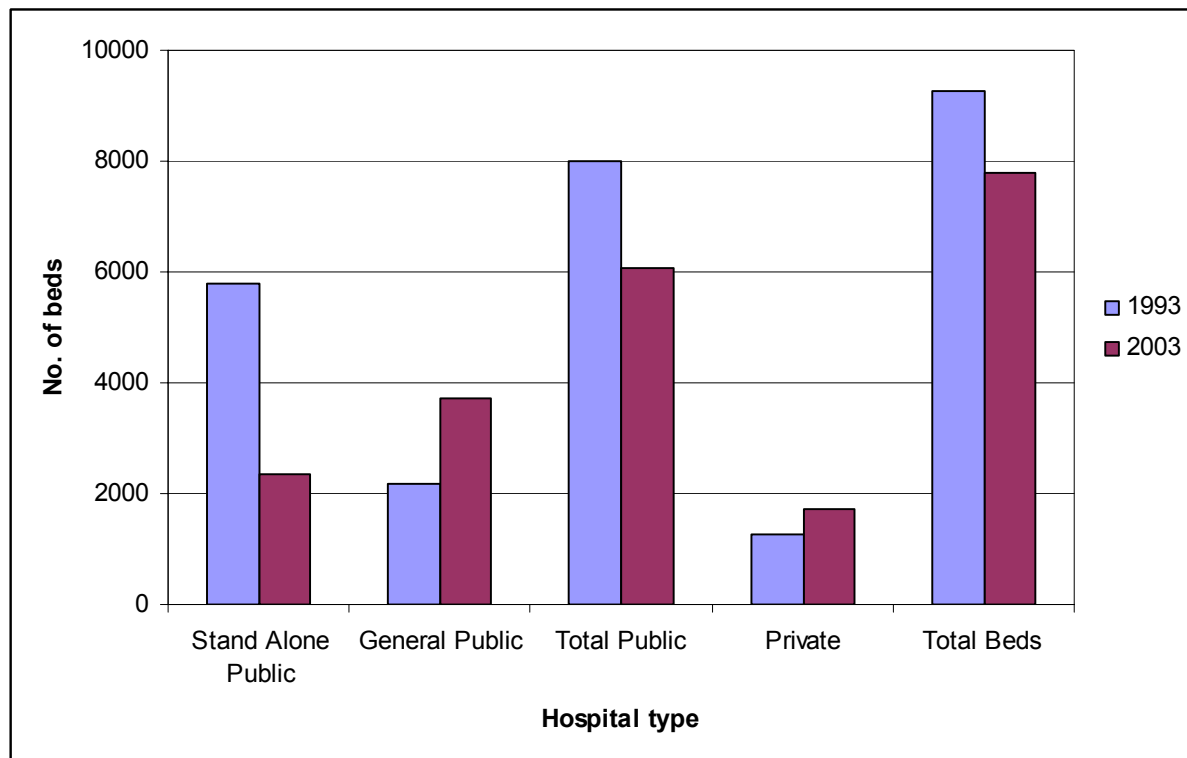
Figure 1: Number of psychiatric hospital beds[7]

8.6   While deinstitutionalisation has meant closure of many stand-alone psychiatric institutions, this closure has not happened in isolation. It was meant to operate hand-in-hand with two parallel developments: *mainstreaming*, involving the location of acute psychiatric care facilities at general hospital sites; and the *expansion of community care*, ensuring that people no longer in institutions have adequate care in their communities.

8.7   However, there is a general sense that mainstreaming and community care have not kept up with the pace of deinstitutionalisation. There are widespread problems with adequate accommodation, quality of care in the new settings, and perhaps most clearly of all, problems for people in gaining access to care in the new environment.[8] In this environment, it is not surprising that the current policy direction is sometimes called into question. The strong consensus that continues to exist around deinstitutionalisation may be threatened if the policy is not fully and properly implemented and community-based services significantly expanded. Much of the disenchantment with the current system crystallises around experiences of acute care, but as this report shows, the answer lies in improvements in every level of care and a great deal more emphasis on community-based services than is currently the case.

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7   Australian Government, *National Mental Health Report 2005*, pp. 120, 160.

8   V. Gerrand, 'Can Deinstitutionalisation Work? Mental Health Reform from 1993 to 1998 in Victoria, Australia', *Health Sociology Review*, vol. 14, no. 3, 2005, p. 265.

8.8   This chapter sets out the issues in relation to the care people seek when acutely ill. People experiencing acute mental illness now usually seek access to one of three types of service: hospital inpatient services; emergency departments; or crisis assessment teams.

Inpatient services

Pressure on acute care places

8.9   Witnesses reported that unless a person experiencing mental illness is considered to be a threat of immediate harm to themself or others, there is little chance of their being admitted to hospital.[9] Some of the most devastating evidence presented to the committee told the stories of those who knew they had become unwell, had tried to seek hospital admission, been denied and subsequently sought to harm themselves or others.

> There were many instances of death or injury that were easily attributed to not being admitted. A patient in Nepean Hospital was placed on leave, while trying to settle over the weekend, and on returning to the hospital unsettled, to his promised bed found it had been filled. He went home and killed himself and others in the family.[10]

> One parent for example rang in saying her son had gone three times to the local community mental health service and was repeatedly sent away. The parents took him once and the Doctor on duty asked him if he was going to kill himself. When he answered no the doctor said there was nothing wrong with him and sent him away. He then drove his car through the hospital front doors and was subsequently admitted for three days.[11]

8.10   A number of state government submissions to the inquiry acknowledged the pressure on inpatient mental health services. The Victorian Government stated:

> In Victoria, the current operating environment is one of sustained demand pressure. There are a number of inter-related issues that place pressure on the mental health system including growing demand, and increases in complex and involuntary clients. Their impact is most evident in two key aspects of the hospital system: adult acute beds and hospital emergency departments.

> Client growth of more than 7 per cent per annum over five years has led to services operating over capacity, as evidenced by high community caseloads and chronic acute bed blockages, with 9.6 per cent of patients staying more than 35 days. This has resulted in crisis driven services responses, difficulties with service and bed access, 'revolving door' clients

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9   See for example, Brotherhood of St Laurence, *Submission 97*; Mr Graeme Bond, *Submission 484*.

10   Associate Professor Brian Boettcher, *Submission 1*, p. 4.

11   Mental Health Association of Queensland, *Submission 312*.

(15 per cent each year) and a significant impact on other social policy areas.[12]

8.11   In New South Wales:

> The level of psychiatric distress and disability in the community is rising. Reasons for this change are poorly understood but may include broad social changes, changes in social supports and social capital, increasing inequality, and changes in patterns of drug use. Available resources have not kept up with increased demand. Across Australia there are problems with access to acute care, continuity of care and the availability of coordinated and comprehensive community support. A time lag exists between recognition of increased demand and construction and commissioning of new units and the development and implementation of community based programs.[13]

8.12   This analysis is supported by other reviews of mental health services, such as the *Not for Service* report,[14] the South Australian Legislative Council inquiry,[15] and the Western Australian Legislative Council inquiry.[16]

The impact of acute bed shortages

8.13   Denying admission can result in ongoing hardship for consumers and their carers. Consumers have in some cases been abandoned to a cycle of homelessness and abuse. The costs of not providing treatment and care when sought, both in terms of quality of life and later need for services, is significant.

8.14   Early discharge from hospital places a significant strain on families, which in turn creates a need for services:

> Discharge from hospital is frequently too soon because of the pressure for beds and carers assume responsibility for the consumer in a state of unwellness. Programs are needed to provide support, information and skills development to enable carers to cope in this kind of situation.[17]

8.15   Individual submissions from carers demonstrated ARAFMI's concern:

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12   Victorian Minister for Health – Victorian Government, *Submission 445*, p. 3.

13   NSW Health – NSW Government, *Submission 470*, p. 23.

14   Mental Health Council of Australia and the Brain and Mind Research Institute, *Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia*, Mental Health Council of Australia, Canberra, 2005, p. 46

15   South Australia, Legislative Council. Select Committee inquiry into Assessment and Treatment Services for People with Mental Health Disorders, Interim Report, 16 February 2006, http://www.parliament.sa.gov.au/committees/committee.asp?doCmd=show&intID=113 accessed February 2006.

16   Western Australia, Legislative Council. Standing Committee on Environment and Public Affairs, 2004, *A Petition on the Provision of Mental Health services in Western Australia - Interim Report*, Tabled Paper No. 2899.

17   ARAFMI National Council Inc, *Submission 23*, p. 1.

> Severe shortage of hospital beds…results in clients not being admitted to hospital when there is a real need, or being sent home too soon, with no other options. I have been called on the day my son is to be discharged, and without prior warning, been told that I am to come and collect him. When I have show reservations because I felt that he was not well enough, and that I couldn't ensure his safety, I have been given the only other option of having him sent to a homeless men's shelter…[18]

8.16   Carers illustrated the significant cost incurred when patients 'recycle' through the hospital system:

> After being put into hospital, my daughter with schizophrenia was given medication for a few weeks and released, despite the family all pleading with the hospital to keep her a bit longer as it was quite clear to us this medication was not reducing her psychosis. In fact she had to be taken back to the hospital within a week. She was put on another medication and stayed in hospital a while. Then, again, despite still having intense psychotic episodes she was let out – despite our huge concern. Off the record hospital staff told me the reason she was let out was due to a shortage of beds! She had to be re-admitted for the third time around August.[19]

> My son was increasingly unwell for three months. When I asked for help because of the case workers heavy work load they said he wasn't ill enough.

> At the end of the three months he was hospitalized six times in two months.

> He was discharged TOO early everytime because there were 25 beds for up to 600 patients. He suffered unnecessarily and stress on the family was enormous.[20]

The causes of acute bed shortages

8.17   The lack of acute beds has several interrelated causes. While insufficient bed numbers was one factor raised, inadequate community-based facilities appeared to be the central issue. Without intervention programs and accessible community treatment, assistance and support, the symptoms of mental illness can escalate, leading to acute episodes and increased demand for inpatient services.

8.18   Following episodes of inpatient care, a lack of 'step down' rehabilitation services and community supports can make discharge difficult, resulting in longer inpatient stays than necessary. Consequently, patients whose needs could be catered for in a less restrictive community environment are retained in hospital, 'blocking' bed availability for new patients. In other cases a combination of insufficient inpatient beds and inadequate community facilities means that patients are discharged too early into inadequate circumstances.

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18   Name withheld, *Submission 122,* p. 3.

19   Name withheld, *Submission 55,* pp. 2-3.

20   Name withheld, *Submission 49*, p. 1, emphasis in original.

8.19   The NSW Nurses' Association reported that premature discharge was the most common response to pressure for acute beds. A survey of their members in 2004 found that:

> Prematurely discharging patients was the number one way of dealing with the problem, with 29 per cent indicating this method. Next highest scoring method was keeping them in emergency departments (23 per cent) or general wards (6 per cent), refrain from admitting them (13 per cent), manage them in the community (11 per cent), or transfer them around the state (8 per cent). About 8 per cent also indicated they routinely had mental health patients sleeping on couches or on mattresses on the floor.[21]

8.20   Dr Morris, Executive Director of the Gold Coast Institute of Mental Health, expressed the view that state mental health acts were being misapplied in order to deny admissions, due to the shortage of acute psychiatric beds.[22]

8.21   Several states acknowledged that some admitted patients could be better served within the community, if adequate supports existed. In Queensland:

> A recent snapshot of mental health inpatient beds conducted in December 2004 indicated that 30 percent of patients did not need hospitalisation if other options were available. Similar pictures occurred across most jurisdictions which participated in the exercise. Difficulty in accessing suitable support and accommodation was the key factor preventing discharge. This represents substantial numbers of patients accommodated in inpatient care, effectively blocking throughput and being accommodated, often at acute bed day costs, placing further pressure on systems already operating at maximum level and with finite resources.[23]

8.22   In South Australia:

> The Homeless and Housing Taskforce of the Australian Health Ministers' Advisory Council (AHMAC) draft report titled Australian Mental Health Inpatient Snapshot Survey 2004 indicates that there were 505 patients in 10 mental health inpatient units on Census day in SA for whom immediate discharge would have been possible if more intermediate treatment, rehabilitation support and accommodation services were available in SA.[24]

8.23   In Western Australia:

> The key findings from the 2004 national survey are consistent with the earlier two state surveys and include:

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21   NSW Nurses' Association, *Submission 391*, p. 4.

22   Dr Philip Morris, Executive Director, Gold Coast Institute of Mental Health, *Committee Hansard*, 2 February 2006, pp. 2–3.

23   Queensland Government, *Submission 377A,* p.19.

24   Department of Health – South Australia Government, *Submission 506,* p. 6

‑ 53 per cent of patients could have been discharged if appropriate alternative services were available and, of these patients, 56 per cent required both appropriate intermediate treatment/rehabilitation, support and accommodation services.

‑ 51 per cent could have been discharged if appropriate support and accommodation services were available.[25]

Responses to acute bed shortages

8.24   There was a strong call from witnesses for additional acute care places, to respond to current shortages. However the Committee's evidence strongly suggested that the key cause of acute bed shortages is the lack of appropriate emergency responses; a rehabilitative focus in acute care; interventions at other levels, particularly step up and step down and respite beds; clinical services in the community; and housing and employment supports. Each of these needs strengthening and expanding to reduce the need for acute care over the longer term. The Australian Mental Health Consumer Network recommended:

> That the call for '*more acute beds*' be understood in relation to the lack of alternative modes of service delivery.[26]

8.25   Dr Freidin, President of the Royal Australian and New Zealand College of Psychiatrists said:

> Increasing the number of hospital beds is not the sole answer either. We need to have an adequate number of outpatient and community services across the public and private sectors and these need to be integrated with all other forms of support. We say that most mental illness is treatable, as demonstrated by the increasing body of evidence. The inability of people with mental illness to get appropriate help is one of the main barriers to the provision of treatment. The treatments are available—it is just that the service system does not deliver them.[27]

8.26   Ms Sheelah Egan said:

> … one hears calls for more beds instead of calls for much better treatment in the community and more appropriate accommodation in the community. Inpatient services are expensive, but could be minimised if sufficient resources were put into the more efficient and cheaper community care. (Unfortunately, in the past, community care has been treated as a cheap option. Good community care is not cheap, but it is cheaper, for obvious reasons, than inpatient care.)[28]

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25   Department of Health – Government of Western Australia, *Submission 376,* p. 7.

26   Australian Mental Health Consumer Network, *Submission 322*, p. 5.

27   Dr Julian Freidin, President, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard,* 6 July 2005, p. 86.

28   Ms Sheelah Egan, *Submission 113*, p. [4].

8.27   The Mental Health Council of Australia acknowledged recent mental health funding increases announced by the Australian Government, but commented:

> …the next step is the most important: to use this funding to build and strengthen the community based primary and secondary care systems which will then take the pressure off the acute and crisis care services.[29]

8.28   The Council submitted that funding for acute care should be limited to 25 per cent of any new funding.

8.29   All state and territory governments' submissions stated that their budgets included funding to improve inpatient services in coming years. In some jurisdictions this funding related directly to inpatient services, in others it related to increased 'step down' facilities, supported accommodation and intensive community support which would relieve pressure on inpatient services.[30]

8.30   In the short term, one strategy being used to lessen pressure on acute care places is increased collaboration between the public and private sectors. The Victorian Government commented:

> Where public mental health services are operating at capacity, it should be possible to make arrangements to use private mental health services. For example, Victoria has purchased acute inpatient beds from private mental health services to manage periods of bed shortage.[31]

8.31   Healthscope Ltd saw opportunities to increase collaboration between the sectors:

> Although the private sector is primarily committed to providing psychiatric services to privately insured patients, the private sector's ability to increase its capacity could be utilised to improve access during periods of bed block. This could be achieved in a number ways:
>
> - Temporary placement of patients requiring acute admission until a public bed becomes available
>
> - Decanting of more stable patients into the private sector as a mechanism of freeing up more acute beds
>
> - Temporary purchase of beds pending capital works
>
> The basic economics of this solution is compelling. A patient cared for in the Emergency Department for 24 hours by an agency nurse will cost $1500

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29   Mental Health Council of Australia, *Submission 262*, p. 14.

30   Victorian Minister for Health – Victorian Government, *Submission 445*, p. [7]; NSW Health – NSW Government, *Submission 470*, pp 5-6; Queensland Government, *Submission 377a*, p. 19; Department of Health – South Australia Government, *Submission 506*, p. 6; Department of Health – Government of Western Australia, *Submission 376*, pp. 9 and 19; Tasmanian Government, *Submission 502*, pp 7-8; Northern Territory Government, *Submission 393*, pp. 20 and 30; Minister for Health – ACT Government, *Submission 165*, pp 4-6.

31   Victorian Minister for Health – Victorian Government, *Submission 445*, p. 11.

per day, when a bed could be purchased in the private sector for approximately $500 per day.[32]

8.32   The committee supports innovative practices and collaboration between sectors to respond to the pressure on acute inpatient mental health services. However, investment in community-based care is required to provide earlier interventions and in the longer term reduce the need for acute services. The committee notes that in Trieste, where there is strong community care infrastructure, it is rare for all the psychiatric beds in the general hospital to be occupied (see Appendix 3).

8.33   Expansion of community services is not simply an issue of cost effectiveness. It recognises the need to increase people's experiences of mental health and where possible reduce the severity of illness experiences. Rather than investing only in responses to acute episodes of illness, resources are required to, wherever possible, prevent people's mental health deteriorating to a situation requiring acute care. Following acute phases of illness, adequate rehabilitation and support services are required to help promote stability and wellbeing, and minimise the need for readmission.

Long stay care

8.34   While much of the evidence presented to the committee about inpatient services concerned the pressures on short-term acute beds, submissions also canvassed the issue of long-term care for the relatively small number of people who are severely and chronically disabled by mental illness.[33] Witnesses observed that keeping long-stay patients in hospital, because of a lack of alternative services, only contributed to the strain on acute care places.

8.35   In 1992, the National Mental Health Policy recognised that long-term care would be required for some consumers:

> It is recognised that too much resource emphasis is currently given to separate psychiatric hospitals. In some cases it may be both possible and desirable to close them and replace them with a mix of general hospitals, residential, community treatment and community supported services. However, a small number of people, whose disorder is severe, unremitting and disabling, will continue to require care in separate inpatient psychiatric facilities and these facilities will need to be maintained or upgraded to meet acceptable standards.[34]

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32   Healthscope Ltd, *Submission 82*, p. 2.

33   See for example, Dr Simon Byrne, *Submission 3;* Mr John Clayer, *Submission 532*; Friends of Callan Park, *Submission 250*.

34   Australian Health Ministers, *National Mental Health Policy*, 1992, p. [3].

8.36   However, the committee was told the NMHS has failed to make appropriate provision for the care of these consumers.[35] Dr Simon Byrne outlined the kinds of services needed for chronically disabled consumers:

> …it is possible to foster and develop long-stay wards with a rehabilitation focus. Such services should be co-located with acute hospital wards, partly because of the economies of scale involved in providing the necessary support services and partly because of the need to rotate staff for training purposes and to maintain morale when working with a very challenging group of patients. The long stay services should have a rehabilitation focus and have continuing active links with a variety of community services including community residential services; thus all patients should be regarded as potential candidates for community living, although the work necessary to achieve this may take very long periods of time and may not always be successful.[36]

8.37   Dr Philip Morris outlined a similar approach:

> We are suggesting that we need a substantial build of supported accommodation. This is not accommodation where someone pops in to see a patient once a day or whatever else. This is accommodation that has 24-hour nursing and an appropriate level of support—medical, nursing, occupational therapy and social worker support for patients. If you start doing that, you are getting back to needing clusters of homes. They can be in the community, but they need to be together. You will need to have them together because you cannot have individual services going out because it is not efficient. We will get to something like having properly based facilities that look different to the old mental hospitals but, nonetheless, the services will be brought back to bear in a sophisticated and specialised way. That will take some time. That is where we need to go and that is the glaring omission at the moment: the longer stay accommodation for people who cannot get back to independent care in the community.[37]

8.38   While some submitters vehemently criticised the implementation of deinstitutionalisation,[38] a return to institutional-based care was not generally considered an appropriate or advisable course for patients requiring long-term care. Witnesses pointed to the stigma, isolation and lack of resources associated with institutional care in the past.[39] Reports have highlighted the abusive practices, discriminatory cultures and lack of accountability which occurred in psychiatric institutions. Rather, witnesses to this inquiry described the need for specialised community-based or co-located services designed specifically for the long-term rehabilitation of people severely disabled by mental illness.

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35   Dr Simon Byrne, *Submission 3*, p. 1.

36   Dr Simon Byrne, *Submission 3,* p. 2.

37   Dr Philip Morris, *Committee Hansard*, 2 February 2006, p. 6.

38   Name withheld, *Submission 518*.

39   Dr Julian Freidin, *Committee Hansard*, 6 July 2005, pp. 85, 93.

Quality and effectiveness of treatment

8.39   The committee received some graphic and alarming evidence about inpatient treatment experiences. Assault and abuse of people with mental illnesses still occurs within hospital settings. Discriminatory and stigmatising attitudes and procedures remain.

8.40   The committee acknowledges that this inquiry has not systematically reviewed all inpatient experiences and that some positive experiences were also reported.[40] However, the committee is disturbed that after many years of reform, abusive and discriminatory practices remain evident. The following contributions reflect some such experiences:

> Another occasion was when the young man's mother and brother visited him and he asked his brother to look at his room. They reached the room to find a large 6ft male lying on his bed. The patient got a shock and was clearly disoriented and went to another room and kicked some blocks around. A nurse brought him back to his room and he appeared very frightened when the nurse ordered a syringe. His brother asked what it was and was told that it was "**like** liquid valium". A doctor and two security men stood over him either side of his bed. Staff asked the mother and brother to leave the room but they chose to stay and in front of those people the patient's pants were pulled down and he went into a foetal position because it was invasive and he was scared, as he had been a victim of rape. The inhumane treatment raises the question of how and what was being done when no family member was present. The patient was then told he could go and have lunch. He left crying.[41]
>
> ......
>
> Seclusion and restraint are used inappropriately and without proper regard to the person. A client of our service was stripped naked and thrown in seclusion for 12 hours when she had a known history as a victim of sexual abuse. Clients report experiences of seclusion, terrified and left alone for long periods of time with frightening psychotic symptoms. Seclusion is used far more on weekends when no programs are available.[42]
>
> ......
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> Instead the two security guards who arrived jumped me, threw me to the ground and proceeded to beat the living daylights out of me. I was repeatedly punched to the left eyebrow and as I wear an eyebrow ring, punching the metal onto bone was exceedingly painful. I was repeatedly punched to the right cheek bone. One of the guards twisted my elbow as far as it could be and then brought his fist down onto my elbow with maximum force. This was done several times. Both guards also bent my hands back at

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40   See for example, Name withheld, *Submission 123*, p. 1.

41   Name withheld, *Submission 54*, p. 2.

42   Mental Health Legal Centre, *Submission 314*, pp. 9–10.

the wrist as far backwards as they would go. I thought they were going to break them. I was kicked in the base of the spine several times…I was kicked in the legs repeatedly. I was punched in the chest and stomach repeatedly. One of the guards grabbed my hair and drove my face forward into the ground, hurting my nose. He then pulled my hair back the other way and repeatedly smashed the back of my head into the hard, vinyl floor.

Throughout the attack I continued to scream and struggle, but this was because I was in extreme agony. One of the guards put his hand around my throat and squeezed to the point no air could enter or leave for at least a minute. I was sure at that moment he was going to kill me. I could barely speak for days afterwards.

The actual nursing and medical care I received … was outstanding so I have no idea why these nurses let the attack go on so long, although one of the guards did lean over me at one point and whispered into my ear, "the nurse can't see what I'm doing from here and you're fucking dead meat". He also laughed and smiled throughout the attack – he was clearly enjoying himself.[43]

……

On arrival [in the 'time out room'] I was ordered to strip all clothes off. The situation was getting more and more bazaar [sic]. I thought I was in hospital because I was sick and needed care. Is this the care that I needed?

I told him "you've got to be joking".

He disappeared for a few minutes and came back with five other nurses. They stripped me naked and put me into pyjamas. I can still see a big guy with tattoos smiling all through the whole thing.

At no point did I abuse anybody or become violent. Why was I getting such heavy-handed treatment when I don't think I deserved it.

After the nurse in charge pushed me into the back of the room they locked the door and turned off the light. There was only a mattress on the floor and the only window was in the locked door. If you have any iota about psychosis you could imagine what was going through my head.[44]

8.41   Ms Isabell Collins, Director of The Victorian Mental Illness Awareness Council asserted that damaging treatment experiences are common:

Having worked in the public mental health care system for some 15 years, I am yet to meet a patient of mental health who has not been damaged by the way he or she was treated and cared for. Indeed, consumers will often say that it takes a good 12 months to recover from hospitalisation just because of the way they were treated.[45]

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43   Ms Sherry Watson, *Submission 504*, Attachment 1, pp[4–5].

44   Mr Stephen Corry, *Submission 440*, pp 2–3.

45   Victorian Mental Illness Awareness Council, *Submission 267*, p. 6.

Put simply, the current standard of practice is to contain people with medication and then discharge them. That is all we do.[46]

8.42 Consumer researcher Ms Cath Roper said:

I had 13 hospitalisations—all of which were involuntary—yet I cannot look back and say that those were healthy for me. There was extremely traumatic forced treatment involved in each of those hospitalisations.[47]

8.43 The Australian Mental Health Consumer Network recommended:

That government takes seriously the consumer warning that some acute experiences leave people psychologically scarred, sicker and more dependent in the long term.[48]

8.44 There have been some reviews of inpatient services and changes that have been implemented to improve service standards.[49] The committee also heard the reality of the complex situations hospital staff are required to deal with. For example:

When he was again admitted to Maroondah Hospital psych ward my son had a 3 week old untreated fractured leg gained after clinging onto and being thrown from a car; he was taken to William Englis hospital emergency ward after the incident but would not remain stationary for long enough for the cast to be applied. There were several prior attempts seeking admission over preceding months mainly due to violent and abusive behaviour.

During this stay in Maroondah hospital my son broke another patients arm.[50]

8.45 Humane and professional responses are needed in what can be complex and difficult situations. The personal experiences shared with the committee show that in some areas inpatient service standards need to improve.

8.46 Mr Graeme Bond submitted that quality standards are required:

When investigating my son's treatment I sought to compare it with any standards I could locate. I was able to locate very few publicly accessible standards published by the Department of Human Services and resorted to statements made by leading academic psychiatrists in a locally published textbook of psychiatry.

There should be a comprehensive set of standards readily accessible to carers and patients so that they can assess the care given against an objective benchmark. Such standards should be the reference against which

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46   Ms Isabell Collins, VMIAC, *Committee Hansard*, 5 July 2005, p. 73.

47   Ms Cath Roper, *Committee Hansard*, 5 July 2005, p. 29.

48   The Australia Mental Health Consumer Network, *Submission 322,* p. 5.

49   For example, Tasmanian Government, *Submission 502*, pp 7-8.

50   Name withheld, *Submission 195*, p. 3.

actions of clinicians and services are judged, particularly in such forums as the Coroners court.[51]

8.47   Observations by the Victorian Auditor-General are pertinent:

> The current set of mental health measures and key performance indicators (KPIs) do not provide sufficient information to management and the Government to measure the effectiveness of the services being delivered. Most of the current measures and KPIs are not tied to departmental objectives and relate to service delivery (i.e. outputs) rather than consumer outcomes.[52]

8.48   Acute care in hospitals needs to be guided by standards of care that are focused on consumer outcomes, and which take a view beyond the points of admission and discharge. This is important because issues raised with the committee extended beyond acute care to the emergency departments where admission took place and to discharge.

Emergency departments

8.49   While hospital emergency departments are one of the few health services available to people with a mental illness on a 24 hour basis, seven days a week, the environment is not necessarily therapeutic and treatment may not eventuate. The NSW Nurses' Association commented that it was not uncommon for mental health patients to wait in the emergency department for up to five days before a suitable bed became available.[53]

8.50   The ARAFMI National Council Inc described the detrimental impact of waiting in emergency departments:

> The consequence can be that the consumer becomes acutely unwell needing emergency treatment possibly though a hospital emergency service. If it is then accepted that the consumer needs psychiatric care in a psychiatric facility there are frequently no beds available and the consumer is kept in a "holding" situation pending a bed becoming available, This is not only detrimental to the consumer but also causes distress and anxiety to the carer.[54]

8.51   Mrs Jan Kealton described the void in emergency departments services for psychiatric patients:

> Once there you wait and wait and eventually you might get lucky. … They take the person through to the triage area and tell them to sit in one of the

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51   Mr Graeme Bond, *Submission 484*, p. 6.

52   Auditor-General Victoria, 2002, *Mental Health Services for People in Crisis,* p. 6.

53   NSW Nurses' Association, *Submission 391*, p. 4; also Dr Georgina Phillips, *Submission 255,* p. [2].

54   ARAFMI National Council Inc, *Submission 23*, p. 1.

blue chairs. The chairs are near the reception area, and then there are all the beds with curtains around them and so on. If you are a bit forceful, like me, you say, 'Excuse me, but I am going too,' and then you, the mother, are also allowed to sit on one of the blue chairs.

The blue chair is not in the treatment area and it is not in the triage area, so you just hope that someone notices the person if they are becoming distressed. You can walk straight out the door—if you do not have your mother with you being nice to you and begging you and bribing you to stay—and not get any treatment at all. Nobody would probably even notice. They are too busy handling all the blood and gore, the heart attacks and those sorts of things to go to somebody who looks perfectly normal, sitting there fidgeting …

We have sat there for seven hours on a number of occasions…[55]

8.52   The NSW Nurses' Association described the hectic environment of hospital emergency departments. They noted that it is not possible in this environment to establish rapport with patients and initiate preventative interventions. The Nurses' Association also pointed out that the 'excessive stimulus generated by the chaos and pressured atmosphere in the department' itself can contribute to escalating behaviour. They stated:

Given that security personnel are engaged to provide supervision for such volatile patients, it is clear that restraint and sedation are the likely and foreseeable outcomes… This is an untenable situation for all concerned.[56]

8.53   The committee heard that people with acute mental illnesses are particularly vulnerable to breaches of their privacy and dignity within the emergency department environment. Dr Georgina Phillips said:

Their ED management is usually carried out in a high acuity, highly visible cubicle in the central part of an ED work area (so that medical and nursing staff can closely monitor them). Many in the ED usually overhear their conversations: staff, security officers, other patients and their relatives. Many observe their appearance and behaviour, and if containment and restraint is required then this is usually carried out in full view of the rest of the ED. This affects not only the mentally ill patient, but can cause distress and potential physical harm to other patients or relatives in the ED. These are daily occurrences in EDs, however few would have space or resources to devise appropriate strategies to provide better and safer care.[57]

8.54   A report by the South Australian Ombudsman points to some of the underlying resource issues creating strain on emergency departments:

55   Mrs Jan Kealton, *Committee Hansard,* 2 February 2006, p. 77.

56   NSW Nurses' Association, *Submission 391*, p. 5.

57   Dr Georgina Phillips, *Submission 255*, p. [2].

It appears that neither the existing mental health system or supporting resources were sufficient to accommodate the significant changes undertaken in this State, in line with the National Mental Health Strategy… Moreover, there was overwhelming evidence during my inquiry from medical practitioners and others that there has been a significant increase in numbers of mental health patients presenting at emergency departments. This clearly, has placed undue strain on junior medical and nursing staff who are left to manage the increasing numbers of patients in crisis in emergency departments.

A common consumer and staff concern was the need to provide a safe and stable environment for mental health patients in crisis and in the community. It was apparent that in most emergency department environments staff face difficulties in separating highly agitated patients and there is an abundance of evidence that has shown that enormous pressure has been created at times when there has been an acute shortage of available beds in psychiatric wards and on discharge for either the emergency department or an inpatient facility, with a distinct lack of support in the community.[58]

8.55   Several submitters recommended specialised emergency departments for people experiencing mental illness.[59] Dr Philip Morris told the committee:

…patients that have been sent to emergency departments do not get the best of care because the facilities are not providing unique services for patients with mental illness. What we advocate now is a parallel—not a separate but a parallel—program of emergency departments located in the setting of the general health sector for patients with psychiatric illness. Some of these things are now starting to happen in Australia.[60]

8.56   The New South Wales Government described a trial of such services:

Psychiatric Emergency Care Centres (PECCs) have been successfully trialled at Liverpool and Nepean Hospitals. These PECCs have resulted in a reduction of the average length of stay in Emergency Departments for psychiatric patients. The PECCs are dedicated services, situated adjacent to the Emergency Department, staffed 24 hours a day, 7 days a week by mental health specialists for emergency assessment and treatment of people presenting with serious mental illnesses.[61]

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58   South Australian Ombudsman, *Annual Report 2001/02, Section 26 Reports*, 'Treatment of Mental Health Patients: Shackling and other forms of restraint', p. 60.

59   For example, Dr Philip Morris, *Committee Hansard*, 2 February 2006; Dr Georgina Phillips, *Submission 255*, p. [3].

60   Dr Philip Morris, *Committee Hansard*, 2 February 2006, p. 4.

61   NSW Health – NSW Government, *Submission 470*, pp. 24–25.

Discharge processes

8.57   Discharge from hospital can be as abrupt as admission can be slow. Submitters told the committee about a lack of discharge planning and continuity of care after discharge from hospital or the emergency department. Poor discharge planning and insufficient community-based services can leave consumers in inadequate environments without appropriate therapeutic care, resulting in increased symptoms and possibly re-admission. Following an acute episode of illness, the risk of suicide is highest in the first weeks after discharge.[62] Where families and carers are contacted and available, early discharge increases their burden in providing care and support.

8.58   Dr Philip Morris said:

> Because of the pressure on bed numbers, patients are being discharged before they are ready to go home. That leads to harm both to them and to their families and the general public. If we had more resources, patients could stay in hospital for longer and be treated to a point where they were much more ready to be discharged. I am not just talking about discharge from acute services. There is no opportunity at the moment to put many patients into longer term facilities where they can be rehabilitated and recover further so they can then go back into the community in a decent state.[63]

8.59   Dr Morris also suggested there is evidence that some practitioners are having patients placed under involuntary treatment orders as the only way to obtain follow up treatment in the community after discharge.[64]

8.60   Mr David Webb shared his discharge experiences with the committee:

> On the strength of that assessment, the psychiatrist judged that I suffered from what he called existential depression and that I did not need to be there. I had attempted suicide just a couple of nights before. He told the social worker and the charge nurse to arrange for my discharge. That was it. The psychiatrist spoke to me about where I would go on discharge and whether I had somewhere to go. I did not have a place to go as I did not have a home in Melbourne at the time. He spoke to the social worker and said, 'Help him find somewhere to go.' I left that hospital with the phone number for the emergency accommodation of the Salvation Army. That was the discharge support that I got a couple of days after a suicide attempt. People tell me that would not happen these days, but I am not sure. I am one of the fortunate ones. There are a lot of people that have been through

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62   Dr Philip Morris, Gold Coast Institute of Mental Health, *Committee Hansard,* 2 February 2006, p. 2.

63   Dr Philip Morris, *Committee Hansard,* 2 February 2006, p. 2.

64   Dr Philip Morris, *Committee Hansard*, 2 February 2006, p. 3

that experience and they have gone straight to the nearest railway line to jump under the first train.[65]

8.61   Carer's also described the lack of services post discharge:

> Another issue in regard to the post acute-care situation is that in the case of our son's first psychosis, I had to initiate post-hospital case work. No-one offered me access to services. I had to seek these out and despite my best efforts to have a case worker assigned while our son was still in hospital to facilitate a smooth transition on his discharge, it proved a fruitless exercise. I knew nothing about mental health services and no-one offered me any help or information. It concerned me enormously that if our son had not had an active advocate in me, then he would have been discharged, unwell, and having to fend for himself, with no accommodation and with no knowledge or ability to access social welfare let alone any mental health services (as inadequate as these turned out to be).[66]

8.62   Ms Isabell Collins commented on the ethical dilemmas facing staff who make discharge decisions:

> Certainly psychiatrists have said to me that they are constantly in this ethical dilemma where they have somebody who is really sick and needs admission to hospital and they have somebody in hospital who is still sick but not as sick as the one who needs to come in. They have to juggle and take these risks. What happens is that they do take the risk. They send them out into the community where there are no supports for them.[67]

8.63   Reviews of service standards indicate that the personal anecdotes shared with the committee are illustrative of systemic failures. A file audit by the Auditor-General in Victoria in 2002 found that 89 per cent of consumers reported that they were discharged while still acutely unwell, with a high level of need for ongoing support. Yet none of the discharge plans reviewed met all required standards.[68]

8.64   Among the disturbing findings, the Auditor General reported:

- 30 per cent of discharge plans reviewed showed no evidence that consumers had been linked into appropriate community-based services for ongoing treatment following discharge;

- In 80 per cent of cases there was no evidence that consumers were consulted in the formulation of the discharge plan. Family or carers collaborated in discharge planning in only 15 per cent of reviewed cases;

- In only 16 per cent of the reviewed plans was the consumer given emergency contact numbers; and

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65   Mr David Webb, Chair, VMIAC, *Committee Hansard*, 5 July 2005, p. 81.

66   Name withheld, *Submission 244*, p. 4.

67   Ms Isabell Collins, VMIAC, *Committee Hansard*, 5 July 2005, p. 77.

68   Auditor-General Victoria, 2002, *Mental Health Services for People in Crisis,* p. 65

- In only one per cent of cases reviewed was a copy of the discharge plan actually provided to the consumer.[69]

8.65   Even where services specifically focus on discharge planning with dedicated resources, evidence suggests that actual follow up remains limited. A study of the emergency department of a Sydney hospital, which has a dedicated Mental Health Liaison Nurse, found that 86 per cent of consumers felt that adequate arrangements had been made with them before they left emergency and 71 per cent were referred to a community mental health team on discharge. However, only 63 per cent actually had contact with the community mental health team after leaving emergency.[70]

8.66   The committee suspects that the lack of discharge planning and support, at least in some cases, reflects the fact that acute service providers know there is nowhere for the person to go. The Mental Health Council of Australia submitted:

> Consumers are often discharged without any rehabilitation plan or even reference to appropriate places because the discharging services knows these services have no capacity to accept further referrals.[71]

8.67   This situation reinforces the concern, expressed throughout this report, that the mental health sector in Australia currently lacks a full spectrum of care.

8.68   One possible consequence of inadequate discharge planning, follow up treatment and care is the deterioration of a person's mental health, which results in readmission. This is an unsatisfactory situation for all involved, with consumers carrying an increased burden of illness, carers suffering increased strain, and services sustaining repeated costs. Even in Victoria, a state with above average investment in mental health services and one of the highest per capita investments in community-based care,[72] readmission rates remain high. In 2005 the Victorian Auditor-General reported that although initiatives had been implemented since 2002 to increase community-based care, and more patients were being contacted in the community before and after admission for acute care, an increasing proportion of patients were being readmitted within 28 days of discharge.[73] In the June quarter 2005, 17 per cent of mental health patients were readmitted within 28 days of discharge.

8.69   This level of readmission suggests that community supports remain inadequate to stabilise and support people with a mental illness following acute episodes. However, the data might also suggest that at least hospitals remain an

69   Auditor-General Victoria, *Mental Health Services for People in Crisis,* 2002, p. 66

70   T. Wand and P. Schaecken, 'Consumer evaluation of a mental health liaison nurse service in the Emergency Department', *Contemporary Nurse*, 2006, vol 21, Issue 1, p. 18.

71   Mental Health Council of Australia, *Submission 262*, p. 19.

72   Australian Government, *National Mental Health Report 2005*, pp 23 and 34.

73   Auditor-General Victoria, *Follow-up of selected performance audits in 2002 and 2003*, 2005, p. 107.

accessible service for people requiring further care, with people being readmitted rather than turned away.

Crisis services

8.70   Crisis services refer to services designed to respond to mental illness related emergencies in community settings. Such services can save lives and are particularly valued by carers. Crisis assistance needs to be timely to be effective, and achieving prompt crisis response is a challenge facing these services, which appear to be constrained by resources as well as perceived safety issues.

8.71   A key issue regarding crisis services is the need for services to attend and assist crisis situations out of business hours. Ms Sharon Ponder remarked on this need:

> Apparently acute episodes of schizophrenia occur at the most "inconvenient" times for our system, It needs to be told that an acute schizophrenic episode is rarely "convenient" for the sufferer, never mind the system.[74]

8.72   The lack of after hours mental health services means that hospital emergency departments and emergency services (police and ambulance) are often the only available services out of business hours. These services are not necessarily trained or equipped to deal with mental illness crises, and can create further distress for people experiencing mental illness:

> The response from the mental health services to after hours crisis is that the refuge phone an ambulance to take the young person to accident and emergency or call the police, this of course creates a scene in front of other young people and neighbours, not to mention the trauma for the young person involved.[75]

8.73   In some areas, after hours phone calls to psychiatric units are simply referred to Lifeline.[76] Lifeline commented that its services are over stretched:

> Lifeline…has become a defacto after hours mental health service with volunteers answering call after call from people with a mental illness that have been referred to Lifeline from other mental health services unable to cope with high levels of demand. Lifeline is not adequately equipped, resourced or developed to fulfil this role appropriately. Many of our traditional crisis callers have not been able to access our service because of the dominant usage of some mental health callers. With over half a million calls per annum being answered by Lifeline volunteer telephone counsellors it is clear that this is a significant community problem.[77]

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74   Ms Sharon Ponder, *Submission 84*, p. [9].

75   Ms Christine Couzens, *Submission 71*, p. [4].

76   Ms Jean Charlton, correspondence 19 September 2005

77   Lifeline Australia, *Submission 329, Attachment 6*, p. 7.

8.74   Lack of services after hours for people experiencing acute mental illness therefore impacts not only on mental health consumers and their carers, but also on wider service providers and their clients.

Crisis assessment and treatment teams

8.75   One service designed specifically to assess and intervene during episodes of mental illness are mobile acute assessment and treatment teams. These teams are 'medical health services which provide home-based assessment, treatment or intervention primarily for people experiencing an acute psychiatric episode and who, in the absence of home-based care, would be at risk of admission to a psychiatric inpatient service'.[78] The services are known by different titles across jurisdictions, including 'psychiatric crisis intervention' services, 'community assessment and treatment' services and 'crisis assessment and treatment' (CAT) services.[79]

8.76   The *National Mental Health Report 2005* describes the essential characteristics of these services as their 24 hour, 7 day per week availability and focus on short-term intervention. However, carers lamented how often they were unable to obtain assistance in crisis situations. Several submissions commented that the poor response record of the Crisis Assessment and Treatment teams had earned them the nicknames 'Can't Attend Today' teams or 'Call Again Tomorrow' teams.[80] If the CAT teams are to be effective and supported by consumers and carers there is a need for better resources and training.

8.77   One submitter described the frustration of the lack of service, as follows:

> …if they are contacted it means that the client or family, or both, needs some help. Instead, you often get this indifferent response, trying to get you to go away as your crisis doesn't fit their criteria. I have even been told that I couldn't be helped because they were too busy with other more urgent matters. This was before I was even listened to…In fact, they have never made a trip for us. The only times I have received help was if my son could be calmed down enough to let me drive him to hospital. If all else failed, I had to call an ambulance.[81]

8.78   Mr Graeme Bond reported his experience with the CAT team:

> Even when I have called reporting the most alarming behaviour which posed a threat to my wife or, on occasions to me, I have been unable to have a CAT Team attend. Indeed, in my area, I believe that after about 7:00pm the CAT Team is one person accessible by a paging service.

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78   Australian Government, *National Mental Health Report 2005*, p. 94.

79   Australian Government, *National Mental Health Report 2005*, p. 94; Minister for Health – ACT Government, *Submission 165*, p. 2.

80   See for example, Name withheld, *Submission 62*, p. 2; Mr Graeme Bond, *Submission 484*, p. 3.

81   Name withheld, *Submission 122*, p. 3.

> The standard advice offered, in response to a request for a CAT Team, is 'call an ambulance' or 'call the police'.[82]

8.79   The Victorian Mental Illness Awareness Council presented strong criticism of CAT services:

> Crisis Assessment and Treatment teams (CATT) are probably the best example of what happens when governments fail to adequately fund services.
>
> From the consumer perspective CATT would be the most disliked and criticised service in mental health.[83]

8.80   However, the CAT team model is effective when adequately resourced:

> Whilst living in the ACT, we experienced excellence from the local CATT which attended our home when our daughter was in a prodromal state and had locked herself in her room late at night. As a result of the CATT dedication, a humiliating and extremely distressing family situation was brought under control without need for hospitalization or the stigma of well-meaning but untrained police presence in our neighbours' presence.[84]

8.81   Even with well resourced prevention and intervention programs, the severe and episodic nature of some mental illnesses means that crisis situations can occur. Without ready access to personnel adequately trained and experienced in intervention and de-escalation, crisis situations can end in tragedy:

> I have just been involved in a coroner's inquest. A young 23-year-old man had been shot dead by the police. He had an agreement with his parents, before becoming unwell, that should he become unwell they would ring the CAT team. He became very unwell and that was not the case. He had knives and he hurt his father. The location was secured and his mother was terrified her son would be shot. She told the police: 'He is all right. He will be able to talk. Please be careful of him.' The police did everything in their endeavours to get the CAT team. The duty person for the CAT team on the evening of that night, when the police called, did not perceive that they were being asked for assistance. They gave the response: 'Yes, this person has been in this hospital. Yes, this person does have a diagnosis of schizophrenia.' But they did not then go on to say, 'And this person, in fact, has asked before to be killed.' So the police, acting as they believed they should, managed this situation. Something really unfortunate occurred: the young man appeared behind the house and came at a police officer with knives and the consequence was he was shot.
>
> At the coroner's inquest, the CAT team thought that the provision of the information I have just provided to you was enough to give instructions to the police in how to take control of the situation and the young man. The

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82   Mr Graeme Bond, *Submission 484*, p. 3.

83   Victorian Mental Illness Awareness Council, *Submission 267*, p. 5.

84   Name withheld, *Submission 129*, p. 1.

police do not have effective training in de-escalation; their training is in control, not de-escalation. My submission is that when you have the police ineffectively prepared, and when you have the CAT team not perceiving that they need to attend and, further, saying that they would not attend if their health and safety were in danger, then even if the police could make their health and safety secure we either have to do something about the function of the CAT teams or do something about the education of the police.[85]

8.82   As illustrated it the above example, coordination between crisis teams and the police is essential in responding to crisis situations involving mental health consumers. The role of police in mental health services is discussed further in Chapter 13.

8.83   There is a need to ensure effective responses for people with mental illnesses requiring emergency attention. CAT teams currently have limited availability and are concerned about attending potentially violent situations. Emergency departments, while always open, are stretched and do not necessarily provide an environment or interventions appropriate for acute mental illness. Similarly, while emergency services such as police and ambulance will attend mental illness crisis situations, they are not trained to respond effectively to psychotic episodes and their presence can escalate the situation.

8.84   One of the NSW Government's initiatives is to improve emergency mental health responses is the establishment of a 24-hour 1800 phone number for each NSW Area Health Service.[86] It was not clear from the NSW Government's submission the extent of the services that would be offered via this phone line. However, a single 24 hour access point for mental health emergencies may assist carers and consumers who currently report a desperate need for assistance. The Council of Australian Governments' proposed National Health Call Centre Network[87] may help meet this need, if adequately resourced to include dedicated mental health professionals and backed up by available intervention and treatment services.

8.85   Two points stand out in discussion of crisis services for mental health. First, the very nature of mental health crises often means that it is quite inappropriate for police or ambulance to respond. Mental health crises need a mental health response. Being told to 'call the police' in particular often seems to be inviting the escalation of a situation that need not necessarily deteriorate. Second, better community-based care and support would almost certainly mean less crises in the first place.

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85   Ms Elizabeth Crowther, Chief Executive, Mental Illness Fellowship Victoria, *Committee Hansard*, 5 July 2005. pp 95-96.

86   NSW Health – NSW Government, *Submission 470*, p. 24.

87   Council of Australian Governments, *Communique 10 February 2006*, www.coag.gov.au/meetings/100206/index.htm, (accessed February 2006).

Contrasting experiences

8.86   Some witnesses expressed a view that evidence presented to the committee may overly represent negative experiences:

> The inquiry will receive a great deal of anecdotal evidence about the inadequacy of services. For various reasons, the inquiry is unlikely to hear from people who are satisfied with the service. For example, stigma is still so great, people who are coping reasonably well will not want to draw attention to themselves.

> Anecdotal evidence can be out of date. Situations can improve or deteriorate quite rapidly. It can come from people who are so shocked, angry or distressed and who wish to find some one or something to blame. Two families can have much the same experience and describe it in quite different ways.[88]

8.87   The Victorian Government commented on the nature of the inquiry:

> The methodology focuses on subjective measures such as submissions and public hearings which will elicit public and expert opinions from those who choose to submit, but will be limited if this information is not balanced by objective evidence of systemic issues regarding state service provision.[89]

8.88   It is difficult to reconcile this view with the Victorian Government's own submission which states that the operating environment in Victoria is one of 'sustained demand pressure', with 'services operating over capacity, as evidenced by high community caseloads and chronic acute bed blockages' and 'crisis driven service responses, difficulties with service and bed access, 'revolving door' clients….and a significant impact on other social policy areas'.[90]

8.89   There is evidence that confirms that systemic issues underlie the personal experience of mental health services. Anecdotal experiences of inpatient and crisis services are consistent with service reviews, such as the Victorian Auditor-General's finding that:

> Increasing service demand and associated levels of unmet demand are resulting in service access difficulties for many consumer, early discharge from hospital, and increased burden on family and carers. These outcomes increase the likelihood of future unplanned re-admissions.[91]

8.90   The NSW Auditor-General similarly remarked:

> The increase in demand for emergency mental health services has offset many (and perhaps all) of the gains from funding increases. The system is

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88   Ms Sheelah Egan, *Submission 113*, p. [4].

89   Victorian Minister for Health – Victorian Government, *Submission 445*, p. [6].

90   Victorian Minister for Health – Victorian Government, *Submission 445*, p. [3].

91   Auditor-General Victoria, *Mental Health Services for People in Crisis,* 2002, p. 6.

under considerable pressure, and patients can face lengthy delays before being admitted to a bed.

It is important that services work together to share resources at times of peak demand. Yet, there are times when the availability of mental health beds means that some patients face being transferred very long distances to access an acute mental health bed.

There is also evidence that some patients spend inappropriately long periods in emergency departments while awaiting acute mental health beds or are discharged from the emergency department prior to a bed becoming available.[92]

8.91   The dearth of outcome reports in the mental health sector also means there is little ongoing, systematic assessment of the actual health outcomes provided by mental health services. There is generally no data to contradict many of the systemic issues illustrated by personal anecdotes to this committee.

8.92   Hearing personal experiences and reporting individual concerns does not belie the substantial reforms that have occurred, the systemic deficiencies that remain and the concerted and coordinated effort required to continue to improve mental health services. The Victorian Government submitted:

A number of [the inquiry] terms of reference sit well outside the mandate of the specialist mental health system and will require vigorous and sustained effort by many different areas and levels of government, including the Commonwealth Government, to address.[93]

8.93   The committee certainly assumes that all levels of government are committed to making the 'vigorous and sustained effort' required to improve mental health services, and ultimately the mental health of all Australians.

Concluding remarks

8.94   There are serious problems facing people with mental illness who find themselves seeking, or being placed in, acute care. There has been some discussion of whether these problems are a result of the way in which the policy of mainstreaming has been implemented. Mainstreaming was intended to involve the replacement of stand-alone psychiatric facilities with a pattern of brief admissions to acute psychiatric wards within general hospitals backed up by community-based care of varying types. However, for many consumers this has not been the reality.

8.95   A key criticism has been the apparent inability of mainstream services to meet the specific needs of mental health consumers. Submitters pointed to the need for tailored treatment and for the treatment environment to be conducive to recovery:

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92   New South Wales, Audit Office, *Performance Audit: Emergency Mental Health Services*, NSW Department of Health, May 2005, p. 2.

93   Victorian Minister for Health – Victorian Government, *Submission 445*, p. [6].

The other point I would like to make in the broad sense is that mainstreaming has failed. Mainstreaming was the idea that you bring all mental health services under the one umbrella of general health and somehow this means that all discrimination goes away. But that is not the case. There is some reduction in stigma. One of the good things about mainstreaming is that it recognised the role of general practitioners. But what it has not done is maintain a focus on the unique needs of patients with psychiatric illness. Because of this loss of focus we now have, for example, inpatient units being built with no space. Psychiatric patients need space. When they are very unwell they are agitated, they are sometimes very sensitive to others and they need room.[94]

8.96   Dr Scott-Orr argued for 'co-located' services, in which psychiatric services share medical resources with general hospitals, but retain a separate environment and specialised care:

It is my view that general hospital architecture and functioning does not lend itself to mental health care. Nor does the recent design of mental health units in general hospitals give me any hope or joy. I consider the place(s) of round the clock mental health care should be readily accessible by walking, to and from the relevant general hospital, and sharing its resources for all sorts of medical reasons and economies.

It needs to provide a 'homey' environment, with that look and feel, in which people are up and about in street clothes, preferably to have its own street address, while having provision for some secure area and ready observation where needed.[95]

8.97   On the other hand, the Royal Australian and New Zealand College of Psychiatrists strongly supported mainstreaming:

We should progressively move to integrate mental health into general health. There are enormous advantages in having the majority of psychiatric services in general hospitals as part of the culture of general hospitals with regard to constant review and quality improvement and in the accessibility of general health care to patients with mental illness as well. There is probably going to be a need for small specialist services for people with particular disorders where all they need is psychiatric intensive care, but I would see that as being a very small part of the much larger integrated system.[96]

8.98   The committee accepts the argument that bringing acute psychiatric care into a mainstream hospital setting helps ensure quality treatment for all of a patient's health needs, and can have workforce and management advantages. Effective acute care, however, needs to involve higher standards of care and the provision of facilities that

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94   Dr Philip Morris, *Proof Committee Hansard*, 2 February 2006, pp. 3–4.

95   Dr Scott-Orr, *Submission 58*, p. 2.

96   Dr Julian Freidin, *Committee Hansard*, 6 July 2005, p. 92.

meet the specific needs (such as open space and a more home-like environment than is typical for a general hospital) of people with mental illness. Above all, these need to be linked in to community-based services, before admission and after discharge.

8.99   There is now a substantial body of evidence before this and other recent inquiries to show that inpatient and crisis mental health services have severe shortcomings. Services have failed to meet the standards Australians should now, after many years of inquiry and reform, be able to expect.

CHAPTER 9

MENTAL HEALTH SERVICES IN THE COMMUNITY

Introduction

9.1   One of the repeated messages to the committee through this inquiry was that although the aims of the National Mental Health Strategy (NMHS) were largely commendable, there has been a distinct failure in implementing the strategy.[1] In particular, the committee heard that funding and development of mental health services in the community have been vastly inadequate to meet increased needs associated with the closure of psychiatric institutions.

9.2   Deinstitutionalisation required not only that therapy and treatment be devolved into community settings, but that a whole range of support and assistance, including housing, living skills, social connection, illness management, meaningful activities and employment be provided in the community. When consumers and carers talk about community-based services, they are looking for this broad spectrum of services.

9.3   The prevailing reality of 'community-based care' is limited and clinically focussed when compared with the needs and expectations of the community. Too many services are being collocated with hospitals or provided out of hospitals, rather than in community settings.

9.4   While recent reports have highlighted an increase in funding to the community-based sector, this positive account does not fit with the experiences shared with the committee. Community-based services remain limited and ad hoc. Many people with mental illnesses are ending up homeless or in prison as community services are not there to support them. Families and carers continue to provide the overwhelming majority of support for people with mental illnesses. They are overburdened.

9.5   This chapter reviews the concept of community mental health services pointing to the absence of a co-ordinated, integrated system. The chapter presents the key issues raised throughout the inquiry in relation to community services: the discord between community expectations and the services actually provided; the mainstreaming of community services into hospital environments; lack of funding and service development for continuous care, including step up and step down facilities; lack of integration of services; and inadequate funding to NGOs. Examples of community-based services are also discussed.

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1   See for example, Mental Health Council of Australia, *Submission 262;* Australian Medical Association, *Submission 167.*

What are community mental health services?

Community expectations

9.6   Submissions to this inquiry show that consumers and carers are looking for a range of services which assist people with mental illnesses to live stable and fulfilling lives in their homes or in home-like environments within their local community. Themes in submissions indicate that consumers, carers and service providers perceive community care as:

- actively managing medical and non-medical treatment for extended periods as required, with a focus on recovery;

- skilling people with mental illness to live independently in the community;

- providing access to accommodation and fulfilling employment opportunities and other activities;

- establishing and maintaining mental health centres or facilities that offer a range of support services and information;

- providing outreach services and home based assistance;

- providing case management that acknowledges the episodic nature of mental illness;

- providing timely access to graduated levels of assistance and intervention;

- services that respond quickly when someone is entering an episode of acute illness; and

- recognising and offsetting the significant burden on families and carers through respite care.

9.7   In general, submitters stressed that clinical services are just one part of the community services needed to assist people with mental illness. For example, Lifeline Australia commented on:

> …the need to view mental health needs through a wider lens that takes in the full scope of what people are experiencing rather than smaller units of need for care that relate to acute crises and treatment.[2]

9.8   Professor Rosen and others described the elements of community-based treatment as:

> Effective community-based treatment entails: ready access to 24 hour crisis intervention and ongoing care, assertive and intensive community case management, professionally supervised residential treatment in the community as an alternative to confining people to psychiatric institutions

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2   Lifeline Australia, 2002, *Lifeline in Mental Health, A Perspective on the Mental Health Needs of the Australian Community*, *Submission 329 Attachment 1*, p. 15.

and real recovery-oriented vocational opportunities for individuals with mental illnesses.[3]

9.9   Others pointed to the range of community services required, in response to the range of experiences of mental illness:

> Those with mental illness are a diverse group, some start quite unable to manage their life, need basic care and help, retraining in hygiene, management of house and clothing, understanding nutrition, financial management, reintroduction to socialisation, time management, location and travel skills etc., where others have lesser needs.[4]

The National Mental Health Strategy Approach

9.10   The NMHS supported the change from an institutional to a community oriented system of mental health care, stating that mental health services should be delivered in the 'least restrictive environment', and that consumers should have the 'opportunity to live, work and participate in the community to the full extent of their capabilities without discrimination'.[5]

9.11   However, the national policy presented no clear, coherent definition of what a community-based mental health system involved or how it would operate. The NMHS vision was for a continuum of care responsive to individual needs, operating within the general health care system and integrated with wider social services:

> A comprehensive mental health service system must provide for continuity of care so that consumers can move between services as their needs change, thus ensuring that they receive the most appropriate service at any time.[6]

9.12   While a range of community-based services were identified in the NMHS,[7] the strategy was not prescriptive as to which community services were essential, the appropriate 'mix' of services, the coordinating structure to oversee the integration of services or the resources to support a continuum of care. Instead, it was understood that implementation of the NMHS policies 'may occur in different ways, depending on State/Territory and regional/area circumstances'.[8]

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3   A. Rosen, L. Newton and K. Barfoot, 'Evidence-based community alternatives to institutional psychiatric care', *Medicine Today,* September 2003, vol. 4, no. 9 (*Submission 108A Attachment 3*, p. 1).

4   Name withheld, *Submission 76,* p. 1.

5   Australian Health Ministers, 1992, *National Mental Health Policy,* p. [8].

6   Australian Health Ministers, 1992, *National Mental Health Policy,* p. [10].

7   Australian Health Ministers, *National Mental Health Policy,* p. [10]; *National Mental Health Plan 1992*, p. [21]; *The Second National Mental Health Plan,* p. [27]; *National Mental Health Plan 2003-2008,* p. [20].

8   Australian Health Ministers, 1992, *National Mental Health Policy,* p. [9].

9.13   The national policy recognised that community-based services were underdeveloped,[9] but did not set targets for their development. The first National Mental Health Plan listed 'expand community based mental health services' as one of its agreed strategies.[10] To its detriment it did not define which services this included or indicate what would constitute 'adequate' levels of service.

9.14   The Mental Health Council of Australia commented on the implementation of the NMHS:

> …the Strategy took an ad hoc approach to building the extensive network of support services in the community required to manage mental illness at the primary and secondary levels. Clinical services, housing and community support, employment, adequate access to appropriate justice support systems and drug and alcohol support have all been patched into the system on a fairly random basis which has left the services themselves struggling to build their own local and regional networks and to cope with demand. Large areas of Australia are still serviced poorly or not at all.[11]

9.15   The committee is concerned that the vague concept of community-based services since the inception of the NMHS reflects an underlying lack of commitment to the development of these services. The Strategy had a clear vision for the closure of psychiatric institutions and mainstreaming of acute psychiatric care, but not for the development of community services necessary to meet the needs that resulted from those policies.

A 'community based system of care'?

9.16   The National Mental Health Report 2005 classifies a range of services under the banner of 'a community based system of care'.[12] However this classification appears to be driven by the need to report relevant funding against 'community-based' services, rather than by the existence of a coordinated, integrated system. The funding reported for 'community-based' services includes:

- *Ambulatory care services* – health services dedicated to the assessment, treatment, rehabilitation or care of non inpatients. These include crisis assessment and treatment services, mobile assertive case management services, outpatient services (whether provided at a hospital or community centre), and day programs such as social and living skills programs.

- *Community-based residential services* – staffed residential units established in community settings that provide specialised treatment, rehabilitation or care for people affected by a mental illness or psychiatric disability. Specialised psychogeriatric nursing homes are included in this category.

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9   Australian Health Ministers, *National Mental Health Policy,* 1992, p. [10].

10   Australian Health Ministers, *National Mental Health Plan 1992*, p. [8].

11   Mental Health Council of Australia, *Submission 262,* p. 13.

12   Australian Government, *National Mental Health Report 2005*, p. 4.

- *NGO programs* – community support services specifically for people affected by mental illness. Programs include supported accommodation services, vocational rehabilitation programs, advocacy programs, consumer self help services, and support services for families and primary carers.[13]

9.17   The committee is concerned that the wide range of services, including hospital services, in the above groups misrepresents the level of investment in community-based care. Three quarters of the reported 'community based' mental health service funding in 2003 went to ambulatory care services which, as noted above, includes hospital outpatient services.[14] While different from the care provided through inpatient services, the committee questions the extent to which hospital-based services fit the concept of community-based care articulated in submissions to this inquiry. It believes, therefore, that the NMHR is probably over-estimating investment in genuine community care.

Mainstreaming community services

9.18   ACOSS commented on the incongruity between the National Mental Health Reports and people's lived experiences:

> …there appears to be some inconsistency between the data reported in the National Mental Health Reports and community perceptions. Current care systems are perceived to be chaotic, under-resourced and overly focused on providing brief periods of medicalised care, largely within acute care settings.[15]

9.19   The committee received evidence that community-based services are being withdrawn into hospital settings. The Victorian government noted that all its clinical area mental health services, other than forensic services, have been mainstreamed with general hospitals.[16]

9.20   While the NMHS set a clear agenda for mainstreaming, this was targeted at acute care and organisational structures:

> Mental health services should be part of the mainstream health system. In some cases, such as acute inpatient psychiatric care, this entails delivering services within a general hospital setting. In other cases a specific mental health service will operate from a central location, but be managed within the wider health system. This policy requires that mental health services be an integral part of whatever organisational structure exists for general health services in a State/Territory.[17]

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13   Australian Government, *National Mental Health Report 2005,* pp 34, 91, 94–95.

14   Australian Government, *National Mental Health Report 2005,* p. 107.

15   ACOSS, *Submission 457*, p. 15.

16   Victorian Government, *Submission 445,* p. 2.

17   Australian Health Ministers, 1992, *National Mental Health Policy,* p. [8].

9.21   The committee received evidence that relocating community services to hospital sites reflects a broader strategy of dismantling community services in response to financial pressures.[18] Professor Rosen observed:

> …a strategy has taken over across Australia lately which is to let the community building blocks go and to have a bed oriented policy.[19]

9.22   Professor Rosen commented that mental health centres and community health centres have been viewed as 'surplus property' and sold off, and that mobile crisis services are being dismantled or retracted into emergency departments.[20] The result is a reduction in home visits and outreach services and a focus on clinical aspects of illness:

> … a lot of crisis services are now based in emergency departments at nights and on weekends. They are doing much less outreach and they are losing that culture of visiting people in their homes and helping people with their crises in their homes. When you present at an emergency department, you tend to present with a lot more clinical symptoms. When you present and get an evaluation at home, you tend to present with more life problems between people. We are losing the ability to see the life problems as well as the high salience clinical issues.[21]

9.23   Submissions confirmed the importance of outreach services and home visits. For example, the Northern Beaches Mental Health Consumer Network commented:

> Assistance is needed with meeting basic requirements once discharged, such as shopping, cleaning, or caring for young children. Home visits are particularly important for consumers that are isolated in the community. Visits are an important means of providing support and advocacy to consumers, with the goal of promoting self advocacy and sufficiency.[22]

9.24   One of the risks associated with moving 'community' services into general hospitals is that people who are not in contact with, or are suspicious of, the health system will not obtain the assistance that they need. Community care services located at hospital sites can carry with them negatives associated with hospital-based care and

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18   Professor Alan Rosen, Secretary, Comprehensive Area Service Psychiatrists Network, *Committee Hansard*, 3 August 2006, pp. 66–68.

19   Professor Alan Rosen, Secretary, Comprehensive Area Service Psychiatrists Network, *Committee Hansard*, 3 August 2006, p. 68.

20   Professor Alan Rosen, Secretary, Comprehensive Area Service Psychiatrists Network, *Committee Hansard*, 3 August 2006, p. 67.

21   Professor Alan Rosen, Secretary, Comprehensive Area Service Psychiatrists Network, *Committee Hansard*, 3 August 2006, p. 67–68.

22   Northern Beaches Mental Health Consumer Network, *Submission 60*, p. 5.

institutionalisation.[23] Blue Care, a community health and residential aged care service provider, observed:

> It is our experience that people with a mental illness have often "lost touch" with the mental health sector. They are often not empowered to manage their own care and there is little ongoing support from the mental health sector. The emphasis needs to shift to lifespan care and the provision of practical home care, respite, valuable support to maintain their connectedness to the community, and education on self management.[24]

9.25　The committee is concerned at the apparent culture of dismantling community-based mental health services and mainstreaming these services with general hospitals. It is difficult to reconcile these developments with a policy of delivering mental health care in the least restrictive environment.

Inadequate funding

9.26　Submitters decried the lack of resources devoted to community mental health services. The effect of inadequate community-based services is reflected in other areas – many people with mental illness are homeless, living in transient accommodation or in prison, readmission rates to hospital are high and the burden on carers can be unrelenting. Anglicare Tasmania commented:

> The severe shortage and limited range of community support services including supported accommodation, home help, recreation, family support, employment and education options – all services which assist people to recover from episodes of mental illness and to negotiate the complexities of life on a low income in the community – means that people's problems escalate until they become unwell and ricochet back into the acute care system. Insufficiencies in service provision have meant that acute care services and community mental health teams are over-stretched to the point where their work is largely reactive to crises and the demand for services continues to outstrip supply of beds, health workers and services.[25]

9.27　Numerous submissions called for increased resources for the community-based mental health sector.[26]　The Mental Health Council of Australia expressed a

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23　A. Rosen, and L. Manns, 'Who owns Callan Park? A cautionary tale.' *Australasian Psychology,* vol 11, No.4, p.449; SANE Australia, *Submission 133 – Attachment 1,* p.8.

24　Blue Care, *Submission 353*, p. 3.

25　Anglicare Tasmania, *Submission 464*, p. 15.

26　See for example, Lifeline Australia, *Submission 329 Attachment 6*; Brotherhood of St Laurence, *Submission 97;* Comprehensive Area Service Psychiatrists Special Interest Group, Submission 108, p.1; Mental Health Foundation ACT Inc., *Submission 112,* p.4; SANE Australia, *Submission 133 Attachment A*, p.1; insane australia, *Submission 2*, p.5; ARC Group, *Submission 14,* p.1; Australian Healthcare Association, *Submission 169,* p.8; Anglicare Tasmania, *Submission 464,* Ms Sheelah Egan, *Submission 113*; Australian Medical Association, *Submission 167.*

view that the current funding arrangements for mental health services are inadequate to support a community-based service system:

> There is a significant mismatch between the community-based mental health service model and the current system of still allocating funding largely on the old service model of 'beds and buildings'. Community-based services, the key component of the National Mental Health Strategy, are unable to effectively perform their role.[27]

9.28 In the Council's view, more flexible funding is required:

> …the success of the Strategy relied on implementing a service delivery model which required more flexible funding so as to build capacity in community based care. However, funding has failed to flow to early intervention, primary and secondary care sectors, and public and non-government organisations so that they could relieve the pressure on the acute care component of the system.[28]

9.29 The ARC Group described the ongoing need for funds:

> There is simply not enough financial support to cope with the amount of people who have been diagnosed, or have the potential to be diagnosed, as mentally ill. Pleas for increases in government funding to support the mentally ill, whether through community health centres or supported accommodation or general health services have been ignored.[29]

9.30 In addition to underfunding, the lack of a reliable funding stream for community-based services was raised as an issue. When community care services are cut, blame shifting can occur:

> … Where is the fault? The Commonwealth for giving encouragement to provide a needed service and then shedding its responsibility? [The] State for not providing funds to take over when Commonwealth funding ceased? A lack of liaison between Commonwealth and State which could have foreseen the inevitable?[30]

Areas of need - a continuum of care

9.31 Evidence to the inquiry suggests that funding is required for a range of services, focussed on providing a real continuum of care. Some of the major areas of need described in evidence included step up and step down care, rehabilitation, respite care and case management.

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27 Mental Health Council of Australia, *Submission 262*, p. 1.

28 *Submission 262*, p. 12.

29 ARC Group, *Submission 14,* p. 1.

30 Mr Peter Hutten, *Submission 185,* p. 3.

Step up and step down facilities

9.32   A number of submissions acknowledged the importance of 'step-up' and 'step-down' services in an effective community care system.[31]   These services deliver an escalated or reduced level of mental health care in accordance with the needs of the consumer, providing an appropriate level of assistance, as and when required.

9.33   Professor Gavin Andrews stated that the lack of step-down facilities is contributing to the burden on the community of caring for people with needs that would be better serviced in more supported environments.[32]   This view was held by a number of submitters, including community groups:

> Clients who manage to gain access to hospital treatment services often are released back to the street with no accommodation, case management, treatment or support in place. This leaves existing community services, that are already under-funded and under-resourced distressed when trying to manage ongoing health and welfare issues for these people.[33]

9.34   Step-down facilities deliver much-needed assistance for consumers making the transition back to community living from hospital-based care. Increased resources for these services can alleviate hospital readmissions by providing a graduated level of return to independent living, minimising the incidence of consumers being discharged without adequate support. In addition, as discussed in Chapter 8, many patients in acute psychiatric care could be better provided for in less restrictive environments if the facilities existed. Increased availability of step-down residential services would provide alternatives for these patients, relieving the pressure of acute care places.

9.35   Evidence also supports the need for improved step-up facilities, to provide more intensive care for people with mental illness living in the community. This approach aims to deliver more support and interventions at an earlier stage, rather than requiring people to become acutely unwell before they can gain treatment. The Committee heard that, for many consumers, the slide into an episode of mental illness is gradual, not sudden; therefore the capacity to access effective support services while a consumer enjoys a measure of insight is critical. As with step-down facilities, step-up facilities can relieve the pressure on acute care services.

9.36   One proposal suggested that community-based residential facilities be referred to as "wellness centres",[34] with the underlying aim that facilities such as step-up and step-down facilities be distinguished from hospitals, both to provide a less intimidating setting and reduce the stigma attached to seeking more supported assistance.

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31   Australian Medical Association, *Submission 167,* p. 18.

32   Professor Gavin Andrews, *Submission 176,* p. 7.

33   Southern Suburbs Taskforce, *Submission 191,* p. 2.

34   Name withheld, *Submission 102,* p. 1.

9.37   The idea of providing graduated levels of care facilities in the community is consistent with National Mental Health Strategy aim of providing care in the 'least restrictive environment'. However, it extends this principle by acknowledging the episodic nature of some mental illnesses and that occasions will arise where additional support is needed to manage mental illness in the community.

9.38   The committee visited a promising model in the provision of step-up / step down facilities at Shepparton in Victoria. The PARC (Prevention and Recovery Care) on Maude facility provides short term care (usually up to 28 days) to help prevent relapse and to assist recovery. It is a partnership between the state government, through Goulburn Valley Area Mental Health Service (GVAMHS), and the Mental Illness Fellowship of Victoria. The Fellowship funds the facility from its patchwork of funding sources, including contracts, memberships and donations.

9.39   The facility appeared to have several valuable features. The relationship between the groups creating the service helped achieve several goals: it involved a consumer and carer organisation in service delivery; it drew on the different strengths of service providers; and it increased the level of cooperation in the sector. PARC integrates health and non-health needs of people experiencing mental illness, with activities designed to assist in:

> living, learning, socialising and working and establish goals to address their areas of need. Participants' goals are achieved through the opportunity to take part in workshops and activities that address life skills, mental health education, exercise, relaxation, creativity and well-being.[35]

9.40   As well as being a better integrated approach, there were also encouraging signs that the PARC facility was achieving two other promising goals. First, PARC appears to be reducing the level of hospital admissions, meaning people with mental illness were able to stay in the community and not go through some of the traumas that can be associated with emergency admissions and acute hospital care. Second, PARC probably produces cost savings in care compared with hospitalisation, freeing up resources to provide care for others, particularly those with less acute symptoms who often receive no care at all.

9.41   The Cairns Integrated Mental Health Service described its endeavours to develop community facilities based on the Shepparton model. Planned facilities include a residential unit offering short-term, intensive transitional support for up to eight people, and a range of residential rehabilitation units dispersed in the community. Mr Mark Millard, Development Coordinator, explained:

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35   Mental Illness Fellowship of Victoria, Specialist Residential Rehabilitation Service (SRRP) and Prevention and Recovery Care (PARC on Maude), http://www.mifellowship.org/ProgramInfo/ResiRehabSRRP.htm (accessed March 2006).

> We are looking at developing a range of intensive support and rehabilitation options to help people make the transition from acute care back into a more integrated life in the community.[36]

9.42   The committee heard about some of the problems the Service has encountered trying to implement the project:

> Essentially our biggest difficulty at the moment has been with the community and the Cairns city council's acceptance of the appropriateness of this kind of transitional residential in a community setting. We have just recently had an application rejected to use a particular residence. We are looking around at other options right now.[37]

9.43   Mr Millard outlined some of the community resistance to the project:

> A lot of people said to us, 'We understand what you want to do. We understand the need for this, but we don't want it anywhere near us.' A lot of the attitudes that came out reflected misunderstanding. They reflected some of the ways that the media report and treat issues surrounding people with mental illness. They reflected fear of the unknown, fear of uncertainty. It has been a difficult exercise, but we have learned about community attitudes. There is still a lot of stigma, a lot of fear and a lot of misunderstanding out there.[38]

9.44   The committee considers that there is a clear role for local governments in supporting specialised community assistance for people with mental illness. There is a need for strong leadership at the local level, to overcome the stigma and community resistance still evident in relation to mental illness.

Rehabilitation

9.45   Rehabilitation performs a vital function in the management of mental illness, particularly when recovery is the focus. The concept of rehabilitation is to assist consumers to reintegrate into life in the community and live independently, despite the presence of a mental illness. The Mental Health Coordinating Council referenced the importance of promoting recovery, including the "longer-term involvement of consumers and carers in decision-making, planning of health services".[39]

9.46   Evidence to the inquiry indicates that not enough attention has been directed towards supporting individuals back into community living. This element of rehabilitation is quite distinct from medical treatment and intervention:

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36   Mr Mark Millard, Service Development Coordinator, Cairns Integrated Mental Health Service, *Committee Hansard*, 5 August 2005, p. 10.

37   Mr Mark Millard, Service Development Coordinator, Cairns Integrated Mental Health Service, *Committee Hansard*, 5 August 2005, p. 10.

38   Mr Mark Millard, Service Development Coordinator, Cairns Integrated Mental Health Service, *Committee Hansard*, 5 August 2005, p. 10.

39   Mental Health Coordinating Council, *Submission 173, Attachment 4,* p. 17.

> Once stability with medication is seen to be achieved, the system is prone to abandon the patient at that stage of rehabilitation for the rest of his life, although spasmodic efforts are made at random to be seen as attempting to carry through a programme of rehabilitation.[40]

9.47   The Australian Medical Association highlighted the shortage of service providers in the area of rehabilitation and the increasing trend to deprofessionalise these services.[41]

9.48   Consumers, carers and their families called for expanded rehabilitation services; notably, residential rehabilitation centres in the community:

> There is no point employing case managers to refer patients to Salvation Army hostels for the homeless. This type of discussion frequently occurs when devising management strategies with case managers who act as referral agents to non-existent mental health facilities. The money funding case managers in existing non residential community health clinics would be better spent on bricks and mortar for residential facilities.[42]

9.49   Historically, most rehabilitation services were managed by public mental health services.[43] In recent years these services have been increasingly run by NGOs. There are three broad models for the administration of supported rehabilitation services in the NGO sector:

- NGOs employ staff to provide outreach support or 'on-site' support in a property owned or leased by the organisation. Residents are able to move between different levels of support or to independent housing, depending on needs;

- Through an established partnership between the government and NGOs, a property is owned by the State Government and NGOs are contracted to deliver support services. Varying levels of residential support are available, with regular meetings held between the partners to assess patients' living requirements; and

- Consumers reside in public or private (owned or rented) housing and receive outreach support provided by NGO staff.[44]

9.50   As was the case with step-up/step-down facilities, the committee visited a promising rehabilitation service in Shepparton, based on the partnership model. The Specialist Residential Rehabilitation Program (SRRP) was also a partnership between GVAMHS and the Mental Illness Fellowship of Victoria. Based in a cluster of normal

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40   Name withheld, *Submission 59,* p. 1.

41   Australian Medical Association, *Submission 152,* p. 1.

42   Name withheld, *Submission 55,* p. 3.

43   Mental Health Coordinating Council, *Submission 173 - Attachment 4*, p. 15.

44   *Submission 173, Attachment 4*, p. 16.

residential dwellings, it provides a service where people with a mental illness can 'learn or relearn living skills in a supportive and safe 'live in' environment. It assists people who require more support than can be provided by visiting workers'.[45] As was the case with the PARC collaboration between the same groups, all the benefits of partnership were evident.

9.51   The Mental Health Coordinating Council cites Psychosocial Rehabilitation Day Programs in Victoria as a positive example of available rehabilitation services.[46] The programs are planned on a state wide-basis and operated by the non-government mental health sector.

Respite care

9.52   The sheer volume of evidence recounting families' and carers' personal experiences demonstrates that a significant proportion of mental health care is provided by ordinary people living in the community. The 'informal mental health workforce' includes families, carers and community members who respond on a local level to the needs of people experiencing mental illness.[47] Their needs – including emotional support and professional assistance, as well as education and information on mental illness treatment and care – must be recognised and met within the context of a community-based system of care.

9.53   A recurring theme in evidence to the committee was the lack of respite care to assist carers and families supporting individuals with mental illness.[48] The community is calling for more respite care or supervised beds to assist carers and families who are supporting people with mental illness in the community over extended periods.

9.54   The Mental Health Coordinating Council highlighted the positive work undertaken by the NSW Health and Carers NSW to establish 'family and carer friendly' services to assist in the care and rehabilitation of individuals with mental health, as well as respite programs to assist carers.[49] However, the Council raised concern about the longevity of such programs if not adequately funded.

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45   Mental Illness Fellowship of Victoria, Specialist Residential Rehabilitation Service (SRRP) and Prevention and Recovery Care (PARC on Maude), http://www.mifellowship.org/ProgramInfo/ResiRehabSRRP.htm (accessed March 2006).

46   Mental Health Coordinating Council, *Submission 173 – Attachment 4*, p. 18.

47   National Rural Health Alliance, *Submission 181,* p. 25.

48   For example: Australian Medical Association, *Submission 167,* p. 18; Australian Rotary Health Research Fund, Submission 68, p. 1–2; Mental Health Coordinating Council, *Submission 173 Attachment 4,* p. 12; National Rural Health Alliance Inc, *Submission 181,* p. 25.

49   Mental Health Coordinating Council, *Submission 173,* p. 6.

Case management

9.55   Evidence to the Inquiry shows that there is a need for ongoing, intensive case management and follow up for some people experiencing a mental illness. Some consumers need assistance that extends well beyond the administering of medication:

> Some clients need constant case management to not only take daily medication but to maintain basic functions of a normal life, like eating, bathing, washing etc. These people consistently need food, shelter, support, health care etc. Turning all people out into the community, without these systems in place, signifies a gross lack of duty of care to the most vulnerable people in our community and needs to be rectified.[50]

9.56   However there is a distinct shortage of case management services. The Brotherhood of St Laurence stated that a lack of funding is leading to long waiting periods:

> It's hard getting the treatment [case management] you need in the country. First we have to meet the very tight criteria and then you get put on a list and have to wait until someone else drops off and you can take the place. They don't look at the waiting list and say 'maybe we need another worker'.[51]

9.57   The Australian Psychological Society Ltd commented on the poor level of discharge planning from acute services and high readmission rates. The Society noted the importance of case management to assist consumers in the process of recovery when reintegrated back into the community and submitted that discharge planners should address both medical and non-medical needs. For example, discharge planning should consider 'agreed responses to early warning signs of illness and risk and protective factors for mental health' and 'goals for rehabilitation and longer-term recovery'.[52]   This emphasises that a holistic approach to case management must be combined with a collaborative approach across the community to managing mental health care.

9.58   The Mental Health Coordinating Council advocates thorough mental health care planning for people exiting hospital-based care, as well as those released from gaol:

> …inadequate follow up care was having a major impact on consumers' ability to live in the community with, at times, tragic consequences such as suicide.[53]

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50   Southern Suburbs Taskforce, *Submission 191,* p. 2.

51   Brotherhood of St Laurence, *Submission 97,* p. 2.

52   The Australian Psychological Society Ltd, *Submission 50,* p. 4.

53   Mental Health Coordinating Council, *Submission 173 - Attachment 1,* p. 28.

9.59   Micah Projects Inc discussed the difficulties in accessing case management for people in supported accommodation. The organisation noted that whilst few people had access to a case manager, even fewer people were having their case actively monitored.[54]

9.60   The Health Services Union and Health and Community Services Union described the lack of resources for case management and consequent unbearable workload for case managers:

> For community clinicians caseloads have become so great that staff are reduced to a revolving door of crisis management. A high proportion of long-term, high need consumers are using the community clinical services and home based outreach and day program services, thus limiting the capacity of these services to take on new clients.

> Community caseloads for community-based workers must be sustained at reasonable levels to allow for proactive intervention that can assist 'recovery' rather than merely maintain people in the community…

> In NSW [it is] not uncommon for case manages [sic] to be looking after between 50 and 60 clients. In Victoria, in some instances clinicians have reported case loads of up to 90…[55]

9.61   Addressing the community's need for case management services will therefore require both increased resources and development of the workforce.

Assertive community management

9.62   Case management covers a wide range of services, but also a wide range of illnesses of differing degrees of severity. For people with severe, prolonged illness,[56] assertive community management is a desirable approach for assisting consumers who can have high levels of care needs.

9.63   Assertive community management is the provision of intensive support and assistance to consumers living in the community with severe or prolonged mental illness. Key features include:

- seven day, 24 hour access to an assertive community treatment team (including crisis response services);

- mobility to travel to a consumer's home or community setting; and

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54   Micah Projects Inc, *Submission 67,* p. 5.

55   Health Services Union and Health and Community Services Union, *Submission 223*, p. 13.

56   A. Rosen, L. Newton and K. Barfoot, 'Evidence-based community alternatives to institutional psychiatric care', *Medicine Today,* September 2003, vol. 4, no. 9; p. 91.

- services specifically tailored to the psychosocial and pharmacological needs of the consumer.[57]

9.64   Studies into this mode of care[58] indicate that assertive community management provides improved outcomes for consumers, carers, their families and the community, including:

> … greater stability in the community… less revolving door administrations, less hospital days, and improved quality of life.[59]

9.65   Compared with standard case management, assertive community management restricts the ratio of case managers to consumers to ensure an adequate level of service is available. Following discharge from hospital-based care, it requires a higher initial injection of funds per consumer. [60] However, this is off-set by the substantial benefits that result from this mode of care.

9.66   Benefits of assertive community management include: the active maintenance of contact between the consumer and case management team; a decreased need to access hospital-based services; and reduction in the likelihood of the consumer stopping treatment.

9.67   Assertive community management results in an overall enhancement in the quality of life of consumers, including improving the ability to maintain stable housing and employment, as well as more normalised social functioning. There is also a reduced reliance on hospital-based care and crisis treatment, leading to a decrease in expenditure on healthcare over time.

9.68   Consumers and the community benefit from fewer disturbances which are commonplace when the mental health of a consumer degenerates, sometimes with dire and irreversible consequences. Given the extent of tragic evidence to the inquiry recounting stories of loved ones ending their lives or committing criminal acts in a state of psychosis, this benefit cannot be overstated.

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57   A. Rosen, L. Newton and K. Barfoot, 'Evidence-based community alternatives to institutional psychiatric care', *Medicine Today,* September 2003, vol. 4, no. 9; p. 91.

58   See for example, A. Rosen & M. Teesson, 'Does case management work? The evidence and the abuse of evidence-based medicine', *Australasian and New Zealand Journal of Psychiatry*, vol. 35, 2001; David Mechanic, 'Policy Challenges in Improving Mental health Services: Some Lessons for the Past', *Psychiatric Services,* vol. 54, no. 9, 2003; A. Rosen, L. Newton and K. Barfoot, 'Evidence-based community alternatives to institutional psychiatric care', *Medicine Today,* September 2003, vol. 4, no. 9.

59   A. Rosen & M. Teesson, 'Does case management work? The evidence and the abuse of evidence-based medicine', *Australasian and New Zealand Journal of Psychiatry*, vol. 35, 2001, p. 732.

60   A. Rosen & M. Teesson, 'Does case management work? The evidence and the abuse of evidence-based medicine', *Australasian and New Zealand Journal of Psychiatry*, vol. 35, 2001, p. 736.

9.69   The committee believes an effective system of community care acknowledges the variation in severity of mental illness and the corresponding needs of consumers. Research supports the effectiveness of assertive community management in helping people with severe and prolonged mental illness to live in the community, reducing the need for hospital-based care and involuntary treatment and its resulting burden on society. Several state and territory submissions made mention of new initiatives in assertive community management or other services that appear to be of a similar sort.[61] The committee urges all jurisdictions to move toward the adoption of this model.

Coordination of services

9.70   While submitters overwhelmingly pointed to the need for expanded and enhanced community services, they also stressed that community services need to be better organised and integrated. The current lack of a coordinated approach to community-based services means that people are 'falling through the cracks' and not receiving the services they need.

9.71   The lack of coordination of community care has also contributed to an uneven spread of services across communities, including the range of services available:

> …there may be Day Programmes, but not Housing in an area, inadequate Support Workers in an area, depending where the particular sufferers are and how informed their Carers, how able is Advocacy for better service, in different State Mental Health boundary areas.[62]

9.72   The West Australian Child and Adolescent Mental Health Services Advisory Committee noted the frustration created by "poor coordination, fragmentation and little cohesion" between services.[63] The Mental Health Council of Australia also recognised this need:

> …making community based care actually work required an increased focus on intersectoral linkages. The National Mental Health Report…does not report on this crucial strategy but consumers report a consistent lack of access to these broader community services which impairs their ability to maintain their health and operate effectively in the wider community.[64]

9.73   Consumers, families and carers are desperately seeking the coordinated management of mental health care across the community. The current disparate and chaotic organisation of community-based services is impacting on the ability of consumers to live in the community:

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61   NSW Department of Health, *Submission 470*, p. 25; Western Australia Department of Health, *Submission 376*, p. 20; ACT Health, *Submission 165*, p. 4.

62   Name withheld, *Submission 76,* p. 1.

63   West Australian Child and Adolescent Mental Health Services Advisory Committee, *Submission 24,* p. 2.

64   Mental Health Council of Australia*, Submission 262*, p. 9.

> … partly the result of a total breakdown of the Dept. of Housing's emergency housing service and its and the Mental Health Centre's (MHC) inability to co-ordinate or communicate. Similarly, I discovered liaison between the MHC and Centrelink was equally inadequate, resulting in my daughter's rent allowance being allowed to lapse… This is an area that needs professional co-ordination and case-workers with enough time to ensure such muddles are resolved quickly.[65]

9.74   ACROD, the National Industry Association for Disability Services observed the need for a change in ideology:

> Because of the continuing prevalence of the medical model of mental illness, health and allied services tend to be viewed as primary (if not superior) and all others as secondary (if not, in extremis, optional). The need to promote inter-sectoral partnerships was a central policy recommendation of the first National Mental Health Plan, but this objective has not been realised in practice. The 2003-08 Plan has the same emphasis. It is essential that this time it be given effect.[66]

9.75   The need for coordination across community support services for people with mental illness is also discussed in Chapter 10.

The NGO sector

9.76   Non-government organisations (NGOs) fill a vital role in delivering community-based programs to people with mental illnesses.[67]   There is growing reliance on NGOs to deliver services not currently available through the public health system. For example, NGOs report that consumers living in supported residential services are 'rarely' visited by case managers or clinical care services from the public mental health system, so the responsibility falls to NGOs.[68]

9.77   The National Mental Health Council provided strong support for the roles filled by NGOs:

> The NGOs provide a wide range of services and are often the best placed to provide essential links into the community and between services. They are to some extent the engine room of reform because of these links and because of their capacity to run flexible and consumer-centred care.[69]

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65   Name withheld, *Submission 55,* p. 3.

66   ACROD, *Submission 335*, p. 4.

67   beyondblue: the national depression initiative, *Submission 363*, p. 8; Lifeline Australia, *Submission 329 Attachment 6*, p. 5

68   Mental Health Coordinating Council, *Submission 173 - Attachment 4,* p. 17.

69   National Mental Health Council of Australia, *Submission 262,* p. 28.

In the Council's view, 'The lack of funding for non-government services is one of the major factors in the under performance of the [National Mental Health] Strategy'.[70]

9.78   Overall, 6.2 per cent of mental health funding went to the NGO sector in 2003, up from 2 per cent in 1993.[71] Victoria spent the highest proportion of its mental health budget on NGOs, followed by the ACT. South Australia and New South Wales spent the least.[72]

9.79   A key issue in the delivery of community-based mental health services by NGOs is the lack of funding for delivering day-to-day services. [73] The current National Mental Health Plan recognises that NGO funding is limited:

> Non-government organisations have performed a key role in providing support services for those with mental health problems and mental illness, in advocating for services to be more responsive, and in educating and supporting carers. While the demand on non-government mental health organisations has increased significantly over the past decade, their funding base remains limited.[74]

9.80   The Australian Mental Consumer Network (AMCN) recommended an increase in funding of 'at least 20 per cent of the mental health grant' to NGOs providing services to consumers.[75] They noted the importance of directing funds to services shown to produce positive results, arguing that funding 'unexamined community clinical services will be just as wasteful as a deluge of money into the funding of more acute beds'.[76]

9.81   Volunteers are an integral component of the NGO workforce, providing valuable support in community-based care.[77] Nonetheless, there are limits as to what can be achieved in a cash-poor environment. The Richmond Fellowship of NSW stated that it is very difficult to attract donor funding to mental health NGOs, leaving them particularly reliant on government funding.[78] The Fellowship argued that funding to NGOs needs to reflect the real costs of delivering services, not only direct program costs but also costs associated with capacity building, meeting OH&S

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70   *Submission 262,* p. 10.

71   Australian Health Ministers, 2003, *National Mental Health Plan 2003-2008,* p. 5.

72   Australian Health Ministers, 2003, *National Mental Health Plan 2003-2008,* p. 5.

73   See, for example: Southern Suburbs Taskforce, *Submission 191,* p. 2; Mental Health Coordinating Council, *Submission 173 Attachment 4,* p. 14; SANE Australia, *Submission 133 Attachment A*, p. 16.

74   Australian Health Ministers, 2003, *National Mental Health Plan 2003-2008*, p. 19.

75   Australian Mental Consumer Network, *Submission 322,* p. 2.

76   Australian Mental Consumer Network, *Submission 322,* p. 19.

77   Mental Health Coordinating Council, *Submission 173 - Attachment 4,* p. 9.

78   Richmond Fellowship of New South Wales, *Submission 266*, p. 4.

legislation and accreditation requirements, as well as other risk management considerations.[79] The Fellowship described its stretched resources:

> The Richmond Fellowship, which provides supported accommodation and other support to people suffering from schizophrenia, has to train social workers and other less qualified people to deal with psychiatric patients in the community in regional areas because there are not enough mental health nurses or community nurses. The Richmond Fellowship has a 2-year waiting list, and looks to remain that way indefinitely if current trends continue.[80]

9.82   Greater collaboration and capacity building in the NGO sector will strengthen the role of NGOs to provide mental health services. This includes areas such as outreach services, psycho-social rehabilitation and residential support.[81] A clear definition of the role of NGOs in mental health care and an understanding and recognition of the community services provided through the NGO sector may assist in streamlining services and responsibilities across this sector.

9.83   For example, NGOs may be further utilised to provide a structured outreach service to patients no longer needing intensive clinical case management through GPs.[82] This would have the advantage of ensuring sufficient time to assess the person's general state of mental and physical health in the patient's home and reduce the focus on assessing clinical aspects of health in perhaps a 'less-friendly' setting. It would also reduce the pressure on GPs to provide ongoing community care, given appropriate circumstances. The success of this approach is, however, heavily reliant upon a formalised arrangement between the outreach provider and medical services, ensuring that 'step-up' assistance is available when required.

Maintaining the focus on community care: the Italian experience

9.84   Italian mental health policy underwent radical reform in 1978 following a decade-long deinstitutionalisation movement similar to that in many other countries including Australia. De-institutionalisation in Italy was initiated by psychiatrists but later joined by other mental health workers, patients themselves, unions, political parties and members of the general public concerned with the state of the country's asylums.

9.85   The 1978 reforms were implemented in Public Law No. 180 (the reform law). Key characteristics of the reform law included:

- the prohibition of the establishment and use of psychiatric hospitals
- development of a network of community mental health services

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79   *Submission 266*, pp 4–6.

80   ARC Group, *Submission 14,* p. 3.

81   Miss Margaret Burton, *Submission 35,* p. 1.

82   Mental Health Coordinating Council, *Submission 173 - Attachment 4,* p. 15.

- prohibition on hospitalisation other than in 15-bed general hospitals, and

- prohibition on involuntary hospitalisation other than in particular circumstances (such as a psychiatric emergency).

9.86   These reforms were implemented as part of a major reform of the Italian health system under which all citizens were entitled to healthcare through local administrations responsible for defined geographical areas.

9.87   Initially, the lack of sufficient residential facilities to meet the need for medium- to long-term residential care was a significant source of discontent (particularly among organizations representing families of the mentally ill). There was also evidence that the decrease in the number of psychiatric hospital in-patients was accompanied by reductions in the quality of care and staff commitment.

9.88   The reforms were later bolstered by a series of National Mental Health Plans that enshrined common service and funding standards and emphasised the integration of mental health services with other services and consumer organizations.

9.89   While the development of an adequate level of alternative services took some time, the controversial reforms have been a success:

> Presently Italy has the most comprehensive and diffuse disseminated network of community psychiatric services than any other country in the world. Persistent differences in the distribution of resources call for improvement but, in the opinion of a vast number of workers and users, do not imply the repeal of the existing legislation. In those many areas where the reform has been applied, empirical evidence proves the effectiveness of community services in meeting all psychiatric needs, including those of the severely mentally ill and their families.[83]

9.90   While clearly the experiences of different patients will vary, the support expressed by one patient, Giovanni, a former state hospital inmate and a patient of the South Verona Community Mental Health Services, illustrates the types of benefits some patients see in the Italian system:

> I was in the hospital for 12 years, and didn't like it. I prefer by far to live in my apartment and wish to express my appreciation to the workers for their respect and support. Let me recommend that action be taken internationally to develop community services instead of psychiatric hospitals.[84]

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83   Lorenzo Burti, 'Italy: radical reform of mental health policy and its consequences', in P. Morrall and M. Hazelton (eds.), *Mental health: global policies and human rights*, Whurr Publishers, London, 2004, p. 75.

84   Lorenzo Burti, 'Italy: radical reform of mental health policy and its consequences', in P. Morrall and M. Hazelton (eds.), *Mental health: global policies and human rights*, Whurr Publishers, London, 2004, p. 74.

9.91   It is notable that Giovanni's enthusiastic support was reportedly the source of some amazement to those observing it as apparently he 'ordinarily spoke only of his delusion of being a descendant of Julius Caesar' and 'had never spoken a complete sentence before'.[85]

9.92   Other observers, however, have urged caution in relation to attempts to adopt 'the Italian experience' in other countries. For example, Australian professor of psychology, Graeme Smith, has noted that while a number of Western countries have engaged in Italian-style reforms:

> all have been criticised for basing the changes on ideology or opportunism rather than on evidence, for failing to prepare the community for the impact of those changes, and for failing to fund them adequately. Subsequent research has justified the changes to some extent—it is clear for one thing that they have facilitated the rights of patients—but tragic consequences remain to a varying degree.[86]

9.93   Despite these concerns, the Committee was impressed by outcomes in Trieste, visited by the Chair in January 2006.[87] The community-based care model sees a strong focus on patients' rights, with very low rates of involuntary treatment and few forensic hospitalisations. Ninety-four percent of the mental health budget is spent on community based care, and savings have actually been achieved compared to 1971 levels of mental health spending. The focus of service delivery is multidisciplinary care delivered through specialised community mental health care centres, with far less reliance on acute psychiatric hospitals than in Australia. The Italian model, as seen operating in Trieste, is a reminder that properly resourced community-based care can be positive for consumers' rights and recovery, as well as for budgets.

Concluding remarks

9.94   Community-based mental health services in Australia are clearly inadequate to enable consumers to live independently in the community. This situation reflects a legacy of underinvestment in service development, and in some jurisdictions the rapid pace of deinstitutionalisation. While the National Mental Health Strategy made broad statements about the need to develop community services, it avoided the hard yet essential task of defining what those services should be and setting targets for their development.

9.95   The impacts of inadequate community care are clear. There is a high rate of homelessness among the mentally ill, many people with mental illnesses are ending up in prison, acute care facilities cannot meet demand and there is a high readmission rate

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85   L. Burti, 'Italy: radical reform of mental health policy and its consequences', in P. Morrall and M. Hazelton (eds.), *Mental health: global policies and human rights*, Whurr Publishers, London, 2004, p. 74.

86   Graeme Smith, 'The Italian experience', *Meanjin*, vol. 63, no. 4, 2004, pp. 81–2.

87   For details, see the Chair's report on the visit at Appendix 3.

to acute care facilities. Resources spent responding to these crises will have only limited impact. Longer term relief will not occur without significant investment in community services that provide earlier interventions to prevent mental illness escalating into crisis, and provide post discharge support in the transition to community life.

9.96   Community mental health services need to be located *in the community*. Currently, mental health services remain clinically oriented and there is evidence that community-based services are being drawn back into hospital environments. Wider support services remain *ad hoc*, with little coordination between different service providers. Stigma and community resistance remain an issue in the development of some services. Therefore strong leadership, at national, state and local levels, combined with increased resources to develop community services are required to fulfil the original goals of deinstitutionalisation.

CHAPTER 10

SUPPORT SERVICES FOR PEOPLE FACING MENTAL HEALTH PROBLEMS

Introduction

10.1   Health and wellbeing are influenced by experiences and opportunities in many intersecting areas of life. For people experiencing mental health problems, community-based treatment is not only about 'health' services but is intrinsically linked to supports and services in other spheres of life:

> I as a carer on occasions have been very disappointed by what I felt was a lack of support. But is it wrong to expect the very best of care for my son when he leaves hospital? Is it wrong to expect he should be able to live independently which from all accounts would be better for him and his illness? Is it wrong to expect he should be able to work so he could regain his self-esteem and confidence again so he can feel he is a normal part of society? I have watched him try and try to just regain his life to just have a small part of what he had back.[1]

10.2   Submissions to the inquiry emphasised that mental health services need to operate within an integrated framework which links related human services such as housing, employment, training, rehabilitation and disability supports.[2] The National Mental Health Plan 2003-2008 acknowledged this need:

> Improving the mental health of Australians cannot be achieved within the health sector alone. A whole-of-government approach is required which brings together a range of sectors that impact on the mental health of individuals, such as housing, education, welfare and justice.[3]

10.3   Evidence to the inquiry canvassed some of the innovative programs that assist people experiencing mental illness, in areas beyond the 'health' system, such as housing, employment and training and on the essential role non-government organisations (NGO) play in providing these services.

10.4   There are significant service gaps, that result in poverty and homelessness and, where services are available, lack of integration remains a significant barrier to the health and wellbeing of people with mental illness. Numerous submissions to the inquiry called for increased linkages and integration across service sectors.[4]

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1   Name withheld, *Submission 123,* p. 2.

2   See for example, Mental Health Council of Australia, *Submission 262*, p. 7; Queensland Alliance, *Submission 288;* Public Interest Law Clearing House (PILCH) Homeless Persons' Legal Clinic, *Submission 41*; Australian Council of Social Services, *Submission 457*; Professor Ian Webster *Submission 458*, p. 33; Mission Australia, *Submission 199*

3   Australian Health Ministers, *National Mental Health Plan 2003-2008*, 2003, p. 13.

4   See for example, Mental Health Council of Australia, *Submission 262;* Australian Council of Social Services, *Submission 457*; Mission Australia, *Submission 199.*

10.5   This chapter provides a brief overview of access to mainstream support services including accommodation, employment and training, and income support and describes some successful programs.

10.6   This chapter does not detail all the funding streams and available programs provided by federal, state and territory governments, but refers interested readers to the relevant submissions for details.

Accessing mainstream services

10.7   The Australian Government submitted that:

> 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.[5]
> 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 illnesses.[6]

10.8   The Commonwealth did not indicate whether this expenditure on support services was higher for those with mental illness than for welfare recipients in general, although it might be expected that the former would have greater welfare needs. The Mental Health Council of Australia (MHCA) stated that generalist housing, education and employment services are reluctant to provide services to mental health consumers without additional support, and there is inadequate funding for these services to help consumers and their carers.[7] They also argued that:

> The lack of concrete data about actual service provision, and more importantly, consumers' access to mainstream health, housing, employment, education and social activities is a distinct weakness in the National Mental Health Strategy.[8]

10.9   There is a lack of integration and coordination across service sectors and difficulties with eligibility requirements for specific programs and services. A strong need is identified for consumer-operated services and increased training and education in mental health.

Lack of integration

10.10   Formal pathways between services are 'virtually non-existent', with a lack of formal supports, agreements or protocols between services:

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5   Australian Government, *Submission 476,* p. 1.

6   Australian Government, *Submission 476,* p. 4.

7   Mental Health Council of Australia, *Submission 262*

8   Mental Health Council of Australia, *Submission 262,* p. 10.

> Individual case managers are left to argue the rights and wrongs of an individual's access to services which, in a well-run system, would be automatic.[9]

10.11   Hanover Welfare Services called for a collaborative approach, and argued that cost savings could be made by restructuring and rationalising the 'current fragmented and silo based programs' into an integrated package of assistance.[10] Submitters called for effective leadership and governance arrangements to ensure that integrated services operate effectively. The Mental Health Association NSW Inc. suggested that programs 'must be whole of government, and controlled by an inter-government/NGO advisory group'.[11]

10.12   For inter-agency integration to work there needs to be a culture change:

> Opportunities for coordination of services would be greatly facilitated by better communication, sharing of information and breaking down of inter-agency "territorialism". There are significant barriers to the coordination of clinical and so called non-clinical or rehabilitation services that seem to be borne out of professional jealousy, ignorance or disrespect. This results in gaps in services to clients due to one service provider either not knowing what other services are available and/or a service provider believing (wrongly) that a service is being provided by another agency.[12]

10.13   Hanover reported on research examining services for women with complex needs that found it was important to locate mental health service expertise within other services, such as housing services, rather than referring consumers elsewhere. Hanover also commented that, at the least, involving support workers in the referral process was helpful as someone in poor mental health may not be in a position to effectively relay sufficient information to other service providers.[13]

10.14   The Department of Families, Community Services and Indigenous Affairs acknowledged the need for integration of services and pointed to some of the issues:

> One of the biggest barriers is privacy. You cannot share information. Another barrier is that the different systems do not talk to each other: IT does not talk to each other, so DEWR's system does not talk to Centrelink's system. There are those sorts of issues. If you try to deliver a number of programs through one case manager, each program's funding has to be kept separate and delivered separately. There are all sorts of barriers. FACS(IA) is now convening an IDC to start to work through some of those barriers to make joined-up service delivery more of a reality for the homeless and people who have complex needs.[14]

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9   Mental Health Council of Australia, *Submission 262,* p. 17.

10   Hanover Welfare Services, *Submission 403,* p. 18.

11   Mental Health Association NSW Inc, *Submission 230,* p. 9.

12   Name withheld, *Submission 244*, p. 5.

13   *Submission 403,* p. 7.

14   Ms Ellen Wood, Section Manager, Homeless Policy and Assistance, FaCSIA, *Committee Hansard,* 7 October 2005, p. 91.

10.15   The lack of integration and coordination between mental health and alcohol and drug services was a major issue raised and is discussed in Chapter 14.

Training and education for service staff

10.16   A lack of understanding about mental health can lead to mainstream service providers excluding people with mental illness:

> Generally there exists a poor level of knowledge and skills amongst staff within both government and non government (non mental health) services (housing, employment, law enforcement, and community development)… Training and consultation programmes are required to assist develop knowledge and capacity within these agencies.[15]
>
> Even where a consumer, carer or support service is able to access other community services, their problems are not over. The [National Mental Health] Strategy does not make adequate provision for funding education and training to enable staff in other health and community sector services to work effectively with mental health consumers. Having won the lottery of access to appropriate support, consumers often find continuing difficulty in dealing with service providers who are untrained in dealing with people with mental illness.[16]

10.17   ACROD, the National Industry Association for Disability Services, argued that significantly greater knowledge transfer among all service providers is necessary to improve service integration:

> In policy terms, this is a long-term goal which will most effectively be achieved by a revision in the training of all services. Put bluntly, it will not be a question of the occasional inter-agency workshop, but an overhaul of personnel training in which, for example, there is more accredited multi-disciplinary training…at an acceptably high level.[17]

Service eligibility requirements

10.18   The requirement that consumers must have a documented diagnosis to be eligible for services creates difficulties:

> …in order to access a range of programs and/or assistance, a diagnosis is an essential pre-requisite. A concrete example of this is the Youth Residential Rehabilitation Program funded by the State Government, where to be eligible for housing, the person must have a serious mental illness diagnosis. Similarly, people cannot access other specialist services without a diagnosis.[18]

10.19   Diagnosis can be difficult, inaccurate and time consuming, or may be extremely challenging to obtain for people who have limited – if any – contact with

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15   Western Australian Child and Adolescent Mental Health Services Advisory Committee, *Submission 24*, [p.] 9.

16   Mental Health Council of Australia, *Submission 262,*p. 18.

17   ACROD, *Submission 335*, p. 12.

18   Catholic Social Services Victoria, *Submission 381,* p. 7.

the health system. People who are homeless or transient often do not have proof of identity or a Medicare card, let alone suitable documentation of a diagnosis.

10.20   Divulging a diagnosis, given the stigma associated with mental illness and real possibility of discrimination, can also be a problem.[19]

Need for consumer-run services

10.21   Submissions emphasised the importance of consumer-run services, and consumer representation on policy formation and advisory committees:

> There remains a severe shortage of community support services, especially those which are consumer initiated and managed, including housing, home help, recreation, family support, employment and education options for people with a mental illness and their families.[20]

10.22   The Richmond Fellowship recommended seed grants for consumer run programs, particularly those run in partnership with larger service providers.[21] Further discussion of the importance of consumer participation in service delivery is provided in Chapter 3.

Accommodation

10.23   A fundamental requirement underlying the policy of community-based care and treatment for people experiencing mental illness is the need for appropriate accommodation. In 1993, the Burdekin Report assessed that the 'absence of suitable supported accommodation is the single biggest obstacle to recovery and effective rehabilitation'.[22] Deinstitutionalisation moved thousands of people out of institutions and into the community, but without a commensurate growth in accommodation. People with mental health problems are not homogenous and along with extreme shortages of short, medium and long term accommodation, the diversity of needs is not being met.

> The only way that I could eventually find security of accommodation for my son was to use a small life insurance payout to put a deposit on a house for him eleven years ago, and to assist him since then with mortgage payments. Previous to that time he had lived with relatives, friends, a privately run sub-standard boarding house, and a small caravan in a caravan park from where he was evicted and sent to hospital on an involuntary order. He then began living in rental properties but all of these were eventually put up for sale and he had to move on. The stress of continually

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19   *Submission 381,* p. 17.

20   ACOSS, *Submission 457,* p. 17.

21   The Richmond Fellowship of Australia, *Submission 234*, p. 5.

22   Human Rights and Equal Opportunity Commission, Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness, AGPS, Canberra, 1993, p. 919.

> moving and trying to find accommodation resulted in the deterioration of my son's mental health, often significantly.[23]

10.24   Shelter and housing are basic human needs. Article 11 of the *International Covenant on Economic, Social and Cultural Rights* provides that all people have the right to adequate housing.[24] Suitable accommodation is critical for several fundamental reasons. Firstly, it is an effective and cost-efficient preventative measure.[25] Secondly, without stable housing, people with mental illnesses experience more frequent and prolonged periods of illness and increased disability.[26]

Current accommodation services

10.25   Public and community housing and crisis accommodation are the responsibility of state and territory governments. The Australian Government has committed to contribute around $4.75 billion under the 2003-2008 Commonwealth-State Housing Agreement (CSHA), which sets the strategic directions for housing assistance.[27]

10.26   Public housing is the largest form of assistance provided under the CSHA and is available to people on low incomes and those with special needs. In 2001-02, 40.8 per cent of public housing allocations were to people with a disability. Public housing rents are usually set at market levels with rebates granted to low income tenants, so that they generally pay no more than 25 per cent of their assessable income in rent.[28] Community housing is 'rental housing provided for low to moderate income or special needs households managed by community-based organisations that are at least partly subsidised by government'.[29] Funding for community housing is typically either fully or partly provided by governments to not-for-profit organisations or local governments. Community housing models vary across jurisdictions.[30]

10.27   In addition to the CSHA, the Australian Government contributes funding to several other programs which may assist people with mental illness to obtain housing. These include Rent Assistance for income support recipients and low income families participating in the private rental market; the Home and Community Care Program, co-funded with the states to support people to live in their own homes; and the Supported Accommodation Assistance Program (SAAP).[31]

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23   Name withheld, *Submission 124,* p. 2.

24   Public Interest Law Clearing House Homeless Persons' Legal Clinic, *Submission 41*, p. 7.

25   *Submission 41*, p. 7.

26   NSW Health – NSW Government, *Submission 470,* p. 33.

27   Australian Government, *Submission 476,* p. 47.

28   Australian Government, Productivity Commission, *Report on Government Services 2005*, p. 16.9

29   *Report on Government Services 2005*, p. 16.8.

30   Australian Government, Productivity Commission, *Report on Government Services 2005*, pp. 16.9–6.10.

31   Australian Government, *Submission 476,* pp. 47–48.

10.28   The SAAP provides funding for transitional accommodation and related support services for people who are homeless or at risk of homelessness. It is a cost shared program between the federal, and state and territory governments. Since its commencement in 1985, the SAAP has been implemented through five-year agreements between the governments.

10.29   The strategic directions for SAAP are subject to the Australian Government agreement, while the management and delivery of SAAP services are the responsibility of each state and territory government.[32] States and territories must 'plan, purchase or fund and develop services to meet agreed outcomes'.[33] Non-government agencies deliver most SAAP services, with some local government providers.[34]

10.30   The Department of Families, Community Services and Indigenous Affairs advised the committee that the most recent supported accommodation assistance agreement, signed in 2005, has a new strategic approach including the following elements:

- Early intervention and pre-crisis intervention – aiming to assist people before they lose their housing so they do not become homeless;

- Longer term support; and

- Better service delivery for people with high and complex needs, including more service linkages.[35]

10.31   They also noted that the new agreement includes an 'innovation and investment fund' to benchmark and disseminate best practice models of service throughout the program.

Accommodation issues

Homelessness

10.32   While it is extremely difficult to determine accurate prevalence rates of mental illness among the homeless, there are clear causal and consequential associations between the two. Studies indicate that between 30 and 80 per cent of people experiencing homelessness also experience mental disorders.[36]

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32   *Submission 476,* Attachment 20, p. 2.

33   Supported Accommodation Assistance Program 2000-2005, Memorandum of Understanding, www.communities.qld.gov.au/community/homelessness/documents/pdf/mou_aug_1999.pdf (accessed December 2005).

34   *Report on Government Services 2005*, p. 15.40.

35   Ms Ellen Wood, Section Manager, Homeless Policy and Assistance, DFACS, *Committee Hansard,* 7 October 2005, pp. 92, 95.

36   See for example, Hanover Welfare Services, *Submission* 403, p. 2, Public Interest Law Clearing House (PILCH) Homeless Persons' Legal Clinic, *Submission 41*, p. 5; Professor Ian Webster, *Submission 458,* p.29; St Vincent de Paul Society, *Submission 478*, p. 3

10.33   Compared to the general population, there are significant barriers which make it very difficult for homeless people to access community services.[37] This includes: financial constraints; competing basic needs; a lack of transport; insufficient documentation, such as a Medicare card or proof-of-identity details; disconnection from support networks and assistance; the requirement to navigate a complex service system to access services; and discrimination, stigma and prejudice from some providers. They may also find it difficult to make and keep appointments. Problems may be further exacerbated if the person has co-morbid conditions, or has had a negative experience in the past.

10.34   Homeless people with mental illness are often left in situations further detrimental to their health. Staff of Hanover commented:

> Homeless people often end up in crowded low cost hotels and crisis accommodation services. These places have many different types of people and are often stressful environments. Drug dealing, assaults and theft are commonplaces. Clients who are trying to recover from depression or schizophrenia often find that their mental health suffers further because they are forced to live in inappropriate places.[38]

Accommodation supply

10.35   While real estate markets differ across regions it is the case that housing prices have risen 124 per cent over the period 1995 to 2005,[39] and there is an undersupply of low cost housing making it difficult for people with mental illness to access the private rental market. The Public Interest Law Clearing House (PILCH) Homeless Persons' Legal Clinic recognised that housing supply is influenced by a range of policies and argued for a 'National Housing and Taxation Plan' that includes strategies to align the supply of affordable housing with demand.[40] St Vincent de Paul called for a task force to investigate 'all aspects of the massive accommodation crisis'.[41] ACOSS said there is a 'chronic mismatch between housing supply and demand', and 'current policy settings are distorting both the home ownership and rental markets and effectively locking out low income earners'.[42]

10.36   While the CSHA now includes indexation, making funding for housing assistance more sustainable,[43] the base grant funding decreased by 54 over the last 10 years.[44] There has been some growth in supported housing and other targeted

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37   Public Interest Law Clearing House (PILCH) Homeless Persons' Legal Clinic, *Submission 41*, p. 6.

38   Hanover Welfare Services, *Submission* 403, p. 17.

39   ABS, Cat. no. 6416.0, Table 10, *House Price Indexes, Established Houses - Index Numbers Quarterly*, September 2005.

40   Public Interest Law Clearing House Homeless Persons' Legal Clinic, *Submission 41*, p. 8.

41   St Vincent de Paul, *Submission 478,* p. 13.

42   ACOSS, *Submission 457,* p. 9.

43   2003 Commonwealth State Housing Agreement, Clause 4(6).

44   *Submission 457,* p. 9.

programs but the concurrent negligible increase in public housing stock and loss of low cost private housing options has resulted in overall reduction in affordable housing.[45] The Brotherhood of St Laurence argued:

> Public housing waiting lists are currently measured in terms of years, not months, with some consumers being told that they are unlikely to ever obtain a public housing unit. Private rental is one of their few options, but the cost of it leaves very little income on which to survive, even in rural and regional areas.[46]

10.37   One of the impacts of an undersupply of suitable accommodation for people with mental illness is an over reliance on inpatient services. A number of submissions indicated that many people currently in mental health inpatient care could be appropriately cared for in community settings if supports were available.[47] The Queensland Government stated that a lack of suitable accommodation and support was a key factor in preventing discharge.[48] In other cases, the undersupply of suitable accommodation results in people with mental illnesses being discharged onto the street, or into unsuitable accommodation.

Accommodation and support

10.38   Welfare organisations argued that there is a need for both increased affordable housing and for ongoing professional support:

> …a significant proportion of households under Segment One [highest priority public housing applicants] vacate their tenancies prematurely or involuntarily. One of the reasons for this loss of housing tenure is the lack of support to prevent vulnerability turning into crisis for individuals with complex issues, including psychiatric disorders.[49]

10.39   The Queensland Public Tenants Association Inc pointed to the unmet support needs of tenants with mental illnesses, observing that adverse outcomes occurred not only for those experiencing mental illness, but also their neighbours and the wider public housing system.[50] The Association commented:

> One tenant we are aware of lives in a 22 unit complex of public housing units in a major regional centre. Within that complex there are approximately five de-institutionalised mental health tenants. One of these tenants screams most of the time, including at night, making a good night's sleep a rare event. A second tenant calls emergency services to attend up to 5 or 6 times a day. …A third, a male tenant, frequently urinates in the open

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45   Hanover Welfare Services, *Submission 403*, p. 18.

46   Brotherhood of St Laurence, *Submission 97*, p. 4.

47   NSW Health – NSW Government, *Submission 470,* p. 33; Queensland Government, *Submission 377*, p. 19.

48   Queensland Government, *Submission 377*, p. 19.

49   Hanover Welfare Services, *Submission 403*, p. 19.

50   Queensland Public Tenants Association Inc*, Submission 505*, p. 1.

garden area. And recently, one of our members walked out his front door and found his neighbour had hung himself off the balcony rails.[51]

10.40   The Association stated that more high needs tenants are entering into public housing without adequate support, and that Department of Housing struggles to manage these complex tenancies. The Association commented that there is a need for increased education and awareness to reduce the 'double-dose of stigmatisation' received by public housing tenants with mental illnesses, as well as increased coordination between levels of government and service providers to meet these tenants' support needs.[52]

Issues with SAAP

10.41   There is considerable unmet need for SAAP services. While on an average day 187 new clients are accommodated in SAAP, just over one in two new people seeking immediate accommodation are turned away. Turn away rates are highest for couples (with or without children), with 81 per cent of these people being turned away each day.[53]

10.42   A review by the NSW Ombudsman in 2004 found that people with mental illnesses were routinely excluded from SAAP services. Over half of SAAP agencies had policies that allowed people to be refused service on the basis of mental illness. There were 290 instances of people with a mental illness being denied access to services in a six month period.[54]

10.43   The Australian Government acknowledged the deficiency:

> Compared with other areas of expressed client needs, assistance with mental health disorders or mental illness has one of the highest levels of unmet need in the provision of SAAP services.[55]

Furthermore, as a transitional program, SAAP relies on other key programs to deliver essential services to homeless people.[56] The submission lists critical gaps in allied service systems which impact upon SAAP service delivery as:

- a crisis service which can respond to people with personality disorder and disordered behaviour, including those under the influence of drugs or alcohol;

- specialist services which can respond to homeless people with dual/multiple problems;

- health and mental health services which are appropriate for homeless people;

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51   *Submission 505*, p. 3.

52   *Submission 505,* p. 1.

53   AIHW, *Demand for SAAP assistance by homeless people 2003-04, SAAP National Data Collection Agency Report Series 9*, p. 59.

54   NSW Ombudsman, 2004, *Summary report: Assisting homeless people – the need to improve their access to accommodation and support services*, p. 40.

55   Australian Government, *Submission 476,* Attachment 20, p. 2.

56   *Submission 476,* Attachment 20, p. 2.

- specialist and generic services which can respond to, or accommodate, people with disruptive behaviour; and

- ongoing support for people with high need to enable them to retain accommodation successfully in the community.[57]

10.44   The Queensland Government reported findings which 'indicate a growing concern among SAAP service providers about the increasing incidence of clients with high and complex needs who require support from services beyond SAAP'.[58] In many cases, SAAP agencies rated the prospect of obtaining assistance for these clients as 'poor' or 'nil'.[59]

10.45   A number of submissions to the inquiry advocated a substantial increase (in the order of 40 per cent) in funding to SAAP to service unmet need.[60]

Tenancies

10.46   The Combined Community Legal Centres' Group (NSW) Inc submitted that the expansion of 'good behaviour agreements' leaves people with mental illness vulnerable to eviction from public housing due to behaviour triggered by their illness. People have also been requested to give up their government housing while temporarily incapacitated in hospital. They recommended that good behaviour agreements be amended to accommodate the specific need of people with mental illnesses, and that Tenancy Acts be amended to place limitations on rent increases thus providing better security of tenure for people with mental illness.[61]

10.47   Residential Tenancy Databases are lists of tenants who real estate agents considered to be a tenancy risk and are used by agents to screen prospective tenants.[62] People with mental illnesses are vulnerable to being listed on these databases, limiting their ability to access rental accommodation. Furthermore, 'they may not be aware of the processes to remove their name or correct their listing or have the capacity to meet the various time limitations for action that could remove their name from the database'.[63] The Centre recommended that the Commonwealth should introduce a national system for the regulation of residential tenancy databases to alleviate misuse and abuse of these databases.[64]

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57   *Submission 476,* Attachment 20, p. 4.

58   Queensland Health, *Submission 377*, p. 20.

59   *Submission 377*, p. 20.

60   For example: ACOSS*, Submission 457;* PILCH Homeless Persons' Legal Clinic; *Submission 41*.

61   Combined Community Legal Centres' Group (NSW) Inc. *Submission 232*

62   Senate Community Affairs References Committee*, Report on poverty and financial hardship*, March 2004, p. 138.

63   Combined Community Legal Centres' Group (NSW) Inc. *Submission 232,* p. 11.

64   *Submission 232,* p. 12.

10.48   The Centre drew attention to the need for adequate intervention and intensive support services to assist tenants with mental illnesses in dealing with landlords or resolving issues with neighbours, before problems escalate to eviction. They also advocated that a service should be established which monitors the progress of tenants with mental illnesses who are evicted from their homes.[65]

Respite accommodation

10.49   As discussed in Chapter 11 family members carry the large burden of care for people with mental illnesses, an arrangement that is cost-effective for government, but not sustainable without adequate support services, including respite accommodation.

10.50   Respite services are more likely to be available to frail, older people with physical disabilities or dementia than those with mental illness. Dr Yun-Hee Jeon submitted that there should be increased resources and flexible respite services for people with mental illnesses, as well as better increased promotion and awareness to over to overcome current problems in the system:

> …inadequate resource allocation to respite care services; health professional and respite staff's lack of awareness about respite care services and access procedures; inadequate promotion of respite to family carers; staff's negative attitudes towards the needs and experiences of family carers of persons with severe mental illness; current service delivery models which are not always timely and flexible, needs-based or person-centred; and lack of collaboration in care provision.[66]

10.51   The St Vincent de Paul Society stressed that respite centres should not be in institutional settings, recommending provision within adequately resourced group homes in the community.[67]

Accommodation services – what works?

10.52   Consumer groups and peak bodies acknowledged as better practice a number of models for accommodation. The Housing and Support Initiative, *Project 300* and Shepparton Housing programs are examined below.

The Housing and Support Initiative

10.53   The Housing and Support Initiative (HASI) is a joint initiative between the NSW departments of Health and Housing and local NGOs. Stage one provided coordinated disability support, accommodation and health services to people requiring high-level support to live in the community. A 12-month trial in South Eastern Sydney showed a decrease in inpatient bed days for patients enrolled in HASI from 197 days to 32 days.[68]

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65   *Submission 232,* p. 15.

66   Dr Yun-Hee Jeon, *Submission 25*, p.2.

67   St Vincent de Paul Society, *Submission 478*, p. 15.

68   NSW Health – NSW Government *Submission 470,* p. 33.

10.54   Stages one and two of HASI focussed on 578 people residing in public and community housing and $8 million has now been allocated to extend the program to 126 more people requiring medium to high level disability support in their homes.[69]

Project 300

10.55   The *Project 300* program assists consumers to move from psychiatric treatment and rehabilitation facilities to the community. The Queensland Government explained:

> The program provides housing, supported accommodation, community access to services and other supports. It operates through the collaborative efforts of disability, mental health and housing services. The *Project 300* model of support is unique, focusing on community integration and participation. It operates with the support of, but not within, a medical model… The success of the model is highlighted by reductions in the level of support required by many individuals as they recover and as informal support networks increase within their own community'.[70]

10.56   *Project 300* commenced in 1995 and aimed to provide sufficient resources in the same budget to three different departments, responsible for clinical mental health services, disability-housing and disability services, to assist 300 people.[71] Each was provided with a 'package', consisting of mental health services, disability support services and community housing. The 18 month evaluation reported:

> The service model demonstrated improved well being for people with significant disability. It showed that clinical, housing and disability support services can be brought together to meet the needs of this population. Eighteen months after discharge, individuals continued to demonstrate improvements in symptoms, clinical functioning and quality of life. Remarkably few disadvantages for the clients were identified. Only 3 of the 218 client discharged returned to long-term care.[72]

10.57   The cost of *Project 300* was also evaluated as 'considerably less expensive' than other alternatives, such as treatment in rehabilitation or community care units.[73] On average, clients cost around $68,900 per client per year, as compared with $85,770 in a community care unit, $90,880 in a rehabilitation unit and $159,500 in an acute care unit.[74] A follow up evaluation of the project is nearing completion.[75]

10.58   The Queensland Alliance said the participation of NGOs was integral to the success of *Project 300* and that the integrated service model underpinning the project

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69   *Submission 470,* p. 33.

70   Queensland Government, *Submission 377a,* pp. 23-24.

71   Queensland Alliance, *Submission 288*, p 17.

72   *Submission 288*, Attachment Two ' Evaluation of 'Project 300', p. 17.

73   *Submission 288*, Attachment Two ' Evaluation of 'Project 300', p. 25.

74   *Submission 288*, Attachment Two ' Evaluation of 'Project 300', p. 25.

75   *Submission 288*, p. 1.

could be replicated to reduce the over-representation of people with mental illness in prisons and among the homeless.[76]

10.59   The MHCA also commented favourably on the integrated service models provided by *Project 300* and HASI:

> Project 300, HASI and other similar state and territory programs demonstrate that intersectoral support for people with mental illnesses is critical to their stabilisation and rehabilitation.[77]

Specialist Residential Rehabilitation

10.60   Committee members visited two programs in Shepparton, Victoria: the Specialist Residential Rehabilitation Program (SRRP) and the Prevention and Recovery Care project (PARC on Maude). The SRRP is an innovative housing project, developed through collaboration between the Goulburn Valley Area Mental Health Service and the Mental Illness Fellowship. The committee also heard from the Cairns District Health Service about a proposal to establish a similar project in that city.

10.61   Residential programs such as this aim to allow people with mental illness 'learn or relearn living skills' in a safe environment, with professional support.[78] The Cairns project outlined the approach as having these features:

- Services should be flexible, and program-based, not facility-based. Facilities provided are part of the program.
- The Program should be centred in the community, and link with natural community settings whenever possible.
- Operate within a rehabilitation framework that recognises participants potential for personal growth and the right to opportunities which support growth.[79]

10.62   These residential services aim to integrate all aspects of recovery-based care, including assistance with employment, and vocational training and education and involve cooperation of different services, and between the government and non-government sectors. Although formal evaluations were not complete, early indications were that this type of program was successful with consumers and cost effective. Residential services are discussed in more detail in Chapter 9.

Public housing protocols

10.63   A tenant driven initiative involving the Queensland Department of Housing and seven community-based organisations has established a set of formal protocols for complex tenancies:

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76   *Submission 288*, p. 8.

77   Mental Health Council of Australia, *Submission 262,* p. 18.

78   Mental Illness Fellowship Victoria, Specialist Residential Rehabilitation Service (SRRP)and Prevention and Recovery Care (PARC on Maude), http://www.mifellowship.org/ProgramInfo/ResiRehabSRRP.htm, accessed January 2006.

79   Cairns District Health Service, Cairns Integrated Mental Health Residential Rehabilitation Service, *Additional Information Received 12*.

> The Protocol process begins with the area office of the Department of Housing, identifying an 'at risk' tenancy i.e. a tenant who is issued with a notice to remedy breach which threatens the sustainability of their tenancy. This tenant is then asked if they would agree to being referred to the network of supporting organisations for help. Of course, tenants retain their right to privacy, and have the right to refuse help. The network of organisations then provides the tenant and their family with the support necessary to resolve whatever issue is threatening their tenancy.[80]

10.64   The Queensland Public Tenants Association reported 'an 80 per cent reduction in evictions from public housing over a two year period' following adoption of the protocols.[81]

Employment and training

10.65   The strong correlation between mental illness and unemployment is well established.[82] The participation rate of people with mental illness in the workforce in Australia is low compared with the population in general, people with other disabilities and people with mental illness in other OECD countries.[83] The MHCA submitted that less than 30 per cent of people with a mental illness participate in the workforce, despite evidence that working is therapeutic.

10.66   A lack of employment options for people experiencing mental illness has significant financial and social impacts: lost income; reduced development opportunities, social interaction and networks; and feelings of self worth. The MHCA stated that 'it is an essential part of early intervention, primary and secondary care for people to maintain engagement with work if at all possible and to be able to achieve an orderly and successful return to work where their illness has required them to leave'.[84]

10.67   Supporting people with mental illness to participate in the workforce also has broader society-wide benefits through increased productivity and savings on income support payments and health services.[85]

Employment and training services

10.68   The Commonwealth State Territory Disability Agreement provides the national framework for the delivery, funding and development of specialist disability services. Under the agreement the Commonwealth has responsibility for specialised

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80   Queensland Public Tenants Association, *Submission 505*, p. 5.

81   Queensland Public Tenants Association, *Submission 505*, p. 5.

82   See for example, Professor Ian Webster, *Submission 458,* p. 25.

83   Mental Health Council of Australia, *Promoting Supportive Workplaces for People with Mental Illness Employer Forums, Report to DEWR*, August 2005, p. 3.

84   Mental Health Council of Australia, *Submission 262,* p. 33.

85   Centre of Full Employment and Equity (CofFEE), *Submission 228,* p. 6.

employment assistance.[86] The Commonwealth also funds Job Network, Australia's mainstream employment assistance program.

Job Network

10.69   Job Network is a national network of community and private organisations contracted to find jobs for the unemployed. A general discussion of the history, role and effectiveness of the Job Network is provided in the Community Affairs References Committee report on poverty and financial hardship.[87] In summary the current Job Network has two major functions:

- Job search support – offering job search training programs; and

- Intensive support and customised assistance – the most personalised and intensive forms of assistance offered, including job search assistance, work experience, vocational training, language and literacy training and post placement support. Providers have access to a pool of funds, the 'job-seeker account', to purchase assistance to help eligible people into work.

10.70   A number of providers in the Job Network have specialist capabilities in working with job seekers with a disability or mental health problem.[88]

Targeted services

10.71   Two specialist services which may assist people with a mental illness into employment are the Disability Open Employment Services and the Personal Support Program. Disability Open Employment Services assists job seekers with disabilities who have significant or ongoing support needs, through training, job placement and on the job support.[89] The Australian Government advised that in 2003-04, Open Disability Employment Services helped 48,431 people with moderate to severe disabilities find and keep work, 24 per cent of whom had a psychiatric disability.[90]

10.72   The Personal Support Program (PSP) aims to bridge the gap between crisis assistance and employment assistance. The program is targeted at people receiving income support 'whose non-vocational barriers (such as homelessness, mental health problems or mental illness, drug or gambling problems or social isolation) prevent them from getting a job or benefiting from employment assistance services'.[91] The

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86   Australian Government, *Submission 476, Attachment 10,* p. 1.

87   Senate Community Affairs References Committee, *A hand up not a hand out: Renewing the fight against poverty, Report on poverty and financial hardship* (hereafter 'Report on poverty and financial hardship') March 2004, pp 65-69.

88   Australian Government, *Submission 476*, Attachment 13, p. 1.

89   *Submission 476*, Attachment 13, p. 1.

90   *Submission 476*, Attachment 13, p. 1.

91   *Submission 476*, Attachment 13, p. 2.

Department of Workplace Relations advised that 46 per cent of participants have a mental health problem.[92]

10.73   PSP participants are identified by Centrelink and may access the program for up to two years. The program is delivered by a network of private and community organisations. Currently 142 organisations, covering 600 sites are funded to deliver services. Approximately 60 sites are registered as having a speciality in mental health.[93]

10.74   Services offered under the program include counselling and personal support, referral and advocacy, practical support, outreach activities and ongoing assessment. The Australian Government stated that 'while getting a job is the ultimate goal, the program recognises that this may not be possible for all people at all times. Social outcomes may be the first steps towards independence'.[94]

Vocational training

10.75   The Australian Government funds vocational rehabilitation through CRS Australia (previously Commonwealth Rehabilitation Services) and described their programs as 'tailored to individual needs and can include vocational assessment and counselling, job preparation, placement and training, injury management and workplace modifications'.[95] CRS Australia assists over 35,000 people annually, with 29 per cent having a mental health condition as their primary disability.[96]

Employer incentives

10.76   Financial incentives are available to employers who employ workers with disabilities through the Workplace Modifications Scheme, which reimburses employers for costs such as modifying the workplace or providing specialist equipment when employing people with disabilities, and the Wage Subsidy Scheme, which subsidises wages for people with disabilities entering work.[97] Funding under the Wage Subsidy Scheme is only available through Open Employment Services and CRS Australia. The wages of each eligible worker may be fully or partially subsidised up to 13 weeks of pay, to a maximum of $1500.[98]

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92   Mr Barry Sandison, Acting Group Manager, Working Age Policy, DEWR, *Committee Hansard*, 7 October 2005, p. 81.

93   *Submission 476*, Attachment 13, p. 2.

94   Australian Government, www.workplace.gov.au/workplace/Category/SchemesInitiatives/PSP (accessed December 2005).

95   Australian Government, *Submission 476,* p. 43.

96   *Submission 476,* p. 43.

97   *Submission 476,* p. 44.

98   Australian Government, *Workplace Subsidy Scheme Guidelines,* www.jobable.gov.au/Files/Wage_Subsidy_Scheme_Guidelines_Jan_2005.pdf (accessed December 2005).

10.77 $1 million has been allocated to research into the area of mental health and income support, including the development of tools providing practical advice to employers about employing people with mental health problems.[99]

Employment and training issues

10.78   People with mental health problems can experience a range of difficulties in accessing and retaining meaningful work. The barriers include cognitive: perceptual and social impacts associated with the illness itself or with treatment; the potential impact on health and supplementary income benefits of returning to work; ignorance and stigma present in workplaces and among service providers; inadequacy of programs and training to assist people with mental illness into employment; and lack of suitably designed jobs.

Workplace stigma

10.79   Stigma is still a barrier to workplace participation:

> The stigma attached to mental illness is wide-spread in the work force. A person may have ample qualifications and work experience to be able to successfully undertake a position, but if mention is made of suffering from a mental illness, you can almost guarantee that the job will go to someone else. The only instance where this doesn't occur is in consumer based employment where a "living knowledge" of mental illness is sought to assist others learning about or living with mental illness. There are not very many of these jobs out there and employers need to be made aware that they are often passing up the most appropriate people for the job.[100]

10.80   Submissions called for better education about mental illness in the workplace:

> Supervisory staff, managers and employees in all workplaces, including insurers need more education and training about mental illness. This might decrease workplaces harassment of people with mental illness and reduce their feeling of alienation.[101]

10.81   The MHCA argued that addressing workplace stigma has been left out of the National Mental Health Strategy:

> By not addressing these issues (workplace stigma), the Strategy fails to provide pressure, impetus or leadership for the necessary changes in support services and the average workplace. It is an essential part of early intervention, primary and secondary care for people to maintain engagement with work if at all possible and to be able to achieve an orderly and successful return to work where their illness has required them to leave.[102]

10.82   MHCA recommended that simple and effective measures for improving workforce participation include 'targeted workplace support programs, workplace

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99   *Submission 476,* p. 44.

100   Mill Park Family Support Group, *Submission 72,* p. 2.

101   Name withheld, *Submission 238*, p. 1.

102   MHCA, *Submission 262*, pp 32-33.

education initiatives, providing meaningful re-training and employment options and improving workplace practices'.[103]

10.83   Mr Geoff Wagorn and Mr Chris Lloyd argued that stigma can be counteracted through 'strategic disclosure to employers and to other third parties throughout vocational rehabilitation' by vocational professionals.[104] They also noted that the services of education and advocacy centres run by mental health consumer organisations are often overlooked in the workplace and can help to educate professionals and service providers.[105]

Limitations of employment services

Funding caps

10.84   The number of places available in the main specialist program of employment assistance for people with disabilities, Open Employment Services, is capped and, as stated by ACOSS, a relatively low proportion of disability pension recipients in Australia receive help with employment or training.[106] Australia's programs are not strong in this area by OECD standards.[107] Similarly, ACOSS noted that funding for Disability Employment Assistance and CRS Australia programs are capped and often have waiting lists.

10.85   Ms O'Toole, Manager of Advance Employment Inc (a Disability Open Employment Service provider) expressed frustration about the impact of funding caps:

> Our agency is capped at 78 …a drop in a very large pond. I consistently have a waiting list of 25 to 30 people. It is soul destroying for me because, for a number of people that come along, their needs are so great initially. Open employment down the track is definitely possible, but we do not receive enough funding to allow us to put the programs in place to assist these people to get to that place.[108]

10.86   Open employment providers have previously argued for the removal of the cap on the appropriation for open employment services.[109] The Australian

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103   *Submission 262*, p. 33.

104   G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, Attachment 1.

105   G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, Attachment 1, p. 19.

106   ACOSS, *Submission 457*, p. 6.

107   *Transforming Disability into Ability*, OECD, 2003, pp.108–112.

108   Ms Catherine O'Toole, *Committee Hansard,* 5 August 2005, p. 23.

109   DEWR, *Report on the Next Steps for Disability Open Employment Services consultations,* February 2005, pp. 3–4.

Government indicated that changing the cap 'would be a major decision for Government and it is not being considered'.[110]

10.87   Although uncapped funding may not be feasible, periodic review of each provider's capacity may be appropriate. Ms O'Toole said:

> I could demonstrate quite clearly over the past 12 months what our waiting list has been. I could demonstrate clearly enough that we could have our outlet capacity increased from 78 to, say, 98, because I have had a consistent waiting list.
> …if we can demonstrate it…I think that is fair and reasonable. That allows another employment consultant to be employed to look after those people.[111]

Uncapped places

10.88   ACOSS argued that while places in the Job Network are not capped, the program is not properly resourced. The highest level of assistance with the Job Network is 'Customised Assistance', however, as ACOSS pointed out:

> …the amount available for each highly disadvantaged job seeker is only about $1,300. This won't buy much rehabilitation or training and people will not generally be eligible for this level of assistance until they have been with the Job Network provider for 12 months.[112]

10.89   Ms O'Toole also pointed out that while Disability Open Employment Service providers must be accredited against disability service standards, Job Network providers do not have to meet this requirement.

Targeted services

10.90   MHCA indicated that even more targeted assistance programs, like the PSP, are not producing effective outcomes and need to be better integrated with other services. Mr John Mendoza said:

> …in some way we have to better connect government programs and not have this shower head effect where people who are, say, on the PSP program for two years really do not have the economic means themselves, nor can the providers that are receiving that PSP change the circumstances for those people. So they simply remain maintained rather than having programs that can intervene effectively and change the circumstances.[113]

10.91   Mission Australia, a PSP provider, reported increasing numbers of clients in its programs with mental illnesses; anxiety disorders and depression the most common. They say there are systemic gaps in the programs for clients with mental illnesses, including: limited availability, accessibility and affordability of specialist services; a lack of supported accommodation, living skills services, education and

110   DEWR, *Next steps for disability open employment services, Questions and Answers,* 7 February 2005, p.7.

111   *Committee Hansard*, 5 August 2005, p. 26.

112   ACOSS, *Submission 457,* p. 7.

113   Mr John Mendoza, Mental Health Council of Australia, *Committee Hansard*, 28 October 2005, p. 89.

training, transport, employment and rehabilitation; and funding for medication and other needs. Some clients also did not want to continue with counselling, and some services refused to work with clients because of a history of violence.

10.92   Mission Australia commented that the most important strategy to improve PSP for people with mental illness is to increase funding for health services, including the provision of 'culturally appropriate services and services for survivors of child abuse', and increased access to health care providers who bulk bill.[114]

10.93   Other suggestions include: more holistic service delivery; free training in mental health for service providers; more supported accommodation and employment options; small group programs, including life skills and personal development; more sustained follow up of clients; and recruitment of specialist volunteers to provide additional support to people with mental illness.[115]

Employer incentives

10.94   While the Australian Government noted that the Workplace Modifications Scheme and Wage Subsidy Schemes are financial incentives for employers who employ people with disabilities, reviews suggest that these programs are not used widely to assist people with *mental* illness. A review by the Department of Families, Community Services and Indigenous Affairs showed that from 1998 to 2002, the Workplace Modifications Scheme was most commonly used to assist employees with a visual impairment (37 per cent of approved applications) and employees with a physical disability (33 per cent). Similarly, information about the Wage Subsidy Scheme for 1998 to 2000 shows that most assisted workers had an intellectual disability (42 per cent), with only around 16 per cent of those assisted having psychiatric disabilities.[116]

10.95   MHCA suggested employer incentive schemes are not adequately promoted. Employer forums reported:

> There were calls for greater financial support to employers for the provision of workplace modifications for people with mental illness. This includes financial support to enable more flexibility in terms of hours worked, timing of work and workload and the provision of mental health services for those employees requiring ongoing assistance in the workplace. The current workplace modification schemes were virtually unknown and seen as overly narrow in scope.[117]

Employment service providers

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114   Mission Australia, *Submission 199*, p. 5.

115   Mission Australia, *Submission 199*, p. 6.

116   Department of Families, Community Services and Indigenous Affairs, *Improving Employment Opportunities for People with a Disability, Report of the Review of the Employer Incentives Strategy*, March 2003, pp. 19–20.

117   Mental Health Council of Australia, *Promoting Supportive Workplaces for People with Mental Illness Employer Forums, Report to DEWR*, August 2005, p. 10.

10.96   ACROD, the National Industry Association for Disability Services, observed that the *episodic* nature of mental illness poses particular problems for employment services. ACROD said that the results-based accountability and performance reporting set in employment providers' service agreements may not adequately reflect the reality of service provision for people with mental illnesses:

> The requisite benchmarks, milestones or performance indicators cannot be predicted or met as readily as in the case of people with physical or intellectual disabilities.[118]

10.97   ACROD also submitted that employment services need to provide varied levels of support over time in accordance with a person's state of mental health. Therefore, the episodic nature of mental illness results in greater levels of personalised support, without additional funding necessarily being available. ACROD summarised that such difficulties create 'a perverse incentive not to take on clients with mental health problems'.[119]

10.98   Some of these difficulties are demonstrated in the following case study:

> J is a 32-year-old male with bipolar disorder. He gained a job through a disability employment service provider, working continuously for 24 weeks. A fortnight before the 26 weeks of work needed for a Case Based Funding (CBF) Worker Outcome he again became seriously ill. J lost his job and was suspended from CBF for three months.
> The employment agency tried to get J a case manager with the local Community Mental Health team when some of the early warning signs of his illness became apparent. Community Mental Health did not consider J to be a high need case, so no manager was assigned. His condition worsened to the point where he agreed voluntarily to go to intake (crisis care). The employment service had to accompany J to make sure he got there safely, the only alternative being to call the police. J was immediately admitted to hospital, remaining there for six weeks. During this time he lost his private accommodation.
> It was only because of his critical illness that J was able to obtain mental health support. But by this time it was too late to stop him losing his job and his accommodation.[120]

Emerging service models

10.99   Research into the effectiveness of vocational rehabilitation for people with mental illness is moving away from comparisons across services, to focus on the key characteristics underpinning successful vocational rehabilitation.[121] Evidence from controlled trials supports seven key principles for mental health vocational rehabilitation. The principles are:

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118   ACROD, *Submission 335*, p. 8.

119   ACROD, *Submission 335*, p. 8.

120   *Submission 335*, p. 6.

121   G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, attachment 1, p. 30.

- Eligibility for services is based on consumer choice – no attempt is made to screen out participants;

- Vocational rehabilitation is integrated with mental health care;

- A goal of competitive, mainstream employment;

- Rapid commencement of job search activities;

- Services are based on consumer preferences, strengths, prior work experience and interests, rather than on a pool of available jobs;

- Continuing support to retain employment – with no end date;

- Income support and benefits counselling – to help consumers make well informed decisions about their entitlements.[122]

10.100 Following a review of current services, a further four principles were identified:

- Intensive on-site support;

- A multidisciplinary team approach;

- Emphasis on the 'rehabilitation alliance' (a shared understanding of the staff member's and consumer's roles in rehabilitation); and

- Explicit stigma and disclosure strategies.

10.101 No Australian service meets all the above principles, with Disability Open Employment Services and CRS Australia Services rating the highest. Aspects commonly missing from Australian services include: integrating vocational rehabilitation and mental health care; providing intensive on-site support; using multidisciplinary teams, and incorporating strategies for countering stigma and managing disclosure.[123] Mr Geoff Waghorn argued that pooling mental health knowledge and expertise with vocational expertise is a key element that could be achieved quickly in Australia.[124]

Labour demand

10.102 The Centre of Full Employment and Equity (CofFEE) submitted that Commonwealth employment programs have focussed heavily on labour supply, without addressing the concurrent issue of labour demand. CofFEE argued that there are two related problems:

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122   G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, Attachment 1, pp. 30–31; Professor Bond, *Committee Hansard*, 19 May 2005, pp. 78–81.

123   G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, Attachment 1, p. 34.

124   Mr Geoff Waghorn, Research Scientist, Queensland Centre for Mental Health Research and Mental Illness Fellowship of Australia, *Committee Hansard,* 19 May 2005, p. 89.

(a) a demand-deficient labour market excludes a disproportionate number of people with mental illness by placing them at the bottom of the queue awaiting work; and

(b) the design of available jobs may be inappropriate for those experiencing episodic illness.[125]

10.103 CofFEE advocated the introduction of a Job Guarantee for people with mental disorders. Under this model the federal government would provide an adequate number of Job Guarantee jobs, with positions flexibly designed to meet the varied support needs or workers with a mental illness:

> Under the JG, the Federal government would maintain a 'buffer stock' of minimum wage, public sector jobs to provide secure paid employment for disadvantaged citizens. The pool of JG workers would expand when the level of private sector activity falls and contract when private demand for labour rises.[126]

10.104 The Job Guarantee model would enable employers to hire from a pool of people with mental health conditions who are already working and maintaining essential labour market skills, rather than hiring from a pool of people who have experienced long-term unemployment or long-term dependence on the Disability Support Pension.[127] At the same time, CofFEE submitted that Job Guarantee jobs would be designed to accommodate the needs of those with episodic illnesses and be integrated with medical, rehabilitation and support services.[128]

10.105 The MHCA also commented on the impacts of the changing nature of the labour market, noting that demand for skilled labour and employment in the service sector has increased, while more traditional sectors such as manufacturing have declined. The Council observed that while employment flexibility in the form of part-time and casual employment has increased dramatically, 'mental health problems are more prevalent amongst those who have not benefited from the increased labour-force flexibility and have been excluded'.[129] The MHCA assessed that while employment has many benefits, jobs with high stress and low levels of control can have adverse consequences. The MHCA stated that 'Good job design can support the wellbeing of current and future employees, including those with pre-existing health needs be they physical or mental'.[130]

10.106 Submitters argued that open, competitive employment is an achievable aim as long as appropriate support is provided. Ms O'Toole emphasised the need for

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125 CofFEE, *Submission 228,* p. 5.

126 CofFEE, *Submission 228,* p. 4.

127 *Submission 228,* p. 9.

128 *Submission 228*, p. 4.

129 Mental Health Council of Australia, *Promoting Supportive Workplaces for People with Mental Illness Employer Forums, Report to DEWR*, August 2005, p. 4.

130 Mental Health Council of Australia, *Promoting Supportive Workplaces for People with Mental Illness Employer Forums, Report to DEWR*, August 2005, p. 4.

employment providers to focus on what people can do, rather than what they cannot do:

> We believe that they can do what they want to do. I had a woman who came to me once and said, 'I am looking for a cleaning job'. She happened to have her resume with her, and she had university qualifications. She was an Indigenous person, and I said, 'I think you're going to be bored.' She said, 'No, I don't want anything with responsibility'. Well, she is now working in a government position. I did not go down the cleaning road. She was absolutely terrified, and with the right support and the talk with her and the building of her confidence and the belief in her, within three months she was working in a government department doing an excellent job. That is the stuff people need.[131]

Impacts on employment for carers

10.107 Many people with mental illnesses are dependent on family members for care and support, which in turn can impact on the ability of carers to participate in the labour market. In some cases carers either leave work or reduce their employment hours to support family members. Employment stress for carers can in turn impact on their financial and social wellbeing and that of their family.

> As for myself, I have had the privelege [sic] of having to abandon my job as a teacher, because there was simply no other way, to cope with the outcomes presented to relatives by this lunatic legislation [deinstitutionalisation]. I was a very good teacher of maths and science, and, what is more, enjoyed doing it very much – all my education and experience has been lost to both myself, and the community, and my role as a carer has ensured that I enjoy an old age of certain poverty – no superannuation for me![132]

> The suicidal tendencies had worsened and she was still heavily medicated. I was fortunate enough to obtain fulltime employment, with a very understanding organization, as I frequently had to take days off to rush her back to hospital when she suffered an episode and required hospitalisation. …I had to find full-time employment so that our family could continue to function and to enable our daughter to access a reasonable level of treatment.[133]

Education

10.108 While much of the evidence relating to education and training focussed on employment-related training, there is also a need to support people with mental health problems in mainstream education. The onset of some of the most severe mental disorders occurs in the teenage years and early twenties, at a time the completion of

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131 Ms Catherine O'Toole, Manager, Advance Employment Inc., *Committee Hansard,* 5 August 2005, p. 27.

132 Name withheld, *Submission 518*, p. 2.

133 Name withheld, *Submission 208*, p. 5.

secondary and tertiary education is important and career pathways are being mapped, as is shown in research.[134]

10.109 In their discussion paper, Mr Geoff Waghorn and Mr Chris Lloyd argued that welfare, vocational rehabilitation and disability employment service reform in Australia throughout the 1990s addressed obtaining employment to the exclusion of higher education and substantive vocational training.[135] They argued:

> Specific strategies are needed to allocate responsibilities for the funding and delivery of disability-specific education assistance in primary, secondary, vocational, and higher education, over and above the generic assistance available to people with all categories of disability at education institutions.[136]

Income support

10.110 Mental illness can have a significant impact on people's income through disruptions to both employment and opportunities (such as education) which are instrumental to later career development. Reduced income limits the capacity of consumers to obtain the supports and services needed to manage their illness. As discussed in Chapter 6 the costs of mental health care are prohibitive for many people with mental illnesses.

10.111 ACOSS observed that all mental disorders are much more prevalent among income support recipients than non-recipients, with almost one in three income support recipients having a diagnosable mental disorder compared with one in five Australian adults not receiving income support.[137]

Income support services

10.112 The principal source of direct income support for people with a mental illness is the Australian Government's Disability Support Pension (DSP). At June 2004, one quarter of DSP recipients were people whose primary disability was a psychiatric or psychological condition. This was the second largest consumer group, behind those with musculo-skeletal and connective tissue conditions (34 per cent). In 2003-04, $1,903 million was provided through the DSP to people experiencing mental health conditions.[138]

10.113 Other income assistance includes:

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134   Mr Geoff Waghorn, *Committee Hansard,* 19 May 2005, p. 83.

135   G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, attachment 1, pp. 12, 37.

136   G. Waghorn and C. Lloyd, *The Employment of People with Mental Illness: A discussion document prepared for the Mental Illness Fellowship of Australia,* 2005: *Submission 253*, Attachment 1, p. 12.

137   ACOSS, *Submission 457*, p. 4.

138   Australian Government, *Submission 476,* pp. 39–41.

- Sickness Allowance – for eligible people who are temporarily unable to undertake their usual work or study due to illness or injury, and have a job or study to return to when they are fit;

- Newstart Allowance – for eligible unemployed people who are seeking paid work or undertaking other activities to improve their employment prospects;

- Youth Allowance – for eligible people aged 16-24 years who are engaged in activities such as education, training or job search that will to enhance their capacity for economic independence.[139]

10.114 People receiving DSP also receive the Pensioner Concession Card entitling them to concessions on prescription drugs through the Pharmaceutical Benefits Scheme.

Changes to income support payments

10.115 The legislative reforms announced in the 2005-06 budget and passed in December 2005 substantially change the operation of DSP. They also change the operation of Parenting Payments which may also be relevant to people with mental illness.

10.116 The Senate Community Affairs Legislation Committee in November 2005, inquired into the Employment and Workplace Relations Legislation Amendment (Welfare to Work and other Measures) Bill 2005 and Family and Community Services Legislation Amendment (Welfare to Work) Bill 2005.[140] A detailed examination of the changes and their anticipated impacts is not provided here, rather interested readers are referred to the committee's report.

10.117 Prior to these changes, eligibility for DSP was dependent upon the following:

> …a person must have a permanent physical, intellectual or psychiatric impairment of at least 20 points under the impairment tables. An impairment is defined as permanent if it is fully diagnosed, treated and stabilised and likely to last for at least two years without significant functional improvement. The person must also be unable to do any work for at least 30 hours a week at award wages, or be reskilled for any work, for at least the next two years because of the impairment; or be permanently blind.[141]

10.118 Under the new legislation, people will not be eligible for DSP if they can work 15 hours or more a week at award wages without ongoing support within the two years from assessment.[142] These people will instead be eligible for Newstart or

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139 *Submission 476,* p. 40.

140 Senate Community Affairs Legislation Committee, *Provisions of: Employment and Workplace Relations Legislation Amendment (Welfare to Work and Other Measures) Bill 2005, Family and Community Services Legislation Amendment (Welfare to Work) Bill 2005*, November 2005, [hereafter *'Welfare to Work'*].

141 Australian Government, *Submission 476,* Attachment 11, p. 1.

142 *Submission 476,* Attachment 11, p. 1; Senate Community Affairs Legislation Committee, *Welfare to Work*, November 2005, p. 19.

Youth Allowance. Newstart and Youth Allowance have lower payment rates than DSP and the implications of private income on these payments differ to DSP.[143]

10.119 Newstart and Youth Allowance, unlike DSP, are also subject to part-time participation requirements. This means that people assessed as able to work at least 15 hours per week unsupported are required to:

- undertake 30 hours per fortnight of paid work; or
- job search for part-time work, participate in appropriate employment services, and/or undertake an annual Mutual Obligation activity.[144]

10.120 The Community Affairs Legislation Committee received mixed evidence as to whether the package of legislative changes would achieve the aims of reducing welfare dependency and encouraging workforce participation. Evidence to that inquiry indicated that DSP recipients assessed as suitable for Newstart stood to be worse off financially following the changes.[145] Others indicated that the new arrangements focussed on getting a job, and that those with the capacity to work stood to be better off financially receiving Newstart and engaging 15 hours of paid work, than receiving DSP.[146] ACOSS, St Vincent de Paul and Hanover argued that the overall outcome for people with disabilities would be increased hardship, poverty and/or disadvantage.[147] The Department of Employment and Workplace Relations said that relevant safeguards for people with disabilities had been incorporated into the legislation, including for people with episodic mental illnesses.[148]

10.121 The government majority on the Community Affairs Legislation Committee concluded there was 'nothing in this legislation which ineluctably will force or coerce any person who is not able to work off income support benefit'.[149] Other committee members dissented from the report with the ALP, Australian Greens and Australian Democrats recommending the bills be opposed on the basis that the 'necessary amendments amount to a complete redraft of the bill'.[150]

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143   Refer to www.centrelink.gov.au/internet/internet.nsf/payments/disability_support.htm; www.centrelink.gov.au/internet/internet.nsf/payments/newstart.htm; www.centrelink.gov.au/internet/internet.nsf/payments/youth_allow.htm, (accessed March 2006).

144   Senate Community Affairs Legislation Committee, Report, *Welfare to Work*, November 2005, p. 20.

145   Report, *Welfare to Work*, November 2005, p. 69.

146   Report, *Welfare to Work*, November 2005, p. 32.

147   Report, *Welfare to Work*, November 2005, pp. 6, 29-30.

148   Report, *Welfare to Work*, November 2005, pp. 41–42.

149   Report, *Welfare to Work*, November 2005, p. 58.

150   Report, *Welfare to Work*, p. November 2005, 93.

Role of Centrelink

10.122 Centrelink determines eligibility for income support payments and is the gatekeeper for the Job Network, although people on DSP are now able to register directly with Job Network. Centrelink, along with Job Network providers, also identifies people eligible for participation in the Personal Support Program.[151]

10.123 The Australian Government submitted that measures are in place to 'ensure that Centrelink and its staff respond appropriately to people with mental health problems or mental illness'.[152] These include that Centrelink:

- works in partnership with many community and mental health services in relation to suicide prevention strategies;
- liaises locally with mental health services to coordinate service provision;
- conducts training for internal staff and external services in relation to identifying and assisting people with mental health problems or mental illness to access government income support benefits; and
- has developed service guidelines to ensure appropriate income support services are provided to people with mental health problems or mental illness.[153]

10.124 The Australian Government stated that Centrelink has a range of specially trained staff, including Centrelink Disability Officers (CDOs) who assist customers and provide training to other staff, 500 social workers who conduct assessments, provide telephone based counselling and provide referrals to other services, and 250 psychologists who target early identification in relation to mental health illness for people on income support payments.[154]

Comprehensive work capacity assessments

10.125 Under the 'welfare to work' provisions a new assessment process – comprehensive work capacity assessment (CWCAs) –apply for people with disabilities seeking income support. These will involve face-to-face interviews with a range of allied health professionals, such as counsellors, occupational therapists and psychologists.[155] The Australian Government submitted that:

> The assessment will be a positive, holistic exploration of a job seeker's participation barriers, work capacity and the nature of interventions and assistance needed to improve current and future work capacity. At the completion of the assessment, assessors will discuss appropriate

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151 Australian Government, www.workplace.gov.au/workplace/Category/SchemesInitiatives/PSP (accessed March 2006).

152 Australian Government, *Submission 476,* Attachment 12, p. 1.

153 Australian Government, *Submission 476,* Attachment 12, p. 1.

154 *Submission 476,* Attachment 12, p. 2.

155 *Submission 476,* Attachment 12, p. 3.

participation assistance options available to the job seeker and will arrange rapid referral of the job seeker to an appropriate provider.[156]

10.126 Assessors will have access to a new Prevocational Assistance Account, to organise short-term assistance aimed at improving work capacity, such as 'pain management courses, work conditioning courses (such as fitness for work) or mental health interventions'.[157]

10.127 It is not entirely clear how these one-off assessments will facilitate a comprehensive assessment of the work capacity of people who experience mental illnesses, particularly those who with disorders that are episodic in nature. Professor Ian Webster submitted that 'medical specialists unfamiliar with real-life situations of people in their communities make hard indeed punitive decisions about a person's capacity'.[158] He argued that professionals engaged in the ongoing follow up of particular patients are those best placed to make judgements about the severity of a person's disability.

10.128 The Australian Government noted that a pilot program is currently being conducted which will inform the set up of the CWCA measure. The pilot will examine the extent and nature of short-term interventions, current service gaps and whether direct purchase of recommended short-term interventions by employment service providers is feasible. It is suggested that the pilot will be of particular relevance to those with a mental illness, as 'the pilot will identify job seekers who, for example, may need access to a short period of cognitive behaviour therapy or counselling to address anxiety and depression prior to commencing focused employment assistance activity, and the success of otherwise in obtaining these services'.[159]

Income support issues

10.129 The committee heard about three main areas of concern: the adequacy of income support, the onerousness of compliance requirements, and problems dealing with Centrelink.

Adequacy of income support

10.130 Submissions raised concern about the adequacy of income support generally:

> the fact that social security payments are generally pegged and paid below the Henderson Poverty Line, is a significant contributor to people either living in or being at risk of poverty, homelessness and poor mental health across Australia.[160]

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156   *Submission 476,* Attachment 12, p. 3.

157   *Submission 476,* Attachment 13, p. 1.

158   Professor Ian Webster, *Submission 458*, p. 31.

159   Australian Government, *Submission 476,* Attachment 12, p. 2.

160   Homeless Persons' Legal Clinic, *Submission 41*, p.32. See also ACOSS, *Submission 457*, p.5.

10.131 The link between inadequate income support and poverty was reported as particularly problematic:

> In addition to being excluded from the earning of adequate income, people with disabilities often have higher costs of living associated with their disabilities. This can be the high and continual cost of medication, equipment or aids, appropriate housing, transport, and services related to personal care or maintenance of a person's home.
> The combination of higher costs of living, along with income deprivation, leads to a strong connection between disability, illness and poverty.[161]

10.132 Anglicare Tasmania observed that the 'poverty experienced by so many people with mental illness doesn't simply restrict their capacity to choose services or activities which are health promoting; it can actively aggravate illness and be a direct cause of hospitalization'.[162] Anglicare described the destitute circumstances of many people with severe mental illness in areas of basic need, such as food, clothing and accommodation.[163]

10.133 The Brotherhood of St Laurence reported consumers' experiences of living on income support long term. One consumer said:

> There is just not enough money to live on, so what you do is rob Peter to pay Paul. Your electricity is going to be cut off so you go into a cycle of debt—you borrow from friends and family and then you borrow from someone else to pay it back. It ends up borrowing and borrowing and borrowing, and you are a burden on the people you know and they start avoiding you because you always need something…you start feeling like a leech. And then you don't want to be seen in the supermarket buying food because you still owe someone money. You wear out your family, you wear out your friends, and you start avoiding people and they start avoiding you. It adds to your exclusion and the other awful thing that follows quickly is that it is very hard to fight the bitterness and the resentment that you start to feel about everything.[164]

Compliance requirements – breaches and penalties

10.134 Breach penalties apply to those who fail to comply with requirements linked to their payments. There are two types of breaches – activity test and administrative. Activity test breaches can be failing to accept a reasonable offer of employment or failing to attend a job interview. An administrative breach can be failure to attend an interview with Centrelink.[165]

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161 ACOSS, *Submission 457*, p.6.

162 Anglicare Tasmania, *Submission 464,* p. 4.

163 *Submission 464,* pp 20-26.

164 Brother of St Laurence, *Submission 97,* p. 6.

165 Senate Community Affairs References Committee, *Report on poverty and financial hardship,* March 2004, p. 34.

10.135 Breach penalties, such as loss of income for even a short period, can have a significant impact on the welfare of people with a mental illness reliant on income support. Anglicare Tasmania commented:

> The new reforms are being heralded as introducing a better compliance framework, based on a new suspension model. However, this system also contains financial penalties for non-compliance (no back pay of suspended income if the allowee's excuse for non-compliance is not deemed reasonable, and 100 per cent loss of income on fourth suspension)… Concerns about the fate of vulnerable jobseekers and children in households with suspended incomes have been responded to with the promise of more intensive case management of vulnerable jobseekers which will ensure that essential bills are paid when suspension penalties are in place. However, with no funding apparently attached to this initiative it is not clear whether this means referral to the Emergency Relief network or a direct crisis voucher system administered by Centrelink. Nor is there any clarity about what constitutes an essential bill. Either way it appears to introduce more complexity into an already punitive and difficult system.[166]

10.136 Complying with activity and administrative requirements, such as keeping appointments, can be exceedingly challenging for consumers during a period of illness. Other compliance requirements, such as proof of identity, are also challenging for people with mental illness in particularly vulnerable situations, such as homelessness. It was suggested that proof of identity requirements be changed so that homeless people can use a letter from a homelessness assistance provider.[167]

Experiences dealing with Centrelink

10.137 Evidence from consumers and carers was at odds with the government's description of Centrelink's services and approach:

> I believe that the accountability and proficiency of agencies such as Centrelink needs to be urgently reviewed. Their treatment of persons with a psychiatric illness and carers is – in my opinion and experience – absolutely appalling. …I believe that Centrelink staff dealing with the mentally ill should have comprehensive training, that outdated claim forms should be replaced, and that it should be compulsory for Centrelink staff to liaise with health professionals when considering claims from and reviews of disability pensions, carer pensions and carer allowances.[168]
>
> …..
>
> As I can only work approximately 10-12 hours per week, and am on a part-pension I have had many dealing with Centrelink. There were times when I was so frustrated with Centrelink that I ended up feeling completely helpless and extremely distressed. Having to fill out the often complicated forms is also a very difficult task for someone with an illness. Turning up for appointments at Centrelink or at a prospective employers is sometimes impossible for someone with anxiety, depression or any other mental

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166   Anglicare Tasmania, *Submission 464*, p. 13.

167   Homeless Persons' Legal Clinic, *Submission 41*, p. 34.

168   Name withheld, *Submission 124*, p. 5.

illness. However Centrelink threatens to cut our payments if appointments are not met.[169]

…..

During this time, she failed to attend an interview, which would have provided her with a disability pension. Owing to her illness, she would often perceive her family members as enemies, so that visiting her was like walking an emotional tight rope. On a rare visit, if I had not accidentally come across the letter informing her that she would <u>not</u> receive the pension because she had failed to attend the appointment, I am certain that she would have continued on her downward spiral. It seemed ironic that the severity of her disability had almost jeopardised her chances of receiving assistance. No attempt had been made to follow up her lack of attendance. This seems to indicate yet another lapse in the support network.[170]

10.138 These experiences was also reported by a health professional:

I visited a patient who was under my care in Liverpool Hospital; he was a long standing patient. He was very poor and had major health problems and depended totally on income support for bare survival. He was extremely disabled.

When I arrived at the bedside he was weeping. He showed me a letter he just received from CentreLink which had cancelled his Disability Support Pension. I can't recall the exact reason but it was a trivial requirement of failing to respond to a request of some kind. I tried there and then to contact the Department to find out what was going on. From my point of view, indeed of anyone who could see, he was a person with severe disability which was unchanged, indeed deteriorating.

That was frustrating. All I achieved was going into a "pushbutton" queue in ever increasing circles. Later in the day I decided to visit the CentreLink office in Liverpool to speak directly to a responsible officer. That did not work either. There was an apologetic somewhat embarrassed officer who did not know what to do: the most that could be offered was a form to fill in…

There is a preoccupation around testable medical states, a search for <u>objectivity</u> and a philosophy which seems to accept that the prime task is to protect the social welfare system against fraud and malingering.[171]

10.139 The committee notes that some of these issues may be picked up in the early intervention and engagement pilot currently being run by Centrelink,[172] although it is not a project specifically targeted at avoiding the access and compliance problems reported in incidents such as those described above.

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169 Name withheld, *Submission 237*, p. 2.

170 Name withheld, *Submission 62*, p. 3.

171 Professor Ian Webster, *Submission 458*, pp. 30, 32–33.

172 Australian Government, *Submission 476, Attachment 12*, p. 2.

Community involvement

10.140 The committee received evidence of the importance of community participation and social involvement for people with mental illnesses. The St Vincent de Paul Society commented:

> The system we now have is setting people up to fail. Social isolation and loneliness are guaranteed to trigger episodes of mental illness and suicide and the vicious cycle starts all over again.[173]

10.141 NGOs are 'fast becoming the only providers of social and recreational services, effective and relevant advocacy, living skills training and rehabilitation'.[174] The Society argued that social and recreational facilities and friendship programs need to be developed, funded and promoted.

10.142 Professor Gary Bond, Visiting International Speaker for Schizophrenia Awareness Week, argued for services to enhance people's wellbeing and fulfilment. He noted that in the United States, mental health and rehabilitation services are increasingly looking at the personal goals of consumers:

> …many mental health programs have been aimed at stabilisation and ensuring that clients take their medication and not be a nuisance in society. The broader vision of mental health services is to look at what are their personal goals and aspirations. It turns out that most people with psychiatric disabilities have the same goals, wishes and dreams for their lives that all of us have. If you asked a person with a mental illness, 'What would you like for your life?' they would say, 'I want a nice place to live, I want to have a girlfriend, I want to have a job' —a job is very high in their priorities—'and I just want to have a decent life.'
> It turns out that helping people to achieve these basic goals is a win-win situation. These are the goals that family members have for their loved ones and, in terms of society, that we want for our fellow citizens who have a mental illness—that is, they are well-integrated in the community, they are contributing members to the society and they are productive members of society and so on.[175]

10.143 While many dedicated people are working to advance mental health in Australia, evidence to this inquiry shows that due to service gaps and lack of integration, these 'win win' situations are not being systematically achieved.

Concluding remarks

10.144 The National Mental Health Strategy recognises that all areas of government, not just the health sector, have a role in mental health. However, the high levels of poverty and homelessness among people with mentally illness demonstrates that

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173 St Vincent de Paul Society, *Submission 478,* p. 6.

174 *Submission 478,* p. 12.

175 Professor Gary Bond, Visiting International Speaker for Schizophrenia Awareness Week, *Committee Hansard,* 19 May 2005, p. 74.

cross-sectoral support is inadequate. There are significant service gaps, and lack of integration and coordination between existing services is a major problem.

10.145 If 'mainstream' welfare services are to be relied upon to provide the range of supports necessary for people with mental illness, it is essential that service staff are educated about mental health issues. Programs need to be designed to be responsive to the episodic nature of some illnesses and staff need to be equipped to work effectively with people experiencing illness.

10.146 The provision of suitable accommodation for people with mental illness requires urgent attention. More than a decade after the Burdekin Report brought to light the dire accommodation circumstances of many people with mental illness, many people remain homeless or transient, living in accommodation unconducive to their mental health, or dependent on family members. Crisis accommodation services cannot meet demand and are generally not targeted to meet the needs of people with mental illness. Low cost independent housing is in short supply and supported accommodation remains scarce.

10.147 While governments have recognised that employment plays an important role in prevention and recovery from mental illness, participation rates among people with mental illness in Australia remain low. This is a key area for better education and advocacy, to counter workplace stigma. The committee met inspiring employment providers who are providing long-term support to help achieve stable employment for people with mental illnesses. There is a need for effective information and knowledge sharing in this field, to build on such experiences.

10.148 As discussed in the previous chapter, community-based mental health services are needed to reduce demand for acute services and increase experiences of mental health. It is imperative that these community services are not silos of 'health' services, but provide the broader supports necessary to sustain independent living.

CHAPTER 11

FAMILIES AND CARERS

Introduction

11.1   Families and carers are usually at the centre of community mental health care, providing the bulk of support and assistance, often with little, if any, specialised training or expertise in the area.[1] The National Mental Health Plan 2003-2008 emphasised the importance of involving carers, in addition to consumers, in all levels of policy, planning and treatment. It acknowledged the central role of carers, many of whom are family members, in the provision of mental healthcare.[2]

11.2   Carers assist people with mental illness, providing housing, personal care, and employment and employment assistance. They often assist in delivery of treatment, make clinical appointments, follow up on treatment and prescriptions, and provide transport. Most of all, carers can provide social networks, love and the positive attitude that is known to assist in recovery.

11.3   Carers are people, but being a carer is a role, not the whole person. The role of a carer may be performed by a family member, partner, friend or neighbour, or may be someone previously unknown to the consumer, such as a worker from a not-for-profit organisation or someone hired to provide a level of service.[3] Regardless of who actually fills the role, it is important to recognise that carers are individuals with their own life and needs.[4]

11.4   Carers said they often lost their sense of self, due to the intensive and demanding nature of the task. Carers may perceive themselves only in the context of being a 'carer', particularly when the carer is also a family member.

11.5   Family members of people with mental illness need adequate opportunities to perform other roles and to promote and maintain a nurturing family environment. They need opportunities to maintain their relationships as wives, husbands, partners, mothers, fathers or siblings, not only as carers. For children who have a parent or parents with mental illness, their ability to just 'be a child' with the room to grow and learn, and have the freedom to explore opportunities available to other children who do not share the same level of additional responsibility can be severely restricted.

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1   Name withheld, *Submission 63,* p. 1.

2   Australian Health Ministers, *National Mental Health Plan 2003-2008,* p. 10.

3   National Network of Private Psychiatric Sector Consumers and Their Carers, *Submission 189,* p. 10.

4   Diane Williams, *Submission 184,* p. 2.

11.6   This chapter reviews family and carer support needs in several areas - education and training; financial support; the special needs of children; and parenting, relationships and family functioning. The chapter then discusses mental health issues related to some particularly complex and difficult family situations.

11.7   In addition to the topics covered in this chapter, the committee acknowledges the importance of access to adequate employment and accommodation in the process of providing care to people with mental illness, as well as the need for respite care to alleviate the burden on carers. These topics are discussed in other chapters - Chapter 10, Non-health support services and Chapter 9, Care in the community.

Supporting the roles of families and carers

11.8   The benefits of having family members involved in care are clear:

> It is generally recognised that the prognosis for people with mental illness, who have family carers, is better than those without such support.[5]

11.9   Families as carers are often extremely devoted and committed to the recovery of the person they are caring for. That commitment is often an advantage in ensuring quality care as well as advocacy on behalf of the consumer. Carers often live with consumers, meaning there is a continuity of care that can be hard to otherwise achieve. And as many submitters pointed out, the care of family members saves governments a great deal of money.

11.10   However, families can become stretched delivering long-term care with limited support.[6] This can be distressing for carers, especially when there are several family members affected by mental illness. One carer, supporting both his wife and son said:

> This system allows carers to become so overburdened caring for their loved ones (that) the carers become depressed and sick. In my current situation, I see no bright future for us to be together…[7]

11.11   It is also important that administrators of psychiatric facilities are sensitive to the role and needs of families in the lives of consumers.[8]

11.12   Carers described the continuing challenges they face obtaining service and support:

> The father described to me how he has to go to the community centre and "have a fit" to get any real attention for his son… I suggested that the father

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5   Name withheld, *Submission 62,* p. 1.

6   The Association for Australian Rural Nurses, the Australian and New Zealand College of Mental Health Nurses and the Royal College of Nursing Australia, *Submission 321*, pp. 12–13.

7   Name withheld, *Submission 132,* p. 3.

8   Confidential, *Submission 489,* p. 2.

needs regular session about once a month to get support. This will be considered a novel and perhaps unnecessary process I suspect. The son is actively psychotic and treatment resistant. There is NO respite or support for the father. He was lucky to find a bulk-billing (for pensioners) psychiatrist. It is little wonder many families consider murder suicide.[9]

11.13   In order to effectively fulfil their roles, families and carers need adequate support in a range of areas:

- Comprehensive and accessible information about acute care and community-based mental health services, as well as information about the relevant mental illness and treatments;

- Respite for carers;

- Access to emergency funding in a time of crisis;

- Mediation support;

- Individual counselling options;

- Family counselling and support for siblings; and

- Early intervention programmes for young people with emerging psychosis.[10]

Families' and carers' need for information

11.14   Carers submitted that they were not usually provided with any information, much less comprehensive information, about the condition of the person for whom they were caring. They were not typically involved in care planning and needed greater access to specialist medical health care providers in the event of hospitalisation:

> … the role of the carer in service delivery is often ignored, rejected or seriously undervalued … The carer's rights are not observed nearly so assiduously. This has particular significance when the consumers are young people who are still the financial and psychological responsibility of their parents.[11]

> When our system chooses to devalue, ignore and disregard the valuable, intimate knowledge and understanding one family member has of another family member, there is a large price to pay for all concerned.[12]

11.15   However, the views of some consumers indicated a tension between the interests of carers and consumers:

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9   Associate Professor Brian Boettcher, *Submission 1,* p. 12.

10   Anglicare Tasmania, *Submission 464*, p. 17.

11   National Network of Private Psychiatric Sector Consumers and Their Carers, *Submission 189,* p. 10.

12   Ms Sharon Ponder, *Submission 84,* p. 9.

> Many consumers like their carers to be involved, however, [also] want to reserve the right to not have their carers involved in every aspect of their treatment and recovery. [H]owever carers and mental health service providers tend to totally step on such boundary issues and ignore the consumer's wishes of when s/he would like to have their carer involved and when s/he would prefer not to.[13]

11.16   Carers explained that the usual reason they were given for not being provided with information was that to do so would be contrary to the provisions of privacy legislation. However, one witness submitted that the Victorian Mental Health Act, for instance, exempts providers from the need to keep information about patients confidential from guardians, family members or primary carers if:

> the information is reasonably required for the on-going care of the person to whom it relates; and

> the guardian, family member or primary carer will be involved in providing that care.[14]

11.17   The witness stated that:

> Clinicians routinely flout the Mental Health Act by ignoring this provision of the Mental Health Act and denying essential information to carers, often, as in my son's case, with deadly results.[15]

11.18   There was a call for clearer guidance in this area:

> National standards that make explicit the methods that can be used to involve carers would be [of] value in addressing outmoded paradigms of family involvement that many clinicians still have.[16]

11.19   The rights of consumers and carers are discussed in more detail in Chapter 3 – The rights of the mentally ill.

Education and training for families and carers

11.20   Living with and supporting family members with mental illness is challenging. Hundreds of carers and family members wrote to the committee sharing their experiences, frustrations and disillusionment with services. One carer commented:

> I now understand why many families let their mentally ill children go – the situations seems impossible and the person with mental illness often does not respond, does not learn, does not show up, changes his or her mind

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13   The Northern Beaches Mental Health Consumer Network, *Submission 60,* p. 14.

14   Mr Graeme Bond, *Submission 484*, pp 4–5.

15   Mr Graeme Bond, *Submission 484*, p. 5.

16   Mental Illness Fellowship of Australia Inc, *Submission 402*, p. 5.

> about nearly everything almost daily, and is adept at lying, stealing – whatever it takes.

> Despite the seeming hopelessness of my daughter's situation, however, I kept in touch…[17]

11.21   There is a definite need for specialised programs to assist carers and families:[18]

> The majority of funding for carer training and support is only available through generic carer support programs where the NMHS does not have a role. The generalist programs have little ability to focus on the specific needs on mental health carers, even if they had the funds to do so. Some of the identified differences are the stigma of mental illness, the course and onset of the illness, financial impacts, dual diagnosis and the rejection of the carer.[19]

11.22   The Mental Illness Fellowship of Australia (MIFA) observed that carers who are educated, trained, informed and supported cope better, and are able in turn to provide better support. This contributes to the long term well-being and rehabilitation of their loved ones, including improving medication compliance and reducing relapse.[20]

11.23   Information and training for carers and families is needed from the initial diagnosis of mental illness. It must be accurate and specific to the individual care and treatment needs of the person they are supporting.[21] Training should be provided in terms that are understandable to non-healthcare workers:

> It is hard enough realising a family member has a mental illness without having to learn the "language" to use when speaking to the service providers and health professionals.[22]

11.24   Training and support for families and carers needs to be cognisant of, and certainly not detrimental to, the independence of consumers:

> [Training] needs to inform and empower family members, building positive, but realistic attitudes and developing interpersonal and problem-solving skills. In the past there has been too much emphasis on the "plight"

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17   Name withheld, *Submission 375*, pp 8–9.

18   See for example, Name withheld, *Submission 53,* p. 1; Mill Park Family Support Group, *Submission 72,* p. 3; Name Withheld, *Submission 75,* p. 2; National Network of Private Psychiatric Sector Consumers and Their Carers, *Submission 189,* p. 10. Consumers and Carers from the NSW Far South Coast, *Submission 5,* p. 2; Brian Haisman, *Submission 114,* p. 2; Mental Illness Fellowship of Australia Inc, *Submission 402*, p. 5.

19   MHCA, *Submission 262,* p. 30.

20   Mental Illness Fellowship of Australia Inc, *Submission 402*, p. 5.

21   The Northern beaches Mental Health Consumer Network, *Submission 60,* p. 14;

22   Mill Park Family Support Group, *Submission 72,* p. 3.

of carers, their "self-sacrifice", their "heroism", etc. This has been unhelpful, counterproductive and isolating from the mainstream community. Training also needs to engender respect for the person who is ill. It needs to include strategies for lifting his/her self-esteem and strategies for attaining as much independence as possible for the person who is ill as well as aiming at including him/her in mainstream community life.[23]

11.25   Carers noted that without information they did not know if their endeavours were providing the best support for the consumer:

We appreciated that the best form of treatment was ours, as it was constant, readily available and there 24/7. However, the frustrating lack of information and support services for families and carers of those with depression left us ill equipped to provide the help and support dad needed. We worry now that perhaps what was well intended may in fact (have) been negative and adverse to helping him with his battle with the illness.[24]

11.26   As with other aspects of mental health service provision, the voices and experiences of consumers are instrumental in educating families and must be central to training programs. Carers and consumers endorsed support groups where experiences can be shared:

Some of the most effective support and advice for people suffering from mental illness and their families is provided by people who share the same problems. There is a need to strengthen and expand the role of so-called "consumer consultants" and make their work in the community a reality.[25]

11.27   Submissions also emphasised the importance of recovery focussed training and support. For carers, who can be overburdened, there is a need for support which enables them to believe in recovery:

Carers need to be well resourced and services to assist them to rekindle their own hope in the people they are caring for. Vital to this are the support groups which help provide links between carers and which are the best equipped to resource and train carers. These mutual self help groups are not receiving sufficient funding to adequately deliver these support services and to organise training for carers.[26]

11.28   Many families will be performing their role as carers for the duration of either their own life or throughout the lifetime of the person with the mental illness, so education, training and support is needed on an ongoing basis.[27] However, intensive, short-term support to families and carers is also required. For example, Anglicare

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23   Ms Sheelah Egan, *Submission 113*, p. [7].

24   Name withheld, *Submission 9,* p. 1.

25   Name withheld, *Submission 375*, p. 3.

26   VICSERV (Psychiatric Disability Services of Victoria), *Submission 347*, p. 21.

27   Name withheld, *Submission 38,* p. 2.

commented on the lack of referral services upon discharge from hospital, particularly after a first admission:

> The length of this waiting list for essential treatment, rehabilitation and support services at a time when individuals and their family are in a state of crisis, confusion, fear and grief is inappropriate and potentially tragic.[28]

11.29   The stress on families related to the lack of discharge planning and community based services to support the transition back into community life is also discussed in Chapter 9.

11.30   Easily accessible information about the services available in the mental health sector is lacking. This can create barriers to seeking care and treatment beyond what may be provided by a family member:

> It was not until in desperation and in urgent need of respite from my home situation that I attended a carer support group where I learned how to describe what was happening for my son; and also how much more support my son needed (than I was able to give), and how the mental health system is structured to meet this need.[29]

Training and support programs

11.31   Non-government organisations are providing valuable programs to assist and support carers in the community, but the lack of resources restricts what is achievable. This is particularly so for community organisations reliant on volunteers, many of whom are themselves the primary carers for a family member with mental illness.[30] Despite these constraints, there are several organisations that provide valuable peer support and training for carers.

11.32   The Association for Relatives And Friends of the Mentally Ill (ARAFMI) is a non-profit organisation, providing mutual support and understanding for people with a mental illness, their families, friends and carers. ARAFMI delivers a range of services, including counselling, information and support, through its numerous branches spread across the states and territories. ARAFMI has a number of initiatives specifically targeting the practical and responsive needs of carers, as well as programs addressing the needs of young people.[31]

11.33   The Mental Illness Fellowship of Australia (MIFA) supports the needs of consumers, their families and friends through a range of education, support and advocacy services. Fellowships exist at state and territory level, and provide a range of community-based services, which include: support and self help programs to enhance

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28   Anglicare Tasmania, *Submission 464*, p. 16.

29   Name withheld, *Submission 100,* p. 2.

30   Canberra Schizophrenia Fellowship, *Submission 103,* p. 6.

31   DepressioNet, Association for the Relatives and Friends of the Mentally Ill (ARAFMI), http://www.depressionet.com.au/famfr/arafmi.html, (accessed March 2006).

the skills of consumers and assist in rehabilitation and recovery; outreach and accommodation services; and, respite and residential rehabilitation services. MIFA stated that the shortage of state and federal funding severely limits its ability to deliver much-needed services to the community.[32]

11.34   Drawing on findings from the NSW parliamentary inquiry into state-wide mental health services, the Mental Health Coordinating Council (MHCC) noted the number of 'family- and carer-friendly' services within the state that seek to increase the involvement of primary carers in treatment, care and recovery, as well as providing education, information and respite to assist carers. Initiatives included:

- Carers NSW has developed a "Carer Life Course Framework: An Evidence Based Approach to Effective Carer Education and Support".

- The Association for Relatives And Friends of the Mentally Ill (ARAFMI) is nearing completion of the Carer Services Mapping Project, providing recommendations for improving services, training, education, information, advocacy, planning and support for carers. The project will lead to the establishment of a carer services information database.

- Establishment of the Carers Support Unit, which is the largest service provider to carers of people with mental illness in the state.

- Development of a "Framework for Family and Carer Support in Mental Health Services."

- Agreement to allocate funds to the Working with Families Project, which is a framework for family and carer support. [33]

11.35   However, MHCC also raised concerns about the inadequacies of, and uncertain future access to, funding for many of these programs.[34] Such concerns occur across jurisdictions. For example, in Victoria the Mildura Mental Health Service has established a Carer Consultant. The position delivers a range of services, including: support to carers; conducting carer surveys; providing input to planning meetings and carer forums; and, implementing policies and strategies for improving carer services. Whilst the value of carer-specific services was recognised in the Victorian Government's 'Caring Together' action plan, the Mildura Health Service voiced concern about the lack of funding to deliver a comprehensive service (the position is currently funded for only two days per week) and the absence of a consistent funding stream to provide a continuum of service.[35]

11.36   The Mental Illness Fellowship of Australia (MIFA) has tried a program for carers ('Well ways – a traveller's guide to wellbeing for families of people with mental

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32   MIFA, *Submission 402,* p. 2.

33   Mental Health Coordinating Council, *Submission 172,* p. 10.

34   *Submission 172,* p. 6.

35   Mildura Mental Health Services, *Submission 96,* pp 1–2.

illness') developed by the Mental Illness Fellowship of Victoria. The program is designed to 'increase the capacity of families, carers and friends to care effectively for themselves, other family members and their relative living with mental illness'.[36] It includes training in the cause, treatment and recovery from mental illness, the experience of families and the legal, health and carers support system. The program is designed to include a monthly support group for up to 18 months, to reinforce learning, provide feedback and support behavioural change. Evaluation of the program found that:

> …caregivers were less anxious and depressed and reported less worry regarding the person with a mental illness following participation in this program.[37]

11.37 However, due to a lack of funding, efforts to roll the program out across all states and territories had limited success:

> Despite the evidence, funding for specific programs in most jurisdictions within Australia is poor or at worst non-existent. The non-government sector of mental health is struggling to survive in many locations throughout Australia. This fact has been borne out during the current project with a number of MIFA members unable to proceed with implementing Well Ways within their state or territory.[38]

11.38 Concerns about funding and development of programs and supports for families and carers were echoed across the community:

> Various Australian standards, policies and guidelines do in fact recognise a real role for carers, but this seems to be largely ignored in practice, despite system rhetoric to the contrary. Implementation lags significantly.[39]

Financial support

11.39 Mental illness can have serious financial consequences, both for the consumer and for those who provide care and support:

> Carers too can find themselves caught in a spiral of social-economic disadvantage if they lose the financial support of family, their family homes or their savings as a repercussion of the care they provide.[40]

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36   Mental Illness Fellowship of Australia Inc, *Submission 402*, Attachment 1, Farnan, S., Crowther, L. and Springgay, M. 2004, 'Well Ways – a traveller's guide to wellbeing for families of people with mental illness, A multi-family peer psycho-educational program', p. 3.

37   Mental Illness Fellowship of Australia Inc, *Submission 402*, Attachment 1, Farnan, S., Crowther, L. and Springgay, M. 2004, 'Well Ways – a traveller's guide to wellbeing for families of people with mental illness, A multi-family peer psycho-educational program', p. 15.

38   Mental Illness Fellowship of Australia Inc, *Submission 402*, Attachment 1, Farnan, S., Crowther, L. and Springgay, M. 2004, 'Well Ways – a traveller's guide to wellbeing for families of people with mental illness, A multi-family peer psycho-educational program', p. 16.

39   Mr Brain Haisman, *Submission 114,* p. 2.

11.40   Family members performing the role of carers are often forced to give up full-time employment, significantly reducing family income. Given the additional expenses incurred in caring for a family member with mental illness, inadequate community support and little financial assistance mean many families cannot cope:

> They are more often than not forced to leave their jobs in order to cope with their family member and the illness. They rarely receive a carer's pension and, even if they do, it certainly does not replace the income they were previously earning. A lot of families disintegrate due to the strain of learning to cope with mental illness and still trying to hold a family unit together.[41]

11.41   While little research has been done on the specific pattern of expense for carers of people with mental illness,[42] the kinds of financial assistance provided include: fees for accessing healthcare professionals not covered under Medicare; travel costs for getting to and from healthcare appointments; replacing items destroyed or lost by loved ones during episodes of psychosis or dysfunction, including clothing, repairs and replacement furniture and lost rental bonds; payment of fines and debts accumulated by the mentally ill family member including court fines, parking fines, credit card debts, hire purchase debts and telephone debts.[43]

11.42   The impact of providing financial support is compounded when the person with a mental illness is geographically isolated and the carer must travel long distances to access support services both for the consumer and for themselves as the carer.[44]

11.43   Anglicare summarised that '(t)he impact of these costs on parents who were themselves on low incomes was significant', and that '(g)iven the many benefits which flow from family support, it is a major concern that so few carers of people with mental illness receive financial support for their role'.[45]

11.44   The committee heard that it is common for families to be unaware of the carer payment available through Centrelink.[46] However, the difficulties in obtaining a carer's allowance were also reported:

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40   Anglicare Tasmania, *Submission 464,* p. 31.

41   Mill Park Family Support Group, *Submission 72,* p. 3.

42   Anglicare Tasmania, *Submission 464,* p. 31.

43   Mental Carers Network Inc, *Submission 286,* p. 4; Anglicare Tasmania, *Submission 464,* p. 31–32.

44   National Network of Private Psychiatric Sector Consumers and Their Carers, *Submission 189,* p. 10.

45   Anglicare Tasmania, *Submission 464,* p. 32.

46   Mental Health Community Coalition of the ACT Consumer and Carer Caucus, *Submission 214,* p. 7.

A carer of someone that requires physical feeding, washing etc is considered the norm but the carer of a mentally ill person who doesn't want to get out of bed to wash, doesn't care what they eat etc is not even acknowledged. It can be equally draining and stressful with similar outcomes but one carer is allowed the benefit the other not.[47]

11.45   Carers also commented on the low level of financial support provided:

I have had to leave my position as a senior social worker RGH(H) after 20 years working in ICU/CCU hospital settings. I receive a carers' allowance of a laughable $45 odd dollars a week. I receive no other assistance, benefits or relief from my most important role as a full-time carer.[48]

11.46   Ageing parents of people with mental illness expressed particular concern about the lack of financial assistance, now and for the future.[49] The National Rural Health Alliance stated the need for long-term planning to alleviate the distress faced by older parents who worry what the future may hold when they are no longer able to care for family members with mental illness.[50] As one mother wrote:

At present our son lives with us, his ageing parents (close to 80 years). Where will he go when we are not here or incapable of looking after him?[51]

The special needs of children

11.47   The experience of mental illness can be traumatic for family members, particularly for children and young people. Mental illness among parents can have a range of impacts on children, including:

- Children of parents with mental illness have a greater likelihood than other children of having emotional and behavioural problems;

- Children worry about their parents and are not given information by mental health professionals which would reduce their anxiety;

- Parents do not seek help and support due to fear of their children being taken from them by welfare authorities; and

- Parents and families are reluctant to talk with children about the mental illness of a family member. As a result children feel isolated not knowing that other children share their family experience.[52]

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47   Ms Paola Mason, *Submission 142,* p. 5.

48   Name withheld, *Submission 144,* p. 1.

49   See, for example: Name withheld, *Submission 61,* p.1; Name withheld, *Submission 144,* p. 2.

50   National Rural health Alliance Inc, *Submission 181,* p. 25.

51   Name withheld, *Submission 56,* p.1.

52   Ms Vicki Cowling and Dr Adrian Falkov, *Submission 386*, p. 4.

11.48   Ms Vicki Cowling and Dr Adrian Falkov noted that 'Schools are opportune settings for increasing community understanding, and changing attitudes towards people with mental illness'.[53] They also point to the need for child and family welfare sectors to work collaboratively with mental health services, and for service providers, particularly after hours crisis services, to be trained in dealing with children of people with mental illness, including explaining events, answering questions and reducing anxiety in the short-term.[54]

Child 'carers'

11.49   One group of children particularly in need of specialised services and support are children whose parent or parents have a mental illness.

> Some children also bear the burden of caring for an adult with mental illness. This is an especially difficult task given the social isolation often associated with mental illness and can in turn affect the mental health of the child. These needs cannot be met by increasing capacity within the general service sector. Young carers and young people in families affected by mental illness should be identified as a priority target within children and youth services.[55]

11.50   The expectation that children can fill the role of carer on an ongoing basis can have a significant impact on a child's wellbeing and future opportunities:

> These children are foregoing a normal childhood because in most cases they 'have' to be the carer as there is no one else available to be. They are given very little assistance with their education and mostly leave school early with a very limited and interrupted education. Many are unemployed as a consequence of limited education, poor employment skills and the time-consuming role of carer. They are ashamed of their situation and are often bullied and victimised by peers who have no understanding of their situation.[56]

11.51   There is a distinct lack of support services designed specifically for children in these circumstances. Submissions noted that the support services currently provided to carers often do not meet the needs of these children. For example:

> The respite care that may be given is quite often restricted by OH&S laws, thus limiting what workers can do and resulting in the children still being responsible for the heavy workload. At other times the respite care is inappropriate, such as a worker sitting on the lounge with the consumer while the child is washing the dishes or making beds.[57]

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53   Ms Vicki Cowling and Dr Adrian Falkov, *Submission 386*, p. 5.

54   *Submission 386*, pp 2–3.

55   MHCA, *Submission 262*, p. 20.

56   Ms Janine Anderson, *Submission 210*, p. 3.

57   *Submission 210*, p. 3.

11.52   Some of the particular needs of children whose parent or parents have a mental illness include:

- emotional and practical support;

- respect for their role as a carer;

- appropriate respite;

- support to maintain the family as a unit;

- advocacy services for their rights and needs;

- personal development;

- assistance to participate in education and social activities; and

- special training and education in their role as carer, particularly as programs developed for adult carers may not be meaningful for a young audience.[58]

11.53   The Network of Carers for People with a Mental Illness recommended continued funding to programs targeting child and adolescent carers, such as Children of Parents with a Mental Illness and Paying Attention to Self, to ensure the needs of these young carers are met.[59]

Relationships and family functioning

11.54   Many families and carers are desperate for assistance which would help them respond appropriately to the needs and behaviours of a family member with mental illness, and also would help them deal with their own feelings and reactions to the illness. The committee heard that some families feel unable to respond to members with mental illness, and that stigma and prejudice is evident in some families:

> When people admit to having diabetes or depression …there is sympathy and support at almost every turn. However, mention that you suffer from schizophrenia and people literally take a step backwards, often as if they expect you to start ranting and raving at them. Most members of the Group have faced constant isolation, even from their own family members. Some relatives feel that the illness might be contagious, so they simply stay away in the hope that they won't "catch it" as well.[60]

> …..

> My son had been noticeably ill for at least 6 months before I considered taking him to a psychiatrist. Immediate family who now do not live with us were not in favour of this course of action, and I also hesitated as it would then label my son with a very difficult and unattractive condition.[61]

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58   AICAFMHA, *Submission 83;* City of Port Phillip, *Submission 326*, p. 17; Health Coordinating Council, *Submission 172.*

59   The Network of Carers for People with a Mental Illness, *Submission 227,* pp. 1–2.

60   Mill Park Family Support Group, *Submission 72,* pp. 3–4.

61   Name withheld, *Submission 100,* p. 2.

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> No patient is alone. He or she is a member of a family; the two cannot be separated. The patient's ill health affects the family; it frightens the family. The family's fears, worries, perhaps deprivation, will affect the mind and anxiety of the patient.[62]

11.55   Even among families with the best intentions and knowledge, family dynamics and relationships can be unconducive to good mental health outcomes for both consumers and carers:

> With limited access to information and support, many families attempt to control the situation by either wrapping their loved one in cotton wool and doing everything for them, or using 'power over' tactics in an attempt to force conformity to their 'beliefs' about how 'their family' members 'should' or 'ought' to behave.

> … A major barrier experienced by many families is the belief that they have bent over backwards to accommodate the needs of their child, parent or sibling to the point where they themselves are experiencing massive stress, anxiety and grief at not being able to 'fix' the 'problem'.[63]

11.56   Consumers described the impact family relationships can have:

> Many carers treat the family member who is a consumer as if they have suddenly lost their adult status as like other siblings and tend to "over protect" the consumer, treat the consumer as if still a child and operate more from feelings of guilt of having brought into this world a person who has developed a mental illness rather than a human being who is capable of anything s/he puts their minds to despite the fact of living with a disability.[64]

11.57   Professor Jorm also commented on family behaviours, and that families' immediate or natural reactions are not necessarily conducive to mental health outcomes:

> There are some basic things that we should all know. A lot of research shows that if people with mental disorders are criticised by those close to them, that tends to give them a worse outcome. Unfortunately, it is a very natural thing for all of us when we do not like the way people behave to try to change their behaviour by criticising them. We naturally fall into it, but it is a destructive thing to do and it is a self-defeating way to try to change people's behaviour. So a very simple message that everybody in the community should know is that criticism only makes it worse.[65]

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62   Mr Peter Hutten, *Submission 185,* p. 19.

63   Ms Sue Koningen, *Submission 538*, p. 7.

64   The Northern Beaches Mental Health Consumer Network, *Submission 60,* p. 14.

65   Professor Anthony Jorm, *Committee Hansard*, 1 February 2006, p. 57.

11.58   One mother described her experience coming to terms with her daughter's mental illness:

> I have learned over time to draw more and more boundaries. As I have gotten better (with coping), I think I could say, I have learned to put more boundaries between me and my daughter…because I know that ultimately she is the one that must decide to take her medicine and so on. On the other hand, I also know that that means that people will die; I am sure of it, even her. I have had to face that fact and the fact that she needs her autonomy…[66]

11.59   Ms Sue Koningen told the committee about her consumer-driven program which 'helps families learn to cope more effectively to support their consumer to learn to self-manage their illness and work toward their recovery'.[67] She outlined the need for families to 'look at their family system, expectations, beliefs, behaviours and communication style so that they can reflect on the impact this may be having on their relationships with the people they love and value most in their lives – the ones they are trying so desperately to save or change'.[68]

11.60   Ms Koningen's program focuses on rebuilding healthy relationships, including building resilience, hope and a focus on recovery.[69] Given sensitivities around reviewing family dynamics, consumer and carer involvement is important:

> There is massive guilt along with massive grief. So much is determined by the facilitator and how they approach it. I have a lot of laughter. … So on the one side, yes, we need to understand which behaviours are destructive but on the other hand we are becoming so much more powerful because we have got a better life, we have got a better relationship with everybody. I do not mean just with the child but with siblings, peers, work, everything. … It is approached very gently. I think it works because I am one of them. If somebody else was to do it, I do not think they would be able to get away with it, quite frankly.[70]

Parenting

11.61   Recognising the important role that families play in promoting mental health, some parents may need assistance to fulfil parenting roles, particularly where a child has a behaviour disorder. Individually tailored strategies for parenting children with challenging behaviours can have enormous benefits for both the child and the parent:

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66   Name withheld, *Committee Hansard (in camera)*, 3 August 2005, p. 10. Agreed for citation with the witness.

67   Ms Sue Koningen, *Submission 538*, p. 2.

68   *Submission 538*, p. 7.

69   *Submission 538*, pp 11–12.

70   Ms Sue Koningen, *Committee Hansard*, 2 February 2006, p. 59.

> I learnt how to deal with a child who had learning disabilities and other problems. They taught me how to do that because you cannot as a parent know how to deal with a child who is uniquely difference (sic), like my son is, and you need to be taught how to discipline them. You do not discipline them like you do your other children. I did not know how to discipline this child. I did not know how to teach him.[71]

11.62   Programs which assist parents, such as the Triple P-Positive Parenting Program, can help provide early intervention and assist in prevention of mental illness. This program contributes to early intervention and prevention of mental illness through recognition that not all parents know how to best fulfil their role as a parent and may need some additional assistance to minimise behavioural difficulties in their children. The Triple P program, developed at the University of Queensland, delivers parenting skills through attendance at either face-to-face individual or group sessions, or through self-help course material.

11.63   The Triple P program is a form of behavioural family intervention, and there is strong empirical support for this approach to treating and preventing childhood disorders.[72] The Queensland Government has stated its commitment to the program by training and accrediting child health nurses and allied professionals to assist in early detection and intervention of child behaviour problems.[73] However, the ADGP has called for a nation-wide roll out of programs, such as Triple P, to provide an 'investment in strengthening the role of families'.[74]

11.64   It is also important to acknowledge the diverse range of family circumstances and childhood disorders that parents face. The Learning and Attentional Disorders Society of WA Inc (LADS) commented that generic behaviour management programs, such as Triple P, are of little benefit to parents of children with ADHD.[75] Specific, targeted programs may be needed for these parents.

Pressures on the family and the impact on mental health

11.65   Breakdown of families, stresses within families and absence of families, combined with a lack of adequate community-based services and support, can lead to families being less than effective and can create or exacerbate mental illness in family members.

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71   Miss Katherine Frances, *Committee Hansard,* 1 September 2005, p. 64.

72   M. Sanders, Markie-Dadds, C. and Turner, M. "Theoretical, Scientific and Clinical Foundations of the Triple P-Positive Parenting Program: A Population Approach to the Promotion of Parenting Competence", *Parenting Research and Practice Monograph No. 1,* p. 3.

73   Queensland Government, *Submission 377,* p. 36.

74   Australian Divisions of General Practice, *Submission 308,* p. 5.

75   Learning and Attentional Disorders Society of WA Inc, *Submission 202,* p. 9.

11.66 The MHCA recognised the potential impact of family breakdown on mental illness:

> The third great failing of the NMHS is that it did not adequately plan for the increase in demand which is such a significant feature of mental health care at the present time. … proper allowance was not made for an increase in mental illness among young people; for increasing incidence of mental illness brought about by family breakdown, decreasing participation in community and recreational networks; and increased drug and alcohol abuse.[76]

11.67 The committee heard about some particular family experiences and circumstances that create great stress and impact on mental health. These circumstances are discussed below.

Families at risk

11.68 Some families face multiple challenges and are at particular risk of psychological dysfunction. Family environments can be far from therapeutic.

> The most difficult client base to work with is the family where mental health issues are complicated by drug and alcohol problems. These families are difficult to engage and workers are often in vulnerable situations where safety is a concern not only for family members but also the worker themselves.[77]

11.69 The Australian College of Psychological Medicine called for more resources and intervention to support socially-disadvantaged parents:

> Supportive intervention needs to occur much earlier to treat parental dysfunction, teach anger management, teach survival strategies that don't involve substances and self harm and above all, help parents manage their children in non-damaging ways.[78]

11.70 Children of parents with mental illness are over represented in the child protection system,[79] partly reflecting the lack of early treatment and support for parents. Catholic Welfare commented on one of its programs aimed at diverting families from the statutory Child Protection System:

> One of the most significant issues seen in this team is the number of parents presenting with symptoms deriving from complex, long term trauma for which they have received little assessment or treatment.[80]

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76 MHCA, *Submission 262*, p. 18.

77 City of Port Phillip, *Submission 326*, p. 18.

78 ACPM, *Submission 411*, p. 11.

79 Ms Vicki Cowling OAM and Dr Adrian Falkov, *Submission 386*, p. 4.

80 Catholic Welfare, *Submission 302*, p. 15.

11.71   Service providers commented on the need for better integration between services to meet the needs of families at risk, for example collaboration between mental health services and wider family services such as family mediation and family therapy:

> Mental illness is one of the factors adding to the increasing complexity of family life, with a number of co-factors: including drug and alcohol use, intellectual disability, and family violence, it requires skilled, joined-up interventions to improve the outcomes for children and families.[81]

11.72   Some families need assistance with living skills and family functioning in order to create an environment conducive to mental health:

> There is no service available to give ongoing practical domestic support and role modelling … Further resourcing and training for Family Support Services would greatly benefit the number of support groups and short term specific support able to be offered in particular to families with children between the ages of 12 and 18 years where support and programs of any kind is inadequate.[82]

11.73   The City of Port Phillip noted that Maternal and Child Health Services offers universal care and support to all families with children aged 0-6 years, giving access and insight into family circumstances at an often vulnerable stage in life. However the service is not resourced to provide the supports needed for families with mental health issues; there are limited counselling and support groups and long referral waiting times.[83] With better resourced community-based mental health services, maternal and child health services would provide a good 'entry point' to identifying and assisting families struggling with mental health related issues.

Forced adoption

11.74   The committee received a number of submissions explaining the long-term mental health impacts of forced adoption and the special need for support and services for women living with the trauma of this experience.

11.75   Origins Inc outlined a litany of appalling practices common during decades of forced adoption, including:

- Denying mothers all knowledge of their legal rights and options,
- Preventing bonding by forbidding the mother to see or touch her baby,
- Forbidding the mother from being discharged until she had signed her baby away,
- Forced suppression of lactation with potent drugs,

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81   Catholic Welfare, *Submission 302*, p. 16.

82   City of Port Phillip, *Submission 326*, p. 18.

83   *Submission 326*, p. 17.

- Unlawful administration of heavy sedation during and post labour,

- Maltreatment of the mother and treating her in a cruel and demeaning manner,

- Physically restraining mothers from seeing their babies,

- Informing mothers that their babies had died at birth when in fact they had been adopted,

- Using overt and covert methods of coercion to obtain consents to the adoption of the child,

- Not advising mothers of the permanent nature of adoption.[84]

11.76　The lifetime damage caused by such experiences can be immense, including loss of trust, shame, sorrow, damaged relationships, loss of self-esteem, denial, dissociation, inability to bond with other babies, educational failure and poor employment outcomes.[85] A range of mental illnesses are related to damage caused by adoption separation, including depression, post traumatic stress disorder, dissociative disorders and panic disorders, alcohol and drug use disorders and personality disorders.[86]

11.77　The personal trauma and pain experienced by mothers decades later were shared with the committee:

> I can remember every moment of my time in that hospital and every waking moment the events are in my head and affect my everyday life. I have recently been diagnosed with Post Traumatic Stress Disorder and still suffer from depression that is helped by medication. … I am currently seeing an excellent Psychologist and having Cognitive Behaviour Therapy, which helps me cope on a day-to-day basis. However, I am not able to be in a social or work situation without becoming extremely distressed and agitated. I am unable to listen to music or watch television and avoid noise as much as possible. I am having flashbacks of both visual and olfactory situations, I have made a personal decision not to drive any more, which isolates me even more, but I do not believe it is safe for other road users for me to be driving while my mind is somewhere else. My dreams are traumatic, both from the deaths of my sons and many other traumatic life events brought on at times by my feelings of having no self-worth and an overwhelming sense of feeling useless in all areas of my life.[87]

11.78　Women talked not only about their personal experience, but of the intergenerational impact of their experience on their other children and family members:

84　Origins Inc Supporting People Separated by Adoption, *Submission 420*, pp [5–10].

85　*Submission 420*, pp 15–18; Name withheld, *Submission 180,* p. 2.

86　*Submission 420*, p. 18; Origins Victoria Inc, *Submission 105*.

87　Name withheld, *Submission 512*, p. 2–3.

> Not having been advised that the adoption may cause a lifetime of emotional distress I believed I was being punished by some external force and my second son had died as punishment for 'giving' away my first born. When my third child, a daughter was born, I was suffering from severe depression and a restlessness that has never abated to this day. I woke her every night for approximately 6 years to see if she was still breathing. I went to work when she was 6 weeks old, as I was frightened of her and too emotional to breast feed or care for her properly, I felt. She had a wonderful babysitter, which I am grateful for, but she has suffered emotional problems through her life due to my depression and inability to 'mother' her sufficiently.[88]

11.79   Current mental health services do not necessarily support the needs of these women:

> I've suffered major depression ever since and haven't known what to do about it. I tried going to 3 psychologists and even a psychiatrist, and they were all hopeless, they were totally uninformed about the long term effects of adoption loss and all of them re-traumatised me even more. Now I'm afraid to seek out help.[89]

11.80   Origin Victoria called for funding to research the effects of forced adoption, to help minimise the suffering by these women and to help in breaking the 'legacy [for] subsequent generations'.[90]

Children in institutional and out-of-home care

11.81   The committee received many submissions from care leavers: people who spent time in institutional and foster care during childhood. They explained that 'many of the children like me had a terrible experience of institutional life – being subjected to extreme cruelty, deprivation, neglect and abuse'.[91]

11.82   Mental illness, related to these childhood experiences, is common among care leavers and suicide rates are high, particularly for male care leavers.[92]

> …many Care leavers have suffered from mental illness for years. We suffer from chronic anxiety; chronic depression; phobias and as well, a large number of us have Post-traumatic Stress Disorder. Our mental illnesses have remained untreated for years because no specific treatment programs have been set up to respond to the mental health of Care leavers.[93]

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88   Name withheld, *Submission 512*, p. 2.

89   Name withheld, *Submission 145*, p. 1.

90   Origins Victoria Inc, *Submission 105*, p. 11.

91   *Submission 370*, p. 1 (received from 182 care leavers).

92   Broken Rites (Australia) Collective Inc., *Submission 340*, p. [5].

93   *Submission 370*, p. 1 (received from 182 care leavers).

11.83   In August 2004 the Senate Community Affairs References Committee presented its comprehensive and compelling report on Australians who experienced institutional or out-of-home care as children. Readers are referred to that report for a better understanding of the horrific experiences endured in out-of-home care, and the lifelong impacts of those childhood experiences on care leavers, their children, families and communities.

11.84   Among the many important recommendations made by that committee are recommendations aimed at addressing the mental health care needs of care leavers. However, this committee was informed that:

> …the majority of organisations that are responsible for the untreated mental illness that we now suffer, have chosen not to respond to our needs and choose not to set up services responsive to our identified and documented needs.[94]

11.85   The Australian Government responded to the Community Affairs References Committee's report in November 2005, acknowledging '[t]he suffering experienced by so many children placed in institutional care is a matter of shame for this country'. The Australian Government stated that '[t]o those whose experiences have scarred them indelibly, we as a nation need to respond with appropriate help',[95] but pointed out that many of the recommendations were a matter for state and territory governments. The federal government noted that it had provided a one-off $100,000 grant to the Care Leavers of Australia Network (CLAN) for counselling services for care leavers.[96]

11.86   Subsequently, the Senate resolved to request that the governments of each state and territory respond to the report's recommendations.[97] The responses received have been tabled in the Senate.

11.87   Without specialised mental health services, care leavers are largely reliant on public mental health services.[98] However, as public services are stretched responding to those in acute phases of illness, particularly those who are suicidal, care leavers are a group at risk of missing out on mental health care.[99]

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94   *Submission 370*, p. 1 (received from 182 care leavers).

95   Australian Government, *Australian Government Response to the Committee's Reports: Forgotten Australians: A report on Australians who experienced institutional or out-of-home care and Protecting Vulnerable Children: A national challenge. Second report on the inquiry into children in institutional or out of home care*, p. 3.

96   Australian Government, *Australian Government Response to the Committee's Reports: Forgotten Australians: A report on Australians who experienced institutional or out-of-home care and Protecting Vulnerable Children: A national challenge. Second report on the inquiry into children in institutional or out of home care*, pp 10 and 12.

97   The Senate, *Journals*, 29 November 2005, p. 1442.

98   Broken Rites (Australia) Collective Inc., *Submission 340*, p. [6].

99   *Submission 340*, p. [4].

11.88   As well as services directed to care leavers, targeted services are also required for people supporting children living in out-of-home environments today. AICAFMHA reported that children under the care of the state have unique difficulties and are highly vulnerable, resulting in more mental health problems that can include severe and long-term mental illness.[100] Foster parents need training and skills to best understand their roles and provide specialised support, given the often complex situations that have been previously encountered by the children placed in their care.

Vietnam veterans

11.89   The sons and daughters of Vietnam Veterans have a much higher rate of suicide than the general population in a similar age bracket, and are more likely to suffer from depression.[101]   The Department of Veterans' Affairs has implemented a number of initiatives to increase the support available to veterans and their families, including a counselling service targeting the specific needs of this group. It is important that long-term damage to the mental health of people returning from conflict situations is understood in the context of consequential impacts on families:

> By preventing or minimising mental illness among veterans of Rwanda, Somalia, East Timor, Bougainville, the Solomon Islands, Afghanistan and Iraq, government may also prevent consequent mental illness among their sons and daughters.[102]

> … we need to know we will be the last generation to face this. We need to know that the Defence Force is paying more attention to psychological care for troops returning from battle, both immediately after service and for some years thereafter.[103]

Child and domestic abuse

11.90   The link between sexual assault, child abuse, domestic violence and poor mental health outcomes is well established.[104] It is estimated that around 50-55 per cent of women with mental health problems or disorders are victims of child sexual abuse. For some illnesses, such as personality disorders and dissociative disorders, the prevalence rate is as high as 70-80 per cent:[105]

> In American patients diagnosed with BPD [Borderline Personality Disorder], 40-70 per cent report the childhood experience of sexual abuse alone. In persons with co-morbid PTSD [Post Traumatic Stress Disorder]

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100   AICAFMHA, *Submission 83,* p. 18.

101   Ms Anne Matheson and Dr Anthony Marinac, *Submission 40,* p. 1.

102   *Submission 40,* p. 5.

103   *Submission 40,* p. 7.

104   Women and Mental Health Inc, *Submission 310*, p. 4; Merinda Epstein, *Submission 207,* p. 15; Newtown WDVCAS: Marrickville Legal Centre, *Submission 51,* p. 2; Rob Moodie, *The health Costs of Violence – A Summary of Findings*, Victorian Health Promotion Foundation*,* 2004.

105   Women and Mental Health Inc, *Submission 310*, p. 3.

and BPD and who have experienced various forms of childhood trauma and abuse, the suicide rate is double that for persons with PTSD alone.[106]

11.91   The strong link between child abuse, domestic violence and mental illness has important implications for service response and clinical treatment. For example, Women and Mental Health Inc note that:

> …considerable skill is required to interpret disclosures [of sexual assault] presented by people who are experiencing a psychotic episode and ensuring that staff understand these disclosures, rather than interpreting them as part of the mental illness.[107]

11.92   The mental health impacts of family and domestic violence can continue through generations. Children exposed to domestic violence have a high risk of developing mental illness.[108] Where a mother has been subjected to domestic violence, this can result in ante-natal or post-natal depression, reducing her ability to interact and bond with her child leading to early developmental problems and poor mental health.

11.93   Collaboration between services and long-term supports are needed:

> Violence is a complex issue and an interagency approach to safety for women and children experiencing domestic/family violence is fundamental if outcomes for consumers are to be improved. This requires that the mental health sector at all levels of the mental health hierarchy, actively support and sustain collaborative engagement with other agencies. Resolution of violence issues takes time and this requires that mental health change its focus to sustained involvement with some families.[109]

11.94   Mental health services are required that are responsive to the needs of those who have suffered, or continue to suffer, abuse.

Concluding remarks

11.95   The benefits of having family members as carers are significant, and have been shown to improve health outcomes for people with mental illness. Families are justifiably proud of their achievements in caring for one, or quite often multiple, family members with mental illnesses:

> As a family we are the primary carers for my son who is able to live independently because of the support he receives from us.[110]

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106   Broken Rites (Australia) Collective Inc., *Submission 340*, p. [7].

107   Women and Mental Health Inc, *Submission 310*, p. 2.

108   AICAFMHA, *Submission 83,* p. 18.

109   Women and Mental Health Inc, *Submission 310*, p. 5.

110   Name withheld, *Submission 95,* p. 1.

11.96   But families as carers, as well as other community members providing care to people with mental illness, need help. Support services should ensure families and carers are able to provide care without feeling overwhelmed in their role, but evidence outlined elsewhere in this report shows that this support is wanting, particularly in the community. There is also inadequate support for carers in the areas of education and training, financial and emotional assistance, and respite. Negative consequences include cessation of their role as carer, inadequate or inappropriate care provided to the consumer, or – as was raised in evidence to the inquiry – the carer develops mental health problems themselves.

11.97   There is evidence that some families may be exposing children to environments which may contribute towards the onset of mental illness or exacerbate its symptoms and effects. Mental healthcare should endeavour to strengthen family relationships and empower all involved members, and recognise that some families may need additional assistance.

11.98   There are a number of programs supporting carers and families in their roles, and it is also clear that the National Mental Health Plan 2003-2008 recognises that the voices of carers should be heard in the formulation of mental healthcare policy, planning and treatment.   However, funding over the long term to sustain such programs is not assured, and there appears to be limited effort directed to benchmarking and rolling out effective carer and family services on a national scale. Given the critical role of families and carers in community based care, adequate resourcing must be provided to support this overworked and overburdened group in the community.

CHAPTER 12

PAYING FOR MENTAL HEALTH CARE

12.1   Mental health services are funded and delivered through both public and private sectors. The types of services delivered, and cost to the consumer in accessing these services, can vary greatly. Public sector mental health services include stand-alone psychiatric hospitals, psychiatric units in general hospitals, community residential units and community mental health services.[1] Other health services, such as hospital emergency departments are also provided by the public system and, as discussed in Chapter 8, now provide a large component of mental health crisis care. Private sector services include private psychiatrists, general practitioners, private psychiatric hospitals and private allied health professionals such as psychologists.[2]

12.2   The development of these two parts of the mental health sector has been characterised by four features:

- an 'illness divide' between the public and private sectors, with gaps developing that neither effectively addresses;

- growth in the private hospital system, raising questions about how this accords with the NMHS;

- a lack of coordination between the two sectors, which is a common complaint in mental health generally; and

- problems with the costs of access to care and with private health insurance.

12.3   The National Mental Health Strategy 2003-2008 sets out bold principles regarding access and equity:

> Australia's universal health care system guarantees access to basic health care (including mental health care) as a fundamental right. Individuals in need of care should not only have timely access to such care, but the services they receive should be of a quality that is at least consistent with other developed countries, if not better. Access to and quality of care should be equitable, and people should not be disadvantaged by, for example, being on a relatively low income, having particularly complex needs or living in a rural area.[3]

12.4   Submitters questioned the extent to which the current mental health care system meets these access and equity principles. As one witness put it: 'Evidence

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1   Australian Government, *Submission 476,* p. 6.

2   Australian Government, *Submission 476,* p. 6.

3   Australian Health Ministers, *National Mental Health Plan 2003-2008*, 2003, p. 10.

abounds of the financial and geographical barriers to timely access to equitable health care'.[4]

An illness divide?

12.5   Mental health professionals working in the public sector are overburdened tending to consumers with low prevalence, acute disorders. There is very limited capacity to provide services to those with high prevalence disorders such as anxiety and depression, or to engage in early intervention and prevention strategies. The committee repeatedly heard stories of how seriously ill people are being turned away from public services. One clinician memorably remarked they were at the point of triaging 'the more suicidal from the less suicidal'.[5]

12.6   Evidence suggests that a divide is developing in the hospital system, with the public system stretched in catering for the most acute cases, while the private sector is providing services for people with high prevalence disorders. For example, in 2002-03, among patients receiving specialised psychiatric care in public hospitals, schizophrenia was the most common principal diagnosis, followed by depressive episodes and bipolar affective disorders. By contrast, in private hospitals the most common principal diagnoses were depressive episodes, recurrent depressive disorders and reaction to severe stress and adjustment disorders.[6] The differences between the two systems were highlighted by a private provider:

> It is becoming increasingly apparent that advanced trainees and medical graduates who go on to become general practitioners are being exposed to a very narrow spectrum of mental illnesses in the public sector. Given the projected growth in conditions such as depression and anxiety, it would be beneficial to rotate medical staff into the private sector so that they can gain greater experience in the treatment and management of patients with high prevalence disorders.[7]

12.7   It is possible to see the two sectors as complementing each other in the provision of mental health services.[8] However, there appears to be at least one significant problem with this view. All consumers may be able to obtain acute care in the public system (though there are serious issues in this area, outlined in the chapter on inpatient and crisis care). Wealthy consumers and consumers with private health insurance can gain assistance with serious high prevalence disorders (depression, substance abuse, and anxiety). However those consumers with high prevalence

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4   Doctors Reform Society, *Submission 220*, p. 1.

5   Dr Andrew Chanen, Consultant Psychiatrist and Senior Lecturer, ORYGEN Youth Health and ORYGEN Research Centre, *Committee Hansard*, 7 July 2005, p. 7.

6   Australian Institute of Health and Welfare, *Mental Health Services in Australia 2002-2003,* Canberra, AIHW Mental Health Series no. 6, pp. 124–25. Data refer to hospital separations for patients who received specialised psychiatric care.

7   Healthscope Ltd, *Submission 82*, p. 4.

8   Australian Private Hospitals Association (APHA), *Submission 143,* p. 2.

disorders, who are not in an acute enough state to receive care in public hospitals and not fortunate enough to have the financial resources to obtain private treatment, are at risk of falling through the divide between the public and the private systems.

12.8   In addition, the divide between public and private services in other areas of the health system impacts on people with mental illness:

> People with mental illness quickly acquire a backlog of health complaints that remain largely undiagnosed and/or untreated. Dental care is beyond the reach of most people with mental illness as well as their families unless they are able to afford private health insurance.
>
> …'You don't have to be mentally ill for long, before you can't afford basic health care. Add in becoming homeless and you soon gather a number of health complaints.'[9]

The growth of private hospitals

12.9   Under the NMHS there has been a targeted reduction in public sector psychiatric beds. The NMHS continued a process of closing stand-alone public psychiatric institutions that had begun in the 1960s. Acute care psychiatric beds were brought into general hospitals and there was an intention to expand community-based services. However, as public sector psychiatric beds numbers have reduced, the number of private sector beds has increased. Between 1993 and 2003, psychiatric beds in private hospitals increased by 37 per cent. By 2003, psychiatric beds in private hospitals provided 22 per cent of all psychiatric beds in Australia, up from 14 per cent in 1993. However, unlike beds in public hospitals most beds in private hospitals (72 per cent in 2003) are in stand-alone psychiatric hospitals.[10]

12.10   The funding arrangements between private health funds and private hospitals effectively encourage inpatient services and are at odds with the NMHS's policy position on moving to community-based care. The Committee is concerned about this trend. The mental health funding tensions for the health funds and private providers is discussed later in the chapter.

Coordination between the sectors

12.11   There was a common call for the public and private sectors to work together more effectively to produce better outcomes for people experiencing mental illness. A lack of coordination was described at many levels, including at the policy level,[11] and in private practitioner care of individual patients:

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9   Mental Health Community Coalition of the ACT Consumer and Carer Caucus, *Submission 214,* p. 3.

10   Australian Government, *National Mental Health Report* 2005, pp. 56; 160. Stand-alone private psychiatric hospitals were defined as those private hospitals in which psychiatric beds made up more than 75 per cent of all available beds. See *Mental Health Report 2005,* p. 157.

11   APHA, *Submission 143,* p. 2.

Integration and partnerships between public and private mental health services and the ability of consumers to traverse seamlessly between settings is required if optimal outcomes are to be achieved. For example, a person may be admitted to the public sector setting during an acute exacerbation of their illness under the care of a multidisciplinary team. When discharged, they return to their treating psychiatrist in private sector office based practice setting. Whilst this appears to be an ideal situation, the facts are that once the consumer enters the public mental health sector, there is very little, if any, consultation with their treating private psychiatrist. Medication regimes are often changed, treatments altered, and discharges occur without the private psychiatrist being aware of such changes. This represents the norm rather than isolated incidences. In these cases, there is a communication breakdown between sectors, and this needs to be addressed.[12]

12.12   Submitters from both the public and private sectors supported calls for increased collaboration. The Australian Private Hospitals Association (APHA) said:

Available data on the ageing of the population, increasing acuity of patients and increasing prevalence of mental illness all point to the need for the public and private sectors to work much more closely together to ensure appropriate and comprehensive care is provided throughout the episode of care.[13]

12.13   The Australian Healthcare Association (AHA) said

The AHA supports more effective partnerships between the public and private hospital sectors including improved mechanisms for collaboration. Implementation of greater coordination and collaboration would require the involvement of health funding bodies and the health insurance industry. A revised system could incorporate mechanisms to fund private hospital mental health service providers to become more involved in crisis response and initial care and to facilitate greater consultation with primary care practitioners.[14]

12.14   Additionally, it would be beneficial if private sector patients had improved access to public services such as allied health practitioners (eg. occupational therapy) and rehabilitation, for more inclusive and comprehensive care.[15]

Constraints on services and the cost of care

12.15   One carer, looking back over years of caring for her daughter with treatment-resistant paranoid schizophrenia, recalled one of the early consultations:

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12   National Network of Private Psychiatric Sector Consumers and their Carers, *Submission 189*, p. 14.

13   APHA, *Submission 143,* p. 3.

14   Australian Healthcare Association (AHA), *Submission 169,* p. 11.

15   AHA, *Submission 169,* p. 11.

> At the consultation the Psychiatrist said that our daughter was mildly psychotic, that it was probably a one-off incident and in all likelihood she would be better within six months. We also received from this specialist the best and most practical advice, which could have been given, which was to sign her up for private medical cover.[16]

12.16   As this carer's experience suggests, affordability of mental health services is a major issue. There are three reasons it is such a problem: limited access to care in the public system; the high cost of private mental health care; and, the often low incomes of people with mental illness.

Limited access to public health care

12.17   As already mentioned above, and in other chapters, public mental health care services are generally hard to access for all other than the most serious cases. These constraints are often felt most keenly by those seeking to access the assistance of specialist mental health professionals, particularly psychiatrists and psychologists.

12.18   While psychiatrists and psychologists are employed in the public sector, the strain on resources in this sector means that services are limited. Psychiatrists working in the public sector are so busy coping with acute crises that they are often unable to provide prevention and early intervention treatments or deal with the high prevalence disorders. While the public sector is a major employer of psychologists, evidence suggests that the sector increasingly employs psychologists in generic positions, such as case managers, rather than in clinical positions to provide psychological assessment and treatment. As with psychiatrists, psychologists in the public sector report being overburdened with the most severe disorders, leaving those with nevertheless complex and disabling high prevalence disorders unattended.

12.19   Given the pressure on the public sector, access to mental health care in general, and psychiatrists and psychologists in particular, is often only possible through the private sector.

High costs

12.20   The federal government subsidises the cost of private sector services in a number of ways. For all patients, the PBS subsidises access to many pharmaceuticals. Under the Medicare Benefits Schedule, rebates are provided for GP and psychiatrist consultations. However, as noted in Chapter 6 not many psychiatrists bulk bill, and although GP bulk billing rates have largely been restored to 2002 levels following government incentives, there are still many parts of Australia where bulk billing rates are low or non-existent.[17] Many submissions argued that the Medicare schedule fee structure discourages the long GP appointments which are often required for mental health care.

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16   Name withheld, *Submission 208*, p. 3.

17   The Australian Council of Social Services (ACOSS), *Submission 457*, p. 11.

12.21   Public funding to assist with access to private psychologists is even more restricted, with no direct rebates available. As discussed in Chapter 6, under the Better Outcomes initiative, accredited GPs can refer patients for psychological treatment, with minimal costs incurred to the consumer. However, this requires that an accredited GP is available, and the number of funded sessions is limited. GPs can also refer patients for psychology services through the Chronic Diseases Management scheme. This does not require the consumer to find an accredited GP, but the rebate is a set price and the cost to consumers remains high. Also, consumers must have a complex and chronic condition to qualify for the service. Therefore, while public funds subsidise consultations with private mental health professionals to some extent, accessibility is an issue and cost remains a major barrier for many consumers.

Low incomes

12.22   Using private health insurance to access private mental health service requires that consumers can both afford the insurance in the first place and also afford any remaining gap payments. Many cannot:

> The role of private mental health services is such that unless mental health consumers have a private income, have employment which affords them paying for private health care, then the private mental health services are simply way out of the reach of mental health consumers.[18]

12.23   Micah Projects Inc commented:

> …the capacity to pay is beyond the means of many who present to Micah with mental illness so private providers are not an option for the poor, those living below the poverty-line.[19]

12.24   The Australian Council of Social Services (ACOSS) said:

> …a disproportionate number of people with mental illness live on low incomes, cannot afford co-payments and do not hold private health insurance.[20]

12.25   Submitters expressed concern that government funding to support the private sector effectively reduces funding to the public sector, where it is most likely to assist those on low incomes. Anglicare Tasmania said:

> …access to private services largely remains the domain of those able to afford private health insurance. The development of this sector should not occur at the expense of the public system.[21]

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18   Northern Beaches Mental Health Consumer Network, *Submission 60,* p. 8.

19   Micah Projects Inc, *Submission 67*, p. 6.

20   ACOSS, *Submission 457,* p. 11.

21   Anglicare Tasmania, *Submission 464*, p. 19.

12.26   The federal government's 30 per cent rebate on private health insurance provides some assistance. However those that cannot afford private health insurance, including many people with mental illness, are not able to benefit from this subsidy.

Conclusions

12.27   In the area of mental health, a divide is becoming clearly evident between the public and private sectors:

> The risk here is that some will continue to fall through the cracks of each sector - with no where to go except onto the streets and into prisons.
>
> Another concern is that a two-tiered mental health system is emerging – one based on a user-pays regime and one based on resource-strapped public provision. This has serious implications for access and equity.[22]

12.28   In an environment of high costs and impaired ability to earn an income, holding private health insurance can be critical to gaining access to affordable and adequate care. The widespread lack of private health insurance amongst people with mental illness means that private services are commonly not an option, particularly amongst those for whom mental illness has contributed to poverty and ongoing hardship. Complex issues regarding private health insurance were raised with the committee during its inquiry, and it is to this that the report now turns.

Private health insurance in Australia

12.29   As at 30 June 2005 there were approximately 8 699 000 Australians covered by private health insurance.[23] There are currently 40 registered health funds in Australia. Of these 40 funds, 26 are open to any Australian resident over 16 years of age, and 14 are restricted to a specific group of people, generally employees of organisations or members of some unions.[24]

12.30   Private health insurance is different to most other types of insurance offered in Australia in that it is community rated, not risk rated, meaning that a person 'should not be discriminated against in obtaining or retaining insurance coverage'.[25] That is, 'in setting premiums or paying benefits, funds cannot discriminate on the basis of health status, age, race, gender, sexual orientation, religious belief, use of hospital, medical or ancillary services or claiming history'.[26] Funds must accept all applicants, within

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22   Micah Projects Inc, *Submission 67*, p. 6.

23   Membership Statistics, Australian Government, Private Health Insurance Administration Council, http://www.phiac.gov.au/statistics/membershipcoverage/hosquar.htm, (accessed 14 September 2005).

24   The Private Health Insurance Ombudsman (PHIO), *The State of the Health Funds Report— 2004*, p. 8.

25   Australian Government, *Submission 476*, Attachment 1, p. 1.

26   Australian Government, *Submission 476*, Attachment 1, p. 1.

certain membership categories. In principle, this means that 'private health insurance policies (and premiums) are the same for people who need mental health care as for people needing any other type of health care'[27] and 'community rating institutionalises cross subsidies from fund members who make relatively little use of health care services to fund members who have relatively high use of those services'.[28]

12.31   There has been much conjecture about whether the community rating approach is working, including whether '[t]he community rated 'community' is now largely made up of older and sicker Australians'[29] and what impact this may have on insurance premiums. This has lead to some watering down of the strict application of the community rating system, through the imposition of 'excesses' and 'exclusions' by health funds. In a submission to the Industry Commission inquiry into Private Health Insurance in 1997, MBF had this to say about the need for innovative arrangements:

> Unless 'innovative' packages attract previously uninsured people and the contribution paid contains a subsidy component for higher claiming members, the main effect is to reduce the funding available from standard cover participants. Over time, the prices of cover for those people most likely to need hospital care will rise to levels such that an increasing number of people cannot afford to maintain membership for the benefit entitlement they need— and the problems for Medicare will grow larger.[30]

12.32   The Australian government has addressed the reduced take up of private health insurance by legislating on portability, providing $2.5 billion in 30 per cent rebates on premiums in 2003–04[31] and a lifetime health coverage regime, to attract and retain new entrants. The advantages of private health insurance cover for in-patient mental health treatment, the fear that premiums would become unaffordable and doubts that the public sector could provide such services, were outlined:

> I am one of the lucky ones in that I have private health cover at the moment, a psychiatrist I am able to trust and one of the few that bulk bills…To date I have been hospitalised on three occasions. I have been able to receive this high quality of treatment at short notice purely on the basis of my having private cover. Given our dwindling financial situation I am afraid that I shall be unable to maintain my current private health cover and

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27   Australian Government, *Submission 476*, Attachment 1, p. 1.

28   Industry Commission (Productivity Commission), *Private Health Insurance, Report No. 57*, 28 February 1997, p. 34.

29   Industry Commission (Productivity Commission), *Private Health Insurance, Report No. 57*, 28 February 1997, p. 35.

30   Industry Commission (Productivity Commission), *Private Health Insurance, Report No. 57*, 28 February 1997, p. 36.

31   Australian Institute of Health and Welfare, *Health Expenditure Australia 2003–04*, p. 27, http://www.aihw.gov.au/publications/hwe/hea03-04/hea03-04-c03.pdf, (accessed March 2006).

> will become another burden on the Public that seems unable to cope with people in my position…[32]

> Pension rates do not allow people with mental illnesses to access private health insurance and decent quality services.[33]

12.33   Health funds are becoming 'innovative' in the way they interpret the 'complex'[34] legislative regime governing insurance and the way they construct the products that they offer. Accordingly, the actions of private health insurance funds, in complying with the community rating methodology, are continually under the microscope.

Mental health service entitlements within private health insurance

12.34   Regulation of health funds is administered by the Private Health Insurance Branch of the Department of Health and Ageing, under the *National Health Act 1953*.[35]

12.35   Only funds registered under this act are able lawfully to carry out the business of health insurance, with the 'conditions of registration covering such matters as: categories of membership, waiting periods for benefits, transfer arrangements between tables and funds, the types and levels of benefits, and requirements about contracting with hospitals and doctors'.[36]

12.36   The Minister for Health and Ageing can apply conditions of registration requiring them to provide certain product offerings.[37] Sanctions for non-compliance with these conditions include deregistration.

12.37   Under regulation, each fund must offer:

- at least a minimum specified level of benefit (ie the basic or default benefit), for all public and private hospitals for all conditions covered in the policy taken out by the fund member; and

- cover in every (ABA) policy for in-hospital psychiatric, rehabilitation and palliative care, at least at the default level.[38]

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32   Name withheld, *Submission 78*.

33   Name withheld, *Submission 208*.

34   Ms Christine Gee, Vice-President, Australian Private Hospitals Association; Chair, Psychiatry Committee, Australian Private Hospitals Association, *Committee Hansard*, 4 July 2005, p. 51.

35   Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch, Department of Health and Ageing (DoHA), *Committee Hansard*, 7 October 2004, p. 73.

36   Industry Commission (Productivity Commission), *Private Health Insurance, Report No. 57*, 28 February 1997, p. 47.

37   Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch, DoHA, Committee Hansard, 7 October 2004, p. 73.

12.38   The reason for mandatory coverage for psychiatric care was best summed up in the Industry Commission report in 1997 by the National Community Advisory Group on Mental Health:

> The extent of mental illness is not well understood or accepted by the community. Members and potential members of health funds are likely to seriously underestimate their risk in requiring psychiatric treatment. Therefore, psychiatric care is not an appropriate form of treatment to be excluded from insurance products.[39]

12.39   Community rating in private health insurance should mean fund members with mental illness are not discriminated against but the Committee heard evidence that this was not the case. The National Network of Private Psychiatric Sector Consumers and Carers (NNPPSCC) said:

> The National Network calls on the Senate Select Committee on Mental Health to address the steady attempt by private health insurers to restrict their coverage for services that are accessed by private consumers who have a chronic mental illness.[40]

12.40   Catholic Health Australia said:

> The packaging by some private health funds of mental health as an 'optional' extra, rather than an essential component of health, leads many people without cover for mental health and psychiatric services. Even when mental health is included in the insurance coverage, portability of private health insurance can be problematic and is an area that could be markedly improved with appropriate policy and legislative responses.[41]

12.41   They also argued that:

> Private health insurers have placed too many restrictions on the types of services they will fund and by their rigid funding controls have essentially defined how private mental health and psychiatric services are delivered in Australia.[42]

12.42   While blueVoices, the consumer and carer arm of beyondblue, identified a key concern as:

> Discrimination in insurance preventing people with common disorders like depression and anxiety from taking out private insurance or resulting in

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38   Industry Commission (Productivity Commission), *Private Health Insurance, Report No. 57*, 28 February 1997, p. 53.

39   Industry Commission (Productivity Commission), *Private Health Insurance, Report No. 57*, 28 February 1997, p. 57.

40   The National Network of Private Psychiatric Sector Consumers and Carers (NNPPSCC), *Submission 189*, p.7.

41   Catholic Health Australia, *Submission 276*, p. 19.

42   Catholic Health Australia, *Submission 276*, p. 20.

high premiums charged to persons who may have a history of these conditions (even if not a current diagnosis).[43]

12.43   This concern was also raised by ACOSS.[44]

What benefit payments do health funds provide in general?

12.44   In general terms, private health insurance provides three types of benefit:

- a supplement to the Medicare rebate for doctors' fees for in-hospital treatment, which can vary from an amount equivalent to 25 per cent of the Medicare Benefits Schedule (MBS) fee, to a higher amount under a gap cover arrangement;

- payments towards hospital accommodation costs; and

- ancillary benefits.[45]

12.45   Regarding the supplement to the Medicare rebate: '[w]hen a doctor's charge exceeds the MBS fee, legislation allows health funds to pay benefits to eliminate or reduce the out-of-pocket payment required from the consumer, providing there is a formal agreement or gap cover scheme in place'.[46]

12.46   There is much variation to what hospital costs a fund will provide from full to limited coverage, depending on the insurance cover purchased, and whether the fund has a contract with the hospital: '*The National Health Act 1953* requires health funds to pay at least the Commonwealth determined default benefits for hospital services where a private consumer is treated in a public hospital, or in a private hospital that does not have a contract with the consumer's health fund'.[47]

12.47   Hospitals and health funds are able to enter into contracts for payment of accommodation costs above the Commonwealth default rates, however, these agreements may:

- place conditions on the payment of psychiatric benefits;

- vary between 100 per cent cover for hospital related costs to partial cover with the consumer paying a known co-payment; and

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43   blueVoices, *Submission 259*, p. 4.

44   ACOSS, *Submission 457*, p. 3.

45   Australian Government, *Submission 476*, Attachment 1, p. 1.

46   *Submission 476*, Attachment 1, p. 2.

47   *Submission 476*, Attachment 1, p. 2.As at 1 July 2005 the default amount was set at approximately $261 for overnight treatment in a shared ward and $157 per day for outreach services, although these figures are subject to adjustment and may now be higher. See Department of Health and Ageing, *Private Health Insurance Circular—PHI 45/05*, 29 September 2005.

- cover the payments of benefits on a total or episodic basis, that is, in a lump sum payment.[48]

12.48   These arrangements allow flexibility for health funds to 'determine benefit levels in light of the overall needs of their contributors and the desire to keep contribution rates affordable for as many people as possible'.[49]

12.49   'Health funds may also pay benefits for non-admitted services offered by allied health care professionals, such as clinical psychologists from their ancillary tables', however, these ancillary benefits are less regulated and cannot provide coverage from which a Medicare benefit is payable.[50] Furthermore:

> These ancillary benefits are usually capped at a dollar figure per service and/or a total annual dollar figure.[51]

Portability

12.50   During the late 1980s funds were imposing significant waiting periods for members who wished to change funds; costs were high and funds were not competitive. The government viewed true 'portability' between funds as the panacea to redress these concerns.

12.51   Portability of private health insurance from one fund to another, without automatically resetting waiting periods, was effected through the *Community Services and Health Legislation Amendment Act 1988* (No. 79 of 1988), adding sections (1a) to (1f) to Schedule 1 of the *National Health Act 1953*.

12.52   The second reading speech by the Minister for Housing and Aged Care said :

> The bill also provides for increased freedom of choice for members of health insurance funds currently locked into a single health benefits organisation. This will be done by removing existing impediments to transfer between organisations.[52]

12.53   The Minister continued:

> The National Health Act is also amended to allow contributors to health insurance who wish to transfer from one health benefits organisation to another, because of factors such as lower contribution rates and other benefits, to do so without having to face difficulties through the imposition of new waiting periods. These measures improve the freedom of choice for that half of Australia's population which currently has private health

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48   Australian Government, *Submission 476*, Attachment 1, p. 2.

49   *Submission 476*, Attachment 1, p. 2.

50   *Submission 476*, Attachment 1, p. 2.

51   *Submission 476*, Attachment 1, p. 2.

52   *House Hansard*, 21 April 1988, p. 1991.

insurance. Members will be able to transfer from one organisation to another without the imposition of waiting periods, or with reduced waiting periods where part or whole of the waiting period has been served in the previous organisation.[53]

12.54   When this legislation passed each fund published the benefits they would pay for each type of service covered. Benefit tables were also broadly comparable.

> Until October 1995, the Commonwealth Government defined a set of benefits that all health organisations had to pay as a minimum when an insured person was treated in any recognised (public) hospital, or licensed private hospital (including day hospital facility). This set of benefits included basic table hospital costs, as determined by the minister for Health and Family Services. Health funds could also offer supplementary cover for the additional costs for treatment in a private hospital (or a single room in a public hospital). The level of supplementary benefits was not regulated.[54]

12.55   Where a person transferred from one fund to another they were covered up to the level of coverage they held in the previous fund. The Australian Health Insurance Association explained:

> …the original portability entitlement was based on the dollars that a fund paid. So if fund A paid $300 per day and a member transferred to a fund that paid $350 per day, the entitlement they took with them was not the new fund's benefit, but the old fund's $300 for the first 12 months of membership, after which they would get the increased amount. This was to make sure that a member—or, for that matter, a provider talking to them – could not strategically upgrade their cover by changing funds, whereas they would not be able to upgrade their own cover within a fund without being subject to a waiting period.[55]

The changing environment—Purchaser/Provider Agreements (contracts)

12.56   Debate on the current portability arrangements intensified when published benefits were replaced with a direct contracting system between health funds and hospitals:

> In 1995, the Keating government legislated to allow purchaser/provider agreements (contracts) between funds (as the "purchaser") and hospitals and doctors (as the "providers"). These provisions were amended in late 2000 by the Howard government to permit medical gap cover without contracts.

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53   *House Hansard*, 21 April 1988, p. 1991.

54   Industry Commission (Productivity Commission), *Private Health Insurance, Report No. 57*, 28 February 1997, Box 3.19, p. 53.

55   Mr Russell Schneider, CEO, AHIA, *Committee Hansard,* 4 July 2005, p. 63.

> Another very important initiative in 2000 was the introduction of Lifetime Health Cover.[56]

12.57   The Industry Commission advised:

> From 29 May 1995…health funds were able to negotiate different agreements with different hospitals. Applicable Benefits Arrangements (ABAs) came into existence. This term describes an arrangement between a health fund and its contributors under which contributors are covered for fees and charges related to hospital treatment (including medical charges). ABAs are more flexible then the basic and supplementary table system.[57]

12.58   Mr Schneider expressed the view of insurers:

> About 10 years ago, contracting of health funds and hospitals moved in to replace the old system of published benefits. So the dollar amount became invisible. The question then became one of whether the fund had a contract with a hospital or not. Our problem is that contracts do not run all the time and they can be broken by one party or the other. When they are broken, it is often the hospital which will initiate the cessation of the contract simply because it does not consider the benefits being paid by one fund are adequate and at times the breaking of the contract may be a strategic part of the whole negotiation process.[58]

12.59   Under this system what a fund will pay a hospital or doctor for a treatment remains confidential to the parties. Accordingly, whilst a person may transfer from one fund to another for a number of reasons, for example, to ensure they retain the same treating physician or to change the type of cover, the negotiated payment between the fund and the hospital for a particular treatment will be different for each fund. Also, and probably just as importantly, negotiations can result in a fund and hospital not agreeing to contract, or contracting to provide some services but not others, ultimately meaning that a member has no, or in the case of treatment for psychiatric illness, only the Minister's prescribed default coverage if they choose to be treated at that hospital.

12.60   This has ramifications for fund members receiving mental health treatment who wish to maintain a relationship with the treating specialist.

12.61   The APHA argued:

> Services offered by private mental health facilities are also influenced by private health insurance funds. For the most part, private mental health facilities receive the bulk of their funding via private health insurance funds

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56   Access Economics Pty Ltd, *Enshrining Portability of Health Insurance*, Final Report for the Australian Private Hospitals Association, June 2005, p. 2.

57   Industry Commission (Productivity Commission), *Private Health Insurance, Report No. 57*, 28 February 1997, Box 3.19 p. 53.

58   Mr Russell Schneider, CEO, AHIA, *Committee Hansard,* 4 July 2005, p. 63.

under Hospital Purchaser Provider Agreements (HPPAs) which operate within a regulatory framework of the *National Health Act 1953*. For many private mental health facilities, this is a flawed framework that does not deliver a level playing field.[59]

12.62   APHA, however, did not go into specific details as to how the playing field is affected.

The Private Health Insurance Ombudsman

12.63   In 1995 the Australian Government, through the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995,* set up the office of the Private Health Insurance Complaints Commissioner (PHICC) with five key roles:

- deal with complaints and conduct investigations;

- publish aggregate data about complaints;

- make recommendations to the Minister and Department of Family Services;

- make available and publicise the existence of the Private Patients Hospital Charter; and

- promote an understanding of the Complaints Commissioner's functions.[60]

12.64   The office of the PHICC was replaced in 1998, through amending legislation (*Health Legislation Amendment Act (No.2) 1998*), by the office of the Private Health Insurance Ombudsman (PHIO). The role and functions of the PHIO were essentially the same as the PHICC, however, there was some minor strengthening.[61]

12.65   Prompted by continuing concern with the way the portability legislation had been interpreted by the various players in the industry the PHIO determined to undertake a review during 2000. The PHIO concluded:

> …the provisions fail because there is a dispute on what constitutes a broadly comparable benefit and the effect of different components within products to establish beyond doubt the relevant part of the relevant benefit.[62]

12.66   In his 2001 Annual Report, the PHIO advised:

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59   APHA, *Submission 143*, pp. 3–4.

60   Private Health Insurance Complaints Commissioner (PHICC), *Annual Report* 1997, p. 9.

61   To allow the PHIO to 'arbitrate disputes between private hospitals and health funds regarding second-tier benefits payable in respect of health fund members', PHIO, *Annual Report* 2001, p. 13.

62   PHIO cited in Access Economics Pty Ltd, *Enshrining Portability of Health Insurance*, Final Report for the Australian Private Hospitals Association, June 2005, p. 12.

A second area where consumers have consistently faced difficulty is in the area of product portability. The National Health Act as it relates to portability is extremely complex and again it is an area where the interpretation and subsequent application of the provisions by funds has been inconsistent.[63]

12.67   On speaking about the results of the review the PHIO went on to further say:

The Ombudsman's office, in liaison with officers of the Department of Health and Aged Care, together with health funds industry representatives combined to produce a set of twenty seven recommendations in a comprehensive review of portability arrangements. The review was completed and published in December 2000.

The basic principle underpinning all of the recommendations is that any member transferring from one product to another, either within a fund or between funds, will never be placed in a more adverse position than a new member entering that product for the first time. Although outwardly this principle seems so evident as to not need stating, it was not the position universally adopted and as a consequence aberrant practices led to significant disputes.[64]

12.68   The review appeared to arrive at an industry consensus as to what behaviour was required to ensure that the industry would not come under such focus as to require more vigorous regulation. In essence, a voluntary adherence to the recommendations of the review appeared to be a preferable option by the industry.

12.69   However, in his 2004 Annual Report, the PHIO advised, once again, of the perennial issues arising through complaints to his office. These issues were listed as:

- the rights of consumers when changing health funds;

- the impact of hospital/health fund contract negotiations;

- the adequacy of information provided to consumers about what costs their health insurance will and won't cover;

- reasonable advance notice of the costs of hospital services in hospitals (Medical Gaps); and

- the application of the pre-exiting ailment waiting period provision.[65]

12.70   The current PHIO, Mr John Powlay, advised the committee that of the 2 600 complaints received by his office annually approximately 25 have related exclusively to psychiatric treatment, however, he suggested that complaints are dealt with which

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63   PHIO, *Annual Report* 2001, p. 8.

64   PHIO, *Annual Report* 2001, p. 8.

65   PHIO, *Annual Report* 2004, p. 7.

may involved issues of psychiatric treatment which are not recorded as such.[66] In any case the number directly attributed to psychiatric treatment was small.

12.71   The PHIO further advised:

> The range of issues about which we have received complaints includes restrictions on the level of benefit for psychiatric treatment, hospital contracting where the hospitals were psychiatric hospitals or the contracting issue involved payment for psychiatric treatment, the application of co-payments where psychiatric programs occurred over a number of weeks and a small number about billing practices of psychiatrists in private practice.[67]

12.72   Dr Wayne Chamley, an accredited health surveyor, in a personal submission, suggested that private patients with mental illness were being discriminated against by the:

- Introduction of co-payments for persons attending Day Program activities. The introduction of the co-payment has been done without any recognition of the patient's prior membership of the fund and it has placed a large cost-burden upon the person with chronic illness.

- Inability of patients with mental illness to exercise their full right of portability.

- Dispute between an individual service provider and an individual insurer can cause great distress to patients and in some cases the patient has been forced to find a new treating psychiatrist.[68]

12.73   Whilst the industry as a whole has attempted to resolve a number of issues, it appears that in the eyes of some stakeholders this has failed. The National Network of Private Psychiatric Sector Consumers and their Carers (NNPPSCC) raised as ongoing problems 'portability between health funds, exclusionary health insurance products, limitations on benefits paid for hospital-based care, co-payments for day programs, and disputes between hospital providers and health funds'.[69]

Portability: issues of concern

12.74   Whilst the intent of the portability arrangements was to enable people to transfer between funds without incurring additional waiting periods, some processes and practices have developed which appear to impact upon this principle.

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66   Mr John Powlay, Private Health Insurance Ombudsman (PHIO), *Committee Hansard*, 28 October 2005, p. 15.

67   Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 15.

68   Dr Wayne Chamley, *Submission 339*, p. 10.

69   NNPPSCC, *Submission 189*, p. 7.

Contract disputes

12.75   Whilst most funds do cover a significant range of hospitals and doctors under contract arrangements, each contract has a definite life and will need to be reviewed at some stage and can be broken by either party. During these contract negotiations and disputes consumer protection is often at risk. The PHIO stated:

> It is disappointing to record that on a number of occasions during this year vulnerable consumers were placed in a position of heightened anxiety when hospitals and health funds were in dispute concerning the outcome of contract negotiations. My office was called upon to placate very frightened elderly, pregnant and sick consumers who were informed by hospitals, that they were no longer covered by their health funds.

> Hospitals, which were unable to negotiate benefits they considered appropriate, contacted past and prospective patients directly, informing them that their health fund would not honour previous levels of benefit and as a consequence the patient would be better off changing funds.[70]

12.76   The PHIO was particularly disturbed to see both the hospitals and health funds engaging patients in the disputes and that these disputes were causing concern for consumers and their families:

> Some families continue to pay private hospital insurance to ensure that their relative can access private hospitals; however there can be difficulties since one of the largest private health insurance funds in Victoria no longer has a contract with one of the largest private psychiatric hospitals.[71]

12.77   Dr Michael Coglin, Chief Medical Officer, Healthcope Ltd said health funds are actively discouraging people with psychiatric illnesses from obtaining memberships by selectively contracting with hospitals:

> Australia's largest health insurer, Medibank Private, is currently engaged in a large-scale exercise the purpose of which is to discriminately choose – as they would have it—hospitals where the members can be treated, and therefore they do not have contracts with hospitals where their members would be disadvantaged. A patient choosing or preferring that hospital needs access to portability if they do not agree with their health insurer's purchasing choices. That person is entitled to say, 'I don't like the fact that Medibank Private doesn't contract with the hospital I have been going to for 20 years, and therefore I would like to transfer to some other fund that does'.[72]

12.78   The most prominent dispute was between BUPA health funds and the Healthscope hospital group. Both parties were large providers and given the ease of

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70   PHIO, *Annual Report 2001*, p. 10.

71   ARAFEMI Victoria Inc, *Submission 536*, p. 5.

72   Dr Michael Coglin, Chief Medical Officer (CMO), Healthscope Ltd, *Committee Hansard* , 5 July 2005, pp. 16–17.

transferability under the portability regime there was great concern by other health funds of the risk of large scale transfers of members from BUPA funds to their funds, seeking immediate cover, putting their funds under enormous financial strain.

12.79   Mr Schneider discussed the effect of this dispute as follows and appears to infer that the providers of health care, being the private hospitals and doctors, may be manipulating the portability provisions through their direct interaction with health fund members:

> The problem with portability at the moment came about from a dispute that took place between a health fund and a private hospital group in South Australia and Victoria [BUPA and Healthscope Inc dispute] in which the hospital group went out of contract with the fund and then actively encouraged members of that fund to go to other health funds. This was at the point of hospital entry. At the hospital gate people were told that they could either produce their credit card or go to another health fund. My understanding is that in some cases the people were presented with membership forms of another health fund, and all they had to do was sign to move there.

> In the current environment, hospitals know what each health fund pays. Doctors know it too. They are in a position where, if the existing arrangements as they are currently interpreted are applied, providers of health care can effectively arbitrage the system.[73]

12.80   Ms Susan Williams, National Program Manager, Psychiatry, Healthscope Ltd, disagreed:

> The doctors are not as sinister as the health funds make out. They are not really interested in the commercial aspects of the hospital and the health funds; they are interested in continuity of care for their patients.

> But there are reasons why the doctors are encouraging patients to move. They may have had a 10- or 15-year relationship with a patient, they no longer have a contract with the hospital, and they have said, 'move to this health fund and I can continue to treat you.' That is the reason why they are encouraging their patients to move.[74]

12.81   Regarding this dispute the PHIO stated:

> Both the hospital group and the health fund agreed to implement the transitional arrangements previously recommended by the Ombudsman in the "Review of Portability Arrangements for Private Health Insurance" as well as other protections for affected members. These arrangements should have provided sufficient assurances for BUPA members and reduced the incidence of fund transfers. However, other actions and decisions by the hospital group and the fund as well as extensive media coverage led to a

73   Mr Russell Schneider, CEO, AHIA, *Committee Hansard,* 4 July 2005, p. 62.

74   Ms Susan Williams, National Program Manager, Psychiatry, Healthscope Ltd, *Committee Hansard* , 5 July 2005, pp. 18–19.

high incidence of fund transfers, including (apparently) by many people who would have been protected by the agreed transitional arrangements.[75]

12.82   The PHIO advised the committee:

During the dispute, Healthscope aggressively promoted the idea that patients should transfer to other health funds. Medibank and Australian Unity were most significantly affected by this mass transfer of BUPA members. The estimate of the numbers transferring is around 50 000 health fund members. These funds initially indicated that they had refused to guarantee full portability for BUPA members transferring—that is, that they would not extend the benefit of their contracts with Healthscope to transferring BUPA members. But, following intervention from me and the department, both funds agreed to do so before contract arrangements ceased.[76]

12.83   The PHIO further advised:

Both Medibank and Australian Unity experienced substantial benefit payments from transferring BUPA members. Most of those members were transferring at the point at which they were having expensive hospital treatment. Most of these transfers occurred in South Australia and were not related to psychiatric or rehabilitation treatment. BUPA and Healthscope settled their dispute and established full contracts with the key Adelaide acute hospitals. But BUPA and Healthscope reached an agreement between them whereby BUPA would provide only minimum benefits for some rehab hospitals and all Victorian psych hospitals and there would be high out-of-pocket costs for BUPA members. I stress this was not a situation where the fund and the hospital went out of contract; the fund and the hospital agreed between themselves that the payment the hospital would receive would be just above the minimum amount. So there was an incentive for BUPA members to transfer. Australian Unity decided to protect itself and its members against the additional cost of these transfers by implementing these benefit limitation periods on psych and rehab for all its products. The department decided not to recommend disallowance, in part because it had previously approved similar rules for BUPA.[77]

12.84   As a result of the significant movement of members from BUPA to other funds, these funds determined to put in place protection mechanisms to minimise the risk posed by this large scale movement.

12.85   These risk minimisation strategies appear to be counter to the intent of the original portability legislation, however, have been allowed to continue under the self regulation regime. The common practices, which had some application prior to the

75   PHIO, *Annual Report 2004*, p. 7.

76   Mr John Powlay, PHIO, *Committee Hansard,* 28 October 2005, p. 16.

77   Mr John Powlay, PHIO, *Committee Hansard,* 28 October 2005, p. 16.

BUPA dispute, include the use of benefit limitation periods, benefit exclusions and restricted benefits.

12.86 APHA advised the committee through their submission that the current contracting process between hospitals and private health funds are circumventing the intent of the regulatory arrangements:

> Feedback from private hospitals indicate that the following restrictions are being imposed by health funds specifically for the treatment of patients with mental illness:
>
> • Refusal to fund Approved Outreach programs…;
>
> • Refusal to fund half-day programs…;
>
> • Restrictions on the number of days of mental health treatment that a patient can receive in a calendar year;
>
> • Restrictions on the number of same day programs that a patient may attend in a given period;
>
> • Restrictions or capping of the number of particular types of treatment that a patient may receive in a given period; and
>
> • Redefining the length of stay for treatment of particular conditions to levels which are out-of-step with clinical practice.[78]

12.87 These practices are effectively the imposition of waiting periods (new member surcharges) under various guises. Waiting periods and the pre-existing ailment rules are aimed at providing a defence to 'hit and run' activity by fund members 'on an itinerant basis, to snare benefits'.[79] It also appears that these practices impact more greatly upon psychiatric and rehabilitation services.

Benefit limitation periods

12.88 APHA claimed that 'funds have found creative ways around…legislative requirements by introducing 'benefit limitation periods', 'restricted benefit periods' or similar'. For example, BUPA (HBA and Mutual Community Health funds) 'have restricted benefits for mental health services ranging from one year ("Top Hospital cover") to the entire life of the policy ("Hospital saver")'.[80]

12.89 Benefit limitation periods are not specifically identified in the relevant legislation. Sections (l) through to (lf) of Schedule 1, *National Health Act 1953* provide the portability provisions of the legislation and refer to terms such as 'relevant person', 'relevant benefit', and 'broadly comparable benefit', although these terms are also not defined.

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78   APHA, *Submission 143A*, p. 3.

79   Access Economics Pty Ltd, *Enshrining Portability of Health Insurance*, Final Report for the Australian Private Hospitals Association, June 2005, p. 23.

80   APHA, *Submission 143A*, pp. 2–3.

12.90   Benefit limitation periods need to be differentiated from waiting periods *per se*. In his pamphlet titled *The Right to Change—Portability in Health Insurance* the PHIO clarifies the difference of these two concepts. In terms of waiting periods:

> In some circumstances, it would be unfair to the wider membership if a transferred member could immediately access the higher benefits of a new product. Federal legislation therefore allows health funds to apply waiting periods in a range of circumstances.

> The 'Legislated Waiting Periods' provide for a 12 month wait for pre-existing ailments and obstetric conditions and a two month waiting period for all other conditions for new members and those upgrading their hospital cover.[81]

12.91   It therefore, stands to reason that 'where the previous fund product has a benefit limitation, and the member is seeking to transfer to a product without a benefit limitation, the fund has the right to apply the legislated waiting periods before the member is entitled to the higher benefits under the new fund product'.[82]

12.92   During 2004 the PHIO had asserted:

> Recently some funds have sought to limit transferring members' access to their hospital benefits if their previous fund did not have an agreement with a particular hospital; thereby exposing transferring members to larger out-of-pocket costs, for a period. Some of those funds have also introduced rules limiting benefits for certain treatments such as psychiatry and rehabilitation for a period after transfer. While the actions of these funds do protect their existing members from additional costs (which would need to be passed on in premiums), they also threaten to seriously undermine an important consumer right for all health insurance contributors.[83]

12.93   The PHIO advised the committee:

> Under the Health Act, funds do have to pay at least the minimum benefit for psychiatric treatment on all their products. Most of the larger open membership funds have what are called benefit limitation periods.

> Benefit limitations periods pay benefits for some specified treatments but the benefit is limited to the minimum for an initial period of membership— generally between one and three years. Benefit limitation periods are more common in Victoria, South Australia and Western Australia because originally they were designed by AXA, now BUPA health funds, which have a significant share of those markets. The treatments that are most commonly subject to benefit limitation periods are psychiatric treatment,

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81   PHIO pamphlet, *The Right to Change—Portability in Health Insurance*, http://www.phio.org.au/showbrochure.php?id=70, (accessed September 2005).

82   PHIO pamphlet, *The Right to Change—Portability in Health Insurance*, http://www.phio.org.au/showbrochure.php?id=70, (accessed September 2005).

83   PHIO, *The State of the Health Funds Report—2004*, p. 6.

rehabilitation, heart surgery, joint replacement, eye surgery, IVF and obstetrics.[84]

12.94   The PHIO also stated:

> Until April 2004 all funds, except the BUPA health funds, waived benefit limitation periods on transfer if the person already had the requisite period of membership with their previous fund. BUPA apply benefit limitation periods on all transfers, including people who transfer between products within their fund. In April 2004 Australian Unity introduced benefit limitation periods covering just psychiatric and rehabilitation on all its products. They applied these benefit limitation periods to all new joiners, including transfers from other funds. As I said, no other fund, other than BUPA and Australian Unity, applies these limitations on transfer. The distinguishing features of the Australian Unity arrangements are that they apply across the full product range for Australian Unity; most funds have at least one product that is not subject to these limitations. The Australian Unity arrangements relate to psych and rehab only across all their products.[85]

12.95   It would appear that funds impose benefit limitation periods for a number of reasons, including limiting benefits for all new members to the fund where the member had no previous private health insurance, or where there has been a significant time lapse. The rationale for this application of benefit limitation appears to be to prevent 'hit and run' practices whereby a person would be able to join a fund on full cover, receive immediate benefits and then once treated opt out of the fund. Also, the practice is seen as a risk protection measure to mitigate wholesale transfers of members from one fund to another.

12.96   Ms Gee, Vice-President of APHA, also in reference to Australian Unity advised: 'one particular health insurer has been given the right to discriminate against consumers with mental illness' and, '[t]his follows the decision of the Department of Health and Ageing [DoHA] to permit that insurer to impose a 12-month limit on benefits for people, transferring to it from other insurers, who need private treatment for mental illness, regardless of whether these consumers have already served their waiting periods with another insurer'.[86]

12.97   The NNPPSCC supports the view of APHA implicating DoHA in allowing the funds to impose limitations on benefits:

> [DoHA] approved an application from the Health Fund, Australian Unity, to impose a twelve-month limitation for benefits only for *psychiatric* and *rehabilitation* services. This meant that consumers of private psychiatric services transferring to Australian Unity would have their benefits paid at

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84   Mr John Powlay, PHIO, *Committee Hansard,* 28 October 2005, p. 15.

85   Mr John Powlay, PHIO, *Committee Hansard,* 28 October 2005, pp. 15–16.

86   Ms Christine Gee, Vice-President, APHA, *Committee Hansard*, 4 July 2005, p. 51.

the default level, which would leave the consumer with significant out-of-pocket expenses, regardless of the level of their private health insurance cover.[87]

12.98   The NNPPSCC have approached DoHA about this issue and were advised that '*portability* is under review and that they are not currently in a position to make a decision'. The NNPPSCC expressed disappointment that 'the review has been on-going for over a year'.[88]

12.99   In summary, up until April 2004 all funds except BUPA waived benefit limitation periods on transfer if the new member had served the period with the previous fund. BUPA apply benefit limitation periods on all transfers (internal and external) and in April 2004 Australian Unity introduced benefit limitation periods on all its products for psychiatric and rehabilitation services to all new members, including those transferring from other funds. No other funds, at this time, have moved to apply benefit limitation periods to transferring members where the member has already served the appropriate waiting period.[89] However, many funds will be keenly watching the actions of Australian Unity.[90]

12.100 In evidence to the committee, Ms Addison, Assistant Secretary, Private Health Insurance Branch, DOHA, acknowledged that Australian Unity had imposed a benefit limitation period of 12 months upon new members transferring to its fund. Ms Addison advised that the fund did so as it felt it was financially 'at risk' given the number of transferring members due to the BUPA dispute:[91]

> Since that time there have been ongoing discussions at an industry level to resolve the concerns related to portability. Portability, as provided under the National Health Act, is about people being able to transfer to a comparable product without having to re-serve waiting periods. There is a school of thought that says that benefit limitation periods are waiting periods. Certainly the Private Health Insurance Ombudsman believes they are. The imposition of a benefit limitation period was seen as the imposition of a further waiting period, which people were concerned about.[92]

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87   NNPPSCC, *Submission 189*, p. 8.

88   NNPPSCC, *Submission 189*, p. 8.

89   Information provided to the Committee by the PHIO, 26 August 2005, unpublished.

90   Dr Michael Coglin, CMO, Healthscope Ltd, *Committee Hansard*, 5 July 2005, p. 16.

91   Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch, DoHA, *Committee Hansard*, 7 October 2005, p. 73.

92   Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch, DoHA, *Committee Hansard*, 7 October 2005, p. 73.

12.101 Ms Addison indicated that the imposition of benefit limitation periods was the only area of discrimination against people with mental illness that has been brought to DoHA's attention.[93]

12.102 As a result of the initial consultation process, requested by the Minister for Health and Ageing, the Minister circulated a 'Condition of Registration Pursuant to Subsection 73B(1) of the *National Health Act 1953*' to private health industry representatives. This proposed legislative instrument was designed to 'prevent a health fund from imposing (in any form) a benefit limitation period on any hospital cover for contributors or dependants transferring to the fund from another fund'.[94]

12.103 Section (a) of this condition states:

> In relation to contributors or dependants transferring from one organisation to another organisation, the receiving organisation must not impose (in any form) a benefit limitation period on any of its applicable benefits arrangements.[95]

12.104 Section (b) of the condition directs funds to cease to impose the benefit limitation period currently being served by a person who has transferred and provides a time limit for this to take effect.

12.105 Importantly, the proposed condition provides the following definition of a benefit limitation period:

> (c) For the purposes of paragraphs (a) …of this condition of registration a benefit limitation period is a period of time set by the organisation during which a contributor or dependant is eligible to receive, in relation to one or more episodes of hospital treatment covered by the applicable benefit arrangement:
>
> (i) for hospital treatment, minimum benefits only [Ministerial default];
>
> (ii) some other form of lesser benefit, including but not limited to, a period of time during which a contributor receives no benefit for an episode or episodes of hospital treatment (that is, a time limited exclusion outside the waiting period times permitted by the *National Health Act 1953*), or, a period of time during which a contributor receives a lesser benefit due to co-payment, excess or front end deductible.[96]

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93   Ms Linda Addison, Assistant Secretary, Private Health Insurance Branch, DoHA, *Committee Hansard*, 7 October 2005, p. 74.

94   DoHA, *Private Health Insurance Circular—PHI 45/05*, 29 August 2005.

95   DoHA, *Private Health Insurance Circular—PHI 45/05 (Attachment A)*, 29 August 2005.

96   DoHA, *Private Health Insurance Circular—PHI 45/05 (Attachment A)*, 29 August 2005.

12.106 Accordingly, the intention of the Minister appears to be to outlaw the imposition of benefit limitation periods not considered to be legitimate waiting periods. Although the instrument has not been signed off by the Minister at this time it is expected that this condition of registration will be formalised. The PHIO was also of the view that this 'condition would go ahead fairly shortly'.[97]

Benefit exclusions/restricted benefits

12.107 Health funds offer a range of products with benefit exclusions or restrictions, targeting specific audiences with more limited products and applicable levels of treatment. Furthermore, funds were not properly advising funds members and prospective fund members of the limitations of the products they were purchasing.

12.108 The PHIO advised the committee:

> I have been very critical of the health funds in terms of the quality of information that they provide when people join, particularly around these areas where there are restricted benefits. I have put the view that I think the funds need to specifically acknowledge when people are joining those areas that are subject to restricted benefits. Pretty well all of the complaints that I get from consumers when they have had a hospital episode and only been paid these restricted benefits, is that they did not understand that that was the limit of their coverage when they signed up.[98]

12.109 The PHIO confirmed that 'all health funds have one or more products that restrict benefits on psychiatry and psychiatric treatment—that is, they pay the minimum benefit amount' only.[99]

12.110 In terms of benefit exclusions and restrictions 'some members may choose, for lifestyle reasons or to reduce the cost of premiums, a product where the benefit on some or all hospital procedures are limited to a level significantly below the hospital charge, or the cost of admission as a private patient in a public hospital'.[100]

12.111 APHA, however, criticised the range of products targeted at young people which have restrictions on mental health services for the entire life of the policy. APHA warned 'the inability of any person to foresee the future onset of illness render such health insurance products as not fit for purpose…quite simply, such products should be prohibited by law'.[101]

12.112 Dr Coglin, of Healthscope private hospitals stated:

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97   Mr John Powlay, PHIO, *Committee Hansard,* 28 October 2005, p. 17.

98   Mr John Powlay, PHIO, *Committee Hansard,* 28 October 2005, p. 22.

99   Mr John Powlay, PHIO, *Committee Hansard,* 28 October 2005, p. 15.

100   PHIO pamphlet, *The Right to Change – Portability in Health Insurance*, http://www.phio.org.au/showbrochure.php?id=70, (accessed September 2005).

101   APHA, *Submission 143A*, p. 3.

There are a number of other techniques which I believe are being employed by some health funds to discourage people with psychiatric illnesses from joining and remaining as members or, if all else fails, from accessing reasonable benefits.

The first of them involves the provision of exclusion products under which people are invited to take out membership of a particular table and then unexpectedly suffer from a disorder. It could be heart disease, a pregnancy requiring obstetrics admission or, in the case we are talking about here, a mental health disorder. The product they have chosen on the trade-off of price says, 'we don't cover you for certain diseases.' Our view is that products containing a mental health exclusion are not fit for purpose and should not be allowed to be offered by health insurers, because of the unpredictability and prevalence of mental illness in the community.[102]

12.113   The PHIO agreed, advising the committee:

I have particular concerns with psychiatric treatment being limited in this way and I am particularly concerned that many of the products that are developed by funds and that target young people restrict psychiatric treatment. My concern is that it is very difficult for anyone to assess the risk of becoming mentally ill. A further concern is that in many cases the publicly provided options are not adequate. In some kinds of emergency treatment and so forth—or even, say, heart surgery—at least you know that there is the public system to fall back on. But in many cases with mental illness—particularly involving drug dependency—there is not the availability of treatment in the public system that people would like to see. That is part of the reason why people take out private insurance. As I said, I am concerned about those products that target young people because the indications are that most of the complaints that I receive are about young people. Indeed, the complaints are made on their behalf by parents. In many cases the parents will be funding the private health insurance for the young person.[103]

12.114   When asked to clarify how funds target young people, the PHIO advised:

The theory of private health insurance companies targeting young people particularly in their advertising is that young people are less of a risk in terms of expenditure.

With many of these products that target young people, the funds feel they have to be made cheaper and more affordable for young people and, in that way, more attractive. Younger people tend to be more interested in some of the ancillary and alternative therapy benefits, so the sorts of products that you see coming onto the market will offer reasonable benefits in relation to alternative therapies but only offer basic benefits in relation to most hospital treatments, including psych. One fund has recently started marketing a product exactly like that. It only provides hospital cover in the

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102   Dr Michael Coglin, CMO, Healthcope Ltd*, Committee Hansard,* 5 July 2005, p. 16.

103   Mr John Powlay, PHIO, *Committee Hansard,* 28 October 2005, p. 20.

case of accidents or sporting injuries. For most things it provides only the minimum, restricted benefit, including for psych.[104]

12.115 The argument put by APHA that these types of products limiting benefits to young people are 'not fit for purpose' certainly has merit when considering the legislation as it stands. Under private health fund registration requirements 'each applicable benefits arrangement…must provide for benefits to be payable in respect of all kinds of hospital treatment that are one or more of the following; palliative care; rehabilitation; psychiatric care'.[105] The legislation also provides that the waiting period for such benefits 'will not exceed 2 months'.[106]

12.116 In terms of products where there are exclusions the PHIO advises:

> Some members may choose products that exclude certain procedures, to reduce the costs of premiums or for lifestyle reasons.
>
> Where the previous fund product has an exclusion attached, and the member is seeking to transfer to a product without an exclusion, the fund has the right to apply the legislated waiting periods before the member is entitled to the higher benefits under the new fund.[107]

12.117 Ms Gee, APHA, said:

> You would be aware that health insurers are prohibited by law from excluding benefits for mental health services in their products. However, some insurers have found creative ways around this by, for example, imposing a limitation on how many occasions a patient may receive benefits for a particular type of service in a calendar year or refusing outright to fund particular types of programs. Another way around this ban is for health insurers to pay benefits for private mental health services at only the default safety net rate, which is set well below the cost of providing patients with the care they need. The result is patients either facing large out-of-pocket costs, seeking care in the overburdened public health system or forgoing treatment altogether and risking deterioration of their illness.[108]

12.118 The NNPPSC advise that the 'default rate can be $150 to $200 per day below the actual service cost'.[109] Dr Coglin, suggests that the out-of-pocket expenses are even greater than this:

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104 Mr John Powlay, PHIO, *Committee Hansard,* 28 October 2005, p. 20.

105 *National Health Act 1953*, Schedule 1, para. 1(bf).

106 *National Health Act 1953*, Schedule 1, para. 1(ja).

107 PHIO pamphlet, *The Right to Change – Portability in Health Insurance*, http://www.phio.org.au/showbrochure.php?id=70, (accessed September 2005)

108 Ms Christine Gee, Vice-President, APHA, *Committee Hansard*, 4 July 2005, p. 51.

109 NNPPSCC, *Submission 189*, p. 8.

> They would get what is called the ministerial default benefit, which is the minimum statutory benefit, which typically is about half the contracted price that would exist were a contract exists between Australian Unity or any other fund and the hospital. In a mental health hospital, the fund would have as its contracted price—in round figures—$500 a day. The minimum default benefit would be $250[110] a day. The patient would have to find the other $250 a day above that.[111]

12.119 Dr Coglin also advised 'that the average length of stay at the Melbourne Clinic is around 18 days' and 'people with chronic mental illness typically are occasional participants in the work force and do not have high levels of income and savings, so the imposition of a $250 a day out-of-pocket cost for a protracted hospital stay, with the possibility of recurring admissions going forward, is not an option'.[112]

12.120 Accordingly, it is not difficult to see how out-of-pocket expenses for privately covered mental health patients could soon become overwhelming, particularly as patients require longer-term hospitalisation.

12.121 Ms Gee also went on to say:

> Allied to this issue is the inconsistency that privately insured patients with mental illness face when they use their insurance in a private hospital. For example, there are inconsistencies between health insurers in their funding of in-patient programs, differing limitations on the funding of day treatments, blanket bans on funding half-day programs and inconsistencies in funding approved outreach for hospital in-the-home services.[113]

12.122 Ms Susan Williams, National Manager Psychiatry, Healthscope hospitals, said private hospitals strive very hard to develop alternatives to inpatient care and that Healthscope have 'something like 70 per cent growth in… day programs' and 'about 80 per cent growth in outreach' programs where they visit people in their homes. She also raised concerns that every time they attempt to 'substitute in-patient care through either day patient care or home based care', they have a fight with the health funds.

12.123 Ms Williams explained:

> They see it as an add-on; they do not see it as a substitute. We have been able to demonstrate that the readmission rate and the length of stay for chronic patients who are cared for in outreach are significantly reduced as a result of that. There are a number of hospitals across Australia that have approval federally to provide hospital care in the home, but the health funds

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110   The Ministerial default amount as at 1 July 2005 is $261 for overnight treatment in a shared ward and $157 per day for outreach services. DoHA, *Private Health Insurance Circular—PHI 45/05*, 29 September 2005.

111   Dr Michael Coglin, CMO, Healthcope Ltd*, Committee Hansard,* 5 July 2005, pp. 17–18.

112   Dr Michael Coglin, CMO, Healthcope Ltd*, Committee Hansard,* 5 July 2005, p. 16.

113   Ms Christine Gee, Vice-President, APHA, *Committee Hansard*, 4 July 2005, p. 51.

will not provide a viable rate for them to provide the service in the community.[114]

12.124 Ms Williams and Dr Coglin referred the committee to a Commonwealth funded and sponsored pilot which evaluated the cost of in-patient care to intensive home based care of a cohort of so called 'frequent flyers'. The result of treating these patents in intensive home based care reduced the cost from $80 000 the previous year as in-patients to $20 000 under the pilot scheme. The committee was also advised the 'clinical outcomes, the satisfaction of carers—that is, psychiatrist and mental health nurses— and the satisfaction of families was at least comparable in the intensive home based model for the same patients as the outcomes in the previous year for hospital based care'.[115]

12.125 Dr Coglin, advised the committee, however, that one insurer did not participate in the project simply because the payments were not subject to the reinsurance pool, 'they are borne only by the fund that the patient belongs to and are not shared collectively by all health funds', regardless of the actual savings identified.[116]

12.126 Ms Williams and Dr Coglin were also concerned that some health funds were capping Healthscope outreach services, saying 'we're going to limit it to 20 visits a year' with the resultant effect of these persons returning to in-patient care if they relapse. There was particular concern that this figure of 20 seemed arbitrary and was not based upon any clinical assessment of the fund member.[117]

12.127 Mr Russell Schneider, on behalf of the private health insurers asserted:

> Some of the most innovative funding arrangements in the private health area have occurred in the area of mental health, despite a number of legislative barriers. Arrangements are currently based on principles of ensuring that there is a range of suitable alternative services, if possible, to substitute for hospitalisation, an emphasis on delivering the appropriate treatment in the appropriate setting and ensuring the appropriateness of utilisation.[118]

12.128 Mr Schneider explained:

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114   Healthscope Ltd, *Committee Hansard*, 5 July 2005, pp. 20–21.

115   Ms Susan Williams and Dr Michael Coglin, Healthcope Ltd*, Committee Hansard,* 5 July 2005, p. 21.

116   Dr Michael Coglin, CMO, Healthcope Ltd*, Committee Hansard*, 5 July 2005, p. 21.

117   Dr Michael Coglin, CMO, Healthcope Ltd*, Committee Hansard,* 5 July 2005, p. 21.

118   Mr Russell Schneider, CEO, AHIA, *Committee Hansard,* 4 July 2005, p. 59.

> Insurers believe that there should be more emphasis, whenever appropriate, on community programs in lieu of hospitalisation, particularly if those hospitalisations are repeated but avoidable.[119]

12.129 And further:

> I think we have to realise that health insurers are always in an exquisite dilemma of trying to combine two conflicting situations. One is the provision of benefits to the level which providers would like; the other is ensuring that premiums are kept sufficiently affordable for the consumer to be able to be insured. As a result of that there are at times some restrictions on benefits, particularly those that are lower priced, because the only way you can provide people with access to a low-priced product is obviously to do one of two things; firstly, restrict people who take out that product to people who are unlikely to claim or, secondly, reduce the benefits that you are going to pay.[120]

12.130 Whilst this approach appears to equate to commercially sound practice, it is questionable as to whether it conforms to the principles of the community-rating model. On its face the practice appears to discriminate against people suffering from mental illness on the basis that the costs cannot be shared across the fund. The approach appears to be more risk-rated.

12.131 The removal of the rigidities in relying upon in-patient care for persons suffering from poor mental health has been recognised by some health funds.

12.132 The PHIO advised the committee that 'some programs offered by private hospitals involve an element of out-patient care and sometimes there can be disputes with funds or different attitudes taken by different funds as to how much of that program they will be prepared to fund'.[121]

12.133 The PHIO further advised:

> In general, in designing their policies the funds do not distinguish between what particular psychiatric services there are. However, sometimes in a contracting arrangement a hospital may propose that the fund pay for certain programs that may include both in-hospital and an out-hospital element. In some cases, funds will agree to do this. Some funds will not.[122]

12.134 The PHIO highlighted an innovative model currently being offered though the BUPA private health insurance fund and Ramsay's hospital in South Australia. Under this model the fund provides, in essence, a capital grant to the hospital for each member with psychiatric illness as opposed to funding on an episodic basis. The

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119   Mr Russell Schneider, CEO, AHIA, *Committee Hansard,* 4 July 2005, p. 59.

120   Mr Russell Schneider, CEO, AHIA, *Committee Hansard,* 4 July 2005, p. 60.

121   Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 21.

122   Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 21.

hospital then designs the most appropriate program to treat the patient, including the provision of in-patient care, out-patient care, community or even home-based care. The PHIO saw this as a very flexible model, but emphasised that specific legislative authorisation was needed to allow the piloting of the program.[123]

12.135 The AHIA provided further information about the funding model, referred to as 'Prospective Payment Model':

> As part of the model, RHC [Ramsay Health Care] are paid an agreed annual figure spread over 12 monthly payments of equal value within each year. Therefore, for the first time, hospitals are assured of a known and regular income and able to plan for financial investment in alternative services.[124]

12.136 This model therefore overcomes some of the financial disincentives for development of private out-of-hospital services, such as establishment costs and loss of revenue from in-patient benefits.

12.137 AHIA reported the positive outcomes of the Prospective Payment funding model, stating: 'Since inception the Model has seen more members cared for with a greater range of services'.[125] Some of the outcomes included: a reduction in bed occupancy; expansion of day programs; significant increases in psychiatric home visits; use of out-patient assessments and pre-admission assessments; introduction of family counselling and telephone counselling services; and a reduction in hospital administration time.

Concluding remarks

12.138 Whilst there have been a number of issues of concern raised by stakeholders the PHIO advised the committee:

> Despite all of the rhetoric and arguments around portability, there is an effective portability regime operating in health insurance at the moment. I have seen no instances of hospitals denying people portability rights on transfer, even when there has been contract dispute.[126]

12.139 The PHIO further advised:

> No fund has broken ranks on portability, and no other fund has sought to adopt the AU [Australian Unity] approach of benefit limitation periods on psych people transferring. My assessment is that there has been no real impact on consumers as a result of the AU changes – other than the fact that the opportunity for them to join Australian Unity is not there. But, in most

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123   Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 21.

124   Hon. Dr Michael Armitage, CEO, AHIA, *Submission 292a*, p. 3.

125   Hon. Dr Michael Armitage, CEO, AHIA, *Submission 292a*, p. 3.

126   Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 16.

cases, consumers have between 12 and 15 other funds that they can transfer to without detriment, and most have taken that opportunity.[127]

12.140 The Commonwealth government's circulated condition of registration relating to benefit limitations periods and evidence provided by the PHIO indicates that the practice of imposing benefit limitation periods will soon be outlawed, therefore the main criticism of the portability regime will no longer be applicable. However, issues pertaining to the nature of health insurance products, including the use of product restrictions and exclusions, particularly those targeted at and marketed to young people, will continue to remain an issue even though there is a minimum default level of cover for psychiatric patients.

12.141 The committee heard evidence from the private hospital sector that they have capacity to provide innovative services relating to in-patient care and intensive home based care, however were being frustrated by health funds not providing sufficient coverage for their members. They also argued, as did the PHIO, that the public system does not have the capacity to effectively deal with patients who drop out of the private system.

12.142 Dr Chamley too suggested:

> The amber light ought to be flashing for state governments here also. I predict that if contributors to private health insurance come to a view that, in respects of coverage for mental health, the private insurers can sidestep some of their prudential obligations, then over time consumers will terminate their private health cover and this is going to put even more pressure upon the public mental health services. Maybe this is the real game of plan of the insurance providers.[128]

12.143 The committee notes however that evidence in other chapters suggests that the many inadequacies of public mental health services and the fact that only the most seriously ill receive attention means that the 'pressure' of people exiting the private system would scarcely make a difference to the already great level of unmet demand.

12.144 The private health insurance sector, nonetheless, advised the committee that they were very much interested in identifying innovative community program approaches to mental health service delivery and the committee is aware that this would likely require legislative change but is not in a position to endorse or otherwise such change.

12.145 The committee received evidence about a successful collaboration between BUPA and the Ramsay's hospital group in South Australia. By moving away from an episodic fee for service model, the program enables individually tailored treatment

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127   Mr John Powlay, PHIO, *Committee Hansard*, 28 October 2005, p. 17.

128   Dr Wayne Chamley, *Submission 339*, p. 11.

programs to be developed, including in-patient, out-patient, community and home-based care. The positive results of the program are clear:

> …since the introduction of the new funding model the focus of care has become more tuned to the individual, with staff taking more time to determine what is the best treatment option for each person. With a variety of services now available, staff are able to recommend the treatment approach that is most suitable.[129]

12.146 This program indicates that there can be innovative service delivery amid collaboration between private hospitals and the health insurance sector. However, the Committee remains concerned that the private hospital sector, by focussing predominantly on in-patient services, provides a largely institutionalised approach to mental health services. This focus runs against the continuing public policy of deinstitutionalisation and increased provision of community-based services.

12.147 The committee agrees that health insurance products that do not provide adequate care for psychiatric illnesses, regardless of the ministerial default payments, are 'not fit for purpose' and the Commonwealth government should take action to outlaw such products.

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129   Ramsay Health Care, quoted in AHIA, *Submission 292a*, p. 3.

CHAPTER 13

MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM

Introduction

13.1   In this chapter the committee considers issues that arise when people with mental illnesses come into contact with the criminal justice system. The publicity given to critical incidents involving mentally disturbed people might lead the public to believe that a high proportion of people with mental illness commit crimes, but this is not the case. Nevertheless, people with mental illness comprise a disproportionate number of the people who are arrested, who come before the courts and who are imprisoned. The reasons for this, the legislation governing the treatment of people with mental illness who commit crimes and their treatment by the criminal justice system, are dealt with in this chapter.

13.2   The Commonwealth and each state and territory have provisions in their criminal laws for the prosecution and disposition of persons with a mental illness or an intellectual disability.[1]

13.3   These laws provide that unsoundness of mind is a defence to a criminal charge. Application of the laws means that some persons charged with criminal offences are judged not fit to enter a plea, or are found not guilty because of mental disorder, and become 'forensic patients' (The treatment of forensic patients in discussed later in this chapter).

13.4   In most jurisdictions, criminal legislation and other relevant acts, such as bail and sentencing acts, interact with mental health services through the operation of mental health acts.

Law reform and human rights

13.5   The report of the National Inquiry into the Human Rights of People with Mental Illness (the Burdekin Report), which had as its focus the human rights of people with mental illness, reported that the rights of mentally ill people in the criminal justice system were covered by the International Covenant on Civil and Political Rights; the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; and the Body of Principles for the Protection of all Persons under any Form of Detention or Imprisonment. In particular:

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1   ALRC Issues Paper 29, *Sentencing of Federal Offenders*, Chapter 14, p. 8. Information regarding the various legislative provisions were submitted in evidence and may be accessed in the relevant submissions. See *Submissions 165, 343, 376, 377, 445, 470, 476, 502 and 506.*

The Principles for the Protection of Persons with Mental Illness specifically apply to prisoners. Principle 20 stipulates that they are entitled to the best available mental health care, and to all the rights specified in the Principles, 'with only such limited modifications and exceptions as are necessary in the circumstances'.[2]

13.6   Health authorities of the Commonwealth, states and territories have developed a National Statement of Principles for Forensic Mental Health. The Principles, which are dealt with in more detail later in this Chapter, include the following statement:

Legislation must recognise the special needs of people with a mental illness involved in the criminal justice system and comply with the International Covenant on Civil and Political Rights, the United Nations Principles on the Protection of People with a Mental Illness and the Improvement of Mental Health Care.[3]

13.7   The evidence demonstrates that state and territory governments are making progress in their endeavours to incorporate or reflect the above principle in legislation. The Queensland Government, for example, informed the committee that a comprehensive review of the state's mental health legislation found that the legislation reflected all significant rights safeguards.[4]

13.8   Other jurisdictions have recently amended relevant legislation or propose to do so. The South Australian Department of Health, for example, stated that among its achievements was a review of the *Mental Health Act* and of section 269 of the *Criminal Law Consolidation Act*,[5] and New South Wales is currently conducting a comprehensive review of the *Mental Health Act 19*90 [NSW].[6] The Australian Capital Territory has announced a review of the *ACT Mental Health (Treatment and Care) Act*.[7]

13.9   It is not clear, however, that the reforms made in all jurisdictions to date have been sufficient to adequately reflect the UN Principles. The Mental Health Legal Centre Inc. (MHLC), a Victorian community legal centre specialising in legal advice, policy and law reform, advocacy and promotion of the rights of people experiencing mental illness, informed the committee that:

2   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness – Report of the National Inquiry into the Human Rights of People with Mental Illness*, Canberra 1993, p p. 753.

3   National Statement of Principles for Forensic Mental Health 2002, p. 18.

4   Queensland Government, *Submission 377*, Part II, p. 49.

5   Department of Health – South Australia Government, *Submission 506*, p. 16.

6   NSW Health – NSW Government, *Submission 470*, p.7.

7   Minister for Health – ACT Government, *Submission 165AA*, p. 14.

> Whilst there has been some reduction in the gap between state and territory regimes and the UN Principles, there is a long way to go …[8]

13.10   The MHLC also commented on the 'huge disparity between Australian jurisdictions' and gave the following as an example:

> … depending on where a person lives they may have their involuntary detention reviewed anywhere between 2 and 8 weeks. They may or may not have a right to legal representation; to challenge the use of ECT; to ask a tribunal to vary their treatment, or to obtain a statement of reasons or a transcript of their review hearing.[9]

13.11   With regard to the right to legal representation before Mental Health Review Tribunals, MHLC commented favourably on the law in the Northern Territory, which mandates that the Tribunal appoints a lawyer unless satisfied that is not necessary, and empowers the Tribunal to order the government to pay costs.[10]

Mental Health Courts and Court Liaison Services

13.12   Under their mental health acts, most jurisdictions have established special courts or services designed to assess the mental health of persons arrested or brought before the courts on criminal charges and to divert for treatment those found to have a mental illness.

13.13   Within Australia, Queensland is the only jurisdiction to have established a Mental Health Court, which determines mental responsibility issues – the insanity defence or the defence of diminished responsibility.[11] The Court is constituted by a Supreme Court Judge who receives expert advice and assistance on clinical matters from two 'assisting psychiatrists'. References may be made to the Court by the accused or the accused's legal representative, the Attorney-General, the Director of Public Prosecutions or the Director of Mental Health. The Court is not bound by the rules of evidence and may inform itself in any way it considers appropriate. It may order examinations by psychiatrists and other health professionals and may make forensic orders to provide for treatment in the mental health system.[12]

13.14   All states and territories have established mental health tribunals to assess the continued detention of both civilly committed and forensic patients in the mental health systems.[13] The work of these tribunals has been described as follows:

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8   Mental Health Legal Centre Inc., *Submission 314*, p. 3.

9   *Submission 314*, p. 3.

10   *Submission 314*, p. 5.

11   Dr Janet Ransley, Senior Lecturer, School of Criminology and Criminal Justice, Griffith University, *Committee Hansard*, 2 February 2006, p. 66.

12   Queensland Government, *Submission 377*, Part 2, pp. 72–73.

13   Dr Janet Ransley, Senior Lecturer, School of Criminology and Criminal Justice, Griffith University, *Committee Hansard*, 2 February 2006, p. 61.

> … tribunals have a very difficult task because they have to balance competing paradigms: the criminal justice paradigm, with the expectation that comes from that paradigm about keeping society safe and keeping dangerous people off the streets, and the health and welfare paradigm, which is about treating people and getting them better.[14]

13.15   The tribunals are constituted differently in different jurisdictions, but typically include people with legal and medical qualifications and a member (or members) of the community. They also have different powers; some may make determinations while others make recommendations to the courts or the executive government. In jurisdictions where the tribunals have an advisory role, the decision to release a person from a custodial order will be made by a court or, in some jurisdictions, by the Governor in Council.

13.16   The states and territories have also established mental health liaison programs designed to assess the mental health of persons who come before the courts.

13.17   In New South Wales, for example, a court liaison program was established in 2002 to provide mental health assessments and referral services to magistrates throughout the state. The NSW Government has reported that in the 12 months to July 2004, 18 902 people were screened for mental health problems, and approximately 10 percent (1945) of those people were referred for a comprehensive mental health assessment. Of these, 1413 were assessed as having a severe mental illness or disorder and, as a result:

- 204 people were diverted to hospital for mental health treatment;

- 702 people were diverted to community care; and

- 507 were referred to custodial mental health services in accordance with magistrates' orders.[15]

13.18   South Australia has established a Magistrates Court Diversion Program of alternatives to incarceration for criminal offenders.[16] The program provides an opportunity for eligible individuals to voluntarily address their health or disability needs and any offending behaviours while legal proceedings are adjourned.[17]

13.19   The need for diversion programs and mental health liaison services becomes clear when the prevalence of mental illness among people who come into contact with the criminal justice system is considered.

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14   Dr Janet Ransley, Senior Lecturer, School of Criminology and Criminal Justice, Griffith University, *Committee Hansard*, 2 February 2006, p. 61.

15   NSW Health – NSW Government, *Submission 470*, p. 50.

16   Department of Health – South Australia Government, *Submission 506*, p.16.

17   Australian Institute of Criminology, *Submission 166*, p. 5.

Over-representation of people with mental illness in the criminal justice system

Studies and statistics

13.20   Most people with a mental illness, including those with major illnesses, do not commit crimes,[18] but people with mental illness nevertheless are over-represented in the criminal justice system.

13.21   Numerous studies of the health of people who come before the courts in Australia and in other countries show that the incidence of mental illness among those people is higher than in the general community. Two studies in particular were brought to the committee's notice: *Mental Illness among New South Wales Prisoners* (August 2003)[19] and *Victorian Prisoner Health Study* (February 2003).[20]

13.22   The New South Wales study found that 48 percent of reception inmates and 38 percent of sentenced inmates had suffered a mental disorder in the previous twelve months (A mental disorder was defined as a psychosis, affective disorder or anxiety disorder[21]). When a broader definition of 'any psychiatric disorder' was used, it was found that 74 percent of the NSW inmate population was affected. In Victoria, 51 percent of prisoners reported that they had been assessed, or received treatment by a psychiatrist or a doctor, for an emotional or mental health problem.[22] Together, the studies show that there is a much higher incidence of mental illness in the Australian prison population than in the general population. These findings are also consistent with those of similar studies undertaken overseas.[23]

13.23   Despite the different methodologies used in the studies, in some respects they produced remarkably similar results. The NSW study found, for example, that the prevalence of 'definite' and 'probable' schizophrenia in the prison population was between 4 percent and 7 percent,[24] while the Victorian study reported that schizophrenia was suspected to be present in about 7 percent of that population.[25] A

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18   Victorian Institute of Forensic Mental Health, *Consolidating and Strengthening Clinical Programs: Addressing Dual Diagnosis and Offending Behaviour in Forensic services*, 2004, p. 9.

19   T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003.

20   *Victorian Prisoner Health Study*, Department of Justice, Government of Victoria, 2003.

21   T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 2.

22   *Victorian Prisoner Health Study*, Department of Justice, Government of Victoria, 2003, p. 28.

23   See for example, T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 6, and accompanying footnotes.

24   T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 19.

25   *Victorian Prisoner Health Study*, Department of Justice, Government of Victoria, 2003, p. 30.

'best estimate' reported by the Victorian Institute of Forensic Mental Health (Forensicare) is that 8 percent of male and 15 percent of female prisoners suffer from a psychotic illness, with 5 percent of males and 6 percent of females suffering from schizophrenia.[26] The NSW study reported that the prevalence of psychosis in inmates was 30 times higher than in the Australian community.

13.24   Butler and Allnut found that female prisoners have a higher prevalence of psychiatric disorder than male prisoners.[27] Approximately 90 percent of female reception prisoners had experienced a mental disorder in the 12 months before their incarceration compared with 78 percent of male prisoners; among sentenced prisoners the relevant figures were 61 percent for men and 79 percent for women.[28] Butler and Allnut also found that substance use disorders[29] were more common among females than males in both the reception (75 per cent vs. 64 per cent) and sentenced groups (57 per cent vs. 34 per cent).[30]

13.25   Comparisons between the incidence of mental illness among prisoners and people in the community are based on data published by the Australian Bureau of Statistics (ABS) in *Mental Health and Wellbeing: Profile of Adults, Australia 1997*.[31] The survey was commissioned by the then Commonwealth Department of Health and Family Services within the context of the National Mental Health Strategy (NMHS). According to the ABS, the results of the survey were to assist in the monitoring of 'initiatives of the NMHS and to provide an Australian baseline against which future activity can be compared and evaluated'.[32] The survey found that 18 percent of adult Australians had a mental disorder at some time during the twelve months prior to the survey.[33] That figure contrasts with 74 percent of NSW prison inmates.[34]

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26   Victorian Institute of Forensic Mental Health, *Submission 306*, p. 14.

27   T. Butler and S. Allnut, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 2.

28   T. Butler and S. Allnut, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 14, Table 3.

29   Substance use disorders describe abuse if, and dependence on substances. They refer to the misuse of substance to the extent that the person's functioning is affected. *See* T. Butler and S. Allnut, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 30.

30   T. Butler and S. Allnut, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 30.

31   Australian Bureau of Statistics, .*Mental Health and Wellbeing: Profile of Adults, Australia* 1997.

32   Australian Bureau of Statistics, *Mental Health and Wellbeing: Profile of Adults, Australia* 1997, p. 1.

33   Australian Bureau of Statistics, *Mental Health and Wellbeing: Profile of Adults, Australia* 1997, p. 5.

34   T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 2.

Causes

13.26　There are several reasons for the comparatively high rate of mental illness among people in Australia's prisons. The contributing factors include general disadvantage, including poverty, homelessness and unemployment, deinstitutionalisation, substance abuse, a lack of early intervention and a lack of mental health services in the community.[35]

Homelessness

13.27　The Burdekin Report found that mentally ill people are especially likely to fall foul of laws concerning drunkenness, offensive behaviour, disorderly conduct, loitering or vagrancy (which commonly coincides with homelessness).[36] It was remarked that:

> … at least 75 percent of participants received fines and charges in relation to behaviour that was the direct consequence of their homelessness or mentally ill status, including: fines in relation to begging, drinking in public and other public space offences; activities caused by extreme poverty, such as travelling on public transport without a valid ticket or shoplifting food or other necessities; and activities relating to one of the underlying causes of homelessness, such as drug or alcohol dependency. This is consistent with studies in the US and Canada which have found a strong relationship between homelessness, mental illness and low-level crime.[37]

13.28　Professor Puplick also identified homelessness as being a cause of bringing people with mental illness into contact with the prison system. He suggested that when there is a campaign to make street people disappear they are eventually driven into positions where they come into contact with the police, who in frustration put them somewhere where they are regarded as being secure.[38] Forensicare submitted that it is vital for the successful community reintegration of people with a mental illness on being released from prison that they have access to stable accommodation. Bail applications generally require an address be stated to the Court in order for the application to be successful and area mental health services in Victoria are provided on the basis of address.[39]

35　For a more comprehensive list of probable causes for the high number of mentally ill people in prison see Butler and Allnutt, *Mental Illness among New South Wales Prisoners*, p. 49.

36　Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993,p. 758.

37　Public Interest Law Clearing House Homeless Persons' Legal Clinic, *Submission 41*, p. 36. The project referred to in this quotation was a law reform project undertaken to identify the difficulties that homeless people face in the court process and to examine options to address those difficulties.

38　Professor Christopher Puplick, *Committee Hansard*, 2 August 2005, p. 43.

39　Victorian Institute of Forensic Mental Health, *Submission 306*, p. 6.

13.29   The Burdekin Report noted that, once arrested, mentally ill people may have trouble obtaining bail because they are too poor to raise bail, because they have no fixed address, or because they do not comprehend or comply with bureaucratic requirements.[40]

Deinstitutionalisation

13.30   A common theme in the evidence was that the closure of mental health hospitals following the Richmond inquiry of some twenty years ago has led to the incarceration of people who formerly would have been housed in those institutions. Sisters Inside submitted that:

> Historically, women have been overrepresented in psychiatric facilities and underrepresented in the prison system. However, with the closure of psychiatric institutions and increasingly overtaxed and under-resourced community based services, Queensland is now witnessing a marked increase in the number of women with cognitive and mental disabilities who are being criminalised.[41]

13.31   Professor Puplick claimed that following the Richmond report, governments were happy to empty out the institutions but not to put money into the community based welfare services that were needed.[42] He also stated that:

> What has become an additional problem since the days of Richmond is the number of people with acute mental health problems, psychiatric problems, which are drug related, which were not at the same level 20-plus years age when Richmond was looking at his original data.[43]

13.32   In a study of the literature on mental illness and the criminal justice system undertaken for the Mental Health Co-ordinating Council, Ms Susan Henderson reported on deinstitutionalisation as follows:

> Deinstitutionalisation is considered by some people within the mental health lobby to be responsible for the high prevalence of people with mental illness in prison … However, … this perspective overlooks an alternative explanation – that people with mental illness present other risk factors of higher risk for imprisonment, such as substance abuse, unemployment, poor education and low income. The confounding role of such evidence was recently demonstrated in an Australian study that showed increased rates of

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40   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, p. 758.

41   Sister Inside, *Submission 283*, p. 43.

42   Professor Christopher Puplick, *Committee Hansard*, 2 August 2005, p. 40.

43   Professor Christopher Puplick, *Committee Hansard*, 2 August 2005, p. 40

inmates with schizophrenia since deinstitutionalisation parallelled by increased rated of imprisonment across the general population.[44]

Inadequate treatment

13.33   The Burdekin Report reported in 1993 that many people are taken into custody or have their detention prolonged as a consequence of their mental illness or disorder going untreated, and that:

> Untreated mental illness clearly causes some people to behave irresponsibly, irrationally or in a bizarre fashion. Sometimes this behaviour brings people to the attention of the police; in a small number of instances untreated mentally ill people commit violence against others.[45]

13.34   The evidence received by the Committee indicated that the lack of treatment for people with mental illnesses and a lack of continuity of treatment remain major factors in the over-representation of those people in prison:

> The long and short answer is … consumers are overrepresented in the criminal justice system simply because they are denied access to a range of quality mental health services which meet the consumer's individual needs and supports them effectively in the community.[46]

13.35   One tragic example that was related in the evidence concerned a young man with a history of mental illness who was found not guilty of charges of child murder and aggravated sexual assault due to mental illness. Less than a month before the crimes were committed this person had admitted himself to hospital fearful that he would become angry and violent. Despite a diagnosis of schizophrenia and despite doctors warning that he was dangerous, he was discharged after several days. These events, in the words of the Probation and Community Corrections Officers Association, offer 'a clear example of the tragic potential of illicit drug use and schizophrenia when inadequately managed'.[47]

13.36   The Mental Health Council of Australia submitted that the over-representation of people with mental illness in the criminal justice system is partly due to the failure of the mental health system to provide adequate support for those at risk of incarceration. The Council considers that the mental health system has failed to help consumers and carers to access existing services and to provide adequate crisis care.[48]

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44   S. Henderson, *Mental illness and the Criminal Justice System*, Mental Health Co-ordinating Council, 2003, p. 9.

45   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, p. 757.

46   Northern Beaches Mental Health Consumer Network, *Submission 60*, p. 20.

47   Probation and Community Corrections Officers' Association Inc., *Submission 503*, p. 5.

48   Mental Health Council of Australia, *Submission 262*, p. 24.

Intrinsic causes

13.37   The issues discussed above are relevant for mentally ill people whether or not they come into contact with the criminal justice system. However, some of the possible causes for the high incidence of mental illness among people in the criminal justice system are intrinsic to the system.

Effects of incarceration

13.38   One possible reason for the high levels of mental disorders among prisoners is the effect that incarceration, or the threat of incarceration, may have on them.

13.39   The committee took anecdotal evidence that institutionalisation itself and the control mechanisms within prisons adversely affect inmates' mental health. Particular mention was made of segregation units and safe cells.[49] One witness, Justice Action, claimed that it had evidence of prison-induced insanity.[50] Another witness provided details of a specific case that occurred at the Brisbane Women's Correctional Centre, which indicated that prison in general and seclusion in particular may have deleterious effects on prisoners who already suffer from a mental illness.[51]

13.40   The deleterious effect of incarceration was remarked upon by Butler and Allnutt in their study of mental illness among NSW prisoners:

> Incarceration results in the loss of many person freedoms taken for granted in the community, including social supports, inter-personal relationships, employment, social status, and social role. These losses are commonly correlated with depressive disorder. At the time of reception almost one-quarter were diagnosed with mood disorder …[52]

13.41   The committee has also noted a comment made in a submission from Professor Gavin Andrews, Scientia Professor of Psychiatry, UNSW at St Vincent's Hospital, which suggested that incarceration may be a factor in the incidence of some mental illnesses among prisoners. He submitted that:

> Anxiety and depression are three times more common among inmates than in the matched general population. They are seldom the reason why the crime was committed and may give an indication of the person's background or current predicament …[53]

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49   See for example, Sisters Inside, *Submission 258*, and Justice Action*, Submission 174*.

50   Justice Action, *Submission 174,* p. 4.

51   Ms Michelle Tanin, *Committee Hansard*, 4 August 2005, pp. 77–87.

52   T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 2.

53   Professor Gavin Andrews, *Submission 176*, p. 12.

Role of sentencing

13.42   Another reason for the over-representation of mentally ill people in prison is that, in the absence of programs to which offenders may be referred, courts may have no option other than to sentence offenders to prison. This issue was brought to the committee's attention by the Northern Territory Legal Aid Commission and the Northern Territory Community Visitor Program:

> Many people who suffer from a mental illness are not suitable for community work or home detention which leaves jail as the only option.[54]

13.43   To the extent that other Australian jurisdictions have established programs designed to divert mentally ill offenders from gaol, this may not be as common a cause nationally as it was in the past. Diversion programs, however, are useful only to the extent that there are practical alternatives to which offenders can be diverted. Diversion programs are discussed in more detail later in this Chapter.

13.44   Another aspect of the role that sentencing plays in the over-representation of people with mental illness in the criminal justice system is the tendency in some jurisdictions towards the imposition of longer sentences. Professor Puplick informed the committee that:

> Mental health problems can be compounded by sentencing practices. Longer sentences inevitably mean a greater habituation to prison environments and a diminished capacity to reintegrate into the external community, especially for those already facing problems of social competence. In this sense longer sentences contribute to the problem of recidivism – thus the endless cycle starts![55]

Access to the legal system

13.45   People with mental illnesses are vulnerable in society and in prison. The Office of the Public Advocate – Queensland (OPA-Q), for example, in a paper submitted to the inquiry, referred to a Victorian Government study, *Mental illness and violence*, that had found that almost one fifth of people with a psychotic illness had been a victim of violence in the previous twelve months.[56]

13.46   The OPA-Q also quoted a study in which it is argued that if the experiences of victimisation are not resolved to the satisfaction of the victim, these experiences may later precipitate critical mental health incidents.[57]

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54   Northern Territory Legal Aid Commission and the Northern Territory Community Visitor Program, *Submission 348*, p. 13.

55   Professor Christopher Puplick, *Submission 226*, p. 10.

56   Office of the Public Advocate – Queensland, *Preserving life and dignity in distress,* Discussion Paper 4, March 2005, p. 32.

57   Office of the Public Advocate – Queensland, *Preserving life and dignity in distress,* Discussion Paper 4, March 2005, p. 32.

13.47   The chances of achieving an outcome satisfactory to a mentally ill victim are not good for a number of reasons, including the victim's perceived unreliability as a witness and the victim's limited access to legal assistance. Apart from general disadvantages such as poverty and homelessness that would limit access to legal redress, many mentally ill people, even if legal aid is available, are not able to take advantage of that aid.

13.48   Mental health problems pose a serious challenge to the provision of adequate legal advice. The problems arise at all points in the process of providing legal assistance, from the provision of initial advice to critical incidents. Some of the reasons given for these difficulties are clients' inability to inform their lawyers of their situation, their paranoia, for example, unwillingness to speak with a lawyer lest the phone be tapped, and unwillingness of many to accept that they suffer from an illness.[58] Ms Vivienne Topp, a lawyer and policy worker employed by the Mental Health Legal Centre, stated, however, that one of the Centre's major concerns is 'the lack of rigour applied in dealing with people's complaints'.[59]

13.49   Whatever the reasons, people with mental illness generally will not have legal redress for cases of victimisation. This may lead to critical mental health incidents in which mentally disturbed individuals come into contact with the criminal justice system.

Role of the Police

13.50   Mentally ill people who come into contact with the criminal justice system usually first come into contact with the police either when they are detained for their own safety or the safety of others in a critical incident, or, more often, when they are arrested for a misdemeanour or a petty crime. One witness has described police officers as 'the front line mental health practitioners'.[60]

13.51   Although critical incidents are relatively rare, they naturally attract publicity because they occasionally result in the death or injury by shooting of a mentally disturbed person, or to the death or injury of other persons, including police officers.

13.52   Police usually have to deal with these critical incidents without any support from mental health professionals. This is true especially of incidents that occur after hours, or when mental health professionals will not attend because their life or safety may be endangered.[61] In regional and especially in remote areas, the only emergency service likely to be available to respond in a crisis is the police service.

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58   Combined Legal Centres' Group (NSW) Inc., *Submission 232*, p. 16.

59   Ms Vivienne Topp, *Committee Hansard*, 6 July 2005, p. 27.

60   White Wreath Association, *Submission 91*, p. 16.

61   See for example, Ms Elizabeth Crowther, Mental Illness Fellowship, *Committee Hansard*, 5 July 2005, pp. 95-96.

13.53 More often the situations in which police deal with people with mental illness do not involve violence or danger, but even in those situations their actions can have serious consequences. One witness whose 21 year old son who had a history of mental illness and who committed suicide informed the committee that:

> My son's behaviour also attracted the attention of one rather vindictive police constable who arrested, charged and remanded him on a charge that would later be disproved in the Dandenong Magistrate's Court. The police paid all the court costs but that didn't spare my son the entire ordeal, including the seven weeks he spent in remand.[62]

13.54 Another witness, the Mill Park Family Support Group, submitted that:

> Many members of the Group have had loved ones imprisoned due to a total misunderstanding of their behaviour and actions. Police are often told that a person has a mental illness, but they still take them away and often hold them over night. This is not only extremely frightening, but also a waste of police resources and community funding.[63]

13.55 Some carers in Victoria expect that crisis assessment teams will respond in an emergency, but that is not necessarily the case – the teams are not an essential service like police and ambulance services.[64] Community mental health teams in NSW likewise may not attend critical incidents.[65]

13.56 The Police Federation of Australia stated that several jurisdictions had developed memoranda of understanding (MOUs) in relation to cooperation of health and police services, especially for dealing with crisis situations, but that these MOUs are often not complied with by mental health staff and hospitals. The Federation recommended that the MOUs be included in legislation.[66]

13.57 The Federation also raised concerns regarding the response to critical incidents involving the mentally ill. As mentioned above, these incidents sometimes result in fatalities:

> A report released in June 1998 on police shootings showed that more than half the 41 people shot dead by Australian police officers since 1990 were under the influence of drugs or alcohol and one third were depressed or had a history of psychiatric illness – a clear indication that the system is failing.[67]

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62 Name withheld, *Submission 15*, p. 1.

63 Mill Park Family Support Group, *Submission 72*, p. 3.

64 Ms Elizabeth Crowther, Mental Illness Fellowship, *Committee Hansard*, 5 July 2005, p. 96.

65 Mr Michael Strutt, *Committee Hansard*, 2 August 2005, p. 95.

66 Police Federation of Australia, *Submission 254*, pp. 4–5.

67 *Submission 254*, p. 13.

13.58   The Queensland Government is attempting to address the issue by establishing Mental Health Crisis Intervention Teams that are intended to involve both the police and mental health personnel acting together to de-escalate crisis situations so as to resolve the situations safely and humanely.[68]

13.59   Police frequently spend hours sitting in hospitals with apparently mentally disturbed individuals awaiting mental health assessments, but the individuals are often found not to be ill under the provisions of the mental health legislation. Police resources get tied up in other ways: using police resources for transporting mentally ill people; having people abscond from institutions because of poor security; and repeated use of the 000 emergency number by mentally disturbed individuals.[69]

13.60   The Police Federation advocated better training for police regarding their obligations to mentally ill people, but it was concerned that better training might be counter productive. For example, the Federation suggested that mental health professionals might not respond to incidents on the basis that the police were trained to deal with them. The Federation also was concerned that the public might take the view that the police were thoroughly trained when in fact they could not be expected to be mental health experts.[70] Nevertheless, it recommended training for police officers not only in regard to their obligations to mentally ill people but also in relation to dual diagnosis.[71]

13.61   A witness whose 29 year old son had been shot dead by a police officer stated that:

> If the police service is to continue to be left to deal with the results of an inadequate health service, they need to be given whatever training is needed to help them to deal appropriately with people with mental illness.[72]

13.62   Another witness stated that:

> … ambulance and police officers need to have competencies in handling the many and varied circumstances they confront. Managing any violence is only one of the potential scenarios. They will most likely also confront persons in various stages of distress …
>
> For the sake of the officer, the patients, the families and others they come in contact with, these officers need up to date training … They also need to care for their own mental health.[73]

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68   Queensland Government, *Submission 37,* Part II, p. 12; Mr L Irons, Senior Research Officer, Office of the Public Advocate, Queensland, *Committee Hansard*, 4 August 2005, p. 99. A possible model for a police response team, the Memphis Crisis Intervention Team, may be found at pp. 25–31 of the Public Advocate's Discussion Paper 4, Appended to *Submission 303*.

69   For more details of these issues, see Police Federation of Australia, *Submission 254.*

70   *Submission 254*, pp. 14–15.

71   *Submission 254*, p. 8.

72   Mrs Jan Kealton, *Submission 537*, p. 4.

13.63   The allocation of more resources to mental health, including more beds in hospitals, more staff and better community programs, would relieve police of the excessive burden of care for the mentally ill, returning the care of the mentally ill to where it can best be managed, by mental health professionals.[74]

Management and treatment of people with a mental disorder in the criminal justice system

The National Statement of Principles for Forensic Mental Health

13.64   The National Statement of Principles for Forensic Mental Health sets down 13 principles for dealing with offenders or alleged offenders who have a mental illness. The Statement was endorsed by the National Mental Health Working Group of the Australian Health Ministers' Advisory Council and was presented to the Correction Service Administrators Conference in May 2003.[75] The Australian Government informed the committee that it was working with the state and territory governments and with the corrections sector to develop approaches to implementation of the principles.[76]

13.65   In addition to the need for Australian laws to conform to the UN Principles, the Statement covers matters such as the proper provision of mental health care for offenders, ethical treatment, skills of the workforce and transparency and accountability.

13.66   The Statement's 'target group' includes people referred for psychiatric assessment or treatment and people found not fit to enter a plea or found not guilty by reason of mental impairment. The target group also includes people in mainstream mental health services who are a significant danger to others and who require the involvement of a specialist forensic mental health service.[77]

Diversion

13.67   As discussed earlier in this chapter, in most Australian jurisdictions mentally ill people may be diverted by the courts from the criminal justice system to the health system. Magistrates' courts may make orders for treatment of offenders following advice received from the relevant court liaison service. Diversion may result in people who would otherwise be imprisoned being released, perhaps subject to a community treatment order. In general, only those persons facing minor summary offences would be released.

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73   Health Consumers of Rural and Remote Australia, *Submission 106*, p. 3.

74   Police Federation of Australia, *Submission 254*, p. 16.

75   Australian Government, *Submission 476*, p. 65.

76   *Submission 476*, p. 65.

77   National Statement of Principles for Forensic Mental Health 2002, pp. 3-4.

13.68   In South Australia a specialist sentencing court has been established to which mentally ill offenders may be directed. The South Australian Magistrates Court Diversion Program (mental impairment) commenced in 1999 as a pilot, and subsequently was funded by the South Australian Government to continue and expand its operation. The program is designed to meet the needs of individuals appearing before the Magistrates Court who have committed certain minor and summary offences and who have impaired intellectual functioning. The program facilitates a range of health and other appropriate services to assist those individuals:

> Participants are being successfully diverted away from long term involvement with the Criminal Justice System by introducing or re-establishing links with treatment and support services while highlighting both the mental impairment and criminogenic needs of participants referred by the Court.[78]

13.69   People who have been charged with indictable offences, especially offences involving serious violence, and who have been found not fit for trial or acquitted on grounds of mental impairment, are likely to be ordered to be treated in a secure facility. Traditionally such people are categorised as 'forensic patients'.

Forensic mental health care

Forensic patients

13.70   Forensic patients constitute a small group in relation to the total prison population and to the prison population with a mental illness.[79] Other people may, however, be treated in forensic mental health facilities. Seriously ill people who were not identified as being mentally ill when they were tried and convicted, people who become seriously ill while in prison, and people in the community who pose a threat to themselves or others may well be confined within a secure facility.

13.71   There are differences between these groups of patients, in that people who were sentenced by the courts will be released when they have served their term of imprisonment, whereas people who were detained without being sentenced face indefinite detention in a secure mental health facility and may in fact never be released.

Facilities

13.72   All jurisdictions make some provision for the care of forensic patients, but that provision is inadequate, both for secure facilities and for follow-up care in the community.

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78   Magistrates Court of South Australia, *Submission 175*, p. 2.

79   See figures quoted earlier by Professor Christopher Puplick, *Submission 226*.

13.73   As at 30 June 2002, in Australia there were 424 inpatient beds for forensic patients.[80] Although NSW had the most beds (166) it seems that the best-resourced facilities for caring for forensic offenders are in Victoria, where a statutory body, the Victorian Institute of Forensic Mental Health (Forensicare), is responsible for providing forensic mental health care.

13.74   Forensicare, which has been described as a world leader in forensic mental health,[81] provides a number of services, including managing a 'state of the art' 100 bed secure inpatient facility, the Thomas Embling Hospital (TEH). Forensicare also provides the courts with opinions on the mental health of persons charged with offences, and treats prisoners and individuals for whom the courts have mandated psychiatric treatment and other individuals who are deemed to present a serious risk of serious offending.[82]

13.75   However, even in Victoria resources are inadequate. Forensicare stated that forensic mental health in Victoria has a pressing and increasing requirement for additional inpatient beds to meet the needs of the criminal justice system. Forensicare stated that although TEH opened as recently as 2000, its capacity was based on a forecast peak prison population of 2500. By June 2004 the prison population had increased to 3624, and imprisonment rates had increased from 66 per 100 00 to 94 per 100 000 of the population.[83] Nationwide, there appears to be no forensic facilities for adolescents, meaning treatment regimes for this group involve transfers back and forth between health facilities and detention, disrupting recovery.[84]

13.76   Another factor affecting the higher-than-expected demand for TEH services is that its bed capacity was determined before the reform of Victoria's mental health legislation in 1997. Forensicare informed the committee that:

> The *Mental Impairment and Unfitness to be Tried Act 1997* is a huge improvement on the earlier system of detaining people indefinitely at the 'Governor's Pleasure', but it has led to more people (appropriately) using the defence. Overseas experience suggests that the current rates of disposition will increase.[85]

13.77   The committee was informed, however, that Trieste in Italy, a region of 1.1 million, had only one forensic patient in January 2006. The level of demand for forensic beds may thus be related to more than just the size of the prison population.

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80   Department of Health and Ageing, *National Mental Health Report 2004*, Commonwealth of Australia, Canberra, Table A-21, p. 77.

81   See for example, Minister for Health – ACT Government, *Submission 165 AA*, p. 14.

82   Victorian Institute of Forensic Mental Health, *Submission 306*, pp. 2-3.

83   *Submission 306*, p. 5.

84   Dr Theresa Flower and Dr Robert Adler, *Submission 263*.

85   *Submission 306*, p. 4.

13.78   Forensicare informed the committee that step-down medium secure/intensive care beds are required, and identified additional needs including the establishment of a unit for elderly forensic patients and an exit unit to manage forensic patients within the community.[86]

13.79   Given that the best-resourced jurisdiction has a 'pressing and increasing requirement' for more facilities, the situation in the other states and territories must be far from ideal. There have, however, been initiatives taken in all Australian jurisdictions to try to address the problem.

13.80   New South Wales and Tasmania are currently constructing secure mental health units, and South Australia is planning a similar facility.[87] Queensland has recently opened a medium and high security forensic facility in Townsville in the north of the state to enable mentally ill offenders to receive treatment closer to their communities.[88]

13.81   Western Australia and the Northern Territory face particularly difficult challenges in providing for forensic patients owing to their geography and large indigenous populations. In the Northern Territory there is not a dedicated forensic mental health facility and 'persons found not guilty of a charge due to mental impairment may be subject to a custodial supervision order at a correctional facility'.[89] There are several beds for forensic patients in Western Australia and the Western Australian Government has made provision in its *Mental Health Strategy 2004-2007* to increase by twelve the number of acute secure beds at Greylands Hospital.[90]

13.82   It seems, however, that the planned facilities when built will still not meet ever-growing demand. In New South Wales for example, the number of forensic patients increased from 21 in 1982 (0.7 percent of the prison population) to 100 in 2003 (1.1 per cent).[91] Professor Mullen, the Clinical Director of Forensicare, in answer to a question about the demand for beds at the TEH, responded as follows:

> So what actually happens is what often happens in any acute medical service: the number of available beds determines the level at which you set your admission, rather than some notion that you would eventually find enough beds for the service. I do not think that is a practicality.[92]

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86   Victorian Institute of Forensic Mental Health, *Submission 306*, p. 5.

87   NSW Health – NSW Government, *Submission 470*, p. 50, Tasmanian Government, *Submission 502*, pp. 9-10; Department of Health – South Australia Government, *Submission 506*, p. 16.

88   Queensland Government, *Submission 377*, Part I, p. 10. Victorian Institute of Forensic Mental Health, *Submission 306*, p. 4.

89   Northern Territory Government, *Submission 393*, p. 22.

90   Department of Health – Government of Western Australia, *Submission 376,* p. 19.

91   Professor Christopher Puplick, *Submission 226*, p. 8.

92   Professor Paul Mullen, Clinical Director, Victorian Institute of Forensic Mental Health *Committee Hansard*, 6 July 2005, p. 40.

Female forensic patients

13.83   There is a pressing need to improve treatment of women prisoners, with the conditions in which they are currently held appearing seriously inconsistent with desirable clinical practice. In Australia there are few separate facilities for female forensic patients. In New South Wales there is no separate dedicated forensic hospital for either male or female prisoners and in Queensland:

> It is also clear that the forensic unit at John Oxley, Wolston Park, is overcrowded and not generally available for women prisoners with serious mental illness who may benefit from its services. There is a shortage of mental health beds in the Queensland health system generally for security patients. Because of the inadequate capacity or the reluctance of relevant authorities to admit and treat acutely ill patients, it appears that on more than a few occasions, women prisoners with acute mental illness may be being inappropriately detained and receiving inadequate treatment in either the CSU [Crisis Support Units], DU [Detention Units] or health units in the women's prisons.[93]

13.84   In Victoria there is a psychiatric unit in the men's prison that 'has at least some potential to provide a therapeutic and holding system for people with mental illness' if they are not able to be admitted to the TEH.[94] There is not a psychiatric unit in the women's prison (Deer Park), however, and:

> Sadly, a number of them [women prisoners with a mental illness] finish up in the block which is designated primarily as a control system and not as a mental health care system.[95]

13.85   When the committee members visited the Brisbane Women's Correctional Centre (BWCC) they were informed that women at the gaol typically wait three weeks after being assessed as needing a bed in the 'men's' John Oxley inpatient facility and that 10 percent of the female prison population of 250 are in secure units. The BWCC employs one senior psychologist and four others who conduct assessments and some group-based programs in cognitive skills, but there is no capacity to engage in long-term psychological intervention. A psychiatrist visits, mostly to review medication. There is also a full-time drug and alcohol counsellor.

Report of the Anti-Discrimination Commission Queensland

13.86   The Anti-Discrimination Commission Queensland published a report *Women in Prison* in March 2006. The Commission found that:

> Many women with mental illness are inappropriately detained in prison while their mental health needs are left unattended. Women prisoners have a much higher rate of mental health problems than men prisoners, but their

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93   Anti-Discrimination Commission Queensland, *Women in Prison*, March 2006, p. 96.

94   Professor Paul Mullen, *Committee Hansard*, 6 July 2005, p. 40.

95   Professor Paul Mullen, *Committee Hansard*, 6 July 2005, p. 41.

needs are not presently addressed. A significant increase in resources is necessary if women with mental illness are to be properly dealt with within the correctional system. Proposed changes to crisis support units, including a reduction in strip-searching, are welcomed, but address only part of this problem. Much more is needed.[96]

13.87   The Commission made seven recommendations on mental health matters. These covered: more diversionary programs for women; addressing systemic issues to reduce the over-representation of women with mental illness in state prisons; enhancement of services, including increasing the number of beds in secure psychiatric medical facilities; limiting seclusion; addressing substance abuse, mental illness and sexual assault issues; training of prison officers; and provision of step-down accommodation facilities.[97]

13.88   The report also recommended that there be an independent review:

That the Human Rights and Equal Opportunity Commission conducts a review into how the justice and prison systems across Australia are dealing with women with mental health issues.[98]

Costs of facilities

13.89   The provision of facilities to treat forensic patients and prisoners with serious mental illnesses is resource intensive and the cost of the facilities and of caring for the health of prisoners is met by the state or territory governments. The daily cost of providing a bed in an Australian forensic facility was $542 in 2001-2002. Costs ranged from $372 in NSW to $938 in the Northern Territory.[99]

13.90   The Northern Territory Government submitted that forensic patients should be accommodated in a safe and therapeutic environment oriented toward rehabilitation and community reintegration, but that establishing such a facility in a very small jurisdiction would require a substantial capital investment and operational funding.[100]

13.91   In relation to the relative costs of caring for mentally ill people, Professor Christopher Puplick, a former chair of the Central Sydney Health Service, informed the committee that:

96   Anti-Discrimination Commission Queensland, *Women in Prison*, March 2006, pp. 5–6.

97   Anti-Discrimination Commission Queensland, *Women in Prison*, March 2006, pp. 12–13.

98   Anti-Discrimination Commission Queensland, *Women in Prison*, March 2006, p. 15.

99   Department of Health and Ageing, *National Mental Health Report 2004*, Commonwealth of Australia, Canberra, Table A-21, p. 78.

100   Northern Territory Government, *Submission 393*, p. 23.

> It costs between $50 000 and $60 000 a year to maintain a prisoner in jail, but up to $200 000 per year to maintain a mental health bed in the NSW public health system.[101]

13.92   Professor Puplick concluded that:

> … 'treating' a mentally ill person by incarceration rather than by hospitalisation is three or four times cheaper to the State budget.[102]

Staffing

13.93   Principle three of the *National Statement of Principles for Forensic Mental Health* states, in relation to the responsibilities of the health and justice systems, that 'mental health services should be staffed by mental health personnel employed by a health service … not correctional agencies'.[103]

13.94   Although health authorities throughout the Commonwealth agree that the management of forensic mental health is a matter for the health authorities, it is not clear that all jurisdictions necessarily accept that argument. In Queensland, for example, the custodial departments are responsible for the mental health of prisoners, but services are purchased from external suppliers, 'reflecting an important separation between the provision of health services and the custodial provider'.[104] In New South Wales a statutory corporation, Justice Health, which reports to the Minister for Health, is responsible for providing medical services to prisoners 'in partnership with the Department of Corrective Services'.[105]

13.95   Butler and Allnutt reported that the majority of mental health providers within the NSW correctional environment are 'obligated to conform with the correctional ethos'. They commented that:

> This is fertile ground for conflicting priorities between clinical needs (the health priority) and security (the custodial priority). The correctional approach to the management of difficult behaviour can be the antithesis of the mental health approach.[106]

Treatment in prison

13.96   Although it is generally agreed by health authorities that prisoners requiring inpatient mental health care should be transferred from prison to an appropriate mental

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101   Professor Christopher Puplick, *Submission 226*, p. 11.

102   *Submission 226*, p. 11.

103   *National Statement of Principles for Forensic Mental Health 2002*, p. 8.

104   Queensland Government, *Submission 377*, Part II, p. 47.

105   NSW Health – NSW Government *Submission 470*, p. 50.

106   T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, 2003, New South Wales Corrections Health Service, p. 50.

health facility located beyond the geographical boundaries of the prison and run independently from correction services,[107] this will not occur in the absence of sufficient appropriate facilities. Moreover, relatively few prisoners with a mental illness are so seriously ill that they require inpatient treatment, but they still require treatment, and that treatment, if provided, will generally be in gaol. The availability and adequacy of treatment for mentally ill people within Australia's prisons are therefore important matters.

13.97   The ACT Government stated that the National Principles provide a clear framework for appropriate care within corrections facilities.[108] The first of those Principles, for example, reads as follows:

> Prisoners and detainees have the same rights to availability, access and quality of mental health care as the general population. Where health facilities are provided within a correctional facility, there should be appropriate equipment and trained staff, or arrangements made for such services to be available, at a standard comparable to regional and community standards.

> Services should ensure equality in service delivery regardless of an individual's age, gender, culture, sexual orientation, socio-economic status, religious beliefs, previous conditions, forensic status, and physical or other disability. This Principle of Equivalence applies to both primary and specialist mental health care.[109]

13.98   NSW Health informed the committee that it 'continued to provide high quality in-reach mental health programs across all correctional facilities',[110] but the evidence is that treatment of mental illnesses in Australian prisons is inadequate. Forensicare, for example, stated that, 'Adequate mental health services are rare in prison'.[111] That judgement is supported by evidence submitted by Sisters Inside, an organisation which advocates for the human rights of women in the criminal justice system, which stated, in relation to mental health resources allocated to Queensland prisons, that:

> In our prison system at the moment we have … 1.5 mental health workers for 3500 prisoners. Prisons have become the de facto psychiatric units but with no mental health professionals.[112]

13.99   Professor Puplick informed the committee that it appears that only 8 percent of men and 23 percent of women who had been diagnosed with some form of mental illness were on psychiatric medication while in prison.[113]

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107   *National Statement of Principles for Forensic Mental Health 2002*, p. 8.

108   Minister for Health – ACT Government, *Submission 165*, p. 14.

109   *National Statement of Principles for Forensic Mental Health 2002*, p. 6.

110   NSW Health – NSW Government, *Submission 470*, p. 50.

111   Victorian Institute of Forensic Mental Health, *Submission 306*, p. 19.

112   Ms Debbie Kilroy, OAM, Director, Sisters Inside, *Committee Hansard*, 4 August 2005, p. 92.

In fairness I should mention that while in prison many of these same people will probably be better fed and housed and have better access to health services than at almost any other time in their lives – itself a shocking indictment of our general level of services for the mentally ill in the community.[114]

13.100 Professor Andrews also commented on the adequacy of mental health services to people in gaol:

NSW Health is providing psychiatric care in prisons, albeit not sufficiently, but almost certainly more than was available to prisoners before they came to jail.[115]

13.101 Professor Andrews stated that priority should be given to providing treatment in gaol:

Once we get 80 percent of people with mental disorders getting treatment [the level of treatment of most physical disorders] we could look at diversion programs for those in the criminal justice system. Until then let us be proactive in arranging good treatment in jail.[116]

13.102 Nevertheless there are difficulties involved in providing treatment in a setting that is not necessarily conducive to effective treatment of people with mental illness. Effective treatment in prison may be impossible because prison officials focus on security and placement issues rather than treatment.[117] The Mental Health Legal Centre stated that men and women with mental health issues report that they are reluctant and even frightened to reveal them because there is little support and lots of discrimination.[118] The Australian Doctors' Fund submitted that imprisonment of the mentally ill is a barrier to the delivery of good psychiatric care.[119]

13.103 In a supplementary submission Professor Andrews stated that some people believe that people who meet criteria for a mental disorder should be in hospital rather than in jail. If that were done, however, a substantial proportion of the present jail population would have to be accommodated in secure mental health units. He suggested that as there is no test for a mental disorder and the diagnosis is based on symptoms, presumably most prisoners when they recovered would continue to

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113   Professor Christopher Puplick, *Submission 226*, p. 8.

114   *Submission 226*, p. 9.

115   Professor Gavin Andrews, *Submission 176A*, p. 1.

116   Professor Gavin Andrews, *Submission 176*, p. 12.

117   Public Interest Advocacy Centre, *Submission 373*, p. 14.

118   Mental Health Legal Centre, *Submission 314*, p. 23.

119   Australian Doctors' Fund, *Submission 356*, p. 1.

complain of symptoms until their jail sentence had expired, for to do otherwise would result in their being returned to jail.[120]

13.104 Treating offenders in hospital rather than imprisoning them also raises the question of whether offenders are able to avoid the full consequences of their criminal acts.

Involuntary treatment and seclusion

13.105 Involuntary treatment of prisoners raises human rights concerns:

> TEH also provides involuntary treatment of prisoners with mental illness, as under mental health legislation Victorian prisons are not able to undertake such treatment. Victoria is of the view that involuntary treatment in prisons without clear separation of custodial and treatment requirements is contrary to the principles contained in the Mental Health Act and in breach of international human rights obligations.[121]

13.106 Professor Puplick told the committee that the incarceration of forensic patients in New South Wales is in 'clear breach of domestic legislation, the National Medical Health Forensic Policy and the United Nations Declaration of Human Rights'.[122]

13.107 Professor Mullen, Clinical Director of Forensicare, stated that in the past, when it was possible to treat mentally ill prisoners compulsorily in gaol, medications had been used, not for treatment but for control and punishment. He stated that although there are many short-term solutions which may appeal, he hoped that the compulsory treatment of patients within prison would be resisted.[123]

13.108 Seclusion of prisoners who have been assessed as being at risk of suicide, self-harm or as a danger to others raises greater concerns. The committee received evidence from Sisters Inside about the 'Crisis Support Unit S4' isolation cells at the Brisbane Women's Correctional Centre (BWCC) and the Chair and one other member of the committee subsequently visited the gaol. At the time, all but one of the nine women in these cells were affected by a serious mental illness. The cells have been designed so that there are no furniture or design features that would allow them to harm themselves. The prisoners are locked down for 19 or so hours a day, are given only a hospital gown to wear and are under constant video surveillance.[124] The Chair was advised by management that strip searches are mandatory for reception, whenever isolation cell inmates are escorted out of their cells and on return, after contact visits, whenever leaving an area in the facility such as the health centre, when placed on

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120   Professor Gavin Andrews, *Supplementary Submission 176*, p. 1.

121   Victorian Minister for Health – Victorian Government, *Submission 445*, p. 9.

122   Professor Christopher Puplick, *Submission 226*, p. 8.

123   Professor Paul Mullen, *Committee Hansard*, 6 July 2005, p. 50.

124   Sisters Inside, *Submission 283*, pp. 15–22.

observation and every evening. The requirement for a further three strip searches at meal break times had recently been removed.

13.109 It is alarming to note that though these women are regarded as at very high risk of self harm, many were on relatively short sentences and would soon be released. The rate of recidivism amongst these women was said to be very high.

13.110 The process of isolating such persons and placing them in seclusion appears effectively to prevent suicide and may prevent disruption to other inmates, but is hardly therapeutic for people who are mentally ill. A former visiting general practitioner to the BWCC, Dr Schrader, made the following observations about the use of the isolation cells at the Centre:

> The treatment is the opposite of therapeutic. The use of seclusion is inappropriate for those of risk of self-harm and suicide. Observation alone does little to help the woman overcome her distress and suicidal or self-harming feelings and is alienating in itself … A key element in suicide prevention is the presence of human interaction.[125]

13.111 The committee heard similar evidence about the use of seclusion facilities for prisoners assessed to be 'at risk' in other jurisdictions. Mr Strutt, a member of Justice Action, a prisoners' activism organisation, referring to the use of isolation cells in NSW, stated that:

> If you are a prison officer and you see a prisoner who seems to be seriously depressed … your No. 1 priority is to make sure that that person does not kill themselves while you are on duty. So basically you put them in a strip cell. For all the talk about care and attention they are getting in prisons and hospitals, the way those institutions are structured means they are not getting the appropriate care and attention.[126]

Treatment of psychotic prisoners

13.112 Although anxiety and depressive conditions appear to be common among prisoners, corrections and health authorities devote most resources to the treatment (or control) of prisoners with relatively low incidence disorders, in particular, psychoses.

13.113 Butler and Allnutt found that psychosis was more common among reception prisoners than among sentenced inmates (12 percent vs. 5 percent).[127] The reason for this is not clear, but it is possible that less access to drugs in prisons may contribute to a lower incidence of drug-induced psychosis and that people in prison are more likely to receive treatment than if they remained in the community.

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125   Dr Tracy Schrader, *Submission 396*, p. 4.

126   Mr Michael Strutt, Researcher and Spokesperson on Forensic and Cirminiological Issues, Justice Action, *Committee Hansard*, 2 August 2005, p. 97.

127   T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, New South Wales Corrections Health Service, 2003, p. 19.

13.114 One psychotic illness in particular is of concern to mental health and criminal justice authorities. Professor Andrews informed the committee that the association between violent crime and schizophrenia is well established in the United States of America and Denmark, and that a careful compilation of state statistics might well show a comparable situation exists in Australia.[128] Professor Andrews referred to a paper with which he is associated and which has been submitted for publication where it is reported that rates for psychotic-like experiences were 11 times higher among people being admitted to NSW prisons than in the general population.[129] Forensicare also referred to evidence that shows that those with severe mental illness, particularly schizophrenic illnesses, are more likely to commit criminal offences and more likely to end up in prison.[130] Forensicare referred to a Victorian study that found that those with schizophrenia make up between 0.5 percent and 0.7 percent of the Australian population but are responsible for 5 percent to 10 percent of homicide and seriously violent offending.[131]

13.115 Professor Andrews submitted that:

> Psychosis is associated with violence and treatment in a secure facility for some is essential, whether we call this a hospital or a jail is irrelevant as long as treatment is delivered.[132]

'Least restrictive alternative' for treatment

13.116 The Human rights and Equal Opportunity Commission (HREOC) informed the committee that Principle 9 of the UN Mental Health Principles 'emphasises the importance of "the least restrictive alternative" in relation to treatment.[133] This principle raises additional issues in relation to the treatment of forensic patients in gaol. Diversion programs are an attempt to treat forensic patients in a less restrictive environment than a prison. Diversion may result in treatment in the community. Both appear to offer a 'less restrictive environment' than does a prison.

13.117 Secure facilities may not necessarily offer a 'less restrictive alternative' than prison if the patient faces an indeterminate period of confinement in the facility. Even where Mental Health Tribunals recommend that people be released, unless the decision is made by, for example, a court, rather than treated as an exercise of executive discretion, people may be confined for long periods. One NSW case brought to the committee's attention concerned a man who shot another, was found not guilty of grievous bodily harm on the grounds of mental illness, whose release into the

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128   Professor Gavin Andrews, *Submission 176*, p. 7.

129   Professor Gavin Andrews, *Supplementary Submission 176*, p. 1.

130   Victorian Institute of Forensic Mental Health, *Submission 306*, p. 14.

131   *Submission 306*, p. 15.

132   *Submission 176*, p. 12.

133   Human Rights and Equal Opportunity Commission, *Submission 368*, p. 2.

community was recommended by the Mental Health Tribunal, but who has not been released by the responsible minister.[134]

13.118 In most Australian jurisdictions the responsibility for deciding on the release of forensic prisoners has been, or will be, removed from the political arena. The Tasmanian Government, for example, is drafting new legislation to provide that:

> Decisions regarding the discharging of patients [from the new secure mental health unit] will be based on health and risk management grounds, with the final decision body being the Supreme Court of Tasmania. This will ensure that management decisions are quarantined from the political process.[135]

13.119 These legislative changes give effect to the following recommendation of the Burdekin Report:

> Decisions concerning the release of persons unfit to be tried or not guilty on the grounds of insanity should be made by courts or independent specialist tribunals. These bodies should exercise determinative powers. The executive branch of government should not have the ultimate responsibility for release decisions.[136]

13.120 The transfer of responsibility for the release of forensic patients to the courts or the mental health tribunals may well result in the release of more people than at present. The (appropriate) release of more people than formerly released makes the provision of proper step-down programs and other treatment options in the community even more important and urgent.

Release policies and practices

13.121 The evidence shows that corrections authorities throughout Australia generally have developed and established relatively enlightened policies for the care of prisoners with mental illness. They also generally have enlightened policies for the release of prisoners. However, it seems that the practice often may be different from the theory, both as regards care and release.

13.122 A study of release policies and practice in Queensland (*In*corrections) was submitted by the Centre for Social Justice, a division of UnitingCare Queensland. The study, among many other things, listed the needs of newly released prisoners - a list that included access to money for immediate needs, accommodation, employment,

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134   Justice Action, *Submission 174*, p. 9.

135   Tasmanian Government, *Submission 502,* p. 10.

136   Human Rights and Equal Opportunity Commission, *Human Rights and Mental Illness: Report of the National Inquiry into the Human Rights of People with Mental Illness*, AGPS, Canberra, 1993, pp. 942–943.

health needs and social and emotional support.[137] It appears from the study that the health needs of former prisoners with mental illness, especially those who have served their full sentences, often are not being met. The study reported that:

> Ex-prisoners and service providers consistently reported that prisoners are often released with 'nothing'. Drug-addicted, mentally disturbed and physically ill prisoners are often released without prescriptions for the drugs they require, or referrals to doctors or other professionals … They are released with no money, no home, no job, and without having met, or been linked with, a worker in the community who they can turn to for help.[138]

13.123 Evidence submitted by other witnesses indicates that this situation is not limited to a single jurisdiction, but may unfortunately be widespread. Forensicare stated, for example, that:

> At the point of release, coherent plans for a managed return to the community with prearranged mental health support almost never occur.[139]

13.124 The *In*corrections study sets down a number of principles for best-practice release of prisoners. These principles have general application, and are applicable to the release of prisoners with mental illness. The principles include 'throughcare', which requires the early assessment and referral of prisoners to appropriate interventions and programs, aftercare and pre-release programs.[140]

13.125 The *In*corrections study found that in a number of re-entry programs that exist throughout the world, the key feature is a solid partnership between prisons and community mental health providers.[141] As discussed elsewhere in this report, community health services in Australia appear to be inadequate. As a result, the adoption of enlightened re-entry programs would require not only the wholehearted cooperation of corrections authorities, but significant allocations of additional resources for community health.

Care on release

13.126 The St Vincent de Paul Society, although agreeing with other witnesses that persons with a mental illness should not be in prisons, stated that in the existing circumstances where there is no other reasonable method of housing some of those people, there needs to be a pre-discharge plan. That plan would include providing

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137   T. Walsh, *Incorrections: Investigating prison release practices and policy in Queensland and its impact on community safety*, Faculty of Law QUT, November 2004, Chapter 2.3, pp. 56-71.

138   T. Walsh, *Incorrections: Investigating prison release practices and policy in Queensland and its impact on community safety*, Faculty of Law QUT, November 2004, p. 100.

139   Victorian Institute of Forensic Mental Health, *Submission 306*, p. 5.

140   T. Walsh, *Incorrections: Investigating prison release practices and policy in Queensland and its impact on community safety*, Faculty of Law QUT, November 2004, pp. 73-75.

141   T. Walsh, *Incorrections: Investigating prison release practices and policy in Queensland and its impact on community safety*, Faculty of Law QUT, November 2004, p. 66.

adequate financial resources, budgeting and living skills and linkage to exit housing with appropriate supports.[142]

13.127 Forensicare suggested the post-prison care of mentally ill prisoners might be approached as follows:

> Inreach services, where local community health teams, or where available, forensic mental health teams, begin to manage prisoners prior to their release would be a major contribution. One potential reform worth considering is that mental health services in all prisons become part of the area mental health service in which the prison is situated, with special Inreach teams, augmented by input from specialist forensic mental health professionals. (As is now beginning to occur in the UK).[143]

13.128 A similar approach was suggested by Psychiatric Disability Services of Victoria (VICSERV) Inc., which made the following recommendations:

- That community-based rehabilitation and support services (CBRS) be engaged to deliver psychosocial rehabilitation within prisons and for post-prison transitions

- That housing resources (with attached CBRS resources) be allocated to assist prisoners with a mental illness to make successful transitions back into community life

- That partnerships and communication strategies be developed between prison authorities, clinical, mental health services, CBRS services and housing agencies

- That intensive transition packages such as Individual Support Packages or intensive home-based outreach funding be established to decrease the possibility of re-incarceration due to relapse.[144]

13.129 However, as reported earlier, the committee heard that the step-down and other community facilities that would enable these approaches are inadequate. Professor Andrews submitted that:

> *Units that can't discharge can't admit*. Australia presently has sufficient acute short stay beds if the beds were occupied only by acute care patients. However it has only a quarter of the rehabilitation beds required and perhaps only 40 per cent of the community beds required.

and that:

> In the absence of step down beds, public sector staff are being asked to maintain patients in the community who are too sick to live in the community and who should be in stable supervised accommodation.[145]

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142   St Vincent de Paul Society, *Submission 478*, p. 14.

143   Forensicare, *Submission 306*, p. 19.

144   VICSERVE, *Submission 347*, pp. 23–24.

Recidivism

13.130 There is a high rate of recidivism among former prisoners with a mental illness.[146] Forensicare informed the committee, in relation to patients suffering with schizophrenias, that:

> Repeat offending in schizophrenia is critically dependent on whether the individual had the ongoing structure provided by open employment, but failing that, sheltered workshop or day centre support. Services have been withdrawn from programs of active work rehabilitation in recent years, but this is a critical element in patient functioning and in reducing offending.[147]

> Ignored, mismanaged, released unprepared, rapidly re-offending and returning to prison. This is all too often the story of the mentally ill offender, repeated and repeated.[148]

13.131 Butler and Allnutt found that, based on a report of a British study, 'The mentally ill often revolve through prisons, with periods of incarceration interspersed with spells in the community and place high demand on services'.[149]

13.132 Forensicare referred to a study, in preparation at the time of the inquiry, examining recidivism in a mentally disordered population with and without co-morbid substance abuse.[150] The committee welcomes that study and would encourage other professionals to undertake studies of recidivism that, among other things, might cast light on the causes for recidivism and that might enable authorities to assess the effectiveness of diversion programs.

13.133 Although there is a need for more data to ensure that approaches to treatment of potential re-offenders are based on sound evidence, the relative absence of data should not prevent authorities from now offering appropriate support. There is sufficient evidence now available to suggest how this support might be provided. Forensicare made several recommendations for action that it considered would reduce the rate of offending and re-offending on those with schizophrenia. These recommendations canvas matters such as providing adequate secure continuing beds and restructuring community mental health services.[151] Forensicare commented that the implementation of those recommendations would be costly but, 'given the

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145 Professor Gavin Andrews, *Submission 176*, p. 7.

146 See for example, Public Interest Advocacy Centre, *Submission 373*, p. 15.

147 Victorian Institute of Forensic Mental Health, *Submission 306*, p. 18.

148 *Submission 306*, p. 19.

149 T. Butler and S. Allnutt, *Mental Illness Among New South Wales Prisoners*, NSW Corrections Health Service, 2003. ISBN: 0 7347 3559 6, p. 50.

150 Victorian Institute of Forensic Mental Health, *Submission 306*, p. 10.

151 *Submission 306*, pp. 19-21.

potential benefits in reduced crime, reduced prison numbers and improved care, they should be viewed as a bargain'.[152]

Dual diagnosis

13.134 'Dual diagnosis' is a term used to describe the co-existence (or co-morbidity) of mental illness and substance use disorders, although individuals rarely experience only two disorders.[153]

Incidence

13.135 Forensicare informed the committee that a recent study of rates of recidivism among people released from the TEH confirms that those patients with a co-morbid mental illness and substance use or dependence disorder were at a particular risk of re-offending. The committee was told that the data clearly shows that substance abuse and dependence and mental illness are independent risks for re-offending, and that when these disorders occur together, there is an exponential risk of re-offending.[154] The South Australian Department of Health cited a study that showed that the presence of co-morbid mental health problems and substance abuse increases the rate of offending by people with mental health disorders discharged from hospital by up to five times.[155]

Treatment

13.136 Dual disorders are extremely complicated and both diagnosis and treatment are clinically difficult.[156] Despite the difficulties, some Australian service providers are attempting to treat the condition. The Queensland Government has developed a 'strategic plan for people with a dual diagnosis' and for which nine change management positions have been established in high prevalence areas across the state.[157]

13.137 Project teams within Forensicare have suggested that the organisation undertake a systematic and comprehensive approach to the assessment and treatment

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152   Victorian Institute of Forensic Mental Health, *Submission 306*, p. 20.

153   Victorian Institute of Forensic Mental Health, *Consolidating and Strengthening Clinical Programs: Addressing Dual Diagnosis and Offending Behaviour in Forensic services*, 2004, p. 25.

154   *Submission 306*, p. 10.

155   Department of Health – South Australia Government, *Submission 506*, p. 16.

156   S. Henderson, *Mental Illness and the Criminal Justice System*, Mental Health Co-ordinating Council, May 2003, p. 8.

157   Queensland Government, *Submission 377, Part I*, p. 16.

of dual diagnosis.[158] Among other things, the Forensicare project teams suggested that consideration be given to the possible use of involuntary treatment for substance abuse in high-risk diagnosis patients, which would require that the concept of treatment under the Mental Health Acts be redefined to include treatment of substance misuse.[159]

13.138   The committee trusts that Forensicare will be able to undertake this work and that the organisation becomes, as suggested in the study, 'recognised locally and internationally as a centre of excellence in the assessment and treatment of dual diagnosis'.[160] However, it also notes that expansion of involuntary treatment could go against the spirit of mental health reform and the desires of consumers to be more involved in their treatment.

Mental illness and the criminal justice system: the role of the Commonwealth

13.139   The Australian Government has only a limited and indirect role in forensic mental health. In its submission to the inquiry, the Government stated that it has no express power to legislate in relation to criminal law, except to the extent that the criminal law may be connected to other federal powers.[161] It does, however, have the power to create offences against federal laws and in that regard the Australian Law Reform Commission (ALRC) is currently inquiring into the sentencing of federal offenders. ALRC has published a paper for comment in connection with its inquiry, which includes a chapter on mental illness and intellectual disability.[162] The Commission observes in that paper that because each jurisdiction has a different scheme, the treatment of federal offenders[163] may therefore be unequal.[164]

13.140   Because the states and territories are responsible for criminal law in their own jurisdictions, it follows that they are also responsible for the care and health of their prisoners, including their mental health.

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158   Victorian Institute of Forensic Mental Health, *Consolidating and Strengthening Clinical Programs: Addressing Dual Diagnosis and Offending Behaviour in Forensic services*, 2004, p. 42.

159   Victorian Institute of Forensic Mental Health, *Consolidating and Strengthening Clinical Programs: Addressing Dual Diagnosis and Offending Behaviour in Forensic services*, 2004, p. 38.

160   Victorian Institute of Forensic Mental Health, *Consolidating and Strengthening Clinical Programs: Addressing Dual Diagnosis and Offending Behaviour in Forensic services*, 2004, p. 42.

161   Australian Government, *Submission 476*, p. 62.

162   ALRC Issues Paper 29, *Sentencing of Federal Offenders*, Chapter 14.

163   A *federal offender* is someone who is charged with, and convicted of, an offence against a law of the Australian Government.

164   ALRC Issues Paper 29, *Sentencing of Federal Offenders*, Chapter 14, p. 8.

13.141 The Australian Government's principal contribution to the costs of treating people with mental illnesses is through Medicare and the Pharmaceutical Benefits Scheme, but prisoners are not eligible to receive benefits under either scheme.

13.142 Section 19 to the *Health Insurance Act 1973* provides that a Medicare benefit will not be paid in respect of a professional service that has been rendered by, or on behalf of, or under an arrangement with a state. A witness from the Department of Health and Ageing stated that:

> Correctional facilities and the medical services that are provided to people within those facilities would be regarded as being under an arrangement with a state.[165]

13.143 In effect, therefore, the costs of treating mentally ill prisoners are borne entirely by the states and territories. This point was made by the Victorian Government, among others.[166]

13.144 In his second reading speech to the *Health Insurance Amendment Bill 1976*, which contained the provision that was inserted into the principal act, the then Minister for Health stated that the Commonwealth was concerned about the rising costs of Medibank and the potential for cost shifting from the states to the Commonwealth. The relevant part of the speech reads as follows:

> … benefits should not be paid to relieve governments, government authorities, or employers of costs that, but for Medibank, should be borne by them.[167]

13.145 The committee notes that the cost of providing health care to prisoners is significant. In NSW alone, the Department of Correctional Services spent $68 million on medical services to prisoners in 2004-2005.[168]

13.146 The committee was informed that prisoners' ineligibility for Medicare can produce 'the most extraordinary situations'.[169] Professor Mullen stated that:

> You can have a prisoner who is physically or mentally ill in a relatively isolated prison … which may very well have a base hospital nearby, but you cannot access the doctors and the skills in that hospital or the practitioners who live nearby and might be prepared to provide care. This is because the state will have funded a health service which may be hundreds of kilometres away, and will transport the prisoners to that service rather than use the facilities right next door.[170]

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165   Ms Samantha Robertson, *Committee Hansard*, 7 October 2005, p. 65.

166   Victorian Minister for Health – Victorian Government, *Submission 445*, p. 11.

167   Minister for Health, Mr R Hunt MP, *House of Representatives Hansard*, 20 May 1976, p. 2349.

168   NSW Department of Correctional Services, *Annual Report 2004-2005*, p. 97.

169   Professor Paul Mullen, *Committee Hansard*, 6 July 2005, p. 47.

170   Professor Paul Mullen, *Committee Hansard*, 6 July 2005, p. 47.

13.147 In its indirect role in the treatment of forensic prisoners the Commonwealth has liaised with the states and territories to develop the *National Statement of Principles for Forensic Mental Health*, which has been discussed elsewhere in this Chapter, and has provided funding for the Drug Use Monitoring In Australia program. This program collects information from detainees at police stations or watch houses to provide an evidence-base for policy making in regards to drugs and crime. A section on mental illness is included in the questionnaire used for the program.[171]

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171   Australian Government, *Submission 476*, p. 63.

'Peter's' story: from submission 456

The environmental component of my depression is made up of how I was raised and the seed of depression that I believe was already there. A potent mix.

I grew up with a step father who was physically, verbally and mentally abusive towards me and my family for the first fifteen years of my life. In response to this I was a complete wild child, always in trouble, aggressive and anti social. At a very early age I remember speaking with counsellors and shrinks. Never once was I asked if I was being abused or even assessed properly as to my mental well being. Just asked why I was so naughty. I think this had to do with my age (at this time I was under eight years old) and also that I lived in outback Western Australia. I'm not sure at whose insistence but I was twice sent to youth detention centres before I was ten years old, where I spent about two years in total. Even in these places I do not believe that I was assessed for my mental well being or probed on my family situation. And both times I was sent back to my abusive home and the cycle started all again.

At age thirteen I stole all the pills I could find and tried to end my life (thankfully I just made myself sick). Once, when I was fourteen I had just had severe belting by my step father and about an hour later I picked up a knife and went into his room where he was sleeping. I was going to kill him. I wanted to but I didn't. I walked out of the room. I didn't want to spend my life in jail because of him. About the age of fourteen I had my first drink and I immediately binged. I would drink until I passed out of threw up or both. I also started smoking pot around this time. I wanted to not feel anything at all so moderation didn't come into it.

At fifteen I left home and spent the next thirteen years battling the depression demon, amongst other things, I ended up in a youth hostel where drinking continued and I was introduced to 'downers', valium and the like. I also got involved in sex work, an occupation that would last for ten years. Also I progressed to harder drugs like ecstasy and speed. Until I was 28 I was a drug addict using marijuana, speed, ecstasy, crystal meth, valium (and assorted downers), alcohol and practically anything else I could find. I also dealt drugs and had run ins with the law for drug offences and assault. During this ten year period I saw many psychiatrists and counsellors and I was prescribed anti depressants, like Prozac and Xanax. I didn't like how I felt on anti depressants, I felt like a zombie. More so than when I was on my other drugs of choice.

So all of the above mentioned crossed with a family history of depression was an unfortunate mix. In my late twenties I had finally had enough of my lifestyle and I stopped taking drugs, finished with the sex industry and got a steady job. I still had to contend with my depression though and I shopped around for a counsellor that was compatible with me that could help me. I realised during these sessions that depression would be with me for life and I made the decision to fight it head on. I chose not to take anti depressants and to fight depression with lifestyle change and understanding my enemy. These days my life is much better but I have to remind myself what I am dealing with and I battle with that each day. Most days are good, some days not so good and some days are just plain terrible. But understanding my enemy has been helpful. I now want to live my life, as opposed to being suicidal for many years.

CHAPTER 14

DUAL DIAGNOSIS

'THE EXPECTATION NOT THE EXCEPTION'

Introduction

14.1   Over the last twenty years the number of people with mental illness who also have a substance abuse disorder has been increasing. Service providers now report dual diagnosis is the 'expectation not the exception' in treated populations.[1] Tragically, many of those affected are young.

14.2   This chapter explores the experience of people with co-occurring mental and substance abuse disorders and identifies some of the obstacles to service provision for them. Reflecting on some of the good models described or proposed during the inquiry, the chapter then suggests a better and more comprehensive way of caring for this vulnerable, high prevalence group.[2]

The nature of the problem

14.3   Dual diagnosis is a term that describes the situation of a person experiencing two or more pathological or disease processes at the same time.[3] Other terms for this are co-occurring disorders or co-morbidity.[4]

14.4   There are two main clinical interpretations of the term 'dual diagnosis'. The first refers to the co-existence of intellectual, developmental or physical disability with mental illness.[5] The other describes the experience of having a mental illness along with a substance abuse disorder. This latter definition, which is the one applied in this report, has the longest history and is most widely used in Australia.[6]

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1   Eastern Hume Dual Diagnosis Service, Statement in support of *Submission 374*, tabled Melbourne Public Hearing, 6 July 2005, p. 2.

2   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 17.

3   *The American Heritage Stedman's Medical Dictionary*, Houghton Mifflin Company, 2002.

4   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 17.

5   See for example Queensland Centre for Intellectual and Developmental Disability Mater Hospital, *Submission 463* and attachments.

6   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 17.

14.5   People with dual diagnosis disorders are not a homogeneous group—substantial diversity exists in the combinations of disorders, in their severity and their individual treatment needs. Eastern Hume Dual Diagnosis Service advises there are three basic categories used for clinical assessment of co-occurring disorders:

- substance use disorders co-occurring with high-prevalence, low-impact mental health disorders (such as anxiety and depression);

- substance use disorders co-occurring with low-prevalence, high-impact mental health disorders (such as psychosis and major mood disorder); or

- any mental health disorder co-occurring with either substance abuse or substance dependence.[7]

14.6   Substances used by people with dual diagnosis may include prescription drugs or other substances, whether legal or illegal, including alcohol, opiates, stimulants and cannabis. The most common form of substance abuse disorder is alcohol dependence. Other legally available substances are solvents and petrol, ingested by 'sniffing'.[8]

14.7   Tobacco use, although frequent among people with mental illness, is not treated as part of the dual diagnosis spectrum.[9]

Self medication and dual diagnosis

14.8   Treatment of substance abuse and mental health disorders is complicated by the fact that alcohol or drugs are often used by mental health consumers to alleviate the stresses of their mental illness, including psychotic systems, depression or to deal with the side effects of medication or the stigma of being mentally ill.

14.9   The Jesuit Social Services Connexions program advised that: 'Young people with mental illness take drugs for a multitude of reasons including to treat their disorder, to reduce anxiety, peer group activity' and to 'assume an identity as drunk or drugged rather than mad because this is socially acceptable'.[10] A Jesuit Connexions case study reports:

> Clients participating in group program for young people with coexistent mental health and substance abuse misuse problems discussed the perceptions they encountered with having dual diagnosis. They felt they were commonly seen as criminals, junkies and worth less than others. One

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7   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 17.

8   Drawn from Ms Nene Henry, *Submission 282,* p. 1.

9   Ms Nene Henry, *Submission 282*, p. 1.

10   The Ignatius Centre for Social Policy and Research, Jesuit Social Services, *Submission 358*, p. 8.

client said he would prefer to be seen as drug affected than labelled a 'nutter'.11

14.10   Professor Ian Webster advised that alcohol abuse can alleviate the discomfort of deprivation and homelessness, making it difficult to determine whether mental illness is the cause or the consequence of the substance abuse:

> People with mental illness drink alcohol to control their feelings and thoughts, alcohol "blots our time" it "takes time away", and it is not always the primary cause of person's circumstances. And when you have chronic pain from an early injury or chronic disease, alcohol is not a bad analgesic when no one will refer you to a pain clinic. If sleep is hard to get when living rough, or when trying to sleep in a crowded dormitory—alcohol is a cheap sedative.[12]

14.11   The Australian Injecting and Illicit Drug Users League suggested that illicit drugs are often used by people with severe psychotic disorders to control symptoms, and to counteract the side effects of prescribed medications:

> Many people self-medicate by using illicit drugs to manage the symptoms of their mental health problems. Anecdotal evidence suggests the effects of heroin and cannabis are 'helpful' in peoples attempts to focus away from the distress and pain of hearing voices (auditory hallucinations), and the effects of cocaine and amphetamine in counteracting the extreme sedation and lethargy induced by anti psychotic medications, and negative symptoms.[13]

14.12   The Centre for Mental Health Studies commented on the high level of substance abuse among people with depression:

> People with depression often respond to everyday situations with a negative interpretation. Symptoms of depression also include low mood, loss of interest in activities, people or places and loss of energy which makes them feel terrible about themselves and the world they live in. Many people then turn to alcohol and drugs for temporary relief.[14]

14.13   The medical contraindications of self-medication are that dual diagnosis sufferers may be less compliant with prescribed treatment regimes.[15] Intravenous drug injection makes people with co-morbid conditions more vulnerable to blood borne infections such as AIDS and Hepatitis C.[16] Moreover, the 'drug cultures' surrounding

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11   Connexions staff interview, 2005, Jesuit Social Services, The Ignatius Centre for Social Policy and Research, *Submission 358*, p. 8.

12   Professor Ian Webster, AO, Emeritus Professor of Public Health and Community Medicine, University of New South Wales, *Submission 458*, p. 29.

13   Australian Injecting and Illicit Drug Users League**,** *Submission 281*, p. 4.

14   Kay-Lambkin Centre for Mental Health Studies at the University of Newcastle, 2004, quoted in Families and Friends for Drug Law Reform, *Submission 319*, p. 8.

15   The Australian Injecting and Illicit Drug Users League, *Submission 281*, p. 4.

16   Ms Nene Henry, *Submission 282*, p. 3.

illicit substance use often means that sufferers, particularly dual diagnosis youth, are both less acceptable to, and less inclined to access, standard support structures provided by mental health services.[17]

14.14   Involvement with illicit drugs also brings the likelihood that people with dual diagnosis will engage in other illegal activities to support drug habits, bringing them into contact with the criminal justice system.

Contact with the criminal justice system

14.15   Studies have shown that dual diagnosis sufferers come into contact with the criminal justice system more often than people with a mental health disorder only.[18]

14.16   Police are the first point of contact with the criminal justice system for people with dual diagnosis. The committee received strong representation from the Police Federation of Australia that police officers are inadequately prepared to deal with the high level of need exhibited by dual diagnosis sufferers in the community. These people end up in custody, then prison, rather than receive appropriate care.[19]

14.17   The Drug Action Information Exchange (DAIE) reported on the situation in the Illawarra:

> Police within the Illawarra are continually confronted with members of the public who are displaying severe symptoms of mental illness. Police acting within the guidelines of the Mental Health Act will transport the patient to a proclaimed hospital for assessment. On numerous occasions the resulting assessment diagnoses a drug induced psychosis. The end result is the patient being released and left with the Police to deal with. Police do not have the training or resources to deal with those patients. If left alone, they are a danger to themselves, if left with friends or relatives similarly those people are now in danger. Police do not have access to drugs which may be able to sedate the person and further do not have the facilities to hold them for any length of time. The persons are inevitably released out onto the street where they commit offences and then are criminally charged.[20]

14.18   Substance use has been identified as an important contributor to the risk of mentally ill people engaging in violent crime.[21] The Victorian Institute of Forensic Mental Health cited recent research that revealed:

> Just as substance abuse alone is a significant risk factor for violence, those who have both a substance abuse or dependence disorder and a major mental illness (i.e., those with a so-called dual diagnosis) also have been

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17   Mental Health Legal Centre, *Submission 314,* p. 18.

18   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 23.

19   Police Federation of Australia, *Submission 254*, pp. 5–7.

20   Drug Action Information Exchange (DAIE) (Wollongong Illawarra) *Submission 222*, pp. 1–2.

21   Cited in Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 23.

found to have an increased level of risk for violence. Dual diagnosis has been associated with high rates of violence and criminal behaviour.[22]

14.19   The rate of criminal conviction for persons with schizophrenia with substances abuse problems was found to be 68.1 per cent, compared to those without substance disorders at just 11.7 per cent.[23]

14.20   Research conducted at the Thomas Embling Forensic Hospital found that 74 per cent of mentally ill offenders have a lifetime substance abuse disorder and 12 per cent have a current substance abuse or dependence disorder.[24] A breakdown of offenders in the criminal justice system indicated that:

- 30 per cent of male prisoners and 50 per cent of females had a diagnosable mental illness before entering the system;

- around 40 per cent of women reported problems with alcohol abuse prior to incarceration, and 60 per cent used illicit drugs;

- illicit drug use for men was at the same rate for women, but alcohol use had been higher, at 50 per cent.[25]

14.21   A disproportionately high number of these offenders are young. The Youth Mental Health Coalition reports that over 30 per cent of the total prison population is under twenty five years of age. Of these, four out of five have been incarcerated for offences relating to alcohol and other drug use; two in five meet the diagnosis for personality disorder and one in five have attempted suicide.[26]

14.22   The Centre of Social Justice records that untreated mental illness and drug addiction are also significant predictors of recidivism.[27] A study of Thomas Embling Hospital inmates confirmed that concurrence of mental illness and substance abuse exponentially increased the risk of recidivism compared with prisoners who had only one or the other disorder.[28]

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22   Victorian Institute of Forensic Mental Health, *Submission 306,* pp. 9–10.

23   Cited in Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 23. Other evidence suggests that people with schizophrenia and no substance disorder may exhibit less criminal tendencies than those with other forms of mental illness, such as people with personality disorder. See *Submission 319*, p. 111.

24   'Current' means symptoms occurring within the past month.

25   Select Committee on the Increase in the Prisoner population 2001, quoted in *Submission 300*, Centre for Social Justice, p. 66.

26   Statistics 2001, Youth Mental Health Coalition, *Submission 285*, p. 7.

27   *Submission 300*, Attachment 1: Tamara Walsh, *INCORRECTIONS: Investigating Prison Release Practice and Policy in Queensland and Its Impact on Community Safety*, Faculty of Law, Queensland University of Technology, 2004, p. 6.

28   Victorian Institute of Forensic Mental Health, *Submission 306*, p. 10.

14.23   Some submitters contended that the combination of a 'tough on drugs' approach in law enforcement and 'zero tolerance' treatment regimes with under-funded service models for dual diagnosis is driving more people with mental illness into the criminal justice system. Jesuit Social Services made a direct correlation between the absence of adequate services, the growing incidence of self-medication and this exponential growth:

> Much of the recent dramatic increase in the Australian prison population can be explained by the relationship between untreated mental health needs, subsequent illegal use of drugs as a form of self-medication, and the eventual intervention by instrumentalities of the criminal justice system.[29]

14.24   The Centre for Social Justice noted that being in gaol significantly reduces any prosect for symptom management and recovery. The 'zero tolerance' approach to alcohol and drugs in the penal systems of most states means that prisoners are expected to go 'cold turkey' without any assistance.[30] Moreover, prisoners have no access to Medicare.[31] These factors contribute to poorer treatment outcomes for prisoners with dual diagnosis.

The extent of the dual diagnosis problem

14.25   As noted in the introduction, expert opinion is that dual diagnosis is the 'expectation not the exception' for people receiving treatment for either a mental illness or a substance abuse disorder. Studies have shown that having either a mental health or a substance use disorder substantially increases a person's risk of developing the other disorder.[32] Any increase in mental health problems therefore reaps a related increase in substance abuse disorders, and vice versa.

14.26   Statistical evidence confirms that substance abuse among those with mental health problems is pervasive.[33] Submissions cited the findings of the 1997 Australian National Survey of Mental Health and Wellbeing (NSMHW), a household survey which assessed 10 641 respondents for symptoms of high prevalence mental health disorders, including substance disorders. The survey found a high correlation between mental illnesses and substance abuse disorders, so that in any 12 month period:

- 9.7 per cent of the population met criteria for an anxiety disorder;

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29   Father Peter Norden, Policy Director, Jesuit Social Services, 'Prison Is Not A Healthy Place': ANEX Harm Reduction Conference, July 2004 , quoted in Catholic Health Australia, *Submission 276*, p. 14.

30   Centre for Social Justice, *Submission 300*, *Submission 319* and Australian Injecting and Illicit Drug Users League, *Submission 281*, p. 5. NSW has a methadone maintenance program, see Prof. Chris Puplick, *Submission 226*, p. 113.

31   Mr Michael Gavin Burt, CEO, Victorian Institute of Forensic Mental Health, *Committee Hansard*, 6 July 2005, p. 47.

32   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 6.

33   See ORYGEN Research Centre, *Submission 284*, pp. 1–2 for discussion.

- 7.7 per cent met criteria for a substance use disorder; and

- 5.8 per cent met criteria for an affective (mood) disorder.[34]

14.27   The NSMHW concluded that one in four persons with an anxiety, affective or substance use disorder also had at least one other mental disorder, so that one in four of the persons with one of the disorders also had one of the other disorders (such as an anxiety and affective disorder, or an anxiety and a substance use disorder).[35] The study also found that those with low prevalence disorders, such as schizophrenia, are most likely to have a substance abuse disorder. However, given the high prevalence of anxiety and depression, the majority of cases of dual diagnosis occur in people with these disorders.[36]

14.28   The Black Dog Institute reported that the growing incidence of both depression (high prevalence) and bipolar disorder (low prevalence) has contributed significantly to an overall increase in 'co-morbid' and secondary psychiatric conditions.[37]

14.29   Alcohol dependence remains the most prevalent substance abuse disorder for males,[38] but mental disorders are more prevalent as a percentage among alcohol dependent women. Figures overall indicate that alcohol dependent people are 4.5 times more likely to have an affective or anxiety disorder than other Australians, whereas cannabis dependent people are 4.3 times as likely to do so.[39]

Age profile

14.30   Since the late eighties, the age profile of people experiencing dual diagnosis has undergone a significant shift.

14.31   Catholic Health Australia reports that an accurate depiction of its client profile was once the stereotypical one of the elderly alcoholic: usually male, isolated, dishevelled and living in rundown accommodation or homeless on city streets. The submission suggests that deinstitutionalisation has brought about a significant shift in the age profile of the group. CHA's typical client is now a middle-aged male between 35 and 60 years. His living conditions are the same but he may be reluctant to access help because of the iatrogenic effects of past treatment:

> Many people who had bad experiences in the past are now reluctant to approach the mental health system for help because of this ongoing fear.

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34   National Drug and Alcohol Research Centre, University of NSW, *Submission 109,* p. 1; and see Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 19.

35   National Drug and Alcohol Research Centre, University of NSW, *Submission 109,* p. 1.

36   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 18.

37   Black Dog Institute, *Submission 170,* p. 1.

38   Australian Medical Association, *Submission 167,* p. 8.

39   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 19.

> The style of treatment they experienced in the past may have been traumatic and in many cases did not focus on educating people about their mental illness. In these cases, people have no sense that there are other options available for treatment and management of their illness.… In many cases, people in this group have both chronic mental and physical health conditions. Often, because of the difficult life they have led, they have physically aged with chronic health conditions such as chest infections, hepatitis, rotting teeth etc. In many cases they need just as much physical care as would an older person in an aged care hostel or nursing home but their age precludes them from eligibility for aged care services.[40]

14.32   The emergence of the 'street kid' phenomenon has also changed the profile of the dual diagnosis cohort. Dr Georgina Phillips advised that it is now 'mostly young, very vulnerable, chaotic people' who suffer from dual diagnosis.[41]

14.33   A disproportionate rise in dual diagnosis presentation among young people appears to be an international trend. The ORYGEN Research Centre cited recent results of United Kingdom studies showing a clear increase, particularly since 1986, in co-morbidity rates, along with conduct and emotional disorders, among young people.[42]

14.34   Drawing on Australian assessments, the Australian Divisions of General Practice (ADGP) advised:

> Co-morbidity is of particular concern for young people aged 15-24 years… the recent Australian burden of disease and injury study found that nine out of the ten leading causes of burden in young males, and eight out of ten leading causes in young females were substance use disorders or mental disorders. Co-morbidity of these disorders is high with over 50 per cent having co-morbid disorders.[43]

14.35   The increased prevalence of bipolar disorder among youth may be significant, given its frequent co-occurrence with substance abuse. The Black Dog Institute has found a dramatic increase in Bipolar II disorder among youth and adolescents over the last ten years.[44] Consistent over decades at between 0.5 to 1 per cent, estimates now suggest that some five to six per cent of the population might now experience Bipolar II over their lifetime.[45]

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40   Catholic Health Australia, *Submission 276*, p. 17.

41   Dr Georgina Phillips, *Committee Hansard*, 6 July 2005, p. 16.

42   ORYGEN Research Centre, *Submission 284,* pp. 1–2.

43   Australian Divisions of General Practice (ADGP), *Submission 308,* p. 38.

44   Bipolar II manifests as long periods of profound depression, without the severely manic 'high' episodes characterising Bipolar I (previously known as manic depression). These states drive suicidal preoccupations and, on occasions, violence and have associated substance disorder.

45   The Black Dog Institute, *Submission 170,* p. 3.

Social profile

14.36   A history of trauma and abuse, social dislocation and distress is prominent in the life experiences of most people with dual diagnosis. The personal account of the dual diagnosis survivor at the beginning of this chapter[46] provides disturbing confirmation of this fact, as do the many other personal stories the committee has received.

14.37   Research confirms this relationship. Overseas studies have found strong correlations between mental health problems and social disadvantage. Children exposed to domestic violence, abuse or neglect or community violence are at greater risk of mental and social dysfunction in later life. Moreover, early trauma may significantly affect brain development in children.[47] Drug abuse by parents creates generational problems in children who experience emotional, cognitive, behavioural and other psychological problems.[48]

14.38   Studies have also shown that foster children and other young people in out-of-home care have a particularly high risk of mental illness, and of drug and alcohol addiction. The Australian Government submission reports a steady rise in the number of children and young people in out-of-home care,[49] implying there may be an increase in youth mental illness as this group grows in size.

14.39   The high incidence of dual diagnosis among Indigenous Australians, who typically have experienced extremes of family and community disintegration, makes a powerful statement about the role of social factors in generation of co-occurring disorders.[50] Indigenous people experience poor diagnosis, higher rates of imprisonment and substance abuse, self harm and suicide than the general population.[51]

14.40   Recent studies have shown that the use of illicit drugs such as cannabis and the psycho stimulants, amphetamines and cocaine is higher amongst young adults with severe mental illness compared to either the general population or to other psychiatric comparison groups.[52] There was some agreement in the evidence that intake of methamphetamines is increasing the number of presentations of youth with

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46   Name withheld, *Submission 456.*

47   Women and Mental Health Inc, *Submission 310*, p. 3.

48   St Vincent de Paul Society, *Submission 478,* p. 18.

49   Australian Government, *Submission 476,* p. 46.

50   Australian Infant, Child Adolescent Family Mental Health Association (AICAFMHA), *Submission 83***,** pp. 20; 26.

51   See for example, Department of Psychiatric Medicine, Children's Hospital Westmead and Tamworth (CAMHS), *Submission 99*, p. 1.

52   Families and Friends for Drug Law Reform, *Submission 319*, p. 5.

drug-induced psychosis.[53] Nevertheless, while there is a clear correlation between substance abuse and mental illness, the causal relationship between the two is not definite. Mr Gary Croton, Clinical Nurse Consultant at Eastern Hume Dual Diagnosis Service advised that it is a case of the 'chicken or the egg':

> I think the wisdom at the moment is that there is a huge range of possible relationships between the disorders depending upon the individual. One disorder may be primary, one disorder may be secondary. The principle that is really emerging strongly now is that, in terms of treatment, you often will not be able to tease out what was the primary disorder and what was the secondary disorder. It will come down to clinician judgement.[54]

14.41   The Youth Substance Abuse Service (YSAS) reported that the 'typical' young person accessing their dual diagnosis services have experienced 'multiple adverse events', involving 'significant levels of trauma and abuse during their childhood and adolescence'. Resulting distress manifests in a range of self harming activities. YSAS explained:

> Young people accessing the services provided by YSAS therefore typically present with a multiplicity of mental health concerns such as self-harm, eating disorders, anxiety and depression. While the behaviours may vary from time to time, the cycles are similar – for example research and practice wisdom demonstrate that substance abuse, bulimia and self-harm show a tendency to occur in clearly patterned cycles of increasing tension, followed by bingeing/purging and then relief. In most cases, emotional regulation is reported to be the primary intent of such behaviours.[55]

Dual prisoners—doubly damaged

14.42   People with dual diagnosis in prison are typically from among the most disadvantaged groups in society. The Probation and Community Correction's Officers Association advises:

> Typically young, male, single, with a history of conduct disorder and family substance abuse, these are the people to whom are applied such pessimistic terminology as 'falling through the gaps'.[56]

14.43   As mentioned, women have a higher incidence of mental illness than male inmates but equivalent histories of substance abuse:

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53   Gold Coast Drug Council, *Submission 553*, p. 5; Families and Friends for Drug Law Reform, *Submission 319,* p. 5.

54   Mr Gary Croton, Eastern Hume Dual Diagnosis Service, *Committee Hansard*, 6 July 2005, p. 16.

55   YSAS, *Submission 211,* p. 1.

56   A NSW Health publication, quoted by Probation and Community Correction's Officers Association Incorporated (PACCOA), *Submission 503*, p. 4.

> Women prisoners are casualties from harmful early life experiences and social deprivation showing mental health and other harms to a very high degree. They are truly outsiders.[57]

14.44   Sisters Inside records that over 50 per cent of women in prison had been placed 'in care' as children and approximately one quarter have been imprisoned in a juvenile detention centre. Further, prior to incarceration, 98 per cent of women prisoners had experienced physical abuse and 89 per cent had experienced sexual abuse.[58] Sisters Inside reports that the number of women in prison in Queensland has being growing as a percentage relative to men, with a rise of 13 per cent over five years to 2003 (up to 325).[59]

14.45   The plight of Indigenous women within this spectrum has been described as one of 'triple disadvantage'. Alcohol, drug abuse and violence are endemic and more often lead to offending. With lower levels of education and employment, Indigenous women also suffer from a higher incidence of past physical and sexual abuse than other prisoners.[60]

The service burden of dual diagnosis

14.46   People with a dual diagnosis have a higher level of need than other mentally ill cohorts and a poorer prognosis compared with those with either a mental or substance abuse disorder alone.[61] This is in part because the complex interrelationship of disorders creates obstacles to effective diagnosis and treatment:

> …the co-occurrence of mental health and substances disorders cases influences the development and severity each condition, and affects the individual's response to treatment and circumstances of relapse.[62]

14.47   Co-occurring disorders are pervasive and have poor treatment outcomes:

> The co-occurrence of drug dependence and mental health disorders is widespread and is associated with higher levels of hospitalisation, incarceration, suicide, homicide, housing instability and homelessness, unemployment and financial difficulties, and lower treatment compliance requiring more complex and more expensive care.[63]

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57   Professor Ian Webster, *Submission 458*, p. 20.

58   Sisters Inside, *Submission 283*, p. 7.

59   *Submission 283,* p. 7.

60   *Submission 283,* Attachment 1, p. 4.

61   National Drug and Alcohol Research Centre, University of NSW, *Submission 109*, p. 1.

62   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 6.

63   Western Australian Network Alcohol and Other Drug Agencies (WANADA) *Submission 171*, p. 2. See also, Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 6.

14.48   People with low prevalence disorders and dual diagnosis experience the worst social and health outcomes:

- experiencing more frequent relapse and hospitalisation;

- are more exposed to violence and exploitation, both as victim and perpetrator;

- are more likely to have a physical disorder;

- a higher incidence of homelessness; and

- more forensic involvement (as discussed above).[64]

Clinical support services

14.49   The high needs of people with a dual diagnosis incur a significant service burden with attendant costs. Eastern Hume Dual Diagnosis Service reports that the overall treatment costs for persons with co-occurring substance use disorders are twice those of people with other co-occurring disorders. These costs are largely attributable to additional acute care needs.[65]

14.50   The prevalence of physical illnesses and injury within this group, consequent to the mental instability suffered, contributes significantly to these costs:

> Co-morbidity of substance use and severe mental disorders is associated with an increased risk of illness and injury including self-harm and suicide. Co-morbid disorders are more likely to become chronic and disabling, and result in greater service utilisation and increased health care costs.[66]

14.51   The inability of the public health system to deal compassionately with threats of suicide and self harming behaviours among the mentally ill has been discussed in other chapters in this report. The record of failure is even more profound for patients with dual diagnosis. Emergency departments are ill-prepared to deal with repeated presentations of this type:

> Patients with both substance abuse and mental illness issues are particularly vulnerable to social and medical risks, including accidental or deliberate self-harm. They are heavy users of the emergency department and are extremely stressful for ED staff to manage, not only because of acute behavioural disturbance but also because of frequent re-presentations and a lack of willingness or capacity of either mental health or drug and alcohol services to own the patient and direct their care. These patients are too

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64   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 19.

65   B. Dickey and H. Azeni, 'Persons with dual diagnosis of substance abuse and major mental illness: their excess costs of psychiatric care', *American Journal of Public Health*, vol. 86, pp. 973–97, 1996, cited in Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 23.

66   National Drug and Alcohol Research Centre, *Submission 109,* p. 1.

complex for the limitations of our current system, yet they are at real risk of harm.[67]

14.52   There can be great difficulty disentangling the effects of drugs from the symptoms of mental illness when patients present at emergency departments with psychosis. Some patients can enter and leave hospital without proper diagnosis or treatment.

14.53   Studies have shown that people with co-occurring psychotic and substance use disorders are also at higher risk of experiencing certain physical disorders than people with mental illness alone. These include diabetes, hypertension, heart disease, asthma, gastrointestinal disorders, skin infections, malignant neoplasms and acute respiratory disorders.[68]   The South Australian Division of General Practice advised that these health needs are largely unaddressed by overwhelmed emergency services and doctors who are disconnected from alcohol and drugs services.[69]

14.54   The absence of dedicated tertiary beds or hospital wards to treat people with dual diagnosis, consequent to their closure under deinstitutionalisation, was raised as an area of urgent unmet need. Professor Kavanagh, of the Mental Health Centre at the Royal Brisbane Hospital, noting extremely high rates of co-morbidity in inpatient wards and in younger patients, warned that 'effective management of co-morbidity is likely to be critical to the cost-effectiveness of [inpatient] services':

> If these patients are not effectively treated, this will have a substantial impact on the overall effectiveness of the service. In practice, management of co-morbidity becomes 'core business' for the service, whether or not this is recognised.[70]

14.55   Aged people with dual diagnosis have extremely poor access to drug and alcohol services. Dr Roderick McKay of the Royal Australian and New Zealand College of Psychiatrists noted that the national drug and alcohol plan has no policy initiatives with regards to the elderly, and that the area seems to have been overlooked as part of dementia services.[71]

14.56   Another significant area of unmet need is in treatment of those with anxiety or depression and substance abuse disorder. This is the largest dual diagnosis cohort. As discussed elsewhere in the report, substance abuse and depression are behind the high

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67   Dr Georgina Phillips, *Committee Hansard*, 6 July 2005, p. 8.

68   Dickey, Normand, Weiss, Drake, and Azeni, 'Medical Morbidity, Mental Illness, and Substance Use Disorders', *Psychiatric Services*, vol. 53, pp. 861–867, 2002, quoted in Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 23.

69   The South Australian Division of General Practice, *Submission 88,* pp. 9–10.

70   Families and Friends for Drug Law Reform, *Submission 319*, p. 2.

71   Dr Roderick George McKay, on behalf of the New South Wales Branch of the Faculty of Psychiatry of Old Age, the Royal Australian and New Zealand College of Psychiatrists, *Submission 219,* p. 6.

incidence of suicide recorded in Australia.[72] Beyondblue has identified this as a priority area in its programs promoting education against stigma and General Practitioner (GP) access.[73] This is discussed in Chapter 7.

14.57   Healthscope and the Australian Health Insurance Association reported that the private sector currently provides care for some high prevalence co-occurring disorders.[74] However, other submissions observed that options for this are limited for the majority of the dual diagnosis cohort, because they typically have low income levels. There is also a shortage of private psychiatrists able or willing to work with people with dual diagnosis.[75]

14.58   Healthscope identified potential to build care capacity in rural areas through use of private providers.[76] This depends, however, on ensuring that health insurance fund cover remains accessible for mental health care, and that health insurance portability is in place.[77] This is discussed in Chapter 12.

Community support services

14.59   Barriers to service provision for dual diagnosis youth in the community include a lack of appropriate accommodation with suitable primary care outreach, and of specialist and 'youth friendly' service models.[78] The Mental Health Coordinating Council (MHCC) submitted that the existence of these barriers contributes to the high imprisonment rate of young people with dual diagnosis:

> Persons suffering co-morbidity, particularly young people, frequently end up living on the streets, their needs unable to be met by the limits of the existing services and the barriers to access due to risk management, inadequate availability of professional clinical staff and suitable accommodation…[they] find themselves involved in the criminal justice system as a result of inadequate mental health and support services rather than inherent criminality.[79]

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72   Professor Ian Webster, *Submission 458,* p. 3.

73   Mr Jeff Kennett and Ms Leonie Young, beyondblue, *Committee Hansard*, 5 July 2006, pp. 2; 6–7.

74   Healthscope Ltd, *Submission 82,* p. 1, and Australian Health Insurance Association Ltd (AHIA), *Submission 292,* p. 6.

75   Dr Ruth Vine, Department of Human Services, Victoria, *Committee Hansard*, 7 July 2005, p. 32.

76   Healthscope Ltd, *Committee Hansard*, 5 July 2006, p. 19.

77   Healthscope Ltd, *Submission 82,* p. 1.

78   ADGP, *Submission 308,* p. 38.

79   The Mental Health Coordinating Council, *Submission 173*, p. 5.

14.60   Catholic Health Australia indicated that current services do not address the needs of the broader cohort of people with dual diagnosis, including the alienated aged and middle-aged homeless who congregate in urban areas:

> … there needs to be much better coordination between drug and alcohol, mental health and disability services together with housing and supported accommodation programs. Mental health services need to be tailored to respond to the needs of inner city dwellers (often people who have a dual diagnosis, are homeless and who have no family support).[80]

14.61   People with co-morbid conditions experience high levels of unemployment. At the same time, they are least able to meet Centrelink and disability payment requirements, because these services do not comprehensively assess or take into account the extent of the debilitation caused by behavioural and mental disorders:

> Very frequently the homeless and other marginalised people are depressed, have great difficulty in personal contact, and lack confidence in their own capacity to relate to other people or indeed to initiate contact with them. The way income support arrangements are implemented at this level does far more harm than the intended good (namely encouraging people back to work).[81]

14.62   The Australian government submission confirms that it is not possible to assess how many people with co-morbid disorders access the Disability Support Pension (DSP). Mental illness represents a major category of disability condition under the Australian Government's DSP.[82] However, the DSP statistics only report the primary disability that qualifies the person for payment; the data does not indicate how many people with co-morbidities, such as anxiety and substance use, receive these payments.[83]

Service delivery response—'service silos'

14.63   People with dual diagnosis have been characterised as 'the forgotten people' of the mental health system.[84] They have more difficulty accessing services than any other people experiencing mental illness and their life circumstances reflect this.

14.64   Dr Andrew Gunn reported that stigma plays its part in poor outcomes for people with co-morbid disorders.[85] People with dual diagnosis and low prevalence

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80   Catholic Health Australia, *Submission 276A,* p. 4.

81   Professor Ian Webster, *Submission 458*, pp. 33; 36.

82   Of the total number of DSP 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).

83   Australian Government, *Submission 476*, p. 43, and see note b.

84   Name withheld, *Submission 251,* p. 5.

85   Dr Andrew Gunn, *Submission 52,* p. 1.

disorders in particular, are likely to be homeless or socially isolated and in poor physical health. Hard to diagnose, hard to treat, and often hard to motivate to attend available services in a system which relies on voluntary participation, the dual diagnosis cohort are difficult and unreliable patients.[86]

14.65   However, while these factors are important, the main problem for the dual diagnosis group is that they fall outside of the discrete treatment spectrums of the mental health system on the one hand, and alcohol and drugs services on the other. Professor Patrick McGorry of ORYGEN Research Centre provides a concise summary of the situation: the 'service silos' are a 'recipe for fragmented care and very poor quality care' of dual patients:

> In the past, 20 years ago, drug and alcohol services were run completely integrated with mental health services, certainly in the two states I have worked in, New South Wales and Victoria. They have been separated off into two separate systems of care. At the bureaucratic level, we have a state director of mental health and we have a state director of drug and alcohol. On the ground, they are separate service systems and separate cultures now. It makes absolutely no sense for it to be like that. They are the same kinds of problems and, quite often, it is the same people with different thresholds of mental health or drug and alcohol problems. If you were to recommend that that be addressed seriously, the territoriality would probably defeat it. But if it were about patient care, you would bring those systems together tomorrow under the same leadership and the same principles of service provision.[87]

Mental health and alcohol and drug services—distinct and different

14.66   Historically, people with drug and alcohol addiction were routinely incarcerated in mental institutions, sometimes indefinitely, even though they may not have suffered mental illness. Modern health legislation has been drafted to address this problem. Each state and territory in Australia has legislation which provides that people with alcohol or drug addiction cannot be subject to involuntary treatment by the mental health system, although they can be detained for a short period.[88]

14.67   While the legislation was drafted this way for sound human rights reasons, the legal distinction underpins the development of the now distinct and different service

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86   ADGP, *Submission 308*, p. 40.

87   Professor Patrick McGorry, ORYGEN Research Centre, *Committee Hansard*, 7 July 2005, p. 19.

88   State and territory mental health legislation tightly defines the nature of mental illness and sets out reasonable grounds for assessing whether involuntary admission might be required. In each case, the definitions state that a person is not to be considered mentally ill because they are affected by alcohol and other substances, although the Queensland legislation allows that a 'person my have a mental illness caused by the taking of drugs or alcohol'. Schedule 2, section 12(3) (2) (i), Queensland *Mental Health Act 2000*.

streams for mental health disorders as against substance abuse disorders.[89] Evidence suggested that overwhelmed mental health service providers are now using this distinction as a legal loophole to deny access to people with dual diagnosis.[90]

14.68   Under current service criteria, people with alcohol and drug problems can be turned away from mainstream mental health systems, which are not required to treat substance affected people. Meanwhile drug and alcohol services may also reject clients with mental health problems. People with dual diagnosis are thus effectively excluded from both 'service silos' and left to wander from provider to provider seeking treatment.

14.69   Submissions provided ample confirmation that the 'buck passing' of high need dual diagnosis patients between the 'service silos' is widespread:

> In the area of drug and alcohol services we still find that people with a dual diagnosis involving mental illness and drug dependence almost invariably fall "between the two stools". People who get referred to Drug and Alcohol services often get told that their mental health problem must be dealt with first, while people with a drug or alcohol problem and a mental illness who are referred to mental health get told the opposite ie that their drug or alcohol problem needs to be dealt with first. This often results in neither disorder being adequately treated.[91]

14.70   Distinct and different clinical perspectives inform the two sectors, allowing people with coexisting disorders to 'slip through the cracks' between both regimes. Dr Georgina Phillips advised: 'psychiatric illnesses are seen as medical and the drug and alcohol problems are seen more as lifestyle issues'.[92]

14.71   The Youth Substance Abuse Service (YSAS) reported the consequence of these differences: 'Inconsistency of concepts, language, and approach remain an obstacle to engagement, retention, and compliance in dual treatments…and reduce capacity to effectively assess both problems'.[93] In particular:

> …the AOD [Alcohol and Other Drug] frameworks highlighted within dual diagnosis models have historically been confrontational, disease based, 12-step approaches. It has been noted that such approaches often sit in direct contradiction to mental health frameworks that advocate pharmacological maintenance approaches to management of mental health issues. It is thought such differences are hard to integrate when moving

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89   See Professor Ian W Webster, *Submission 458,* pp. 16–18 for discussion.

90   This is not a new phenomenon. In 1993 the Burdekin Report observed that 'increasing specialisation and exclusivity of services' has erected significant barriers to clients experiencing multiple needs simultaneously across distinct service systems. See YSAS, *Submission 211*, p. 6.

91   Consumers and Carers NSW Far South Coast, *Submission 5*, p. 3.

92   Dr Georgina Phillips, *Committee Hansard,* 6 July 2005, p. 16.

93   YSAS, *Submission 211*, p. 5.

between the two service systems, and can often lead to confusion over appropriate treatment approaches for clients.[94]

14.72   People with dual diagnosis are thus effectively excluded from mainstream care in many states. Their care falls back on to an overwhelmed non-government sector. Brotherhood of St Laurence advised:

> Individuals who have a mental illness as well as a drug or alcohol problem are even more limited in their access to services. Drug and alcohol agencies are not set up to deal with issues of mental illness, and mental health agencies often declare their work sites to be drug and alcohol free. People with a dual disability find themselves in a bind. There are services available that cater for them, but like most other organisations, they are under resourced and over burdened.[95]

14.73   The Gold Coast Drug Council reported that its drug and alcohol service has been extended and transformed in recognition of the growing burden of need, in absence of dedicated health services for its clients on the Gold Coast:

> Whilst we are primarily a service designed to treat people who have a drug and/or alcohol problem, we are finding now—and have been finding for many years—that in up to 80 per cent of cases there is a co-existing mental health disorder. Consequently, we have had to expand our service delivery. I suspect many other services have either had to expand or very soon will have to do so, in order that we can treat mental health problems as well. So whilst from the public's perspective we are providing a drug and alcohol treatment service, we are also providing a very comprehensive service to treat mental health problems as well.[96]

14.74   Non-government service providers maintained they are overwhelmed by the extent of unmet need and must turn away many seeking help. Evidence also provided many examples of the tragic human price that is being exacted because of the failure to develop a proactive mainstream approach to treatment of dual diagnosis. The White Wreath Association related this account:

> One woman, who did not wish to be named, talked about her son who died from a heroin overdose a year ago. She said her son, who was 27 when he died and was a heroin addict from the age 14, developed a mental dysfunction after trying to get off a methadone 'cold turkey' program. He spent several months in a psychiatric ward, but she said the hospital did not treat his drug problem. 'It's almost like you go to hospital with hospital with cancer and a broken arm, and they treat your broken arm but not your

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94   YSAS, *Submission 211*, p. 5.

95   Brotherhood of St Laurence, S*ubmission 97*, p. 3.

96   Ms Mary Alcorn, Executive Director, Gold Coast Drug Council Inc., *Committee Hansard*, 2 February 2006, pp. 15–16.

cancer,' she said. 'That's what happened. They don't liaise with the drug counsellors, and its killing kids'.[97]

14.75   The committee did hear about government and non-government initiatives trying to bridge the gaps created by the divisions between services, discussed below, but also about other gaps that were creating problems for those seeking help.

Dedicated youth services—bridging the gap

14.76   Access to adequate treatment for youth with dual diagnosis is compounded by another 'silo' problem: the division between child and adolescent services on the one hand and adult services on the other.

14.77   Stakeholders advised of the gaping service gap in this area of most urgent need: the 16 to 24 year-old age dual diagnosis group:

> Drug and alcohol service delivery for young people, especially in their late teens and early adulthood are inadequate. Opportunities for effective prevention programs (targeting early adolescence) have been poorly realised nationally and effective early intervention programs are yet to be made generally available in the community. This is a major gap. The significant overlap of risk factors for drug and alcohol and mental health disorders in young people suggest some potential synergies for prevention/early intervention programs for children and adolescents.[98]

14.78   Non-government organisations, under various funding arrangements, step in to fill this gap. ORYGEN, which runs one of the few targeted youth services of this type, reports there is nevertheless 'tremendous resistance' among state and territory governments to a mainstream response to this category of unmet need. Principal to the problem is that targeting 'youth' as a cohort, would involve the adding of an additional youth to young adult tier to the existing three age bracket system, comprising child and adolescents services, adult services and aged services.[99]

14.79   There are, nonetheless, methodological and socio-cultural reasons to suggest that this should be a discrete group for service provision purposes.

14.80   As discussed in Chapter 15, treatment within the adult mainstream services offers a depressing introduction to life with a mental illness for the young and, incidentally, is an indictment on adult services. One young person wrote to the committee:

> Where I have felt like less of a person is within the adult mental health system. There is a general atmosphere there that you have no future, your

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97   The White Wreath Association, *Submission 91*, p. 9.

98   The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA), *Submission 83*, pp. 14–15.

99   Professor Patrick McGorry, ORYGEN Research Centre, *Committee Hansard*, 7 July 2005, p. 8.

> illness means you can be ignored, spoken to rudely, be made to feel like you are taking up too much time and you don't deserve any patient respect because you are struggling with living.[100]

14.81   Service providers report that the clinical model for mental health services is particularly repellent to young people with dual diagnosis, and not conducive to their accessing or continuing to engage with available services. The Mental Health Legal Centre advised that young people with mental illness often rely on drug use to provide them with a peer group which accepts their mental illness. They find that drug and alcohol services are more respectful of these needs. The Centre recommended that service agencies should address this by giving consumers options for self-management, including in development of treatment plans and access to services.[101]

14.82   A number of submissions referred to the services provided by ORYGEN Youth Health services in Victoria as meeting these criteria.[102] ORYGEN's model addresses the mix of clinical and social needs of the targeted group, and received glowing endorsement by young clients who had found hope for recovery and a sense of self-determination within its youth program. On the basis of her experiences, Ms Jolan Tobias of the ORYGEN Youth Health Platform Team stated:

> We recommend that all young people who need a mental health service should be able to access services that are specifically for young people, no matter where they live. All mental health services should have group programs and do more than just prescribe medicine. Social, vocational and emotional goals are crucial to psychiatric recovery. We recommend that young people should be involved in the design and delivery of mental health services for young people.[103]

14.83   Dr Dan Lubman of ORYGEN explained that the success of the approach relies on strong regional links between youth and the drug and alcohol services.[104] Other submissions agreed that linkages must be built between local services to allow for the integrated approach to service provision to the youth dual diagnosis group, and this should include housing support, extended counselling assistance, and mechanisms to better address health needs.

14.84   The ADGP suggested that adjustments should be made to Better Outcomes requirements to allow co-location of GPs in environments targeting dual youth needs, observing:

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100   Youth Mental Health Coalition *Submission 284*, case study, Jolans' story, pp. 14–15.

101   The Mental Health Legal Centre, *Submission 314,* p. 18.

102   For example, NCOSS—Council of Social Service of New South Wales, *Submission 274*, p. 9.

103   Ms Jolan Tobias, ORYGEN Youth Health, *Committee Hansard,* 7 July 2005, p. 22.

104   Dr Dan Lubman, Consultant and Senior Psychiatrist, ORYGEN Youth Health and ORYGEN Research Centre, *Committee Hansard*, 7 July 2005, p. 9.

> They require a different psycho-social approach to meet their health needs which relies on good rapport with general practitioners and other care providers and access to "youth friendly" systems. Marginalised young people and those disconnected from family and school do not necessarily access mainstream services such as general practice. There is a need for specialised services to reach these young people, and for these services to have a strong primary care interface so that discharge for recovery and rehabilitation in primary care can occur…Better Outcomes needs to allow enrolled GPs to deliver mental health care in settings where young people 'hang out' such as youth centres and clinics. At present, this is not possible if the centre is not accredited.[105]

14.85   The Gold Coast Drug Council endorsed these views, noting that bulk-billing of GPs and psychiatric specialists is essential if sustainable, integrated, community-based support is to be available for this cohort.[106] It recorded a definite increase in dual diagnosis among amphetamine users, reporting that younger clients are now seeking treatment earlier. This reinforces the need for 'holistic' service approaches to cater for the younger teenager through to the young adult age group.[107]

14.86   The next section will consider some of the issues surrounding proposals for a more integrated care model of public health services to better meet the complex care needs of people with dual diagnosis.

Service integration—the state of play

14.87   There is a strong body of evidence which supports the view that a more integrated approach to service provision for people with dual diagnosis will not only improve outcomes for those affected but will be more efficient and cost effective.[108]

14.88   Dr Phillip Morris, Executive Director, Gold Coast Institute of Mental Health, reported World Health Organisation data that demonstrates that in countries where there had been reform of drug and alcohol services along with mental health acts and policies, there has been a fall in suicide rates.[109] By contrast ORYGEN Research Centre, commenting on the situation of Australia's dual diagnosis youth, advised:

> The lack of integration between drug and alcohol and mental health services in Australia has significantly contributed to the poor detection and treatment of mental illness amongst young people with substance abuse.

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105   ADGP, *Submission 308*, p. 32.

106   Ms Mary Alcorn, Executive Director, Gold Coast Drug Council, *Committee Hansard,* 7 July 2006, p. 17.

107   Gold Coast Drug Council Inc, *Submission 553*, p. 5.

108   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 5

109   Dr Phillip Morris, Executive Director, Gold Coast Institute of Mental Health, *Committee Hansard*, 2 February 2006, p. 3.

> This results in waste of resources and long-term psychiatric and substance use problems for individuals who could otherwise be helped.[110]

14.89 Nevertheless, some advances have been made in individual states and territories. A number of stakeholders referred positively to developments in Victoria, which introduced a state-wide dual diagnosis initiative—the Victorian Dual Diagnosis Initiative (VDDI)—in 2002. The initiative, jointly funded by both mental health and drug services, was given $9 million in the Victorian state 2005-06 budget to improve service integration and workforce development over four years.[111] The VDDI aims to:

> …support the development of better treatment practices and collaborative relationships between drug treatment and mental health services. The key activities of the initiative are the development of local networks; training, consultation and modelling of good practice through direct clinical intervention, and shared care arrangements.[112]

14.90 Victorian-based Youth Substance Abuse Service (YSAS) commented on the success of the model in its submission:

> The development of dual diagnosis positions in each metropolitan Department of Human Services (DHS) region, including the development of youth focused dual diagnosis positions, appears to have improved cross-sector knowledge around target populations, demand characteristics, service response capacities, and the understanding of co-morbid substance use and mental health conditions.[113]

14.91 Other states also reported progress on integration and reform to better address the needs of people with dual diagnosis. Queensland has undertaken a two year strategy of reform, appointing nine new managers to head up an integrated mental health and alcohol, tobacco and other drugs services department.[114] The Tasmanian Government told the committee of its appointment of two co-morbidity executive positions to progress a memorandum of understanding between mental health and drug and alcohol services. The MOU will cover a range of initiatives to assist partnership and joint service delivery, and to link services that will remain separate. The Minister has also announced the establishment of an expert co-morbidity task

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110   ORYGEN Research Centre, *Submission 284*, p. 11.

111   Victorian Government, *Submission 445*, p. 6; and Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 30.

112   Victorian Government, 2005, quoted in Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 30.

113   YSAS, *Submission 211*, p. 4.

114   Queensland Government, *Submission 377*, p. 20.

force.[115] Western Australia has an integrated mental health and AOD service operating in the Kimberley and Pilbara regions.[116]

14.92   While these developments are commendable, there were concerns that each state is progressing the issue without the benefit of a consistent plan, or with any agreed theoretical direction, for implementation of service integration.

Debate about integration models

14.93   There were different views about how integration of services might be best achieved. Discussion of the Victorian model, which is the most developed, revealed emerging criticisms of the approach in that state.

14.94   In particular, it was suggested that VDDI programs are not resulting in the desired coordination of treatment between the two services but may instead be developing a 'third tier' of 'niche' dual services. Jesuit Social Services reported advice from its service providers:

> Discussions with Connexions staff around the impact of dual diagnosis teams in Victoria, considered positive outcomes to be the increased capacity of drug and alcohol staff and mental health staff to recognise mental health issue or substance use issues in their respective clients … on the negative side it was felt that the problem of staff in each sector not wanting to work with dually diagnosed clients persists. They also expressed concerns that dual diagnosis was in danger of becoming a niche market and services were becoming more fragmented as organisations within different sectors establish dual diagnosis specific services. Coordination was seen as a key component of integrating treatment.[117]

14.95   In its submission Eastern Hume Dual Diagnosis Service warned that specialisation of skills in a 'third tier', providing treatment only for those with co-occurring disorders, may exacerbate rather than alleviate the likelihood of these individuals 'falling through the gaps'. The reason for this is that access to appropriate treatment relies on staff being adequately trained to identify and assess complex disorders, which they would not be inclined to do if dual diagnosis is regarded as the domain of specialists.[118]

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115   Associate Professor Des Graham, Tasmanian Department of Health and Human Services, *Committee Hansard*, 1 February 2006, pp. 76; 19.

116   The Northwest Mental Health Service and Kimberley Community Drug Service Team provides community based mental health services in both regions, and AOD services in the Kimberley. See Department of Health, Western Australia at: www.health.wa.gov.au/services/detail.cfm?Unit_ID=267, (accessed March 2006).

117   The Ignatius Centre for Social Policy and Research, Jesuit Social Services, *Submission 358,* p. 6.

118   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 35.

14.96   Eastern Hume also predicted that treatment of people with dual diagnosis in a third tier may generate a turf war among service providers given that drug and alcohol services could lose between 30 and 70 per cent of patients, which would be counter productive to development of a sustainable approach.[119]

14.97   Most stakeholders argued that it was preferable for existing services to be utilised for any reformed dual diagnosis treatment, although there were different opinions about whether drug and alcohol services or mental health services should take primary responsibility for coordination of care for dual diagnosis clients. YSAS for example, considered the ideal would be for AOD services to provide integrated care for dual diagnosis clients in consultation with mental health services, rather than simply referring them to a mental health service. In contrast, the Western Australian Network of Alcohol and Other Drug Agencies (WANADA) and St Vincent de Paul Society recommended referrals be made to mental health services.[120]

14.98   There was also debate about comparative models for integrated care, such as whether a single agency or 'one-stop shop' would better service the needs of the target group compared with the referral-based service paradigms currently applied.

14.99   As noted, Eastern Hume warned against trends towards specialisation in a distinct service tier. It also referred to United States findings that specialisation of skills in a particular agency, or in an individual within an agency, does not develop the system's overall capacity to provide integrated care.[121] By contrast, Ms Nene Henry, a mental health case manager and registered nurse, cited United Kingdom Department of Health studies which concluded that integrated care, delivered by one team, appears to deliver better outcomes than serial care (sequential referrals to different services) or parallel care (more than one service engaging the client at the same time).[122] Ms Henry recommended:

> Urgent implementation of an integrated model which provides the concurrent provision of both psychiatric, and drug and alcohol interventions. This would require the same staff member (or clinical team), working in a single setting, to provide relevant psychiatric and substance misuse interventions in a co-coordinated fashion.[123]

14.100 The single service model was also advocated in particular for Indigenous dual diagnosis needs, with successful integrated models in operation in South Australia.[124] Indigenous mental health needs are discussed in more detail in Chapter 16.

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119   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 35.

120   YSAS, *Submission 211*, p. 6, WANADA *Submission 171*, p. 2, St Vincent de Paul Society, *Submission 478*, p. 11.

121   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 35.

122   Ms Nene Henry, *Submission 282*, p. 4.

123   Ms Nene Henry, *Submission 282*, p. 4.

124   SA Division of General Practice, *Submission 88*, p. 8.

14.101 Whatever the service paradigm, it was agreed that viable access points to services must be established for people with dual diagnosis. As YSAS and others argued, a prime objective is to ensure that there is a genuine 'equity of access' or a 'no wrong door' policy so that, irrespective of which organisation or service system is initially engaged, the dual diagnosis client can be accurately assessed and directed to an appropriate service response for treatment.[125]

14.102 To achieve this crucial objective it was agreed that there must be a focus, both at national policy and service delivery level, on systemic 'capacity building' to achieve the necessary linkages within and across the mental health and drug and alcohol systems. Eastern Hume Diagnosis observed that this could be achieved cost effectively if the approach is comprehensive:

> International experience has demonstrated that rapid development of a system's recognition of and response to co-occurring disorders can occur without the input of significant extra resources. Improving the system's recognition and response requires the strategically-planned, collaborative and robust implementation of top-down and bottom-up strategies towards well-defined, locally-grounded goals. Integrated strategic planning processes and policy deployment are central to effecting enduring improvements to systems' recognition of and responses to co-occurring disorders.[126]

14.103 The remainder of the chapter will explore the requirements for 'capacity building' of integrated services for people with dual diagnosis.

The building blocks of service integration—'top-down'

14.104 The following 'top-down' strategies were advocated as the building blocks of service integration:

- national vision and appropriate policy levers, including legislative requirements, to direct the system towards more effective integrated treatment;

- education and training strategies based on national curricula, accreditation, competency standards and including modules aimed at adjusting clinical attitudes; and

- improved diagnostic screening tools and clinician focussed training manuals.[127]

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125   YSAS, *Submission 211*, p. 6.

126   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 5.

127   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 5.

National policy levers

14.105 Progress on integrated service delivery requires that dual diagnosis be recognised as 'core business' for mental health services. This relies on strong leadership and commitment on the part of governments.

14.106 Eastern Hume cited advances in the United Kingdom on the government's announcement that dual diagnosis is 'a mainstream responsibility for mental health services'. The publication of a mental health policy implementation guide, the *Dual Diagnosis Good Practice Guide,* had supported and reinforced progress.[128]

14.107 The United States government has also shown strong leadership, delivering an integrated approach potentially useful to inform an Australian model.[129] In the US, the improvement of treatment and services for individuals with co-occurring disorders is one of the highest priorities for the Federal Substance Abuse Mental Health Services Administration (SAMHSA), which liaises with the Co-Occurring Centre for Excellence, established to provide training and methodological direction and linkages between SAMHSA and the states' communities and providers. The Comprehensive Continuous Integrated System of Care (CCISC) is operational in a number of states. It takes the position that dual diagnosis is an expectation of service, and leverages substantial development of treatment largely within existing resources.[130]

14.108 However, it was contended that the Australian Government, despite repeated strong rhetorical commitments to better integrate mental health and drug and alcohol services, has failed to put in place effective 'policy levers' to secure that objective. Submissions referred to the following deficiencies:

- lack of articulation between key policy documents and of supporting guidelines to direct comprehensive reform;[131] and

- lack of consultation mechanisms and centres of research to assist and inform the process.[132]

Providing leadership: policy documents and guidelines

14.109 The Australian Government reports a range of initiatives aimed at enhancing mental health service delivery for the dual diagnosis cohort. The vision for integrated service is set out in two key policy documents:

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128   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 27.

129   *Submission 374,* p. 27.

130   *Submission 374*, p. 28.

131   *Submission 374*, p. 9.

132   Dr Timothy Rolfe, Consultant Psychiatrist to Eastern Hume Dual Diagnosis Service and Clinical Director to Southern Hume Diagnosis Service*, Committee Hansard*, 6 July 2005, p. 22.

- The National Mental Health Plan 2003–2008, the third plan, aims to strengthen and consolidate the vision of the second plan mental health services. It recognises the effect of mental illnesses occurring together with drug and alcohol problems and other conditions;[133]and

- The National Drug Strategy Australia's Integrated Framework 2004–2009, which aims to provide 'a framework for a coordinated, integrated approach to drug issues in the Australian community'.[134]

14.110 Despite this commitment to interlinking services, Eastern Hume Dual Diagnosis Service notes that the National Mental Health Plan undercuts the potential for connection in declaring:

> In Australia, drug and alcohol problems are primarily the responsibility of the drug and alcohol service system.[135]

14.111 Consequently, the key documents fail to provide advice on strategic directions for integrated treatment of individuals with coexisting substance abuse and mental health problems. Families and Friends for Drug Law Reform observed:

> These peak policy documents fail in any meaningful way to address the links between mental health and illicit drug substance abuse. The National Mental Health Plan 2003-2008 passes responsibility for drug and alcohol problems to the national drug strategy. The National Drug Strategy: Australia's integrated framework 2004-2009 makes the platitudinous point that there should be strong partnerships between the treatment services. It also specifies that there should be integration of policies and programs without indicating what this involves.[136]

14.112 In this regard, Eastern Hume Dual Diagnosis noted that the NMHP provides no advice on key implementation issues, such as the relative efficacy of different integration models. It concluded: 'it is difficult to discern at what points and in what manner the two strategies [alcohol and drug, and mental health] are linked.[137]

14.113 Submissions asked that the government exhibit strong leadership on integrated service reform. The Australian Medical Association suggested that service integration might be better advanced if mental health strategies were brought together with AOD as part of the national chronic disease strategy initiative.[138]

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133 Australian Government, *Submission 476,* p. 20.

134 Australian Government, *Submission 476,* p. 67.

135 Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 29.

136 Families and Friends for Drug Law Reform, *Submission 319*, p. 2.

137 Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 9.

138 The Australian Medical Association, Submission *167,* p. 34.

14.114 Another option is the introduction of national guidelines and performance reporting to encourage integration of services. It was noted that progress in the United Kingdom was underpinned by national mental health policy implementation guidelines for treatment of dual diagnosis.[139]

14.115 In the Australian context, where mental health legislation in each state may vary treatment outcomes, such guidelines could be an important means of promoting comprehensive and consistent service integration. National guidelines could promote inter-agency cooperation and potentially promote, for example, a broader recognition of the role of generic welfare services in achieving good outcomes for people with dual diagnosis than current state mental health legislation encourages.[140] They could also be used to establish inter-agency service agreements and memoranda of understanding as well as agreed approaches to training and performance delivery.[141] At present a number of states and some regions have initiated drafting or implementation of these guidelines independently.[142]

Mechanisms for coordination, consultation and research

14.116 Advancement overseas has also been due to the establishment of national vehicles for coordination, consultation and research. A federally convened and funded forum or research body could assist states and territories to agree on a service trajectory, in a 'whole of government' approach. The Office of the Public Advocate, Queensland, recommended:

> A whole-of-government approach to mental health policy and funding should emerge from the Commonwealth, in order to see the same level of integration in the States' delivery of services…resources could be better utilised if various silos of government were to develop more effective collaborative arrangements.[143]

14.117 Dr Timothy Rolfe, Consultant Psychiatrist to Eastern Hume Dual Diagnosis Service and Clinical Director to Southern Hume Diagnosis Service, advised the committee that at present the states and territories have no opportunity to learn from each other, nor any repository for shared knowledge:

> I hesitate to comment on someone else's system but it is interesting that Western Australia, from the outside—from my perspective— devoted a large amount of resources and expertise to putting an integrated response together and now seems to have moved away from that. I would really like

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139   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 27.

140   UnitingCare NSW, *Submission 279,* pp. 11–12.

141   WANADA, *Submission 171*, pp. 4–5.

142   See Queensland *Submission 377*, p. 20; and see The Drug Action Information Exchange (DAIE) Wollongong, *Submission 222*, p. 8 for discussion of regional implementation of NSW health guidelines under the Illawarra Drug and Alcohol Strategic Plan 2000-2005.

143   Office of the Public Advocate—Queensland, *Submission 303*, p. 9.

to know from a national and Victorian perspective why that happened so that we can learn from that. One of the things that happens is that people in different states are doing different things and we are not learning from one another. There is no capacity to be able to share experiences and to be able to learn other than at the very informal level. There is no single centre or body of people that holds this knowledge. That is a real difficulty, I think.[144]

14.118 It was suggested that national initiatives such as the National Co-morbidity Taskforce need to be reinstated.[145] The Taskforce ceased to function as a co-morbidity specialist forum twelve months ago, its functions being absorbed into the intergovernmental task force on drugs.[146] Dr Timothy Rolfe, a member of the former Taskforce, took the view that the Australian Government should now demonstrate leadership by funding a new national consultative body to foster information exchange. The body could also coordinate funding and research to build more cost effective and improved dual diagnosis service delivery:

> It would be in a good place to coordinate such efforts of collaboration. It should encourage collaboration between the states or encourage collaboration through the distribution of research moneys and the sharing of information about the effectiveness of services so that people are not in the position of reinventing the wheel over and over.[147]

14.119 The Eastern Hume Diagnosis Service submission suggested that this centre should be like the US's Co-Occurring Disorders Centre of Excellence, which works to identify and disseminate evidence-based practices, develop training approaches and provide linkages between the states, communities and providers.[148]

Professional practice and skills

14.120 As discussed in Chapter 6, mental health services are experiencing chronic skill shortages. The erosion of the skills base among psychiatrists and nurses is in part a consequence of the specialisation of service delivery into separate streams, for example, mental health as against substance disorder services, and in part due to systemic dysfunction since deinstitutionalisation.[149] This has considerably reduced the

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144   Dr Timothy Rolfe, Consultant Psychiatrist to Eastern Hume Dual Diagnosis Service and Clinical Director to Southern Hume Diagnosis Service, *Committee Hansard*, 6 July 2005, p. 22.

145   Australian Injecting and Illicit Drug Users League, *Submission 281,* p. 5.

146   Dr Timothy Rolfe, Consultant Psychiatrist to Eastern Hume Dual Diagnosis Service and Clinical Director to Southern Hume Diagnosis Service, *Committee Hansard*, 6 July 2005, p. 22.

147   Dr Timothy Rolfe, Consultant Psychiatrist to Eastern Hume Dual Diagnosis Service and Clinical Director to Southern Hume Diagnosis Service, *Committee Hansard*, 6 July 2005, p. 22.

148   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 39.

149   For example, the Burdekin Report's finding, which concluded that 'increasing specialisation and exclusivity of services' has erected significant barriers to clients experiencing multiple needs simultaneously across distinct service systems. See YSAS, *Submission 211*, p. 6.

capacity of mental health services to respond flexibly to patient needs, in particular to complex needs.

14.121 A national commitment to build skills among service providers in both mental health and AOD services is vital if 'services silos' are to be broken down. This would involve investment in widespread upgrading of the skills base, with a focus on cross-skilling of health professionals to support service integration. Specialist staff and services could be developed within this framework, but should not dominate in a third service tier:

> NCOSS supports the need for cross-sector training and skilling so that mental health workers and drug and alcohol workers can effectively support people with a dual diagnosis of both mental illness and substance dependence, no matter which service they are initially referred to. Maintaining a separate work force for each area would only continue the effect of "siloing" of service delivery and down skilling of staff, apart from being non conducive to a holistic view of health, however NCOSS also supports a limited network of specialist workers and specialist services for those who have particularly complex needs.[150]

14.122 The strongest message from health professionals was that they do not have the competencies to deal with the growing number of complex dual diagnosis cases.

14.123 The submission from the Association for Australian Rural Nurses (AARN), the Australian and New Zealand College of Mental Health Nurses (ANZCMHN) and the Royal College of Nursing Australia (RCNA) reported that a lack of government commitment to training is affecting rural staff retention and services:

> The National Mental Health Strategy outlines integration of mental health services with alcohol and drug services as a key objective. However, there has been a lack of investment in initiatives to address training of staff in dual diagnosis. Rural staff who work in districts without clinical alcohol and drug services have often not had education in terms of dual diagnosis competency development. This lack of training impacts on the ability to retain nursing staff in the rural and remote setting, and has obvious negative connotations for the services delivered.[151]

14.124 In particular:

> There are intense demands on acute mental health treatment related to substance misuse. The input of the general community increase in illicit substance misuse is seen impacted in the number of presentations of first episode psychosis in young people and also in the increased levels of violence concomitant to these presentations. North Queensland (for example), which is viewed as a young overseas tourist destination, has a

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150 NCOSS—Council of Social Service of New South Wales, *Submission 274*, p. 9.

151 Association for Australian Rural Nurses (AARN), the Australian and New Zealand College of Mental Health Nurses (ANZCMHN) and Royal College of Nursing Australia (RCNA), *Submission 321*, p. 8.

higher than average increased use of potent methamphetamine. The increased potential for violence associated with psychotic disorders for clients when intoxicated impacts significantly on occupational health and safety issues for staff and clients of health services.[152]

14.125 The ADGP advised:

GPs encounter difficulties similar to those experienced by most health care providers involved in the care of people with mental health and substance use co-morbidity. Patients with co-morbidity are considered by GPs to be problematic to work with, difficult to evaluate, and even harder to find treatment for. These views are exacerbated by low levels of education and training in co-morbidity issues and little access to clinical support or supervision for GPs by specialists.[153]

14.126 There are severe shortages of psychiatrists able to treat people with dual diagnosis.[154] Dr A Gunn commented on professional prejudices among psychiatrists:

Prosperity and pleasantness are common casualties of severe mental illness. One would hope that psychiatrists, of all people, could accept this but like most doctors, psychiatrists rarely show enthusiasm for, or understanding of, patients who are neither cashed up nor personable. In a rural area, the local psychiatrist once refused my referral of an actively suicidal patient with major depression. She was drinking and he didn't see drinkers—but could a psychotic depressive live in a rural Aboriginal community without drinking?[155]

14.127 These problems call for a national action plan to upgrade skills for assessment, referral and treatment of dual diagnosis. Stakeholders recommended that this plan involve:

- the development of national training competency standards and training modules for dual diagnosis for undergraduate nurses and other service providers in mental health and drug and alcohol services;[156]

- establishment of a national accreditation system for training of psychiatrists, which addresses clinical attitudes as well as knowledge and skill competencies;[157]

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152 AARN, ANZCMHN and RCNA, *Submission 321*, p. 8.

153 ADGP, *Submission 308*, p. 40.

154 Dr Timothy Rolfe, Eastern Hume and South Hume Dual Diagnosis Service, *Committee Hansard*, 6 July 2005, p. 23.

155 Dr A Gunn, *Submission 52*, p. 1.

156 Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 37; AARN, ANZCMHN and RCNA, *Submission 321*, p. 8.

157 For example, Health Services Union, *Submission 223*, p. 15.

- incentive-based training opportunities for doctors though the Better Outcomes Initiative to build knowledge of dual diagnosis;[158] and

- training for all medical practitioners to better recognise the relationship between physical and mental conditions, such as the concurrence of depression, heart disease with substance abuse, including nicotine addiction.[159]

14.128 Other training initiatives to promote integration could include:

- targeted training strategies for state-employed psychiatrists to lead the management of service integration;[160]

- provider training on how to implement protocols and memorandums of understanding at a local level;[161]

- establishment of a network of specialist co-occurring fieldworkers to assist in training development, delivery and clinical supervision;[162]

- rotation of staff across agencies in the different service sectors to promote cross-skilling;[163] and

- targeted strategies to increase numbers and upgrade skills among Indigenous health care workers to address the complex needs of Aboriginal and Torres Strait Islander communities.[164]

Improved diagnostic tools

14.129 The development of appropriate diagnostic tools such as screening processes, practitioner manuals and referral databases is important to facilitate service integration. Submissions maintained that the development and use of such tools will support other training initiatives and will improve the capacity of professionals to accurately diagnose and refer people with dual diagnosis to appropriate services.

14.130 Under the present service paradigm a different diagnosis may exclude a person with co-occurring disorders from receiving treatment or accessing an appropriate degree or type of service:

> The opinion of one 19 year old female about mental health services was "they don't help when you need them and they won't go away when you don't want them". With a history of drug induced psychosis, depression and

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158   Australian Medical Association, *Submission 167,* p. 34.

159   The SA Division of General Practice Inc, *Submission 88,* pp. 9–10.

160   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 37.

161   NCOSS, *Submission 274,* p. 9.

162   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 38.

163   Eastern Hume Dual Diagnosis Service, *Submission 374,* p. 33.

164   AICAFMHA, *Submission 83*, p. 18, and Ms Jenine Bailey, *Submission 93*, p. 3.

abuse of heroin, cannabis, amphetamines, benzodiazepines and alcohol, this young woman was an involuntary patient at age 15 and 17. She felt that CAHMS [Child and Adolescent Mental Health Services] was too intrusive and too quick to diagnose. The diagnosis of psychosis became a label that did not fit. She was later diagnosed with depression and has been unable to access mental health care though AMHS [Adult Mental Health Services].[165]

14.131 General practitioners are often the first point of contact for people experiencing co-existing mental and substance abuse problems.[166] However, surveys of unmet need in 2001 revealed that GPs did not recognise mental health disorders in 56 per cent of cases and were less likely to do so if the disorder was common (such as depression) or the client was less than 25 years old, male or not born in Australia.[167]

14.132 To address this problem it was considered vital that appropriate diagnostic screening tools must be developed and applied in all service practice areas. Eastern Hume recommended that, as a high priority, practical, user-friendly, clinician-focused manuals (describing integrated screening, assessment and treatment approaches) be developed for each of the mental health and AOD workforces.[168]

14.133 YSAS members asked for specific screening mechanisms for youth with dual diagnosis:

> The development of tools facilitating the identification, screening, assessment, case planning, treatment and evaluation of outcomes related to young people under 25 years of age presenting with co-morbid conditions across all sectors of the service system, not just mental health services.[169]

14.134 Screening mechanisms in different languages could also be developed for CALD groups, which experience difficulties accessing service due to lack of translation and multilingual services.[170] There is also an urgent need to improve mechanisms for identification of mental health disorders among Indigenous people, who record lower identification, but have high incidence of behavioural and psychological disturbance by population percentage than other groups.[171]

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165   The Ignatius Centre for Social Policy and Research, Jesuit Social Services, *Submission 358*, pp. 3–4, citing NSW Association for Adolescent Health, *Caught in the Gap: Dual Diagnosis and Young People*, A Report on Issues, August 2003.

166   Eighty-three per cent of all patients see GPs each year; 5 per cent of these patients have alcohol dependence; 10 per cent of these patients have other AOD problems. See AMA, *Submission 167*, p. 29.

167   The Ignatius Centre for Social Policy and Research, Jesuit Social Services, *Submission 358*, p. 3.

168   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 15.

169   YSAS, *Submission 211*, p. 8.

170   See for example, Australian Polish Community Services, *Submission 168*, p. 2.

171   Victorian Institute of Forensic Mental Health, *Submission 306*, p. 8.

14.135 The Centre for Psychiatric Nursing Research and Practice reported that it is leading the development of a multi-disciplinary project to examine the practice of screening for drug and alcohol use in in-patient mental health services in metropolitan Melbourne and Rural Victoria:

> It is intended that the findings from this study will be utilized to identify, implement and evaluate strategies to enhance nurses' preparedness and ability to routinely screen for drug and alcohol usage on admission to mental health services. It is expected that training programs will be developed to enhance the progress of this initiative.[172]

14.136 Ms Janine Anderson, who manages a social recreation program for adults with a mental illness, considers that the screening process will aid holistic assessment and integrated treatment of all patient needs:

> The integration of services requires staff to undertake training so that each service has a better understanding of the other. Intake forms need to have questions that will indicate any other areas of the consumer's life [such as whether they have children] that may need expert attention, so that appropriate referrals and assistance can be given.[173]

14.137 To underpin the implementation of this approach, the National Drug and Alcohol Research Centre recommended that any services which receive government funding should be required to screen for co-morbid disorders and that accountability measures be put in place to ensure best practice is implemented for both single disorder and co-morbid conditions.[174]

Capacity building in the community

14.138 Service integration cannot occur without a robust network of interlinking agencies and service providers functioning at local and regional level.

14.139 Capacity for integrated service access should be grown from the ground up. Submissions emphasised the importance of involving both government and non-government agencies, along with consumers and carers, in treatment models offering a mix of options to address the range of dual disorder diagnoses. Dr Rolfe told the committee this is not just about access to psychiatrists and specialists:

> …it is a matter of having a whole-system approach where people can access the level of expertise that is required according to their needs. It is a matter of filtering people and building links between the various service elements so that people can get the highly specialised care that they might need—

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172   The Centre for Psychiatric Nursing Research and Practice, *Submission 217,* p. 14.

173   Ms Janine Anderson, *Submission 210,* pp. 2; 14.

174   National Drug and Alcohol Research Centre, *Submission 109,* p. 3.

from a psychiatrist, for example—quickly and expediently through a process of good communication through the network of agencies.[175]

14.140 An integrated approach to community mental health services also means more than breaking down the 'silos' of mental health and AOD services:

> Such an approach should address relationships between mental health services and the broader health service, as well as the links between mental health and other government agencies such as Housing, Education, Corrective Services, Juvenile Justice, Police and Transport.[176]

14.141 Carers wanted more involvement in, and more integrated, treatment regimes. Carers WA asked for opportunities to 'communicate between all parties, staff, psychiatrists, social workers, case workers or community nurses…and more integration with drug and alcohol services/psychologists for on going maintenance of care and treatment'.[177]

14.142 This vision is a giant step away from the acute care paradigm presently followed by mental health services. It places emphasis on early access and preventive care taking place in consumer friendly and interconnected treatment environments. This relies on well developed local referral systems and may be based on 'precinct' or accommodation based models. Tertiary level beds for detoxification may be collocated, along with GP services or support care by visiting or resident volunteers and professionals may be offered.

14.143 These models will require significant commitment at every level of service provision. Given the patient overload and under-funding of mental health services, which evidence suggests are compounding the 'service silo mentality', it is not to be assumed that top down initiatives will flower without sustained work at ground level.

Integrated community service models—the vision

14.144 Integrated community service models rely on having a developed methodology for agency referral, accountability mechanisms and incentives to encourage agency partnerships. Of paramount importance is the establishment of agreed treatment paradigms for the different disorders, so that access to appropriate services is streamlined and automatic. This will develop consumer, carer and service staff confidence, counteracting the sense of hopelessness which currently pervades the mental health sector.

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175 Dr Timothy Rolfe, Eastern Hume and South Hume Dual Diagnosis Service, *Committee Hansard*, 6 July 2005, p. 23.

176 NCOSS, *Submission 274*, p. 5.

177 Carers WA, *Submission 297*, Attachment 2, p. 2.

Building regional and local partnerships

14.145 Eastern Hume Dual Diagnosis Service has recommended the implementation of the CCISC model adopted in the USA. As already mentioned, this model requires that governments recognise dual diagnosis as a mainstream mental health issue and set out ways in which existing services can provide better treatment.[178]

14.146 Eastern Hume submitted a template for improving the capacity of the system to address complex needs by consolidating local partnerships and regional links.[179] The model would provides both 'the carrot and the stick' necessary to secure change. It would also facilitate information gathering, service networking, education and leadership at a local level, by:

- establishment of Regional Implementation Groups;

- appointment of trained specialist co-occurring disorder field workers; and

- nomination of 'agency co-occurring champions'.

- *Regional Implementation Groups*—comprise mental health and drug treatment local management, consumers, carers, clinicians from each agency, specialist co-occurring disorders workers/portfolio holders. These groups would be policy advisers, repositories of management advice and local knowledge. They could act as coordinators of local partnership initiatives and generation of 'buy in' (local ownership) by service providers into an integrated service model. Specific tasks could include:

    - generation of Regional Profiles of co-occurring issues, to map the extent and nature of local needs and identify service gaps;

    - generation of Regional Integrated Treatment Plans, to identify specific local barriers to service, and generate statements identifying which agency will treat specific co-occurring disorder cohorts, interagency protocols, local education strategies, and plan review mechanisms; and

    - development of mechanisms for cross-agency treatment planning for complex clients.

- *Specialist co-occurring disorder fieldworkers*—deliver training and education, clinical supervisor, primary and secondary consultation (with orientation to co-occurring disorders), tertiary consultation, protocol development and development of worker competency standards. Eastern Dual Diagnosis Service considers that these field workers could be a potent force for building local capacity for integrated treatment as they will monitor and support implementation

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178   Eastern Hume Dual Diagnosis Service, *Submission 374*, p. 28.

179   Outline of the proposal drawn from Eastern Hume Dual Diagnosis Service, *Submission 374*, pp. 37–38.

of central policy directives to prioritise co-occurring disorders among middle management.

- *Agency co-occurring disorder champions*—each agency would nominate a 'portfolio holder' of information on co-occurring disorders accumulated in the agency to the Regional Implementation Group. The person would act as a repository of agency knowledge about co-occurring disorders, mentor other staff as well as evaluate the agency response to clients with co-occurring disorders.[180]

Community care 'hubs' —user friendly services

14.147 Another proposal was collocation of services in the same venue or area. This model was considered particularly effective for young people. Professor McGorry of ORYGEN told the committee that the ideal for young people was the development of youth 'precincts' offering a mix of services, including vocational recovery and drug and alcohol services, as well as medium stay beds.[181]

14.148 The Gold Coast Drug Council proposed the establishment of 'community-based hubs', some of which could target youth. These 'hubs' are basically small scale step-up step-down housing arrangements, with a focus on social integration and building of living skills rather than merely on psychiatric treatment.[182] An advanced integrated recovery model of this type may reduce the burden on the acute sector by enabling it to more adequately support the most complex clients. The model would be characterised by:

- development of psychiatric community-based hubs which would provide an holistic approach to the treatment and support of clients;

- holistic treatment for clients including: disorder specific clinical models for managing the symptoms of chemical dependence and of mental and personality disorders; cognitive therapy for changing irrational thoughts that drive the target problems; affective therapy for changing unmanageable feelings that drive the target problem; behavioural therapy for changing self-defeating behaviours that drive the target problem;

- early identification and assessment of clients with mental health problems through training of community organisations, public sector services and GPs;

- easy to access, prompt and accurate advice, and support services for clients, families and friends, other agencies;

- family support options for clients with families, to avoid family separation and homelessness as a result of unemployment;

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180 Eastern Hume Dual Diagnosis Service, *Submission 374*, pp. 37–38.

181 Professor Patrick McGorry, ORYGEN, *Committee Hansard*, 7 July 2005, pp. 19–20.

182 Ms Mary Alcorn, Executive Director, Gold Coast Drug Council, *Committee Hansard*, 2 February, 2006, p. 21.

- daily activity programs to address living skills, employment, nutrition, social networks and training;

- support officers to provide on-going support and contact with clients living with ongoing mental health problems to prevent relapse, these can be suitably skilled volunteers rather than specialist mental health staff;

- development of appropriate supported accommodation including 'step-down' support for those coming out of hospital;

- development of specialist residential units to provide holistic treatment and support for specific client groups—such as non-addicted dual youth, aged etc; and

- a career pathway for workers in the mental health sector which provides training and development as well as recognition for skills and experience.[183]

14.149 Bulk billing of doctors and psychiatrists would be essential and medical health services should be collocated with multidisciplinary care teams. The 'hub' would function as an access point to a range of other agencies including Centrelink and the departments for housing, and families, and for education and training.[184]

14.150 GCGC advises that an important role for federal and state governments would be to ensure that medical health professionals, especially doctors and psychiatrists find the model attractive. Options for alternative models of employment and funding for GPs to encourage them into the mental health sector, such as salaried positions, employment loadings and sessional contracts could be considered.[185]

Continuing care networks for dual diagnosis prisoners

14.151 The Australian Injecting and Illicit Drug Users League developed a plan of action to provide more equitable treatment, and follow up assistance, for people who have been in contact with the criminal justice system.[186] It recommended that workforce development plans be developed to integrate mental health and AOD services and other related services, and that:

- harm reduction strategies be recognised as valuable component of treatment for people living with co-morbidity;

- prisons develop assessment and referral models for when people leave prison and return to the community;

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183   Outline drawn from Gold Coast Drug Council, *Submission 533*, pp. 7–8.

184   Gold Coast Drug Council, *Submission 533*, p. 7.

185   *Submission 533,* p. 8.

186   See also Centre for Social Justice, Qld*, Submission 300*, Attachment 1: Tamara Walsh, *INCORRECTIONS: Investigating Prison Release Practice and Policy in Queensland and Its Impact on Community Safety*, Faculty of Law, Queensland University of Technology, 2004, p. 6.

- there be diversion to ethical and appropriate treatment programs as an alternative to custody for people living with co-morbidity;

- people living with co-morbidity be empowered to retain a stronger advocacy role within the various sectors;

- the role of peer education and support be expanded; and

- national initiatives such as the National Co-morbidity Taskforce which has been disbanded need to be reinstated with appropriate funding.[187]

14.152 The Centre for Social Justice, Queensland, also suggested proposals to address the special needs of Indigenous prisoners. It recommended:

- prison officers be given cross-cultural training;

- Aboriginal Liaison Officers be recruited with at least one in every prison. These officers should liaise between prisoners, their families and communities, the prison and the correctional department; and

- Indigenous prisoners be given access to prison release accommodation support which they are often denied on the basis that accommodation applied for does not meet scheme criteria.[188]

Leading by example —funding existing strengths

14.153 In the absence of a commitment to assist people with dual diagnosis in public mental health systems, non-government organisations have had to think and work hard to improve, adapt and expand their services. As a consequence of this, many of the most innovative and successful treatment models for people with dual diagnosis have been formulated by drug and alcohol service groups.

14.154 As discussed, people with dual diagnosis most commonly present at drug and alcohol services for their clinical needs.[189] These services are mainly provided by non-government organisations which overwhelming rely on government grants and project-based funding. This was not considered a good model for systemic capacity building of existing service strengths.[190]

14.155 Organisations that are the most innovative—offering the most effective comprehensive and integrated treatment—are under the most pressure. As mentioned, the Gold Coast Drug Council reported that it had expanded and transformed its services to meet the needs of clients, some 80 per cent of whom have dual diagnosis.[191] The GCDC provides a good case study of the challenges facing non-

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187   Australian Injecting and Illicit Drug Users League, *Submission 281,* p. 5.

188   Centre for Social Justice, Qld, *Submission 300,* Attachment 1, pp. 23; 146–47.

189   Charity organisations also provide assistance, including housing and other support.

190   NCOSS, *Submission 274*, p. 10.

191   *Committee Hansard*, 2 February 2006, pp. 15–16.

government organisations of its type. The Mirikai Residential Therapeutic Community Program is a prototype of the 'community hub' treatment model set out above. The goal of the program is to enhance the capacity and commitment of some 40 residential clients, aged 16 to 29, to achieve and maintain an optimal level of personal and social functioning free from harmful drug use. The program has four stages with each stage taking six to eight weeks.[192] Ms Alcorn, GCDC Executive Director, describes the process, citing a Mirikai success story:

> A young woman—let us call her Jane—comes in from Robina. She has been there for seven months, probably on an involuntary treatment order, having an amphetamine issue diagnosed with bipolar and a psychotic disorder…Her mental health worker comes and visits her once a week for 20 minutes…She would have gone through the whole rehabilitation program; learnt lots of cognitive behavioural therapy; learnt to swim; go for walks on the beach and do all the things that people need to do; learned to take responsibility for her actions to manage her disorder, her medication— and had education around medication. Most of all, she was with a whole group of other young people, and that is a really healthy thing to happen for you: to be able to mix again. From there, after six months of that, she went into a training scheme funded through DET for landscaping. She made a decision that she would like to go to TAFE, and she is currently doing a diploma. She is in the halfway house and is about to move out.[193]

14.156 The GCDC reported that, as result of the expertise developed, the service is now experiencing the referral of the most complex clients from mental health services as well as the wider community.[194] This organisation, like ORYGEN and equivalent service providers, is carrying the lion's share of the growing service burden of dual diagnosis, without adequate recognition of that role:

> The GCDC is supported by both State and Federal grants, but many of these do not provide for cost increases year on year and all are fixed term agreements. Recruiting and retaining staff in this environment is a continual challenge. For example, the Youth Dual Diagnosis Worker position has been filled by three different professionals since August 2004, as the salary available for this position is not sufficient to compete with similar roles in the public sector…In 2004/5 the Mirikai Residential Therapeutic Community Programme bed cost was @ $21 000 p.a. Other States such as Victoria and New South Wales have bench marked their costs for particular client beds, with the cost of an equivalent bed in New South Wales and Victoria running @ $30 000 per year, with this funding including a component related to complexity. Queensland Health have repeatedly confirmed that they do not intend to benchmark costs for specific services or to provide financial incentives for specific client groups. Without financial recognition for the complexity of clients supported, it may simply

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192   GCDC, *Submission 533*, pp. 12–13.

193   Ms Mary Alcorn, GCDC, *Committee Hansard*, 2 February 2006, p. 18.

194   GCDC, *Submission 533*, p. 9.

not be possible to provide the environment and staff to deliver these services safely into the future.[195]

14.157 Consistent with arguments that overall expenditure on mental health services should reflect the extent of need, submissions maintained that as dual diagnosis has the highest disease burden, it should be funded accordingly. It was also considered that it is more cost effective to fund early prevention programs than to carry the significant burden of self and societal harms generated if these high needs are not met. ORYGEN made the point forcefully in its submission:

> Specialist interventions required by young people with serious mental illness are often unavailable or inappropriate. Most young people in Australia with serious mental illnesses will have access only to child or adult services that are not designed to meet all of the unique challenges faced by young people. Instead, they focus on the needs of younger children or chronically unwell adults. Due to resource restrictions, ORYGEN is able to treat only 40 per cent of the 2 000 young people referred to it each year. Even though research shows ORYGEN correctly targets those 'most in need', a substantial number of very unwell young people have to be turned away. Almost two thirds of those not admitted to ORYGEN have at least one mental illness and nearly one in four of this group have made a suicide attempt in the previous year.

> Consistent with the model those services which most efficiently service the cohort should be funded for continuous service; the expertise of non-government organisations needs to be 'mainstreamed' in the process of service integration, by being brought into core funding agreements.[196]

14.158 To extend this model, the federal government should also implement successful pilot programs nationally. Existing programs could be trialled for longer term implementation in specific regions:

> NCOSS supports the development of a number of funded trials on a range of service types across NSW (rural, remote and metropolitan) that would lead to an external evaluation of their effectiveness and the commitment to implementation and ongoing funding of the best 'models' for each area. For example, mental health peaks in discussion with NCOSS, raised an option of the establishment of a small number of residential treatment services for people with complex needs that would employ a number of different service models.[197]

14.159 With a national coordinating body in place, advanced models developed by state agencies for all dual diagnosis cohorts could also be identified, trialled and implemented nationally with federal support. The Public Advocate in South Australia reported that the state runs a very successful Exceptional Needs Program for dual

195   GCDC, *Submission 533*, p. 9.

196   ORYGEN Research Centre, *Submission 98*, p. [3].

197   Council of Social Service of New South Wales (NCOSS), *Submission 274*, p. 9.

diagnosis clients. He regards the program as a model of multi-sectoral intervention and recommends it for wider implementation:

> South Australia is one of a small number of states that offers a holistic resource stream to clients deemed to live with exceptional needs. It provides a model of service delivery that is genuinely holistic, dedicating resources to the individual person, targeted to the key domains of their lives. Commonly, this combines issues of housing, daily support, case management and therapy. The success of this program is that it is well resourced, allows resources to follow needs rather than diagnostic or multiple eligibility criteria and it's commitment to clients is strong.

> This stands in stark contrast to the more typical picture, where housing, health and welfare services are discrete entities that create a degree of inertia that can mitigate against positive outcomes for clients.[198]

Acute care—community-based beds

14.160 Many operators of dual diagnosis services favoured collocation or close location of detoxification beds to avoid possible iatrogenic effects of hospitalisation and ensure consistent progression of a treatment plan. A view consistently held was that the consolidation of collaborative community-based care would reduce the need for dedicated acute care beds for people with dual diagnosis. Dr Andrew Chanen of ORYGEN told the committee:

> …an artefact of that coercive environment is, of course, that there is an increased need for beds. There is a kind of sentimental attachment to the old days when we had more beds, because we were more coercive and we could utilise those beds. In a collaborative environment the need for beds decreases, not increases.[199]

14.161 However, it was agreed that deinstitutionalisation has hit the dual diagnosis cohort particularly hard. The Health Services Union commented:

> Closure of tertiary alcohol and drug services intervention beds and competitive tendering has resulted in fragmentation of services as providers were forced to compete and cut cost rather than work together reaching cooperative benchmarks and industry service standards.[200]

14.162 As indicated, community-based support is not adequately funded to provide long stay detoxification beds. Consequently it was generally agreed that:

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198   Public Advocate, South Australia, *Submission 268,* p. 21.

199   Dr Andrew Chanen, Consultant Psychiatrist and Senior lecturer, ORYGEN Youth Health and ORYGEN Research Centre, *Committee Hansard*, 7 July 2005, p. 14.

200   Health Services Union, *Submission* 223, p. 22.

There is an urgent need for more resourcing and coordination of services on the full continuum of drug prevention treatment, including medium intensive residential services for post detox treatment and support.[201]

14.163 As set out above, the policy of integrating people with dual diagnosis into mainstream emergency wards has proven spectacularly unsuccessful.[202] Evidence also suggested that integration of people with dual diagnosis into psychiatric wards reduces treatment outcomes for all patients, as well as being difficult for staff. Former psychiatric nurse Mr Jon Chesterson advised:

Many vulnerable patients who are treated for other psychiatric or single disorders are frequently subjected to shared inpatient environments where they feel unsafe, unprotected and threatened by other patients, particularly by young males who may be acutely unwell during the initial phase of treatment or detoxification, whether vicariously or planned. It is not uncommon for patients with a dual diagnosis to continue using whilst receiving inpatient treatment, and despite clear policies and procedures, it can be extremely difficult and often compromises the therapeutic relationship and environment, when nursing staff are expected to police these situations.[203]

14.164 In recognition of this problem, the combined Queensland Gold Coast Mental Health and the Alcohol, Tobacco and Other Drugs Services (ATODS) has made a submission for the establishment of a 24 bed inpatient facility for management of people with dual diagnosis at the proposed new Gold Coast Health Services District Hospital. ATODS Director Dr Lynn Hawken advised:

While patients with a mental illness are generally better managed in MH [mental health] wards during the acute stage of psychosis, those with co-occurring substance use problems who are non-acute, may often be better managed in a detoxification ward where staff have the necessary training and expertise, and where a safer and more secure environment can be provided for them.

With respect to the intersection between GCHSD Mental Health Services and Alcohol, Tobacco and Other Drug Services, we feel the best way of supporting mental health services in its challenge to better manage co-occurring substance use problems among its patients would be to establish a specialised alcohol and other drugs detoxification ward here on the Gold Coast.[204]

14.165 There is also potential to build services for dual diagnosis in private settings, As discussed above, the model would require guaranteed government funding, perhaps through a bed buying arrangement as applied in Tasmania. Medical insurance

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201   Health Services Union, *Submission* 223, p. 23.

202   See quote: Dr Georgina Phillips, *Committee Hansard*, 6 July 2005, p. 8.

203   Mr Jon Chesterson, *Submission* 177, p. 15.

204   Background information provided to the committee, 18 January 2006.

and Medicare bulk billing options would also be required to make it affordable for this cohort.[205]

Concluding remarks

14.166 Governments appear to have difficulty engaging with the realities of dual diagnosis. This is reflected in the declaration in the National Mental Health Plan that 'drug and alcohol problems are primarily the responsibility of the drug and alcohol service system'. The evidence before the committee clearly indicates that it is counterproductive to separate out mental health and drug and alcohol services in such a definite way.

14.167 Progress overseas has been achieved by comprehensive review of both mental health and drug and alcohol policies. Suicide rates have dropped. This is credited to reduced access to drug supplies in combination with increased provision of integrated drug and alcohol and mental health services.

14.168 It is doubtful that being 'tough on drugs' without the existence of a robust well integrated service network to support this vulnerable group will yield the desired results. People with dual diagnosis—now the 'expectation rather than the exception' amongst those with mental health problems—will remain 'forgotten people', and continue to fall through the cracks, either into gaol or to their deaths.

14.169 The enormity of the problem suggests an immediate response from government. Federal government must grasp the 'burning brand' and lead the states on service integration. As potently argued in the evidence there is an urgent need to build bridges by taking what's best and developing on existing successful models.

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205   Healthscope, *Submission 82*, p. 1, and Australian Health Insurance, *Submission 292*, p. 6.

CHAPTER 15

SERVICES FOR CHILDREN AND YOUTH,

OLDER PEOPLE AND CALD COMMUNITIES

Introduction

15.1   Mental health services are failing some of the most vulnerable groups in society; medical health care will need to be the overhauled and revitalised if community expectations are to be met:

> 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.[1]

15.2   This part of the report will provide a needs assessment of particular groups—those requiring a more specialised service response—within the broad-spectrum of needs addressed in the body of the report. Some of the groups identified above as 'falling out of the health care system' are discussed; others have been dealt with in detail elsewhere in the report.[2] The groups covered in this chapter comprise children, youth, older people and CALD communities. The service requirements of rural, remote and Indigenous Australians are explored in Chapter 16.

15.3   Obviously, there is much room for duplication in this assessment; most chapters canvass the diverse needs of particular groups to some extent. Discussion of children and youth inevitably highlights the importance of early intervention programs covered in Chapter 7, while the growing prevalence of youth with dual diagnosis, touched upon here, is a focus of Chapter 14. In other areas information of service requirements was comparatively limited. Less was received on older people with

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1   Australian Government, *Submission 476*, Part 10, p. 71.

2   People with co-morbid disorders, otherwise termed dual diagnosis, and those in the criminal justice system are treated in separate chapters. This reflects the growing prevalence of co-morbidity, and the significant influx of people with mental health disorders into the criminal justice system.

mental illness, perhaps supporting the view that older Australians are a 'voiceless' and neglected group. The situation of Australia's Culturally and Linguistically Diverse (CALD) communities is distinctive, and is addressed in terms of established community groups, and of refugees or new arrivals. Some consideration is given to the situation of Temporary Protection Visa (TPV) holders and immigration detainees with mental disorders in the discussion on refugees, reflecting the importance of the matter to submitters.[3]

Children and youth

15.4   It well known that social disadvantage, violence and instability in childhood reduces the chance of an individual enjoying good mental and physical health in later life.[4] Experts have conjectured that improved living standards would reduce the incidence of health problems. Studies have recently shown, however, that despite the general increase in amenity in the lives of people in developed countries compared with 40 years ago, there has been an alarming deterioration in the overall health of children in recent decades. Pre-eminent in that is a dramatic increase in the incidence of mental illness among the young.[5]

15.5   In Australia, between 14 and 18 per cent of children and young people between the ages of 4 and 18 years now experience mental health problems of clinical significance. This equates to in excess of 500 000 individuals nationally.[6] On this basis Professor Fiona Stanley, Australia of the Year 2003 and child health expert, has argued for a more a holistic approach to child health, one that recognises the interaction of social, economic and health policies, to produce a society which can foster and sustain the physical and emotional health of children and young people. Essential to her vision is the promotion of an early intervention approach, away from the 'end of pathway' policy responses currently modelled:

> Modernity's paradox is that in contemporary Australia we just have not been providing enough good early childhood experiences and for some children, our Indigenous children, this has had major negative impacts on their life chances, in spite of us having such a success with our economy…the policy responses on the whole have been at the end of

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3   Comprehensive analysis of the circumstances of detainees has been undertaken during the Palmer Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau, and most recently by the Senate Legal and Constitutional References Committee in its report on the administration and operation of the *Migration Act 1958* (March 2006).

4   Women and Mental Health Inc, *Submission 310*, p. 3.

5   See discussion, Professor Fiona Stanley, 'Before the Bough Breaks: Children in Contemporary Australia', Kenneth Myer Lecture 2003, National Library of Australia, www.nla.gov.au/pub/gateways/archive/64/pages/p17a01.html, (accessed 10 March 2006).

6   Findings of the Child and Adolescent Component of the National Survey of Mental Health and Wellbeing (Sawyer et al., 2000) and the Western Australian Child Health Survey: Developing Health and Wellbeing in the Nineties, Quoted in Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA), *Submission 83*, p. 10.

pathways and, whilst that's understandable, they will not deliver the long-term solutions to reduce those problems and neither have researchers actually adequately investigated these problems…we need to respond to this by acknowledging these issues and acknowledging this is happening in today's Australia and we need to start to change our emphasis and activities to make it a better place for our children and young people.7

15.6   This report cannot address the wider issues of social and economic policy which affect the happiness and well being of Australian youth. It can nevertheless acknowledge that the capacity to reduce the incidence and impact of mental health problems in the community[8] is affected by broader social and economic frameworks set up by Australian governments. As discussed in Chapter 7, the lack of support for early intervention is just one, albeit very important, aspect of this. This section will not focus on early intervention services for children as discussed in that chapter, but will look across the spectrum of child and youth need to discuss major service gaps affecting these groups.

15.7   The first and foremost issue is the extent of unmet need. Studies[9] have shown that alarmingly few young people have access to the necessary mental health services:

Only one in four young people with mental health problems receive help and even among those with most severe mental health problems, only 50 per cent receive professional help. Family doctors, school-based counsellors and paediatricians provide the services that are most frequently used by young people with mental health problems but even then young people are under-represented in the number of general practice visits as a percentage of the population. Of greater concern, they are also under-represented in visits for mental health issues, even though this issue provides the highest morbidity in this age group.[10]

15.8   Submitters identified multiple deficiencies in national policy as underpinning this low rate of access:

- first, the absence of a national template to drive development of services that are both targeted and better integrated;

- second, insufficient recognition of the diversity of child and adolescent health needs in the structure and provision of services; and

- third, the need for adequate funding to develop the necessary family and community support systems.

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7   Professor Fiona Stanley, 'Before the Bough Breaks: Children in Contemporary Australia', Kenneth Myer Lecture 2003, National Library of Australia, www.nla.gov.au/pub/gateways/archive/64/pages/p17a01.html, (accessed 10 March 2006).

8   National Mental Health Plan 2003–08, p. 6.

9   See National Survey of Mental Health and Wellbeing (NSMHW) 1997, quoted above in AICAFMHA, *Submission 83*, p. 11.

10   Australian Divisions of General Practice (ADGP), *Submission 308*, p. 31.

15.9   These failures articulated into significant service gaps in high areas of need, including those for youth and young adults with emergent mental health problems.

National child and adolescent mental health framework

15.10   The lack of an articulated plan for addressing child and adolescent mental health has been identified as a major policy flaw in an otherwise progressive National Mental Health Plan 2003–2008. AICAFMHA advised:

> A recent study reviewing international policy development on child and adolescent mental health by Shatkin and Belfer (2004) ranked Australia a B (on a scale from A-D) which reflected that Australia had national policies that recognised the unique needs of this population but *did not enumerate a unifying plan of action*. This finding is consistent with previous commentary by AICAFMHA on former drafts of the now current National Mental Health Plan 2003-2008.
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> The minimal recognition of the difference between child/adolescent mental health and adult mental health in the language of the National Mental Health Plans may also be a contributing factor in the National Mental Health Strategy policy areas being inadequately implemented in the infant, child and adolescent mental health fields.[11]

15.11   The West Australian Child and Adolescent Mental Health Services Advisory Committee supports the view that, without such a template for action, child and adolescent services will continue run second in the struggle to fund adult mental health demands:

> CAMHSAC is constantly frustrated with the inability to attend to these issues due to the absence of capacity to marshal resources given the relative position of CAMHS providers within the current organizational structure and the demand for acute clinical services. The current organisational structure is based on mental health districts in which CAMHS service leaders report to the local mental health district Clinical Director who are almost always preoccupied with adult mental health services requirements and imperatives. This leads to a tendency to overlook the needs of children, adolescents and their families and carers and to view them as the "next issue" needing attention. "When the needs of adults are fixed then we will attend to the needs of children" This has been the refrain of senior mental health management for decades.[12]

15.12   Child development studies suggest that models responding to the diverse needs of children and youth across the spectrum of growth, rather than focusing on distinct age based service provision, will be the foundation of improved treatment outcomes for these groups:

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11   AICAFMHA, *Submission 83*, p. 9.

12   Western Australian Child and Adolescent Mental Health Services Advisory Committee, (CAHMSAC), *Submission 24*, p. [2].

Infants, children and young people are not small adults. They have particular emotional, social and physical needs that should be considered within a developmental framework. Services should be designed specifically for infants, children and young people that work within this framework and address these specific needs.[13]

15.13   The absence of transition frameworks for children moving between service tiers and, in particular, for those moving out of adolescent services into adult streams, creates service gaps for patients with complex needs. The problems of youth aged 14 to 24 with co-occurring disorders, as discussed in the chapter on dual diagnosis, are indicative, and are recognised by government:

Young people with emerging mental health problems or disorders often have multiple difficulties that make diagnosis difficult and may mean the young people do not clearly fit into specific programs or criteria. The report, *Barriers to Service Provision for Young People with Presenting Substance Misuse and Mental Health Problems*, published in 2004 by the National Youth Affairs Research Scheme, found that a lack of holistic professional expertise covering both mental health and substance misuse issues was one of the key barriers to services for young people with dual diagnosis.[14]

15.14   Clearly, greater coordination and cooperation within an interagency framework between child and family focused services and other agencies is needed. This is essential to support the early intervention and prevention services discussed in Chapter 7:

In a well functioning mental health system which truly cares for children, services should be child centred, family focussed, community based, and culturally sensitive with adequate access to a variety of services suited to their needs including clinic, home based, school based services and crisis services, residential centres, and social services which provide attention tailored to their individual needs. In order for this to happen the *health, community and education sectors need to be integrated* for families requiring assistance.[15]

15.15   However, as Professor Margot Prior of the School of Health and Behavioural Sciences, University of Melbourne noted, despite these ideals being well articulated in the National Mental Health Strategy 'current systems are light years away from the ideal', especially when the low access and high rates of need are taken into account.[16]

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13   AICAFMHA, *Submission 83*, pp. 3, 4, 7.

14   Australian Government, *Submission 466*, Attachment 4, p. 2.

15   Submitter's italics, Professor Margot Prior, Professorial Fellow, School of Health and Behavioural Sciences at the University of Melbourne, *Submission 32*, p. 2.

16   Professor Margot Prior, *Submission 32*, p. 2.

Responding to the diversity of child and adolescent health needs

15.16   What is lacking in child and adolescent services is the capacity to provide appropriately tailored services and treatment responses within a care pathway that ensures easy transition between service streams.

15.17   As noted in Chapter 7, there are some concerns about early identification of mental health problems in young people. The NSW Commission for Children and Young People advised that the issue is really about appropriate service access, not the 'labelling' of young people with disorders:

> Discussion should continue to clarify and share definitions of terms like mental health, mental illness, mental disorder and mental health problem. While it is important that agencies are clear about their responsibilities within the service system, we need also to avoid excluding people with manifest problems in behaviour, conduct or mental health from service provision because no agency role statement includes their particular problem.[17]

15.18   The Commission considered that to achieve 'universal non-stigmatising service delivery' for children and families, general health services need to have, or have access to, mental health expertise.[18]   However, Professor Prior advised that because of the generic service model currently imposed on service providers, diagnosis and treatment methodologies for child and youth mental health disorders are poorly developed, even among mainstream health specialists:

> Many clinicians working in this field are significantly under trained for the work that is required, lacking specialist graduate qualifications in child and adolescent mental health. The wholesale adoption of the generic model in these services means that treatment is not matched with assessed needs of the client, and when referral is taken up it is likely to be potluck what kind of professional (eg nurse, occupational therapist, psychologist etc) is allotted to the case. Further those professionals who are well trained in the field often do not have adequate opportunity to practise the assessment and therapy skills in which they have been trained and which are needed because of pressures for 'case management'.[19]

15.19   The very serious consequence of this is that evidence-based treatments, even where known, are not often applied:

> Much of the treatment provided in current Child and Adolescent mental health Services is not evidence based. Two salient examples illustrate this point. Numbers of children with anti-social or conduct disorders are seen in psychotherapy over long periods of time. Not only is this absorbing scarce funds but it is known that this mode of treatment is ineffective for children

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17   The NSW Commission for Children and Young People, *Submission 399*, p. 3.

18   *Submission 399*, p. 1.

19   Professor Margot Prior, *Submission 32*, p. 2.

with such difficulties. Children with anxiety disorders often do not receive the treatment for which evidence is strong, ie. Cognitive Behavioural Therapy.[20]

15.20   Screening tools are important for early recognition of the different childhood mental health problems. While sensitivities exist about early screening of children for mental health problems, the case for introducing screening to assist early identification for high risk groups is strong. One such group would be children entering out of home care:

> Young people entering care for the first time usually do not have comprehensive psychiatric or medical assessments despite the fact that this group are a high risk group for both physical and mental disorders. We undertook a pilot project (Stargate Project) providing such assessments for all children entering care over a twelve month period, combined with parent and carer interventions. We reasoned that early intervention might reduce the difficulties and produce better outcome for a highly vulnerable group, preventing further potential trauma from being in care. We found that there was indeed a high prevalence of psychiatric disorder, learning difficulties, and physical and dental problems in this group. Prompt intervention and assessment enabled better planning for the young people and resulted in a more rapid reunification where this was possible but also enabled carers to manage the young people and their problems more effectively, providing support for foster carers, who are unsung heroes looking after some of the most difficult children. Unfortunately the funding for this pilot project was not recurrent.[21]

15.21   Beyondblue argued that screening mechanisms should be more broadly applied by mainstream health services for early identification of emerging disorders in children, and to address the growing incidence of co-morbidity among the young:

> Areas recommended as most likely to produce best outcomes include community screening and treatment for disorders in childhood and well-trained service providers who are adequately versed in the detection, management and referral of people with co-morbid problems. Particular focus is being placed on primary care as a key setting for the identification and treatment of co-morbid alcohol misuse and mental health problems and, while a number of small projects underway are investigating potential models for co-morbid clients, there is little focus on co-morbidity with high prevalence disorders. More focus and investment in this area is required.[22]

15.22   Mainstream and recurrent funding under the national health budget could be an incentive to the states to develop routine health screening mechanisms of identified high risk groups for nascent mental health problems. The Central Australian Aboriginal Congress reported the success, for example, of the new 710 Aboriginal

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20   Professor Margot Prior, *Submission 32*, p. 1.

21   Royal Children's Hospital, Melbourne, *Submission 557*, p. 1.

22   beyondblue, *Submission 363,* p. 8.

Adult Health Check, which it uses to assess emotional and social disorders in Indigenous people aged 15 to 55. This project, however, is not funded as part of mainstream health services.[23]

15.23   Given the lack of agreed methodologies on early intervention and prevention across the spectrum of child and youth mental health disorders, funding for research and developmental consultation mechanisms seems essential. As a case in point, the risks of pharmacological treatment of children and youth with depression and anxiety are not established nor well understood by practitioners, indicating that definitive action must be taken to identify and promulgate key findings on the subject:

> There are some specific issues in regard to the prescribing of antidepressants in regard to young people and children, with little being known about the optimal duration of treatment and the effectiveness of pharmacotherapy in this group. There have been calls for the withdrawal of SSRIs for young children and protocols regarding labelling to highlight potential side effects, including suicidal ideation and attempts. beyondblue has facilitated a national focus group including The Australian Medical Association, The Mental Health Council of Australia, The Royal Australian College of General Practitioners and The Royal Australian and New Zealand College of Psychiatrists and the group are developing a joint statement and highlighting the research in regard to the use of anti-depressant medication in the treatment of depression in children and young people, with a view to ongoing review of this issue.[24]

15.24   The difficulties of achieving appropriate diagnosis for children can place extreme emotional and other demands on their families; then comes the challenge of accessing appropriate services. When the child's disorder involves high support needs, the consequences of not providing early and adequate assistance can be very grave for all concerned. A4 Autism Aspersers Advocacy Australia cited the case of Jason Dawes and his family, heard at Parramatta, on 2 June 2004:

> Jason Dawes was born on 2 Sept 1992. His autism was diagnosed in March 1994 when he was eighteen months old. His parents were advised that Jason was in need of early intervention, but [the local service] advised that they did not have a place for him. He went for years without intervention.
>
> Jason's mother was required to educate, feed, toilet, bathe, entertain and love Jason…She constantly lived with the fact that her son had lost his best chance of acquiring later life skills because of the failure of authorities to provide appropriate intervention during his early formative years.
>
> Jason's father said autism caused constant stress in the family and pervaded all their relationships, "[His mother] had to fight so hard for help for Jason – early on I couldn't cope at all".

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23   The Central Australian Aboriginal Congress, *Submission 486,* p. [8].

24   beyondblue, *Submission 363*, p. 7.

> Judge Ellis said…it is clear that the present system within New South Wales leaves a lot to be desired and was a significant stressor for Jason's mother over an extended period of time.
>
> On 24 August 2003…Jason's mother held his hand, placed her hand over his mouth and nose and held him until he ceased struggling. In so doing she took her son's life… [Jason's mother] then went into the bathroom, took a razor and severely lacerated her wrists.[25]

15.25   The submission concluded: 'Jason Dawes had autism, a mental disorder that required treatment that the state did not provide and that he did not get. The fact that authorities failed to provide appropriate intervention for his autism contributed to his parents' mental illnesses and to his death'.[26]

15.26   To address the urgent and diverse unmet needs of children and adolescents with mental health problems, submissions requested comprehensive review of 'service silos' which prevent the development of expertise, and the marshalling of scarce resources to treat the range of disorders across the age spectrum. Beyondblue recommended that a research project of national significance is required to develop best practice approaches for wholesale youth mental health service reform, and research be undertaken to establish and promote:

- an expanded developmental phase to encompass a youth population;
- the epidemiology of mental disorders in young people; and
- young people's access to standard health care systems.[27]

Youth transition—specialised services

15.27   A significant body of evidence to this inquiry concentrated on the particular obstacles to service access for the young people with mental illness, early teen through to age 24 years. This group, as acknowledged by government, has the highest incidence of mental illness of all age cohorts, and the lowest access rate of services:

- mental disorders are most prevalent during adolescence and young adulthood, and account for 55 per cent of the disease burden of those aged 15 to 24 years.
- only 25 per cent of young people aged 13 to 17 with mental health problems used one or more services.[28]

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25   Comments on Judge Ellis' summing up the in the matter of REGINA v DANIELA DAWES, 04/21/1041 NSW District Court, Parramatta, quoted in A4 Autism Aspersers Advocacy Australia, *Submission 92*, p. 4.

26   *Submission 92*, p. 4.

27   beyondblue, *Submission 363*, p. 9.

28   Australian Government, *Submission 476*, Attachment 4, p. 1.

15.28   The 1997 ABS National Survey of Mental Health and Wellbeing found that rates of mental disorder peak at age 18 to 24 years, with more than one in every four young adults having one or more mental disorders. The prevalence rate of anxiety disorders for young people aged 18 to 24 was 11 per cent, 7 per cent for affective disorders, such as depression, and 16 per cent for substance use disorders. Substance use disorders were most common in young males and depressive disorders were most common in young females.[29]

15.29   Happily, the suicide rate for young people continues to decline,[30] although levels among young males, particularly regional or rural males, remain high.[31] Young people overall continue to record substantially higher rates of self harm than those of older adults:

- suicide accounted for 22.5 per cent of all deaths for young people, second only to motor vehicle accidents; and

- 42 per cent of adolescents experiencing very high levels of mental health problems had seriously considered suicide and one in four had made a serious attempt in the last 12 months.[32]

15.30   Reflecting this data, young people's hospitalisation rates for mental disorders have also risen over recent years with about 43 000 hospitalisations for mental health and behavioural disorders recorded between 2000 and 2001 alone. The most common causes for these hospitalisations are depression, schizophrenia, severe stress and eating disorders.[33]

15.31   As widely discussed in this report, the acute care focus of mental health services yields contradictory and very negative service consequences for people with mental illness. On one hand, under deinstitutionalisation, acute care services have been wound back creating a shortage of available beds. On the other, underdevelopment of the necessary community based and crisis management services ensures people with mental illness in desperate situations have no recourse but to go to hospital emergency departments, which are not adequately equipped to deal with them:

> In particular, young people between the ages of 16 years and 18 years have
> no dedicated emergency response for acute mental disorders and frequently

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29   Australian Government, *Submission 476, Attachment 4,* p. 1.

30   The suicide rate recorded by the NMHS in 1997 was 15.2 deaths per 100,000 young people. Suicide rates are now 23 percent below that. See 'Suicide Rate Falls', The *Australian*, 15 March 2006.

31   These are double the rate of the rest of the population. NSW Farmers Association, *Submission 410*, p. 4.

32   *Submission 476, Attachment 4,* p. 1.

33   ADGP, *Submission 308,* p. 31.

are hospitalised in adult facilities which are not adequately resourced, staffed and structured to meet the needs of this population.[34]

15.32   Submitters maintained that emergency departments are the worst place for young people in acute states of need. The committee received numerous reports from young consumers lamenting their treatment in hospitals, such as shackling and forced injection, sometimes simply because the consumer expressed frustration at being left in the waiting area, or mentioned suicide ideation.[35] Insane australia reported:

> If you talk about suicidal feelings, it is quite likely that you are going to be locked up and then you will have quite invasive treatments imposed on you against your wishes. We find that people are absconding from our mental health services, whether they be voluntary or involuntary, specifically to go and kill themselves. There is quite clear data about that but no-one is asking the question: what is happening in these services that people are escaping to go and kill themselves? To me it is very understandable: if you present to someone seeking help—perhaps your last grasp at staying alive—and you find yourself being assaulted, it is to be expected that you will flee that situation.[36]

15.33   As serious as this is, the main systemic obstacle to better youth service access is the age-based clinical distinctions establishing child and adolescent services, as against adult services, from years 16 to 18.[37] Mr Jurgen Hemmerling, a youth worker from the Albury Wodonga, reports that this unhelpful division militates against children and younger teens accessing out-of-hours emergency care in his region:

> Working in the youth sector has highlighted some serious short comings in the child and adolescent mental health fields. In Victoria, child and adolescent mental health services do not operate an after hours service, so only persons aged 16yrs and above are eligible for the adult mental health system after hours intervention, young people are required to wait til 9am-5pm service delivery. Currently the wait list for service in this region is at least six weeks, hardly satisfactory.[38]

15.34   At the other end of the spectrum, turning 18 can mean losing access to whatever specialised services are available:

> To date the service structure is such that upon turning 18 a young person must utilize the services of an adult service only if they have a defined 'serious mental illness' (meaning in most cases psychosis, especially schizophrenia). Therefore the mental health problems of most young people

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34   CAHMSAC, *Submission 24*, pp. [4].

35   See for example, Ms Jolan Tobias, Platform Team Member, ORYGEN Youth Health, *Committee Hansard*, 7 July 2005, pp.22–23 and Anglicare Tasmania, *Submission 464*, p. 28.

36   insane australia, *Committee Hansard*, 5 July 2006, p. 28.

37   Mr Jurgen Hemmerling, *Submission 366*, p. 1.

38   *Submission 366*, p. 1.

in the 18-25 age group largely go either undetected or receive no intervention whatsoever.[39]

15.35   In addition, youth with complex disorders must negotiate the gaps between other service 'silos'. As discussed in Chapter 14, dual diagnosis youth for example may 'slip through the cracks'[40]between mental health and alcohol and drugs services:

> Up to 50 per cent of our current client group, who are aged 12-21yrs with serious alcohol and other drug issues, have significant psychiatric pathology, ranging from self harm to depression, anxiety and psychosis. These young people…are poorly serviced by the current mental health system. It is well known, that young people are one of the most difficult of client groups to engage in service delivery, long wait lists, lack of after hours services and the stigma often attached to mental health services are a constant barrier to service access for these young people.[41]

15.36   In addition to the development of transition frameworks and restructuring services to comprehensively address the needs of the young teen to 24 age group, submitters asked for a more holistic approach to support youth mental health needs:

> Basically it is only hard-core psychotic illness that can be looked after in the public system, with access to adjuvant supports such as case managers, linkage to employment and rehabilitation services etc. Yet there are a huge number of needy, but not wealthy people who simply cannot access the services that would help them. A large number of these have mood or personality disorders, and many of them are young. There are significant financial barriers to accessing medical models of mental health care with declining rates of bulk-billing and the rise of a "user-pays" system, and even greater barriers to accessing non-medical models of care which are known to have lasting therapeutic value. General Practitioners (GPs) cannot offer all that is required. Community mental health services are overwhelmed with mostly young people referred for assessment by GPs, who need longer-term talking or behavioural therapies, yet no affordable and available services can be found.[42]

15.37   The focus on symptomatic assessment does not provide young consumers with the emotional or practical support needs to negotiate life with a mental illness:

> When children and young people do present to services, it is often for other matters, such as homelessness or family problems, and the mental health issue may not be immediately apparent. Agencies need to work collaboratively, focus on building trusting and lasting relationships with children and young people and be linked to specialist mental health services.

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39   beyondblue, *Submission 363*, p. 9.

40   Dr Georgina Phillips, *Committee Hansard,* 6 July 2005, p. 16.

41   Mr Jurgen Hemmerling, *Submission 366*, p. 1.

42   Dr Georgina Phillips, *Submission 255*, p. [3].

The existing mental health service system is complicated and frequently compartmentalised to focus on single issues or acute problems. As a result, responses to vulnerable children and young people are sometimes limited to the treatment of a mental illness, rather than recognising and addressing the full range of problems which the child or young person may face.[43]

15.38   To overcome the stigma and other difficulties faced by young consumers, targeted youth friendly services were suggested. The Youth Mental Health Coalition advised:

Young people are often reluctant to seek help and are very discerning about when, where and from whom they seek assistance. There is a critical need for youth oriented services. Young people who don't necessarily have a 'serious mental illness', and even those who do, must also deal with the stigma associated with attending a mental health clinic.[44]

15.39   ORYGEN Research Centre advocated the national implementation of a model which combines the best of clinical and life skills assistance:

Young people with emerging severe mental illnesses should have access to specialist youth mental health services. Young people aged 12-25 should be treated in publicly funded youth mental health services alongside their peers where the therapies, physical environments, group activities, vocational support, staff and work-practices are appropriate to the needs of young people. Access to such specialist youth mental health services should not be a quirk of geographic location—currently access to the only such publicly funded service in Australia is confined to residents of the Western and North Western regions of Melbourne.[45]

15.40   Essential to the model is consumer participation. AICAFMHA recommended that the 'voice of children and young people' be heard in the development of mental health policy, services, interventions and programs which affect them.[46] The report of a young ORYGEN client, cited by the Youth Mental Health Coalition, exemplifies the note of hope that recovery based services of this type can achieve:

I like to think of myself as an ORYGEN graduate, not a mental health patient, yes I am one of those crazed and deranged people that society is so cautious about. It's funny that, because when I look at what's happening in society today it seems to be on the brink of madness, materialism, consumerism, terrorism, genetics and morals. You must have viewed or at least heard of the saying "the worlds gone mad". Maybe a bunch of people like me in society should get together sometime, us crazy people know our stuff, we could help out.[47]

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43   NSW Commission for Children and Young People, *Submission 399* , p. 2.

44   The Youth Mental Health Coalition*, Submission 285*, p. 9.

45   ORYGEN Research Centre*, Submission* 184, p. 11.

46   AICAFMHA, *Submission 83*, p. 5.

47   *Submission 285*: case study: Jolan's Story, p. 15.

Funding child and youth services adequately

15.41   Many service providers reported the alarming extent of unmet need in their practices. Professor Peter Birleson, Director, Eastern Health CAMHS, Adjunct Professor in Psychology, Deakin University, felt the urgency of the situation personally:

> As I see more children being turned away from my service, and see my staff becoming more stressed trying to meet impossible demands, I am more convinced that we cannot give up. We must communicate about the personal and financial costs of not having enough services, must ally with consumers to make more noise about this problem, and must show we deploy our resources as efficiently and effectively as we can. We can all do this locally, but the College can help us by strengthening its policies, building political partnerships with consumer organizations, actively including the Child Faculty and providing information.[48]

15.42   Professor Birleson considered a reasonable a response by government would be to double the funding allocated to specialist CAMHS from 7.5 per cent to 15 per cent of the specialist mental health budget.[49]

15.43   In similar vein, the AICAFMHA calls on government to 'undertake specific child and adolescent national mental health policy and planning development with defined accountabilities'. It suggested an increase of 15 per cent of mental health funding by 2010 for infant, child and adolescent mental health care, with a further target of 20 per cent of mental health funding by 2015 to facilitate servicing the 30per cent of the population who are in this target age range.[50]

15.44   The announcement of the successful tender of ORYGEN Research Centre, with the Sydney-based Mind and Brain Institute, to run a National Youth Mental Health Foundation is promising for youth mental health reform. The $54 million funding for national service provision will be a good start,[51] but the Government should consider its commitment as a long term one, and act promptly to implement recommendations.

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48   Professor Peter Birleson, Director, Eastern Health CAMHS, Adjunct Professor in Psychology, Deakin University *Submission 429,* Attachment 1, pp. 16–17.

49   *Submission 429*, Attachment 1, p. 17.

50   AICAFMHA *Submission 83,* p. 10.

51   The Hon Christopher Pyne MP, Parliamentary Secretary, Minister for Health and Ageing, National Youth Mental Health Foundation, *Media Release*, CP70/05, 12 December 2005.

Older people with mental illness

15.45   Australia has an ageing population but the provision of mental health services to the aged is underdeveloped compared with other groups in the community.[52] The ratio of mental illness among the aged is lower than in the general population, at around 6 per cent for those aged 65 and over, compared with 18 per cent for general population.[53] Studies have suggested that getting older might reduce anxiety and depression,[54] implying perhaps that there is less unmet need among the elderly. Other factors suggest that older people with mental illness are another particularly vulnerable group neglected by current mental health services frameworks.

15.46   The concurrence of dementia with other mental illness presents special challenges. As the population ages, dementia is increasingly common. As the number of people in dementia rises, so too does the number of those with another mental illness, such as anxiety, depression, or personality disorder. These consumers, particularly the last group, can not be readily managed in mainstream aged care facilities, which lack services to assist them. At the same time specialised community based or acute services remain underdeveloped for this cohort.

15.47   One indicator of this is the very high suicide rate for males over 65: 29 suicides per 100 000. The risk factors for depression and suicide for this age group are influential: death of a spouse, loss of independence, income and status through retirement, increased social isolation and loneliness, reduced capacity or inability to participate in favourite leisure activities and pastimes concomitant to physical illness, and chronic pain associated with injury or disease.[55]

Limited progress under the National Mental Health Strategy

15.48   The National Mental Health Strategy has had limited effect in improving mental health services to older people with mental illness. Dr Roderick McKay of the Royal Australian and New Zealand College of Psychiatrists reported findings that suggest medical service access for those over 64 years is actually in decline:

> The National Mental Health Strategy has had limited effect in improving the mental health care of older Australians in NSW. Although there has been a reduction in patients managed in long term mental health beds there has been no co-ordinated system developed across the State to optimally manage older people with mental health disorders in the community. There is a marked shortage of inpatient resources of all types. There is an even greater, severe, shortage of resources to manage older people with mental

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52   Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219, passim*.

53   Australian Government, *Submission 476*, Part 10, p. 65.

54   A. F. Jorm, 'Does Anxiety Reduce Anxiety and Depression? A Review of Epidemiological Studies Across the Lifespan', *Psychological Medicine*, vol. 200, no. 30, pp. 11–12.

55   *Submission 476*, Part 10, p. 65.

illness in the community in all areas of NSW. Some areas have no access to specialist mental health services for older people. As a consequence of this older people with mental illness do not have access to a comprehensive range of mental health interventions. Furthermore older people have less access to private psychiatric services in Australia. An analysis of 1998 Medicare data revealed that per capita the proportion of Medicare expenditure allocated to adults aged less than 65 years was 4.1 times that for adults over 64 years. This was a decline since 1985–1986.[56]

15.49   The main objective articulated in the 2003 Public Health Action Plan for an Ageing Australia is to reduce the future incidence of aged debility, rather than addressing current unmet need of older consumers.[57]   The Federal government has funded the ANU's Centre for Mental Health Research to conduct research for this purpose. The Beyond Ageing Project focuses on prevention of depression or cognitive impairment, and improvement of mental health literacy for this cohort. The project will report late in 2006.[58] The Federal Government otherwise reports only one targeted seniors initiative, the Seniors Portal, an internet site providing information about service access. It noes that other broader 'whole of community' 'may address some risk factors'.

15.50   Lack of clarity regarding responsibility for funding between different levels of government, and within each level, is a significant ongoing barrier to improvements in mental health care for older Australians. Similarly, state governments do not appear to be moving at any pace on unmet need for the elderly. The NSW Government's Plan for Mental Health Services released in March 2005 proposes the development of only one aged care mental health unit in the state, in the Illawarra.[59] Dr McKay concluded 'there is a pressing need for clear policy responsibility at a national level for older persons with mental illness'.[60]

Service comparison with other groups

15.51   Submissions remarked that specialist services for older people in all settings are markedly under-resourced, and are significantly less developed than mental health

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56   Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, pp. [1–2], quoting Draper and Koschera, 2001.

57   Which aims to 'to progress the health and wellbeing key result area of the Commonwealth, State and Territory Strategy on Healthy Ageing'. See Australian Government, *Submission 476*, Part 10, p. 65.

58   Australian Government, *Submission 476*, Part 10, p. 65.

59   Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, p. [2].

60   *Submission 219*, p. [2].

services for the remainder of the population. The lack of research and well trained staff were listed as major obstacles to adequate care for the elderly.[61]

15.52   While some evidence based models for elderly care have been developed, service systems are not well defined to address the coexistence of dementia and mental illness in the elderly. The Australian Government submission advised:

> 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.[62]

15.53   At hearings, Professor Henry Brodaty, appearing with Dr Roderick McKay of the Royal Australian and New Zealand College of Psychiatrists, explained the stark implications of this:

> We know that dementia is largely looked after by Commonwealth policies and services and mental health problems are looked after by states. If you have both, often you are not looked after by either. We know that rates of mental health problems in people with dementia are huge. Ninety per cent will have some behavioural or psychological symptom at some time during their dementia. Having aggression, depression, delusions or hallucinations is a big risk factor for institutionalisation. We currently spend about \$3 billion a year on nursing home costs, and direct costs for dementia are set to rise to \$6 billion by about 2011. A large part of that is accounted for by the mental health problems associated with dementia.[63]

15.54   The South Australian Division of General Practice reported the care response in that state:

> Dementia, depression and confusion can be seen by families, carers and the health care system as part of ageing, which leads to acceptance of these problems and not enough attention paid to potential solutions…The Home and Community Care (HACC) system has had difficulty accepting mental health as a source of disability despite figures demonstrating mental health as the largest cause of non-fatal burden of disease. As with all areas, comorbidities with physical illnesses and disabilities impose additional strain on consumers and carers but are not well managed or treated.[64]

15.55   Elderly people with coexisting mental health disorders and substance abuse problems are reported to have extremely poor access to drug and alcohol services. Dr McKay noted that the national drug and alcohol plan has no policy initiatives with

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61   Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, pp. [2; 5-6.]

62   Australian Government, *Submission 476*, Part 10, p. 65.

63   Professor Henry Brodaty, *Committee Hansard*, 2 August 2005, p. 72.

64   SA Division of General Practice, *Submission 88*, pp. 7–8.

regards to the elderly, and that a focus on youth co-occurring disorders disregards incidence of dual diagnosis with dementia.[65] The Department of Veteran Affairs has targeted the needs of veterans generally in this area, particularly for alcohol based co morbid conditions, and has increased its focus on aged mental health.[66]

Depression in aged care facilities

15.56   Older Australians in residential aged care facilities are at particular risk of depression, but have poor access to services. In 2004, the Department of Health's Challenge Depression Project reported the results of its national survey of 1758 residents in 168 aged care homes. The project found that 51 per cent of high care and 30 per cent of low care residents are depressed. Assessments of those with severe cognitive impairment able to participate indicated that 38 per cent of high care and 26 per cent of low care residents are depressed. The report concluded that, under normal circumstances, a significant proportion of depressed residents go unnoticed, as staff are poorly informed about and have no framework for systematic assessment of depression in their patients.[67]

15.57   Improved training for nursing home staff is clearly required, as the depression carer support organisation blueVoices observed:

> In reviewing education around the country, we would recommend that a program is funded which offers appropriate education and input into depression and anxiety disorders in older Australians for the many staff who work in these types of facilities. The majority of direct client care in Residential Aged Care is carried out by Grade III Certified Nursing Staff (Assistants in Nursing). These staff often have minimal educational qualifications, and therefore do not have very high levels of knowledge around the areas of depression and anxiety and other mental disorders. This in turn can quite unwittingly contribute to the further deterioration of their clients, instead of assisting older Australians to optimise their level of functionality.[68]

15.58   The New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, observed that the lack of long term acute inpatient care and community care options for people with low prevalence disorders such as bipolar disorder has potential to increase the likelihood that

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65   Dr Roderick George McKay, on behalf of the New South Wales Branch of the Faculty of Psychiatry of Old Age, the Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, p. [5].

66   Australian Government, *Submission 476*, Attachment 26, p. 1.

67   *Depression in Residents of Aged Care Homes, The Final Report of the Challenge Depression Project* (Challenge Depression: Final Report), Report to the Department of Health and Ageing by The Hammond Care Group, March 2004, p. vii.

68   blueVoices, *Submission 259,* p. 9.

residential aged care facilities will have to accommodate more older people with these disorders, to the disadvantage of all concerned.[69]

15.59   Dr Georgina Phillips advised that the current situation for these patients is untenable, as many have no where to go but to hospital emergency departments:

> There is a growing trend for EDs to be used as a form of crisis containment for the mentally unwell aged (psychogeriatric) person. By the time these people end up in an ED, their degree of mental and behavioural disturbance is severe, and chemical and/or physical restraint is necessitated. It is a particularly frustrating phenomenon as often the mental and behavioural issue is not new, but because of inadequate community assessment, management and support, the nursing home/hostel/families/neighbours end up in a crisis situation. The aged are particularly vulnerable to the stresses of ED care and can suffer exacerbations of their mental illness, dementia or delirium simply from prolonged time in such a non-therapeutic environment, as well as a higher risk of physical injury from falls, physical restraints etc.[70]

15.60   To address pressures on care systems and to reduce the level of depression and other mental illness among older people, the NSW Department of Health recommended that more supported accommodation should be made available in the community.[71] Positive results could be also achieved by implementing a national network of suicide prevention workers.[72]

The case for more specialised services

15.61   The capacity building of community support services for older people with mental illness is clearly essential. Support packages such as those developed in Tasmania for assisting people with mental illness in the community, for example, could be extended to offer specialised support to aged consumers and their carers.[73]

15.62   However, experts in the field of geriatric psychiatry also argued that the distinct needs of the aged with mental disorders needs better systemic recognition:

> Mental health problems in old age are different. It is not that older people are just adults grown older. In the same way that child and adolescent psychiatry is qualitatively different from adult mental health, in old age mental health there are qualitatively different conditions, different reactions to medication and different treatment strategies. Old people do not do well in mainstream psychiatric services. The clinicians are not particularly

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69   Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, p. [2].

70   Dr Georgina Phillips, *Submission* 255, p. [4].

71   NSW Department of Health, *Submission 470*, pp.38–39.

72   *Submission 470*, p. 23.

73   Tasmanian Government, *Submission 502,* p. 7.

interested in older people. In psychiatric wards they often get knocked around by younger, violent psychotic patients. There are strong arguments for having dedicated, discrete services for older people, as we do for children and adolescents.[74]

15.63   The development of discrete targeted services of the aged seems inevitable given the very real limitations of the present arrangements to provide both timely and continuous care, particularly for the acute patient:

> Problems arising from lack of expert assessment and definitive care [are] particularly delayed in the aged population, as CAT teams, psychiatric triage and community mental health services limit themselves according to patient age (usually < 60yrs). Psychogeriatric services are ess experienced in acute care and crisis management, and often do not have resources to provide immediate or even 'same-day' assessment. Similarly, psychogeriatric inpatient beds do not have a high patient turnover, and the delay to accessing these in an acute situation often stretches to days.[75]

15.64   The demands that aged people with these disorders put on their carers, often elderly also, needs an urgent and sympathetic service response. At present, older people with mental illness and their carers have little input in the increasingly important consumer and carer movements within mental health, which may explain their relative neglect. Factors such as stigma, very prevalent in rural areas,[76] as well as cognitive impartment, and lack of respite care may reduce the capacity of this cohort for lobbying and involvement and service planning—and all are indicators of their relative powerlessness to change their circumstances.[77] Dr Roderick McKay concluded:

> In summary, despite the increasing concern in the broader community regarding the impact of an ageing population upon our health system, the delivery of services to improve the mental health of older Australians has received very limited resources, and development is hindered by lack of clear responsibility for planning or funding of services. This situation is exacerbated by the reality that older Australians with mental illness and their carers are not as vocal, nor as likely to be in the media, as their younger counterparts. There are known effective systems for improving the mental health of older people, but they require adequate resourcing. We believe that nation has a responsibility to offer equivalent access to mental health care to older Australians as it does to younger Australians. We do not believe this is currently the situation.[78]

74   Professor Henry Brodaty, Private Capacity, *Committee Hansard*, 2 August 2005, p. 72.

75   Dr Georgina Phillips, *Submission 255*, p. [4].

76   Australian Rotary Health Research Fund, *Submission 68*, p. [2].

77   Dr Roderick George McKay, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Submission 219*, p. [5].

78   *Submission 219*, p. [6].

15.65   Statistical projections suggest that the need for improved services for older Australians with mental illness and their carers will soon become more urgent. With the number of baby boomers in their eighties likely to quadruple in the next 40 to 50 years, the case for expanded services must inevitably be put on the agenda.[79]

CALD communities and refugees

15.66   Australian society is culturally and linguistically diverse. One in three identify as having a culturally and linguistically diverse background; two and a half million were born in countries where English is not the primary language, and 15 per cent of the population speak a language other than English at home.[80]

15.67   During 2003-04 the Australian Government commenced consultation with multicultural organisations to produce the Framework for Implementation of the National Mental Health Plan 2003-08, which identifies priorities for action on multicultural mental health services. Multicultural Mental Health Australia took part in the process and expressed support for the plan but cautioned that the Framework must be progressed with commitment by the Federal Government according to a comprehensive implementation plan, with agreement by all governments, and must be supported by adequate resources and infrastructure in all jurisdictions.[81]

15.68   Submitters questioned whether this commitment would be forthcoming, given that the pressures on mainstream mental health services around the country are so great. The Forum of Australian Services for Survivors of Torture and Trauma (FASST) noted: 'In most states and territories mental health services are not appropriately resourced to provide continuity of care and culturally sensitive assessment interviews'.[82]

15.69   This section will assess the capacity of and identify the challenges to service providers to people with mental health problems from CALD backgrounds, including that subset of the most vulnerable: refugees and other humanitarian entrants.

CALD established communities

15.70   Information on the level of mental illness and service access in CALD communities is not freely available. This is partly because of underdevelopment of mechanisms of collect and collate information, and partly because available data is not

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79   Professor Henry Brodaty, *Committee Hansard*, 2 August 2006, p. 71.

80   21.9 per cent of Australians reporting in the 2001 Census as having been born overseas, and 13.3 per cent born in non-English speaking countries. See Victorian Transcultural Psychiatry Unit, *Submission 216*, p. 1, and Multicultural Mental Health Australia, *Submission 200*, p. 1.

81   Multicultural Mental Health Australia, *Submission 200*, pp.3, 10.

82   Forum of Australian Services for Survivors of Torture and Trauma (FASST), *Submission 397*, p. 4.

published.[83] The Victorian Transcultural Psychiatry Unit provides advice from known studies in a comprehensive coverage of significant CALD service issues, some of which are:

- there is great variation in prevalence of mental disorders across CALD communities, and higher rates of mental disorder in some, including several of the more established resident communities;

- CALD communities have greater difficulties in gaining access to specialist mental health services (both inpatient and community services) compared with the Australian-born;

- they have higher rates of involuntary admissions to inpatient facilities and evidence suggests that they may access services at a late stage when the clinical state is more severe;

- representation in community mental health services is lower than in inpatient facilities and representation in any form of mental health services is particularly low for those with lower English language facility;

- stigma associated with mental illness— both among CALD communities (consumers, carers and families) and health professionals— remains a major problem;

- competence in conducting clinical work across language and cultural barriers remains low among many mental health clinicians and workforce turnover;

- community development and partnerships strategies have been difficult to establish given the structure and funding priorities of mental health services; and

- consumer and carer participation in the development and delivery of mental health programmes continues to lag behind for CALD communities relative to the mainstream.[84]

15.71   These issues are discussed in relation to stigma and access to information, and provision of culturally appropriate services.

Stigma and access to information

15.72   For many non-English speaking communities, mental illness is a taboo subject.[85] Submissions reported that traditional prejudices and fears about mental illness endure among many Australian CALD communities, acting as a powerful

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83   Multicultural Mental Health Australia, *Submission 200*, p. 20, and FASST, *Submission 397*, p. 8.

84   Victorian Transcultural Psychiatry Unit, *Submission 216,* pp. 8–10.

85   National Network for Private Psychiatric Sector Consumers and their Carers, *Submission 189*, p. 15.

disincentive to self referral.[86] This is despite the significant psychological stresses experienced in those communities, which can be transgenerational.[87]

15.73   Jesuit Social Services, which runs the Vietnamese Welfare Resource Centre in Melbourne, for example, reported a high prevalence of significant anxiety and depression among people presenting for housing and other assistance.[88] Despite the level of need, program participants generally deny the existence of mental health problems. They may seek advice from family or GPs, but avoid professional help until the need becomes acute:

> …the stigma attached to mental illness within the Vietnamese community is so profound that the mere association with a mental health professional is believed to bring shame and disgrace on the self and the family—for example at one of the information sessions, the mental health worker asked to be introduced as a general health worker for fear being rejected by the group.[89]

15.74   A lack of knowledge about mental illnesses and about the potential to recover or manage disorders through early invention and other services supports the stigma associated with mental illness and supports the reluctance to access care:

> In many CALD communities the concept of recovery is rare or unknown. Mental illness is seen as a lifetime disease from which consumers do not recover. Their families and carers are also permanently affected by the stigma associated with mental illness. These community perceptions, beliefs and judgments about mental illness, based often on lack of information on mental health and wellbeing and the absence of effective promotion can reinforce social isolation and potentially override an individual's positive outlook about their recovery.[90]

15.75   An assessment of Victoria's CALD communities indicated that Hong Kong and Malaysian communities access mental health care at less than one quarter the rate than the Australian born.[91] One submission reported that that residents from the People's Republic of China access mental health services 75 per cent less than do the general population:

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86   Victorian Transcultural Psychiatry Unit, *Submission 216*, p. 9.

87   FASST, *Submission 397A*, p. 15.

88   Social isolation, lack of family support, intergenerational tensions and language difficulties are problems, particularly for the young, the aged and single mothers. Unemployment, low income, migration and acculturation problems, domestic violence, parental problems, gambling or drug addiction are other stressors within the Vietnamese community. The Ignatius Centre for Social Policy and Research, Jesuit Social Services, *Submission 358*, p. [13].

89   *Submission 358*, p. [13].

90   Multicultural Mental Health Australia, *Submission 200*, p. 16.

91   Victorian Transcultural Psychiatry Unit, *Submission 216*, p. 13.

They don't have basic knowledge of mental disorders and are not aware of existing mainstream mental health service and approaches (such as counselling and psychotherapy) to be able to combat with mental health problems. In P. R China, such services and related ideas on mental health do not exist. Thus, without well-planned and long term mental health awareness promotion, they will not use the services and they will continue suffering silently.[92]

15.76   Submitters urged the need for appropriate culturally based information campaigns to address this problem:

Whilst there may be some similar attitudes towards mental illness that cross cultural and linguistic groups, education programs are not effective unless there is an understanding of the attitudes and experiences of each community towards mental illness, the availability of treatments and services in other countries that may influence how a particular community views the issues. Education to de-stigmatise mental illness can only be effective when it is developed in collaboration with the community, the "correct" language is used to reach each community and genuine attempts are made to provide culturally and linguistically relevant information and support.[93]

15.77   The Victorian Transcultural Mental Health Centre model was criticised for inefficiencies in this respect:

Developing one single standardised model or promotion material and then translating them into different languages in a hope of one-meeting-all often miss out the crucial characteristics of the specific community. If considering there are many such mini projects going on at the same time and sum of money being spent, it is even no more cost-effective than a single, holistic, systematic and long term project rooted deeply in the specific culture community.[94]

15.78   Multicultural Mental Health Australia also urged support for CALD carers, who need training to better understand their role. An important aspect of this is the provision of accurately translated information on the rights and responsibilities of mental health consumers and carers. This and other information should be circulated to community leaders and through the ethnic media.[95]

15.79   There has been some recognition of the needs of carers in the area of mental health first aid course development. Professor Anthony Jorm and Ms Betty Kitchener, forerunners in course development advised:

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92   Mr David Han Yan, *Submission 473*, p. [1].

93   Australian Polish Community Services, *Submission 168*, p. 3.

94   *Submission 473,* p. [2].

95   Multicultural Mental Health Australia, *Submission 200*, pp. 14, 17.

The Mental Health First Aid program has core elements that translate across various cultural groups. However, there is always a need for some cultural modification. In Australia, we have developed the course to suit the mainstream of society, but we recognise this is not suitable for cultural minority groups. Versions of the course are currently being developed for Aboriginal Australians and have recently been developed for a number of groups with non-English speaking backgrounds, including Vietnamese, Croatian and Italian. Instructors have been trained from each of these communities.[96]

Provision of culturally appropriate services

15.80   To overcome the significant cultural resistance to admission of mental health problems by CALD consumers and they families, services to CALD groups must be culturally and linguistically accessible. Overall, mental health service provision to CALD communities was considered to be patchy at best. Multicultural Mental Health Australia contended that, nationwide:

- service availability 'lacks consistency in both range and quality';

- project based funding is undermining development of sustainable programs which can build partnerships with mainstream services, and

- the lack of adequate data collection on the quality of services prevents establishment of performance and accountability benchmarks.[97]

15.81   Short-term project grants to both government and non-government organisations are a much criticised feature of the mental health funding model. CALD support groups maintained that mainstream services, even when funded to progress nationally identified mental health programs, can try to offload their responsibilities onto resource poor CALD communities.[98] The experiences of the Australian Polish Community Services tend to support this view:

When we approached one agency specifically funded to respond to depression in the community, particularly prevention and early intervention, to determine the availability of information in community languages, we were informed that they don't provide materials in community languages but if we wanted to translate it for them, that's okay. Unfortunately, that's not okay. As an agency we are not funded to undertake translations for other services and agencies, and more importantly, our staff are not accredited translators. The implications of taking this approach displays a lack of professionalism on the part of the other agencies and a lack of understanding about the importance of accurately and appropriately

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96   Prof Anthony Jorm and Ms Betty Kitchener, *Submission 47*, p. 5.

97   Multicultural Mental Health Australia, *Submission 200*, pp. 9–10.

98   FASSTT, *Submission 397*, p. 5.

translated information to ensure the correct message is being passed along.[99]

15.82   Scarce funding can also be hijacked by issues with political significance, to the detriment of real community needs. Mr David Han Yan, a case worker to the Chinese community advised:

> …sudden availability of funding from Casino Benefit Fund in NSW has created a field of Chinese Gambling Counselling. My observation is that underlining the gambling problem, it is the great mental health problems in CALD community. Immigration stress, relationship problems, loneliness and isolation and other mental disorders all find their "legitimate" expressive form in gambling problems. Restricted by funding requirement while I was working in the gambling counselling field, I found difficult to go to tackle real, deep issues.[100]

15.83   The submission from the Victorian Transcultural Psychiatry Unit confirmed that while VicHealth made a large investment CALD mental health in 2001, the funding was for 'demonstration' projects and will not be incorporated in the mental health system.[101] This supports the view that funded CALD mental health projects tend to be 'innovative' and 'one off', rather than integral steps in the capacity buildings of mainstream mental health services to address CALD community needs.[102]

15.84   A lack of language trained practitioners and mental health professionals is a problem for culturally diverse communities, and for the aged in particular. Submitters suggested developing specific training programs in tertiary institutions to support transcultural mental health research, and to develop the capacity of the bilingual workforce. [103] Fostering the knowledge of GPs under the Better Outcomes initiative was another important way that early identification and continuous care could be initiated and maintained:

> Primary care needs to be culturally appropriate and to provide interventions of an enduring nature, where service providers are engaged as part of their everyday practice in cross cultural awareness, understanding stigma and dealing in an informed way with the needs of people from culturally and linguistically diverse backgrounds, their families and communities. All primary health care providers, including general practitioners need cross-cultural competency education, to develop increased capacity in early recognition and intervention, accurate diagnosis, referral and follow-up.[104]

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99   Australian Polish Community Services, *Submission 168*, p. 2.

100   Mr David Han Yan, *Submission 473,* p. [2].

101   Victorian Transcultural Psychiatry Unit, *Submission 216*, p. 9.

102   FASSTT, *Submission 397,* p. 9.

103   *Submission 473,* p. [2].

104   Multicultural Mental Health Australia, *Submission 200*, p. 11.

Refugees

15.85   Australia, like many other countries, has become a recipient in recent years of refugees who have experienced extremes of social and cultural dislocation.[105] As a subset of the CALD community, these 'humanitarian entrants' as termed by the Department of Immigration and Multicultural Affairs (DIMA) have significantly more complex needs. Discussion of these groups in the evidence included reference to 'temporary' entrants—Temporary Protection Visa Holders and Immigration detainees.

15.86   The *Report on the Review of Settlement Services for Migrants and Humanitarian Entrants* (released in May 2003) records that between 1 July and 31 December 2002, the largest groups of entrants were from Sudan (28.5 per cent), Iraq (27.0 per cent), Afghanistan (8.7 per cent) and Ethiopia (4.8 per cent). The report advised:

> Feedback from public consultations and submissions to the review has suggested that this shift towards Middle Eastern and Horn of Africa countries is resulting in a greater proportion of new arrivals with high level of poverty, larger families and lower levels of education and English proficiency. They are facing more complex barriers to settlement.[106]

15.87   The review reports that these people, in most cases, have significant mental and physical health issues related directly to torture or trauma associated with their refugee experience.[107] Studies have found that between 39 per cent and 100 per cent of these people suffer from post traumatic stress disorder (compared to 1 per cent of the general population) while 47 to 72 per cent suffer from depression.[108]   FASST provides the following breakdown the mental health effects of refugee experience:

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105   Eastern and Central Africa Communities of Victoria Inc, (EACACOV), *Submission* 394, p. 1.

106   *Report on the Review of Settlement Services for Migrants and Humanitarian Entrants,* May 2003, Chapter 8, p. 169; http://www.immi.gov.au/settle/settle_review/pdfs/chap08web.pdf (accessed February 2006).

107   The Victorian Foundation for Survivors of Torture found that 80 per cent of refugees assessed in 2003–04 had experienced psychological or physical violence of some kind; a study of refugees who settled in NSW found that 25 per cent had been subjected to severe trauma and torture. FASSTT, *Submission 397*, p. 2.

108   FASSTT, *Submission 397*, p. 1.

Table 15.1 Mental health effects of the refugee experience[109]

Mental health effects	Key issues
- depression - anxiety - grief - guilt - somatic disorders - attachment and relationship difficulties - a loss of a sense of hope, meaning and purpose to life - loss of identity and a diminished sense of belonging - internalised mistrust and post traumatic stress disorder symptoms - cultural adjustment suspicion and intergenerational issues	- mental health effects associated with exposure to traumatic experiences and other antecedents in the course of the refugee experience - may persist long after arrival in a safe country - can be exacerbated by stresses and lack of resources in the period of resettlement.

15.88   Over the last decade Australia has settled over 110 000 people under its Humanitarian program. The Government has recently increased this program to 13 000 places per year.[110] Of these, 6 000 places are allocated to refugees (a 50 per cent increase on previous years), and 7000 places are allocated to the Special Humanitarian Program and onshore protection. About 75 per cent of the offshore places are planned to come from Africa and about 20 per cent from the Middle East and South West Asia.[111] Yet despite the predictable and growing need, submissions reported significant under-resourcing is preventing development of sustainable programs to support these complex cases.

Capacity building of refugee services

15.89   Humanitarian entrants to Australia are processed under DIMA's Integrated Humanitarian Settlement Strategy (IHSS). The IHSS is designed to provide intensive initial settlement support to newly-arrived humanitarian entrants. The aim of the IHSS is to ensure that all of these entrants have access to the information, personal tools, services and basic material requirements they need to rebuild their lives in Australia. The IHSS works with the Early Health Assessment and Intervention (EHAI), Community Support for Refugees and other support services to provide this initial

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109   FASST, *Submission 397A*, p. 6.

110   *Submission 397A*, p. 2.

111   *Submission 397A*, p. 4.

assistance.[112]   Services are provided to refugees, defined as 'people who have experienced persecution in their countries', and Temporary Protection Visa Holders, who are entitled to limited services, including EHAI and torture and trauma entitlements, during the life of the visa. [113]

15.90   The Forum of Australian Services for Survivors of Torture and Trauma (FASSTT) agencies are the principal contractors to the DIMA to provide EHAI services. These services are in part funded through the Department of Health and Ageing's Program of Assistance to Survivors of Torture and Trauma (PASTT). FASSTT reports significant pressure on services as PASST funding levels have been frozen for ten years, with only CPI increases. This is not commensurate with the increased level of need:[114]

> The level of funding forces FASSTT agencies into a reactive rather than proactive position. For example, we recognise the need to develop, in addition to conventional one-to-one interventions, a range of community based interventions in response to the needs of certain client groups (for example African clients). However some FASSTT agencies are struggling to maintain existing services levels, making it difficult to work in a developmental way. Instead, resources that ideally would be spent on training and sector development particularly in regional and rural areas get diverted into acute response— particularly, in some states, with respect to the needs of clients holding Temporary Protection and Bridging visas.[115]

15.91   Other service providers working with recent African arrivals, the projected source of most future refugees, confirmed that the capacity of mainstream and community mental health services to assist this high needs group is extremely limited. Eastern and Central Africa Communities of Victoria (EACACOV) advised:

> It is our experience as African, social and community support workers in the field that when we have clients who display psychotic disorders symptoms/behaviour or suffering from psychological disorders; mental disorder/illness, on a number of times we have contacted many mental health services providers and we have found that there are no strategies for prevention or early intervention.…Mainstream service providers lack awareness about pre and post migration experiences, such as: torture and trauma, vast differences in cultural, religious and gender issues between

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112   *Report on the Review of Settlement Services for Migrants and Humanitarian Entrants,* May 2003, Chapter 8, pp. 163; 167, www.immi.gov.au/settle/settle_review/pdfs/chap08web.pdf, (accessed February 2006).

113   The TPV provides three years' temporary residence in Australia for unauthorised arrivals who are subsequently found to be refugees. See *Report on the Review of Settlement Services for Migrants and Humanitarian Entrants,* May 2003, pp. 167–8.

114   FASSTT, *Submission 397*, pp. 1, 3–4.

115   *Submission 397,* p.4.

countries of origin and Australia and their impact on family relationships and mental well-being.[116]

15.92   FASSTT argued that mainstream services ugently need resources to build the responsiveness necessary to treat this category of patient, whose diagnosis is complicated by post traumatic stress disorders and cultural and communication barriers:

> In all States and Territories there is now a significant proportion of the population who have particular needs as a result of trauma impacts from their refugee or refugee-like experience. All mental health service providers whether in the acute or community sector need to be more aware of the needs of refugee survivors of torture and trauma. For example, practices such as the use of restraints, placing distressed individuals in isolation and forcibly administering medication replicate torture and other experiences that have led to trauma. This greatly increases the level of an individual's distress and potential retraumatisation. Working with such survivors requires specialist skills to recognise their specific needs. Failure to recognise these needs compounds the failures of the mainstream mental health system to deliver coordinated continuity of care.[117]

15.93   Particular concerns were expressed about the lack of early prevention services to refugee children, now the largest entrant group.[118] FASST notes that preventative measures have been found effective in dealing with the trauma and dislocation experienced by these children have experienced,[119] however the emphasis on parental and family assistance means these measures are not systematically employed.[120] A case study shows how, with the service gap in place, identification of even the most plangent needs can be serendipitous:

> A teacher noticed a 15 year old girl in the classroom who was withdrawn and had scarring on her hand which she was trying to hide. The teacher contacted the FASSTT service in her state who arranged through the school to seek permission to speak with her parents. Her parents had in fact been killed and she was living with her relatives who had recently arrived. The young girl was assessed as depressed and suffering severe post traumatic stress disorder symptoms. She had witnessed her mother's face blown off in a sniper attack and suffered burn injuries. She formed a close relationship with the Early Intervention counsellor-advocate, with whom she was able to share her grief. He was able to find a suitable school work-experience placement for her, something she had been dreading and he facilitated a

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116   Eastern and Central Africa Communities of Victoria Inc, (EACACOV), *Submission 394*, p. 2.

117   FASSTT, *Submission 397*, p. 4.

118   The proportion of children and young people in the Humanitarian program has increased from 38 per cent in the year 2000 to 53 per cent in 2004. This increase has been particularly significant in the 0–9 age group. See *Submission 397A*, pp. 8–9.

119   *Submission 397A*, p.11.

120   *Submission 397A*, pp. 10, 15.

referral to a plastic surgeon. These interventions led to an immediate improvement in active participation at school. Her guardians were offered support which they felt they did not need but they supported the assistance being provided to their niece.[121]

15.94   Concerns were expressed that DIMA's policy of dispersing humanitarian entrants into regional areas will make delivery of approriate servces to children and young people more difficult to achieve.[122] The children of TPV holders are at particular risk, given the limited access this group have to health and other services and the degree of anxiety, and perception of prejudice, they experience as a result of their temporary status.[123] To address this, FASSTT recommmended that the IHSS should build the capacity of the education system in regional and rural areas to provide a supportive environment to refugee students, working closely with new arrivals programs.[124]

15.95   The Department's policy of regional placement, for both humanitarian entrants and TPV holders, is directed by client choice and access to appropriate services. Service capacity exists in number of regional centres.[125] However submissions warned that the present level of need is not being met. Hume City Council reported that a large proportion of new entrants to Hume City require counselling and support services, and should be receiving long-term assistance:

> There is a need to develop specialist mental health services for culturally diverse communities, and for these services to be located in communities, such as Hume City, where new arrivals are settled by DIMIA. The culturally specific mental health services should be developed in partnership between all levels of government, Migrant Resource Centres and other organisations, including the Foundation for Survivors of Torture. Any government assistance for new arrivals to access mental health services needs to recognise the lifetime impacts of trauma and torture, and not be time limited to the initial period of settlement.[126]

15.96   Like other CALD groups, lack of knowledge and understanding about mental illness and of available services, in combination with fear and stigma, supports the

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121   *Submission* 397, p. 9.

122   *Submission 379A*, p. 15.

123   *Submission 379A*, p. 11–12.

124   *Submission 379A*, p. 19.

125   IHSS services are currently available in regional areas such as the Coffs Harbour, Wagga Wagga and Newcastle areas of New South Wales; Geelong in Victoria; Townsville, Cairns, Toowoomba and the Logan, Beenleigh and Gold Coast region in Queensland; and in the Northern Region of Tasmania. Unlinked refugees can be and are sent to these areas. see . Report on the Review of Settlement Services for Migrants and Humanitarian Entrants, May 2003, Chapter 8, p. 177, http://www.immi.gov.au/settle/settle_review/pdfs/chap08web.pdf (accessed February 2006).

126   Hume City Council, *Submission 298*, p. 7.

tendency of refugees to avoid assistance until crisis point.[127] EACACOV reported that African refugees in acute states commonly present at emergency departments in the care of police. On release many end up extremely disoriented, homeless, and may be taken to immigration detention centres:

> In January 2005, one of our clients with a mental disorder was locked up in Villa Wood Detention centre Sydney, because he had no identification or travel documents with him, he had not been taking his medication, he was confused and he had lost all his documents, plus his mobile phone. He was released from the detention centre and admitted to Banksia Mental Health Hospital/Psychiatrist Unit when an inmate from Sudan contacted EACACOV's workers on the client's behalf. The staff faxed a copy of his travel document which was on his client file to the case worker/officer.[128]

15.97   A number of proposals were made to address the threat to CALD people with mental illness under the government's detention policy. EACACOV took a holistic view, stressing the importance of the capacity building of community based services to reduce the possibility of such circumstances. These services should provide culturally appropriate assistance and advice, reflecting traditional customs, to address the extreme social dislocation experienced by these people, and to reduce the incidence and severity of mental health problems. It was also suggested that DIMA should advertise any detainment of individuals taken from community, and in particular, utilise the knowledge of CALD community groups and ethno-specific organisations to identify individuals.

15.98   The Mental Health Foundation ACT thought a nationwide missing persons system an imperative as there are many situation in which individuals wander from state to state and cannot be found by loved ones and fall through the cracks in the system or end up in inappropriate situation such as happened to Cornelia Rau.[129]

Mental health of detainees

15.99   In the wake of the Palmer report and the sequential revelation of harms and inefficiency in its detention centres, a number of submissions questioned the wisdom of continuing with the Government's detention policy. Suicide Prevention Australia (SPA) was among the many who saw that the custodial nature of a detention centre is counterintuitive to delivery of appropriate mental health care:

> Mental illness is neglected in immigration detention for a number of reasons. The framework for managing detainees treats them as law-breakers whose behaviour must be deterred. Such a deterrent approach treats suffering and psychological harm to detainees as acceptable 'collateral damage'. Former Minister Philip Ruddock asserted that depression among detainees is not a mental illness, and that self-harm is manipulation (rather

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127   EACACOV, *Submission 394*, p. 2.

128   *Submission 394*, p. 2.

129   The Mental Health Foundation ACT, *Submission 112*, p. 6.

than a reflection of despair). He frequently referred to asylum seeker self-harm 'inappropriate behaviours' and 'moral blackmail', and suggested actions such as lip-sewing stemmed from their cultures and were repugnant to Australians. IDCs [Immigration Detention Centres] are therefore custodial and punitive, rather than being treatment- based. They resemble prisons in that they hold people under maximum security, use solitary confinement, employ prison staff etc, but differ from them in that the inmates are indefinitely detained.[130]

15.100 Submitters called on government to recognise that the policy of detention is conducive to mental illness, referring to conclusive findings:

In ten asylum-seeker families held for protracted periods in a remote IDC, all adults and children met diagnostic criteria for at least one current psychiatric disorder with disorders identified among 14 adults, and 52 disorders among 20 children. Persistent suicidal ideation was reported by all but one adult, and over half the children; five adults and five children had engaged in self-harm or attempted suicide. Retrospective comparisons indicated that adults displayed a threefold and children a tenfold increase in psychiatric disorder subsequent to detention. Exposure to trauma within detention was commonplace. All adults and the majority of children were regularly distressed by sudden and upsetting memories about detention, intrusive images of events that had occurred, and feelings of sadness and hopelessness. The majority of parents felt they were no longer able to care for, support, or control their children.[131]

15.101 Various suggestions were made about how the situation should be addressed. The Mental Health Foundation ACT recommended the government should 'change its 'hardline' attitude to refugees held in detention' which it considered informs 'an uncaring culture' in the IDCs. It suggested that the centres should be located in less isolated locations so that detainees can readily access specialist services when required and that Detention centre staff be given training or refreshment courses on duty of care.[132]

15.102 The Victorian Transcultural Psychiatry maintained that detainees, being at high risk of mental illness, should become an identified group for preventative assistance under the National Mental Health Plan. It recommended in particular that DIMA develop an approach for treatment of detainees with dual diagnosis, and that tensions between detention and other service providers be resolved by developing interagency agreements.[133] The SPA argued that a judicial inquiry into the detention process should be held, referring to sustained international criticism of the human rights affront represented by the policy:

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130   Suicide Prevention Australia, *Submission 425*, pp. 24–25.

131   *Submission 425*, pp. 24–25.

132   Mental Health Foundation ACT, *Submission 112*, p. 6.

133   Victorian Transcultural Psychiatry Unit, *Submission 216*, pp. 6–7.

Australia remains the only industrialised country in western civilisation that continues to routinely impose mandatory detention on those who seek refugee protection. Those who arrive on our shores without a valid visa, including unaccompanied children, are detained in facilities in remote areas for several months, even years. Such practices have been condemned by the international community as breaching human rights standards with the ill treatment of refugees in Australia being clearly documented by the United Nations Human Rights Commission and the Human Rights and Equal Opportunity Commission (HREOC). Such international instruments demand that each person is afforded the highest attainable standard of physical and mental health available. To date, every independent inquiry into the immigration detention centres of Australia have highlighted the poor mental health of detainees with particular emphasis on the risks to children's wellbeing.[134]

15.103 The Senate Legal and Constitutional References Committee, recently reiterated that view, concluding:

…the prolonged and indeterminate immigration detention is inherently harmful to psychological well being and its abolition should be a priority.[135]

15.104 The recent court decision awarding compensatory payment to the family of 11 year old Iranian child Shayan Badraie sets a precedent which may prompt the Government to further review its detention policy. During the proceedings, former DIMA (then DIMIA) officials, reversed the official view, and acknowledged the connection between detention and mental illness[136] also confirming the system is not functioning as intended.[137]

15.105 DIMIA facilitated a visit of the Senate Select Committee to Baxter Immigration Detention Facility on Wednesday, 28 September 2005. The Baxter facility is in remote South Australia, and while controlled by DIMIA it is run by a private service provider. The facility is built to house up to 660 detainees,[138] but at the

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134   SAVE, *Submission 483*, p. 2.

135   'Tender for New Client Focused Detention Service Arrangements', *On the Move to Improve DIMA's Progress on Palmer, Fact Sheet:*
http://www.immi.gov.au/department/dima_improvements/index.htm, (accessed 1 March 2006).

136   Former head of border control, Philippa Godwin, for example, contradicted the department's previously held position by acknowledging that conditions at Woomera had led to mental illness experienced by Shayan. Dan Box, 'Boy, 11, Wins Payout Over Detention Trauma', The *Australian*, 3 March 2006, p. 3.

137   Mr Alan Clifton, former operations manager, confirmed that Woomera's private detention centre operator, Australian Correctional Management, had not honoured requirements and falsified reports to the government that it was providing education to children and leisure and well being courses to adults as required. Rebecca Gilsenan, 'In Denial over Living Hell', The *Australian*, 7 March 2006, p. 12.

138   DIMA, Immigration detention, Baxter Immigration Detention Facility (BIDF) - Port Augusta (SA), http://www.immi.gov.au/detention/facilities_baxter.htm (accessed March 2006).

time of the visit there were around 125, all adults. The visit included briefings from the DIMIA manager of the facility, and from a representative of service provider Global Solutions Limited (GSL). The Committee toured the facility, and held a round table discussion with some of the detainees.

15.106 In the wake of the problems revealed by the erroneous detention of Cornelia Rau, the Federal Government began implementing changes in immigration detention. The Committee saw some of the first changes already underway during its visit to Baxter, such as modifications to the living environment and the way the movement of detainees within the facility is regulated. GSL stated that their new environmental change program was intended to reflect a community rather than an institutional approach to detention. Procedural changes at Baxter since the Palmer Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau delivered its findings included:

- a 'revamp' of operational procedures;

- mental health screening;

- changes to seclusion times;

- a different approach to mental health services; and

- all GSL officers attended a one day training course run by the mental health team within Baxter.

15.107 A discussion (facilitated by an interpreter) was held with three immigration detainees who volunteered to talk to the committee following a letter from DIMA. The length of stay of the three detainees varied between 4 months and 3 years. There was a sense of isolation and depression amongst the detainees with whom the committee met:

> It is quite obvious we are like a bird in a cage. We would be better happier outside. Of course we would be happier waiting for a visa outside. Here we can only see the sky and the ground - we would be free outside.

15.108 Discussions with medical staff at Baxter indicated that there were difficulties in providing services. Baxter was deliberately established to be remote, and that very remoteness has made it hard to recruit health professionals, challenging to retain them, and adds to the logistic challenges involved in securing effective treatment in cases of serious mental illness. Despite these difficulties, medical staff did say that they were able to communicate successfully with most detainees and overcome barriers to building effective relationships with them.

15.109 Responding to a contemporaneous review of its detention services, DIMA moved quickly to implement a package of reforms. One aspect will be the national implementation of an improved mental health care program being trialled at Baxter Detention Centre, under the auspices of an MOU signed with the South Australian Department of Health. DIMA will also re-tender all detention services, and will award

separate health and psychological services contracts, to be managed by the department.[139]

15.110 These developments answer requests for official acknowledgment of the mental health implications of the Government's detention policy, and show the department's responsiveness in that direction[140]. They do not however address the strongly expressed concerns to this inquiry about the long-term mental health consequences of the detention process, or the damage done to Australia's reputation as friendly nation proud of its cultural diversity.

15.111 The shift to community based accommodation progressed by DIMA for those with identified special needs,[141] and for women and children is a positive development; the Government may wish to review its position on detention in the interests of ensuring unauthorised entrants with mental illness are treated 'humanly, decently and fairly', as intended.[142]

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139 'Stronger Focus on Mental Health', and 'Tender for New Client Focussed Detention Service Arrangements' *On the Move to Improve DIMA's Progress on Palmer, Fact Sheet,* www.immi.gov.au/department/dima_improvements/index.htm (accessed 1 March 2006)

140 Suicide Prevention Australia, *Submission 425*, p. 26

141 Australian Government *Submission 476*, Part 10, p. 59.

142 Australian Government *Submission 476*, Part 10, p. 61.

CHAPTER 16

SERVICES FOR RURAL, REMOTE AND INDIGENOUS AUSTRALIANS

Introduction

16.1   People with mental illness in rural and remote communities, including many of Australia's Indigenous people, often are living in communities which offer high levels of social support. However, they also face great challenges in accessing effective health care. This was touched on in Chapter 6, which highlighted the low numbers of mental health professionals in rural and remote Australia, and this chapter looks at some of the issues in more depth.

16.2   In rural and regional areas stigma can be as socially isolating as the experience of mental illness itself, as this case study shows:

> …wife on farm with depressed and angry husband, combination of alcohol and isolation fuels deteriorating capacity for communication or appropriate decision making—husband will not ring anyone, husband will not go to visit anyone, "they are all useless anyway and what would they know"— wife doesn't go out because she's scared to leave him alone, and she's embarrassed by his drinking when out.[1]

16.3   The tyranny of distance on remote farms and stations, means being attended in a crisis by rural police officers, with very expansive geographical and policing responsibilities, and poor knowledge of mental disorders.[2] It can also mean long waits for the flying doctor service, and being sedated, or going out into the paddock with a gun.

16.4   For Indigenous Australians it can entail being taken far away from your country among strangers to an alienating clinical environment or, if you are lucky, connecting with an Indigenous health worker who can mediate your cultural and clinical needs with sensitivity. This chapter will assess the service requirements for Indigenous Australians in particular, after first surveying the situation of people with mental illness in rural and remote locations generally.

Rural and remote services

16.5   The challenges faced by people with mental illness in rural and remote areas are well known; they are a subset of those negotiated by all country people to obtain timely and appropriate health assistance at distance from hospitals and other specialist

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1   NSW Farmers Association, *Submission 410*, p. 4.

2   Health Consumers of Rural and Remote Australia (HCRRA), *Submission 106*, p. [3].

services. In a situation where health services generally, and mental health services in particular, are under extreme pressure to meet urban population needs, the capacity of state governments to fund specialist services to people with mental health problems outside the cities is much diminished:

> Rural and remote areas remain under-serviced. Even rural specific services are generally run from the larger regional centres and service provision declines as distance from the centre increases. While some of this is going to be difficult to overcome—population based funding will always focus on putting workers where there are more people to see—outreach services need to be specifically funded to reach more isolated populations.[3]

16.6   The difficulty of attracting medical and health professionals to rural areas remains a perennial problem:

> There is also poorer access to mental health support in rural and remote areas. It remains difficult to attract and retain health workers in rural / remote areas, and mental health workers are no exception. Doctor and psychiatrist to population ratios are low, and there are fewer charity services to offer support. Members of the [NSW Farmers] Association have suggested that rural mental health support, from prevention through to crises care, is "virtually non-existent".[4]

16.7   Living in connection with the land can be stressful. Rural organisations reported that the hardships for country people after long years of drought compound those arising from the restructuring of the economy and other social changes.[5] Farmers end up in debt and rural support industries are squeezed. The cumulative effect of this 'financial drought' will last a decade or more, putting some rural families under unsustainable pressure to keep afloat.[6]

16.8   While the closeness of rural communities and their networks of support can assist some who are 'not coping', stigma against mental illness, underpinned by strong cultural pressures to show independence and resilience in the face of adversity, means that many of those affected will suffer silently.[7] For those with low prevalence disorders such as schizophrenia or bipolar disorders, which generally onset during the teens to early adulthood, mental illness in rural communities can be particularly dispiriting:

> In a big city it is easy to hide if you want to. In the country it is impossible. It is impossible to go the local doctor without the whole town knowing, so some patients are even more reluctant to seek treatment. Parents feel

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3   SA Division of General Practice, *Submission 88*, p. 9.

4   New South Wales Farmers Association, *Submission 410*, p. 3.

5   HCRRA, *Submission 106*, p. [5].

6   Mr Alan Brown, Board Member and Chair, Rural Affairs Committee, NSW
     Farmers Association, *Committee Hansard*, 2 August 2005, pp. 15–16.

7   National Rural Health Alliance Inc (NRHA), *Submission 181*, p. 3.

> isolated as well, and become unable to have social relationships. I understand from speaking to people in Long Reach that their chances of finding accommodation or care near there home is very slight.[8]

16.9   The very public consequences of untreated depression and anxiety in country areas were widely recorded in the evidence: unemployment, family breakdown, domestic violence, mysterious accidental deaths by car or gunshot, homelessness, increases in substance abuse, showdowns with police and imprisonment.[9]

16.10   The prevalence of these factors may support speculation that the incidence of mental illness in rural communities is higher than in urban ones.[10] The relationship between unrelieved stress, lack of knowledge about mental illness, and limited service options are widely acknowledged catalyst to the high incidence of suicide among rural males (effectively double that of the rest of the population)[11], although this has not been empirically verified.[12] The National Rural Health Alliance (NRHA) referred to research indicating that it is the lower use of services rather than the prevalence of mental disorder which contributes to high suicide rates in rural and regional Australia.[13] This suggests that service access, not the incidence of mental illness, is the key issue for country people.

16.11   The isolation of remote communities exacerbates service delivery problems and decreases the likelihood that problems such as depression will be diagnosed. A factor contributing to poor health outcomes for rural and remote Australia is the higher proportion of Indigenous people living there. While Indigenous people suffer the same problems as other Australians in rural and isolated areas, namely reduced access to timely and continuous specialised services, the invidiousness of their situation is exacerbated by additional historical and cultural factors.[14] Indigenous Australians in cities also have discrete service access problems.[15] For these reasons, Indigenous service issues are covered in detail in the next section dedicated to them.

16.12   The two outstanding issues for urgent attention addressed in this section apply to rural and remote communities generally, and are:

- stigma and lack of information; and

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8   National Council of Women of Australia Inc Ltd, *Submission 435*, p. 5.

9   NSW Farmers Association, *Submission 410*, p. 3; NRHA, *Submission 181,* p. 10.

10   Health Consumers of Rural and Remote Australia, *Submission 106*, p. 5.

11   NSW Farmers Association, *Submission 410*, p. 4.

12   NRHA, *Submission 181*, p. 9.

13   Professor Brian Hickie, 'Reducing the Burden of Depression: Are We Making Progress in Australia?', *Medical Journal of Australia*, 181 (7), 4 October 2004, pp. S4, 5. Quoted in NRHA, *Submission 181*, note ix, p. 9.

14   NRHA, *Submission 181*, p. 10.

15   See discussion of the findings of the Western Australian Aboriginal Child Health Survey (WAACHS), below.

- poor service access, with a particular focus on GP, carer and community support services.

Getting it out in the open: stigma in rural communities

16.13   Stigma against mental illness, and lack of willingness to talk about it was identified as a major obstacle to early intervention, treatment and preventative approaches for people with mental illness and their families in rural communities. In absence of adequate services to seek people out, a lack of willingness to seek treatment means no treatment is received.[16] For men and particularly young men, being 'tougher than John Wayne'[17] reaps the outcomes above; for women having to be 'the strong one' under conditions of adversity can mean having 'a lot of responsibility and no control', with serious psychological consequences.[18]

16.14   The National Rural Health Alliance conjectured that the effects of stigma have broad implications, setting up a vicious circle between under identification and under servicing of rural mental health need:

> There is a long history of shame and stigma being associated with mental illness, partly due to people not understanding its nature, causes and effects. There are lower general levels of education in rural and remote areas, suggesting that these problems might be worse there than in major cities. Shame, stigma and associated ignorance may contribute to the relatively low level of resources devoted to mental health in Australia, and to the low level of priority that mental health care seems to attract, including in rural and remote areas.
>
> These attitudinal factors contribute to a reluctance to seek help. Consequently it is important to implement innovative ways to reach out to people under stress or facing early stages of mental illness. Barriers to seeking help are complex and may include issues of confidentiality and trust in a small community. Also there may be little expectation of help, leading to a tendency not to seek it.[19]

16.15   In recognition of these problems, the beyondblue depression initiative has made rural stigma a target:

> One of our great challenges, particularly with men and with people in rural Australia, is to have them talk about their illness and seek help and treatment in order to return to as healthy a condition as possible. We are championing the cause to have this illness recognised as any other illness.

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16   HCRRA, *Submission 106*, p.[1].

17   Mr Jeff Kennett, Chairman, beyondblue, *Committee Hansard*, 5 July 2005, p. 9.

18   Dr Simone Fulgar*, Submission 235*, Women's Recovery from Depression Research Project 2004-05, Attachment 1, p. 1.

19   NRHA, *Submission 181*, p. 26.

> Whether it be AIDS, breast cancer or a broken arm, an illness is an illness and it is not a crime to be sick.[20]

16.16   Rural and regional organisations considered that campaigns like beyondblue's have positive results in the bush.[21] Submissions advised that leadership by a well-known figure like beyondblue Chairman Jeff Kennett had attracted unprecedented media attention to the issue at the drought summit, held in Parkes in May 2005. It had also made 'depression' acceptable talk:

> —It was good to have Jeff Kennett there and to be talking so openly about depression—the fact that it was a figurehead and someone people recognised and that it was okay to talk. When you go to follow-up meetings, not even on drought, it is interesting to hear people say, 'Did you see Jeff Kennett?' They are actually talking by accident about depression. The media gave it a great run, and they gave a great run to the fact that we did not just have a session talking to politicians about what we needed from drought; we had a session called 'bugger the drought'—about how we actually manage the human side of things. The fact that the media picked it up and ran with it was, I thought, historic, really.[22]

16.17   The drought summit itself was an important mechanism to get rural mental health on the agenda, having both a cathartic and therapeutic effect:

> Grown men stood up in an audience of 2,000 farmers with tears streaming down their face and talked about how close the end can seem, how desperate farming can be and how bad they felt that this one drought summit, which was about getting a political result, was the only reason they had left the farm in three months.[23]

16.18   The personal story has great power to dispel prejudice and increase understanding of mental illnesses in rural situations. The committee heard from a number of individuals who had dedicated themselves to reducing stigma in rural communities, using their own experience to bring things out into the open, and to build empathy and understanding. One approach is through public speaking. Mr Noel Trevaskis, a Regional Manager Agricultural company and Rotary District Governor, reported:

> Just over twenty years ago I suffered from severe depression and spent over 5 months in hospital as a result. I found the hardest thing for me to do was

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20   Mr Jeff Kennett, Chairman, beyondblue, *Committee Hansard*, 5 July 2005, p. 1.

21   NSW Farmers Association, *Submission 410*, p. 5; HCRRA, *Submission 106*, p. [4].

22   Mr Alan Brown, Board Member and Chair, Rural Affairs Committee, NSW Farmers Association, *Committee Hansard*, 2 August 2005, p. 20.

23   Ms Brianna Casey, Senior Policy Manager, Rural Affairs, NSW Farmers Association, *Committee Hansard*, 2 August 2005, p. 19.

to go back to a small rural area to live with my wife and three small children because of the stigma that is attached to mental illness.[24]

16.19   During the last six years Mr Trevaskis has spoken of his experiences in a voluntary capacity to over 15 000 people at over 180 public forums, seminars and conferences across Australia for organisations such as the DPP and NSW Bar Association, NSW Farmers, Landcare, farmer drought meetings, Vincent Fairfax Foundation, Women in Agriculture, NSW Agriculture, Rotary Clubs, Community Mental Health Awareness Forums, Area Health Services, Road Transport Association and many others.[25]

16.20   Publishing your story is another method. HCRRA reports how a young woman with bipolar disorder decided to 'normalise' her illness after moving to a new town by raising awareness in rural Australia:

> She wrote an article for a newsletter of a prominent women's agricultural organisation. As a result many local people who also suffer from mental illness or who have family members similarly afflicted, have approached her. She reports the benefits of this 'outing' as enormous as a support network has developed.[26]

16.21   The need for broader information campaigns targeted at youth and the aged were noted in particular.[27] Rotary clubs, with government sponsorship and the assistance of the Australian Rotary Health Research Fund and beyondblue, has the capacity to launch more far reaching education campaigns.[28] But the funding of larger campaigns is beyond most rural organisations, despite the good ideas and rich personal experience to be drawn on in rural communities. The NSW Farmer's Association advised that its work on depression, for example, could not be expanded to a 'whole of mental health campaign' without funding assistance.[29]

16.22   The care support depression group blueVoices saw education initiatives as integral to capacity building of rural health services generally, and particularly to community and outreach services.

16.23   Of particular concern to us is the funding in rural Australia where services at best are mediocre, and in a number of instances they are non-existent. Funding should be made available not just for institutional-based services but a significant portion of

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24   Mr Noel Trevaskis, *Submission 523,* p. 1.

25   Mr Noel Trevaskis*, Submission 523*, p.1.

26   HCRRA, *Submission 106*, p. [3]

27   Australian Rotary Health Research Fund, *Submission 68*, p. 2.

28   Rotary's rural van has travelled the outback and convened over 350 rural fora focussing on depression and mental illness since 2000, Australian Rotary Health Research Fund, *Submission 68*, p. 1.

29   Ms Brianna Casey, Senior Policy Manager, Rural Affairs, NSW Farmers Association, *Committee Hansard*, 2 August 2005, p. 19.

funding should be allocated to the funding of community services, outreach services and educational programs within local communities. Groups such as Lifeline for example should be funded significantly to address the mental health activities which they perform.[30]

16.24   Carer organisations could play an important role but capacity is largely determined by available funding:

> ARAFMI Hunter offer workshops on stigma, educational materials on mental illness, group programs on family sensitive practices for mental health professionals and they distribute information on mental illness throughout local shopping centres and at community functions. However due to a lack of funding ARAFMI Hunter can only educate on a small scale and this means that they cannot greatly impact upon negative attitudes about mental illness as much as they would like to.[31]

16.25   New technologies are a very promising means of increasing knowledge about mental illness in rural communities, proving immediate access to the web-based information such as that on the beyondblue website[32] and the Reach Out! youth website developed by the Inspire Foundation.[33] The potential of the internet to widely disseminate information in rural and remote communities is entirely dependent however on connection availability and speed of access, something quite uncertain in many rural communities.[34] The use of technology as a clinical tool is discussed below.

Comprehensive country wide services

16.26   As already mentioned, comprehensive data on the true levels of unmet need for mental health services in rural communities is not available; there is little epidemiological data to inform local priorities for mental health interventions, and there are no benchmarks to determine what constitutes the best mix of services.[35] However anecdotal evidence, supported by hard statistics relating to the high incidence of suicide, of accidental gun and vehicle deaths, and the social breakdown in small communities across Australia, suggests there is 'something seriously wrong' in the bush[36] and that a holistic response is required.

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30   blueVoices, *Submission 259*, p.20.

31   ARAFMI [Association of Relatives and Friends of the Mentally Ill] Hunter, *Submission 231*, pp. 5–6.

32   blueVoices, *Submission 259,* pp. 20-21.

33   The Inspire Foundation, *Submission 491*, p. 4.

34   HCRRA, *Submission 106*, p. [1].

35   See discussion of the population health model below.

36   Mr Jeff Kennett, Chairman, beyondblue, *Committee Hansard*, 5 July 2005, p. 11.

Service gaps and pressures

16.27   Rural and remote communities reported chronic shortages of services and health professionals to staff them. They asserted that the obstacles to comprehensive management and continuous care are obvious once you step outside of any regional centre: medical health practitioners find themselves working long hours isolated in small communities with high levels of need; psychiatrists are in short supply; nurses are underprepared for growing problems such as dual diagnosis; and community support services to help people of all ages keep healthy are underdeveloped compared with other areas. Pressure and isolation encourage high staff turnover, militating against continuity in care.[37]

16.28   This results in a situation where services gaps affecting more well supported communities open out dangerously, as the Burdekin Report noted:

> The irony is that in many of the areas where the need is greatest the services are fewest. This is particularly the point in small country communities where mental health services—and certainly mental health services for children and adolescents—are almost entirely non-existent.[38]

16.29   The West Australian Child and Adolescent Mental Health Services Advisory Committee (CAMHSAC) provided insight into the implications for children and youth in rural and remote communities and their families in WA:

> Models for the funding of adequate rural and remote services should be based on a population weighted formula as rural and remote area services frequently perceive that little consideration is given to the needs of rural and remote services for young people. Tertiary "state-wide" services are not really accessible to rural and remote families as the programs only cater for people who live in metropolitan WA or who can readily access the statewide facilities which are metropolitan Perth based and are run on a Monday to Friday basis. There is little or no suitable accommodation provided for rural family members to be near their children who have been admitted to inpatient facilities. That inpatient beds in the state wide inpatient facilities (PMH and Bentley hospital) are limited (3 authorised beds at Bentley) resulting in young people being admitted to adult facilities. Recent funding for more authorised beds only went to the adult sector. CAMHSAC would like to see appropriate "youth friendly" beds made available for the 13-25 year olds.[39]

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37   Rural training and staffing issues are discussed in more detail in Chapter 6.

38   Quoted in Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA), *Submission 83*, p. 20.

39   The West Australian Child and Adolescent Mental Health Services Advisory Committee, (CAMHSAC), *Submission 24*, p. 2.

16.30   The shortage of locally-based psychiatrists and psychologists in rural and remote areas considerably increases the burden. Only 7.5 per cent of all psychiatrists, for example, are based in rural and remote areas, while 90 per cent of those practising in non-metropolitan areas are located in major regional centres.[40] Consumers and Carers from the NSW Far South reported:

> There is a severe shortage of all mental health professionals but we particularly feel the shortage of psychiatrists in our area. At present our sector (including Bega Valley and Eurobodalla Shires which stretch for more than 250 kms in 6 major centres along the coast and includes about 70 000 people) has funding for 38 hours per week of visiting psychiatrists' time (including aged, child and adolescent and adult), however 4 to 5 hours of this time is taken in travel. There is no substitute for a psychiatrist living in the area and we believe more could be done to attract psychiatrists to rural areas. It is essential that funding and appropriate incentives be provided for a psychiatrist to reside in the area.[41]

16.31   Lack of appropriate crisis and acute care services in communities, and of private hospital services, puts unsustainable pressures on rural public hospitals ill-prepared to meet demand:

> There is no crisis service after 10 pm in our area, and people are forced to utilize the emergency departments at local hospitals without adequate expertise or training for the nurses who deal with these problems. We have an emergency department Clinical Nurse Consultant however he must cover 7 hospitals over Monaro, Bega Valley and Eurobodalla shires. The shortage of acute care hospital beds in the Southern Area causes many problems. The only resource for this purpose is at Chisolm Ross Centre at Goulburn, which is up to 7 hours travel by road for patients and carers, and contains only 15 beds available to people from the old Southern Area. On a per capita basis we should have 45 acute care beds to cater for this population according to present policy.[42]

16.32   On the same theme, NSW Farmers Association advised:

> Wagga base hospital has around 20 mental health beds available for a catchment of 180,000 people. If you have that part of the state and draw in 180,000 people, it is a massive area. Most of those areas do not have access to mental health facilities within a reasonable distance.[43]

16.33   These hospitals offer the only possibility for respite care. This poses particular problems as the care is rarely remedial and is particularly unsuccessful for Indigenous people.[44] The inadequate spread of community-based support services more generally

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40   HCRRA, *Submission 106*, p. 5.

41   Consumers and Carers from the NSW Far South Coast, *Submission 5,* p. 2.

42   Consumers and Carers from the NSW Far South Coast, *Submission 5,* p. 1.

43   *Committee Hansard*, 2 August 2005, p. 13.

44   HCRRA, *Submission 106*, p. [2].

puts immense pressure on families unlucky enough to live in or near towns without any support systems:

> In our rural town…There is simply no accommodation service and the rehabilitation service comprised only irregular visits by a case worker.
>
> This is why we have had to relocate our son (after his second psychosis) to another town so we could get him admitted to a program which does offer rehabilitation and accommodation services. And despite assurances from our local Community Health and the Area Health Service, our experience was that our son could not get an admission to this other service unless he had an address in this other town. So we had to tear around and find him a flat to live in this other town to facilitate this admission. He lived here for a number of months while still acutely unwell, until he was deemed to be "a local", was assessed and then he had to wait for a place at the accommodation facility to become available.[45]

16.34   Community 'drop in' centres or other social support networks reduce the burden of stigma and make people feel more positive and less isolated, but are not available in rural areas.[46] The lack of services to treat the growing number of people with dual diagnosis in rural areas[47] is compounded by a total absence of support services common in the city:

> I live thirty minutes away form Albury/Wodonga and find travelling major cost…and time to get the support and help I need to maintain some sort of normality in my life…I wish that a group could be set up for people like me…I am amazed to find many other people suffering from mental illness and substance abuse.[48]

16.35   The general practitioner is usually the first person to diagnosis a mental illness in a rural setting.[49] However rural and remote communities can struggle to find and retain sufficient GPs for their local population. The committee met doctors and community members in Port Hedland. Members were struck by their dedication, but also by the heavy workload that came from having fewer doctors in the practices there than were needed.

16.36   Despite the promise of the Better Outcomes initiative, rural and remote GPs are rarely able to get away to do the prerequisite training to participate. SA Divisions of General Practices advised:

> The more remote Divisions report considerable difficulty accessing the required training for their GPs to participate in the BOiMHC [Better Outcomes] scheme, and difficulty attracting appropriately qualified and

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45   Name withheld, *Submission 244*, p. 4.

46   Brotherhood of St Laurence, *Submission 97*, p. 3.

47   HCRRA, *Submission 106,* p. [2].

48   Albury Wodonga Anxiety and Depression Support Group, *Submission 151*, p. 13.

49   NSW Farmers Association, *Submission* 410, p. 6.

experienced personnel. Training of GPs to do counselling themselves (Level 2 under BOiMHC) is likewise difficult as it requires the GP to do 20 hours of training – not available in the country thereby necessitating the GP to leave their practice unattended for a number of days. With the lack of available locum coverage to backfill, and rural doctors required to provide after-hours emergency care, this may leave entire towns and regions without any medical care.[50]

16.37   Consequent to the lack of specialist support, attendant work pressures and problems of distance GPs tend to follow a medical model of treatment for conditions such as depression. Submitters identified a number of problems with this approach. Changes in medication can have unpredictable outcomes, such as unforseen medical or psychological affects.[51] The availability of guns at home can increase the risk of suicide or violence.[52] Referral to a mental health caseworker brings other attendant risks given the long waiting lists.[53]

16.38   In remote locations this combination of factors can be even more risky. There may be access to a GP or specialist on a fly-in fly-out basis but follow up by case workers and social workers and maintenance programs are not usually accessible.[54] Further, the transport and treatment of individuals in acute states can be complicated by different mental health regulations, for example, in the Northern Territory:

> People suffering psychotic episodes in a remote area, are required to be sedated to be evacuated by air. To travel by aircraft, these people require sedation. From the time they are sedated, travel to a health facility and recover from their sedation, the period of time a person can be kept against their will has expired. This means a seriously ill person can leave a health care facility without having received any treatment for their mental condition.[55]

16.39   Even if relocation of people for treatment is feasible, it can also be disruptive, and work against recovery. At Port Hedland the committee heard how specialist treatment could involve relocation thousands of kilometres to Perth. Such distances make it difficult for any family to maintain contact and support; for Indigenous families and consumers it can be particularly traumatic. Service provision in places like the Pilbara/ Kimberley region can also bring jurisdictional issues into focus. It would frequently make more social and economic sense for consumers to get specialised care in Darwin rather than Perth, but crossing jurisdictional boundaries can make this difficult or impossible.

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50   SA Divisions of General Practices, *Submission 88*, p. 9.

51   HCRRA, *Submission 106*, p. [3].

52   Mr Alan Brown, Board Member and Chair, Rural Affairs Committee, NSW Farmers Association, *Committee Hansard*, 2 August 2005, pp. 16–17.

53   NSW Farmers Association, *Submission 410*, p. 4.

54   HCRRA, *Submission 106*, p. [3].

55   HCRRA, *Submission* 106, p. [4].

16.40   In rural and remote absence of adequate follow-up and maintenance programs increases the likelihood of relapse. Carers may be isolated with very unstable family members and have to travel long distances to gain treatment and support. A focus on developing more adequate relapse prevention and respite support for people in rural areas is necessary, and may include ensuring that carers are aware of available pension support and travel assistance allowances.[56] Information and training for police, who attend and manage crisis situations without specialist advice across vast geographical areas is also essential.[57] Mandatory mental health first aid training or programs such as Living Works which have a 'train the trainer' aspect were recommended to dispel misunderstandings and enhance skills among rural police, ambulance drivers and crisis carers.[58]

Technology—clinical services and counselling

16.41   Technological developments including teleconferencing and video conferencing were cited as having significant potential to improve services to rural and remote communities. Telepsychiatry is one of the newer technologies which is being used to deliver better mental health care services to rural and remote communities:[59]

> In rural and remote mental health services a programs approach has been adopted with the CAMHs program being run within a generic mental health service usually managed by adult mental health team leaders/mangers/psychiatrists with only CAMHS specialists available by video conference only. This is likely to result in a broad range in the capacity of services to provide specialist CAMHS clinical services particularly in rural and remote areas.[60]

16.42   Ms Jenine Bailey, an Indigenous researcher who provides mental health counselling through the correctional centre at Townsville, reported the usefulness of teleconferencing to establish continuing treatment plans and to make important personal introductions to released Indigenous people to health workers back in their home country:

> I did teleconferences to introduce the people. I actually referred them to services or workers to meet them once they got there, to basically start that. Before that, you would discuss and co-case what I had done with the person within the facility and, once they were released, in the community. You put the strategies in place before they get out. You have a fair idea of their

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56   HCRRA, *Submission* 106, p. [4].

57   HCRRA, Submission 106, p. [3].

58   Consumers and Carers from the NSW Far South, *Submission 5*, p. 5; HCRRA, *Submission 106*, p. [3], and see Professor Anthony Jorm and Ms Betty Kitchener, *Submission 47*.

59   blueVoices, *Submission 259*, pp. 20–21.

60   CAMHSAC, *Submission 24*, p. 2.

release date, so you make sure that things are in place so the person is not left out in the cold and lost and therefore may get up to mischief again.[61]

16.43   Access to training and referral advice for health professionals in remote and regional Australia is one important benefit provided by internet access. The Northern Territory Government reported that its on-line mental health program site is a training reference and resource tool to clinicians.[62] The development of cognitive behavioural therapy sites, as a subset of e-mental health and information services discussed above, also has great potential for rural and remote consumers. BlueVoices commented:

> There are a number of cognitive behaviour therapy programs online to assist people, and whilst these should not be seen as being able to take the place of direct service intervention in rural or remote communities, they can offer a service where none currently exists. Web-based services can also be used to offer education and we cite the beyondblue website as well as our virtual network as examples of how technology can be used to increase education and support for persons in rural and remote communities as well as urban communities.[63]

16.44   While the relative benefits of on-line services and other counselling approaches have not yet been evaluated, there are positive cost and service efficiencies:

> Since 1997, Australia has been leading the world in the delivery of e-mental health services; however, no consistent investment has been made by Government in these emerging technologies, and little research has been done into the comparative benefits of web-based service delivery over phone-based and face-to-face service delivery. The research that has been undertaken indicates that web-based services that provide mental health information and support can significantly improve mental health outcomes. New developments in technology mean that cognitive behavioural therapies can be adapted into an online environment and be delivered without a counsellor, while still providing the same mental health outcomes at a fraction of the cost.[64]

16.45   The clear success of online services like that provided by depressioNet, which runs a peer-based 24 hour online information, counselling and chatroom facility for

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61   Ms Jenine Bailey, Indigenous Researcher, Rural Health Research Unit, James Cook University, *Committee Hansard,* 5 August 2005, pp. 38-39.

62   Northern Territory Government, *Submission 393,* p. 36.

63   blueVoices, *Submission 259,* pp. 20-21.

64   The Inspire Foundation reports that a recent review of telecounselling found that the average cost of delivering counselling to one person via a phone service ranged from $19.87 to $58.89. By contrast, during the 12 months to the end of June 2005, the cost of one person accessing the Reach Out! website, which provides mental health information and may provide comparable benefits, was $1.12. See Inspire Foundation, *Submission 491*, pp. 4–6.

depression sufferers,[65] demonstrates the need for these types of services, and argues for more reliable and efficient online capacity in country areas.[66]

16.46   The Inspire Foundation's Reach Out! for example, fills a niche for rural youth, not covered by the telephone counselling service Kids Help Line, which assists the under 18 years, or Lifeline, which receives only 10 per cent of calls from the 14 to 18 age group. Inspire reports that, in the financial year ending 2005, there were 760 000 individual visits to Reach Out! The service currently attracts 75 000 plus individual visits each month.[67]

16.47   At the same time, online services must complement not replace an early human response in a crisis. This advocates for increased mental health and crisis support services in the bush, including support for telephone counselling services like the Kids Help Line which focuses on 8 to 18 year olds in rural and regional Australia, on the premise that these kids are at greater risk of mental illness than those living in cities.[68]

A 'population health' response

16.48   A piecemeal approach to mental health reform will not, it was argued, be sufficient to address the considerable obstacles imposed by distance and culture in rural and remote communities. Instead, a holistic model of service is required. In this regard, rural stakeholders expressed disappointment that the National Mental Health Plan 2003-2008 has failed to acknowledge the specific needs of rural, regional and remote communities. Moreover, as the National Rural Health Alliance (NRHA) noted, two of the Plan's most relevant priorities—'increasing service responsiveness' and 'strengthening [service] quality'—remain distant goals for most rural communities, given chronic service and staff shortages.[69]

16.49   Drawing on the template of its *Healthy Horizons Outlook 2003-07* policy document, the NRHA proposed that the Government immediately implement a 'population health' approach to rural and remote menta health.[70] This holistic model aims to breakdown intersectoral service barriers and build partnerships between social, community and health services. Based on the Department of Health and Ageing's *National Action Plan for Promotion and Prevention and Early Intervention*

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65   depressioNet, *Submission 475,* p.1 reports that depressioNet.com.au was the most visited Australian health website within four months from conception with no promotion or advertising.

66   HCRRA, *Submission 106*, p. [1].

67   Inspire Foundation, *Submission 491*, p. 4.

68   The program trains rural and remote young people to respond to calls from their peers, Boystown, *Submission 107*, p. 10.

69   NRHA, *Submission 181*, p. 11.

70   National Rural Health Alliance and National Rural Health Policy Forum, 'Healthy Horizons', 1999 and update sub-committee 2002.

for Mental Health, the model has an early intervention emphasis, but assesses problems across seven priority age groups. This program of attack necessarily relies on sustained and judicially allocated funding to achieve 'appropriate treatment and continuing care services, and [a] comprehensive approach to prevention'.[71]

16.50   Project-based funding was heavily criticised by rural commentators as being particularly onerous for overburdened rural health professionals. The HCRRA noted that staff burnout is a serious issue in the country because of the hours, large caseload and geographical area to be covered. 'Application burnout' becomes endemic as these overworked rural staff struggle to retain project-based grants'.[72] Non health trained staff who play an important role as mental health lightening rods in rural communities, also fall prey to the problem. One important player during the drought years has been the Rural Financial Counsellor, as the NSW Farmers Association advised:

> The Rural Financial Counsellors…are often the first to receive a farmer in despair. Whilst these counsellors provide financial assistance, they are skilled in identifying farmers with emotional need and referring them on. The services these counsellors provide are absolutely essential for the wellbeing of farmers, particularly during times of hardship such as drought, something their long waitlists attest to. Unfortunately the Rural Financial Counsellors continue to face uncertainty in their positions as they must regularly reapply for funding through an arduous administration process.[73]

16.51   The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) and others that argued that the many proven 'innovative' approaches to service delivery and training in rural and remote areas now deserve Government's commitment.[74] To achieve this result, and support the revitalisation of rural communities, the NRHA advocated that funding to support continuous care should be based on the population health calculation, under which rural communities at 30 per cent of the population, should receive proportionate health budget increases. Moreover this funding should be recurrent and subject to monitoring and reporting requirements. This should be achieved as part of an increase in overall health funding to 12 per cent of national expenditure.[75]

Indigenous Australians

16.52   During this inquiry, health outcomes for Indigenous Australians were described as 'completely inadequate'.[76] The National Rural Health Alliance stated:

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71   NRHA, *Submission 181*, pp. 13–14.

72   HCRRA, *Submission 106*, p. [3].

73   NSW Farmers Association, *Submission 181,* pp. 6–7.

74   AICAFMHA, *Submission 83*, p. 20.

75   NRHA, *Submission 181*, p. 17.

76   AMA, *Submission 167*, p. 1.

The appalling health of Aboriginal Peoples and Torres Strait Islanders is a major contributor to the overall poorer health of people living in rural and remote communities.

This group must be given priority in improving mental health outcomes.[77]

16.53   The Royal Australian and New Zealand Congress of Psychiatrists (RANZCP)[78] and the Royal Australian College of General Practitioners (RACGP) have both issued clear position statements on Indigenous health. The RACGP submission stated:

The RACGP has a clear position statement on Aboriginal and Torres Strait Islander health that recognises improving the health of Aboriginal and Torres Strait Islander people is one of Australia's highest health priorities.[79]

16.54   Data set out in evidence before the committee establishes the uncontrovertible truth that Indigenous Australians have neither the life expectancy, the emotional or psychological security, nor level of material comfort other Australians enjoy:

- the perinatal mortality rate for babies born to Indigenous women is twice as high as that for babies born to non-Indigenous women;[80]

- Indigenous Australians have at birth a life expectancy of twenty years less than other Australians;[81]

- Indigenous people have much higher rates of premature death due to external causes, 16 per cent of all deaths compared with 6 per cent for other Australians. Death due to deliberate self harm was 33 per cent for men and 15 per cent for women;[82]

- Indigenous people have a significantly higher risk of experiencing major life stressors than other Australians, which affects their mental health and general wellbeing. Indigenous children are at higher risk of clinically significant emotional or behavioural difficulties; at 24 per cent

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77   NRHA, *Submission 181*, p. 23.

78   The Royal Australian and New Zealand Congress of Psychiatrists (RANZCP), Position statement 2002.

79   Royal Australian College of General Practitioners (RACGP), *Submission 311*, p. 6.

80   Australian Government, *Submission 476*, Attachment 24, p. 1.

81   Australian Government, *Submission 476*, Attachment 24, p. 1.

82   Australian Bureau of Statistics for 1998–2001, quoted in Association for Australian Rural Nurses, *Submission 321*, p. 12.

compared with an equivalent figure of 15 per cent in the general population;[83]

- Indigenous people are twice as likely to die of alcohol attributable diseases, despite the fact that alcohol intake is equivalent to that of the general population;[84]

- Indigenous youth self-harm and suicide rates are much higher compared with other Australian youth. Of Indigenous youth 12 to 24 years, 31.1 per cent per 100 000 intentionally self harmed, compared with 6.4 per cent in a 100 000 of other Australian youth.[85] More than one in six, 16 per cent, of Indigenous 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.[86]

- Indigenous Australians have higher rates of unemployment, poorer educational outcomes and lower rates of home ownership;[87] and

- at June 2002, Indigenous people were 11 times more likely than non-Indigenous people to be in gaol.[88]

16.55   The marginalisation of people with mental illness is therefore compounded in the lived experiences of Indigenous peoples, making them potentially, as the United Nations recently suggested, the most disadvantaged community in the world today.[89]

Policy responses

16.56   With these circumstances unimproved after many years of various policy approaches, the Government has recognised that overturning poor Indigenous health outcomes requires attention to the full spectrum of Indigenous life experience. This

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83   Western Australian Aboriginal Child Health Survey (WAACHS)—The Social and Emotional Wellbeing of Aboriginal Children and Young People found that 20 per cent of Indigenous children had experienced seven or more of life stresses during the previous 12 months, compared with 0.2 per cent of non indigenous children. Life stresses assessed included family death, hospitalisation, a family member being imprisoned and loss of employment. 'Aboriginal Health'—*Health Report ABC*, 7 November 2005, p. 5, and see Auseinet, *Submission 441*, p. 12.

84   One contributing factor is that 20 per cent of Indigenous drinkers consume at higher risk levels compared with 10 per cent of other drinkers. Department of Psychiatric Medicine Children's Hospital Westmead and Tamworth (CAMHS), *Submission 99*, p. 6.

85   Department of Psychiatric medicine Children's Hospital Westmead and Tamworth (CAMHS), *Submission 99*, p. 1.

86   WAACHS, Australian Government, *Submission 476*, pp. 53–56.

87   Australian Institute of Health, 2004, quoted in Auseinet, *Submission 441*, p. 12.

88   Office of Aboriginal and Torres Strait Islander Health (OATSIH), Australian Government *Submission 476*, Attachment 24, pp. 7–8.

89   Ms Leanne Knowles, Manager, Social Health Unit, Wuchopperen Health Service, *Committee Hansard*, 5 August 2005, p. 42.

was first acknowledged in The National Aboriginal Health Strategy (1989), which defines Indigenous health as:

> Not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.[90]

16.57   The Office of Aboriginal and Torres Strait Islander Health (OATSIH) reports further advances on this holistic agenda, with the development of the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Social and Emotional Wellbeing and Mental Health 2004–2009 (the SEWB Framework). OATSIH advised:

> The SEWB Framework aims to broadly address the social and emotional wellbeing and mental health needs of Aboriginal and Torres Strait Islander people. The document acknowledges that a range of government policies and practices has impacted on the social and emotional wellbeing of all Aboriginal and Torres Strait Islander peoples, including the 'terra nullius' policy, protection and assimilation policies, as well as the removal of children from their families. The document aims to provide a framework for action by all governments and communities to improve Social and Emotional Wellbeing in Aboriginal and Torres Strait Islander communities over the next five years.[91]

16.58   However, despite being due for release in March 2005, OATSIH reports that arrangements are just now being made for the publication and dissemination of the Framework.[92] The tendency to delay the rollout and implementation of important components of Indigenous mental health policy—which have been agreed to and supported by Aboriginal people—was strongly criticised in submissions.[93] The Aboriginal Health and Medical Research Council of New South Wales stated:

> The National Aboriginal Health Strategy (1989) is the foundation national document for policy, resource allocation and service delivery to Aboriginal people in health and health related matters and it has to be noted that many of the recommendations defined in that document are yet to be implemented. The Ways Forward and Bringing Them Home Reports documented and validated issues that Aboriginal people have been

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90   National Aboriginal Health Strategy Working Party, A National Aboriginal Health Strategy, 1989, quoted in the Aboriginal Health and Medical Research Council of New South Wales, *Submission 406,* p. 3.

91   The framework was agreed to out of session by the Australia Health Ministers Advisory Council in 2004. See OATSIH, Australian Government *Submission 476*, Attachment 24, p. 7.

92   The Human Rights and Equal Opportunity Commission, *Submission 368*, Attachment 1, p. [7] for release date and OATSIH, Australian Government *Submission 476*, Attachment 24, p. 7.

93   The National Aboriginal Health Strategy- An Evaluation, Evaluation Committee, December, 1994 stated that the NAHS was 'never effectively implemented' and that 'governments have grossly under-funded NAHS initiatives in remote and rural areas.'. Quoted in the Human Rights and Equal Opportunity Commission, *Submission 368*, Attachment 1, p. [3].

constantly raising, and the needs and strategies addressed in these reports continue to be relevant.[94]

16.59   The consequence, as National Rural Health Alliance observed, is that Indigenous health needs remain largely unaddressed:

> The National Aboriginal Mental Health Policy and Plan, published in 1995, canvasses extensively issues relating to mental health for this vulnerable group and included strategies and goals. Despite this the mental health of Australia's Indigenous Peoples remains poor.[95]

16.60   With the policy framework further refined to better acknowledge the extent of damage inflicted by the history of colonisation and the past policies of family separation and assimilation, submitters exhorted the committee to urge adherence to key policy commitments made in the framework, principally that services be:

- Culturally appropriate—responsive to the diversity of Indigenous peoples and their beliefs, and delivered by trained Indigenous health workers of the appropriate sex; and

- Community-controlled health services—funded and operated by communities.

Culturally appropriate services

16.61   Indigenous people with mental illness experience extremes of social and psychological divorcement. Alienated from their families and country of origin, and hence from their identity, many are out of touch with traditional networks of help. This has important implications for the nature of services to be provided:

> Primary prevention requires a greater focus on the social determinates of mental illness amongst Aboriginal people. This includes the need to recognise and address the historical trauma created by the experience of colonisation and dispossession as well as the specific trauma of the Stolen Generations. It has been suggested that the extent of this trauma is such that many Aboriginal people are suffering from symptoms suggestive of Post Traumatic Stress Disorder. This has been more extensively described for Aboriginal people in Canada but is almost certainly true in Australia as well.[96]

16.62   As indicated here, research on the extent of this damage and on the most effective means of addressing Indigenous mental health needs is underdeveloped in

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94   Aboriginal Health and Medical Research Council of New South Wales, *Submission 406,* p. 3.

95   NRHA, *Submission* 181, p. 23.

96   The Central Aboriginal Congress, *Submission 486*, p. 5.

Australia.[97] For example, diagnostic tools for assessment of mental illness among indigenous are underdeveloped.[98] The Human Rights and Equal Opportunity Commission noted that while the Western Australian Aboriginal Child Health Survey (WAACHS), quoted above and below, provides a watershed: 'A first step in any address to Indigenous mental health is to address the paucity of data collections in this area'.[99]

16.63   Notwithstanding this, the major contention in the evidence was that the situation has not improved because the long espoused commitment to deliver culturally appropriate services has not received full government support.[100] In this regard, Indigenous researcher Ms Jenine Bailey, a Jagara woman from Brisbane now resident in Townsville, told the committee that the key message to mainstream health providers is: 'You are not listening to me; Aboriginal mental health is different'.[101] She explained:

> As an Aboriginal mental health worker, I have experienced first-hand the frustrations related to access and/or deliver of culturally appropriate mental health services to the community, when continually confronted by obstacles, gaps or lack of capacity in service delivery that hinder my work practice. These obstacles include lack of funding and/or inappropriate recognition for Aboriginal mental health, inadequate support from mainstream mental health workers and services, the stigmas associated with Aboriginal mental health, misunderstanding that Aboriginal mental health and the concept of health is different to western concepts of health and therefore there are different needs, and no recognition for cultural mental health differences between different Aboriginal communities.[102]

16.64   One myth exploded by the WAACHS findings was that living in rural and remote communities confers poorer health outcomes on Indigenous people. Submissions referred to WAACHS data indicating that the environmental safety and health (ESH) of Indigenous children actually improved with isolation, that is, in

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97   The NHMRC noted in 2002, mental health research on Aboriginal and Torres Strait islanders features in only 1 per cent of mental health research publications and attracts only two per cent of mental health research funding, despite the high and growing incidence of mental health problems and associated negative social outcomes. See OATSIH, Australian Government *Submission 476*, Attachment 24, p. 3.

98   See for example, Victorian Institute of Forensic Mental Health*, Submission 306,* pp.8–9.

99   The Human Rights and Equal Opportunity Commission, *Submission 368*, Attachment 1, p. [9]; Catholic Health Australia , *Submission 276* p. 13.

100   Combined Community Legal Centres Group NSW, *Submission 232*, p. 14.

101   Ms Jenine Bailey, Indigenous Researcher, Rural Health Research Unit, James Cook University, *Committee Hansard,* 5 August 2005, p. 31.

102   Ms Jenine Bailey, Indigenous Researcher, Rural Health Research Unit, James Cook University, *Committee Hansard,* 5 August 2005, p. 32.

remote communities. Children living in Perth had significantly poorer (five times worse) ESH than those living in very remote communities.[103]

16.65   While Indigenous people are the largest group as a proportion of remote and rural populations and experience problems consequent to that isolation.[104] The important realisation arising from these findings is that culturally appropriate assistance to urban Indigenous people is urgently needed.[105] It was suggested that urban-based services must recognise the psychological effects of cultural dislocation, such as through the stolen generations policy,[106] and still be responsive to the different Indigenous cultural expectations, linking back to the particular beliefs of the client's country of origin:

> There are those complexities in our culture. It depends where that person is from. The same applies to a woman speaking with a male psychiatrist; she would not feel right. There were times when I had the whole extended family, including an aunty, an uncle and cousins, because they take it all on. It is not just a one on one with the psychiatrist, it is a very big family group, and they will have a family meeting about it. It is just that understanding that it is just not one person going through the mental illness; it actually involves the family, and therefore it ripples out into the community. It just depends on the person who walks through the door. You must be aware of that. Torres Strait Islanders are different from Aboriginals, and it depends where the community is from. Just because they are an Aboriginal does not mean that way of treating and therapy, or applying strategies for care or whatever, will work for them as it does for somebody in Alice Springs, for instance.[107]

16.66   Because the Indigenous concept of health is quite different to European understandings, the cultural nuances of diagnosis are complex.[108] Self harming can be part of ritual observances for mourning, or an expression of depression or other grief;[109] hearing voices can be seen as communication with ancestors, a men's business matter. Trained Indigenous workers of the right sex with appropriate cultural

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103   See The Human Rights and Equal Opportunity Commission, *Submission 368*, Attachment 1, p. [10].

104   See NRHA, *Submission 181,* p. 10, and as discussed below and in the previous section on Rural and Remote.

105   See 'Aboriginal Health'—*Health Report ABC*, 7 November 2005, p. 6.

106   It has been suggested that in remote settings, traditional family connections have remained comparatively intact, with fewer individuals had been subject, or exposed thorough family connections, to forcible removal policies See 'Aboriginal Health'—*Health Report ABC*, 7 November 2005, p. 6.

107   Ms Jenine Bailey, Indigenous Researcher, Rural Health Research Unit, James Cook University, *Committee Hansard,* 5 August 2005, pp. 34–35.

108   Dr Roger Crib, *Submission 261*, pp. 3–5.

109   *Submission 261*, p. 5.

knowledge are essential to assess, interpret and assist. Mainstream psychiatrists in urban settings have little capacity to do this.[110] At the same time shortages of psychiatrist in rural settings ensure that access to these services is even more limited for remote Indigenous communities.[111] The Central Australian Congress provided its template for more responsive care:

> There needs to be greater attention given to the language and cross cultural barriers that arise when psychiatrists are employed who have English as a second language…there is also a need to address the shortage in mental health nurses working in remote areas. Acute care facilities need to have access to interpreters and Aboriginal liaison officers who can ensure that there is good communication between inpatients and there families. There also needs to be close liaison with the primary health care sector and many patients should have pre-discharge care plans developed with their primary health care provider to ensure that follow up is collaboratively planned. Congress has re-developed the job description of our mental health worker position to make this the prime focus of his job and we hope this will lead to better coordination of care and follow up of our patients who are in and out of ward.[112]

16.67   Indigenous health workers carry much of the load in building bridges in communities, although this in currently not recognised. Service providers argued that the key to improving Indigenous health outcomes relies on handing over control for design and delivery of these services to those who know best:

> …we need to recognise the clinical and cultural capacity of Indigenous mental health workers within [the] mainstream to direct and guide service delivery for Indigenous users.[113]

16.68   Mr Jonathan Link is of Australian Aboriginal and Maori descent[114] with health program qualifications. He is a Community Liaison and Development Officer with the Royal Flying Doctor Service, working in remote areas of the northern Cape

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110   Ms Jenine Bailey, Indigenous Researcher, Rural Health Research Unit, James Cook University, *Committee Hansard,* 5 August 2005, p. 35.

111   For shortages in rural and remote areas see HCRRA, *Submission 106*, p. 5.

112   The Central Aboriginal Congress, *Submission 486*, p. 7.

113   Ms Leanne Knowles, Manager, Social Health Unit, WuChopperen Health Service, *Committee Hansard*, 5 August 2006, p.

114   Descendent of the Kuku Uulangi tribe, between Mosman and Cooktown (on his father and grandmothers side), and the Ngapuhi Te Autu of Aukland NZ (from his grandmother on his mother's side). Mr Jonathan Link, Community Liaison and development Officer, Royal Flying Doctor Service, *Committee Hansard*, 5 August 2006, p. 47.

York where services are spread thin.[115] His experience resonates the important role of Indigenous health workers in bridge building in these communities:

> I have been travelling to these communities for two years now and through meeting people in their homes, at the clinic, whatever the organisation, we try to express that individuals need to take control of their community, especially in their homes. For example, if I was going to your place, you would not expect me to come and invade your home. It is the same principle of us coming into a community and trying to tell them how to be. My role is to give them an opportunity to see that there is support. You are not going to always have the answer within communities, especially around raising awareness issues. Mental health is a stigma in Indigenous communities, so my role is to just be a person who will listen. That is a very important factor there. The communities tend to be reactive rather than proactive; if there is an issue there they tend to act on it straight away without actually coming together as a group. Listening to them, showing that you are transparent and not promising things that you cannot deliver are important. I believe I have made inroads there. [116]

16.69   Mr Link considers that lack of services and employment are major catalysts to mental illness in Indigenous communities, particularity among men and boys.[117] He advocated a two-pronged approach: development of social and cultural infrastructure; and attention to the training and working conditions of local Indigenous health workers:

> I would like to see cultural schools. I would like to see drop-in centres for youth, elders and people in the middle age groups. I would like to see traditional healers and elders having a bit more input into the way people feel. There is a big gap in the way our people interact with each other. Also I would like to see more money for health workers and a health worker exchange program. When nurses have holidays, there is always a replacement, but there is nothing there for Indigenous health workers. If you could implement and fund that particular initiative, that would be great.[118]

16.70   The depression initiative, *beyondblue* endorsed the view that social mentoring activities have potential to address mental health issues in Indigenous communities.

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115   He flies fortnightly services to four Indigenous communities, taking a medical officer on a weekly run, a psychiatrist on three monthly visits, and delivers a psychologist who services eleven communities in total. See *Committee Hansard*, 5 August 2006, pp. 47–48.

116   Mr Jonathan Link, Community Liaison and Development Officer, Royal Flying Doctor Service, *Committee Hansard*, 5 August 2006, pp. 48.

117   Mr Jonathan Link, Community Liaison and Development Officer, Royal Flying Doctor Service, *Committee Hansard*, 5 August 2006, pp. 53–56.

118   Mr Jonathan Link, Community Liaison and Development Officer, Royal Flying Doctor Service, *Committee Hansard*, 5 August 2006, p. 51.

Mr Kennett referred to the copycat suicides of a dozen young Aboriginal men Swan Hill in Victoria as an indicator of urgent unmet need:[119]

> …the Aboriginal community does respond very well to peer influences and particularly to footballers. Most Aboriginal communities are involved in football. We are actually looking at the moment at incorporating one or two of these people, properly trained—and there are a number who have suffered depression but who are very good communicators—to try to lift self-respect amongst some of the communities. The important thing is not to go in and conduct a program and then leave them. We have to have a method of going back every three months, six months and 12 months. That is fairly costly, but it has to be done. You cannot just go in once and think that you have educated someone. [120]

16.71   Submissions confirmed that the difficulty of obtaining and retaining skilled locally-based Indigenous health workers, particularly male workers, in all areas is a major obstacle to delivery of continuous culturally appropriate mental health care.[121] Studies show that Indigenous people are discouraged by hierarchal and 'silo' structures in the medical health industry and have a lack confidence in negotiating the education process,[122] leading to low rates of retention in both instances.[123]

16.72   Indigenous only education venues have proven successful in providing the type of collaborative culturally affirming learning environments essential to achieve positive outcomes for Indigenous people.[124] Mr Link achieved his qualifications at the Bachelor Institute Indigenous College which he suggested should have support.[125] Ms Leanne Knowles, Manager, Social Health Unit, WuChopperen Health Service proposed the introduction of scholarships for Indigenous health professionals, and incorporation of Indigenous Health curriculum in mainstream courses would assist.[126]

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119   Mr Jeff Kennett, Chairman, beyondblue, *Committee Hansard*, 5 July 2005, p.11.

120   Mr Jeff Kennett, Chairman, beyondblue, *Committee Hansard*, 5 July 2005, p. 10

121   Mr Jonathan Link, Community Liaison and development Officer, Royal Flying Doctor Service, *Committee Hansard*, 5 August 2006, p. 49, and see for example, Consumers and Carers from the NSW Far South Coast , p. 3.

122   See discussion of 'Seasonal Worker Syndrome' in Tom Brideson and Len Kanowski, 'The Struggle for Systemic' adulthood' for Aboriginal Mental Health in the Mainstream: the Djirruwang Aboriginal and Torres Strait Islander Mental Health Program' in Jane Havleka, Charles Sturt University, *Submission 438*.

123   *No Shame Job, Careers in Health*, Department of Education, Science and Training, 2002.

124   *Indigenous Vocational Education and Training: at a Glance*, National Centre for Vocational Education Research, Novermber 2005, www.ncver.edu.au/publications/1630.html (accessed 16 March 2006).

125   Mr Jonathan Link, Community Liaison and development Officer, Royal Flying Doctor Service, *Committee Hansard*, 5 August 2006, p. 52.

126   Ms Leanne Knowles, Manager, Social Health Unit, WuChopperen Health Service, *Committee Hansard,* 5 August 2005, p. 41.

16.73   A ray of hope in both respects is the Djirruwang Program at Charles Sturt University which offers a Bachelor of Health Science (Mental Health) Degree to Aboriginal and Torres Strait Islander people. The Program adheres to the *National Practice Standards for the Mental Health Workforce 2002*, to ensure graduates are imbued with the skills and ethical values of the profession while maintaining 'a deep sense of cultural integrity'.[127] The submission recommended the Djirruwang *Program Clinical Handbook and Course Competencies* be adopted as the standard for national accreditation in Indigenous mental health practice to promote culturally supportive practices in the mainstream health system.[128]

16.74   The inadequacy of available treatment for people with dual diagnosis is a matter of national concern addressed elsewhere in the report. The lack of specialised services to assist Indigenous communities to deal with co-occurring disorders was raised in submissions as a cause for shame. The Probation and Community Corrections Officers' Association Incorporated (PACCOA) advised:

> A PACCOA member recently reported that there is a significant problem in Aboriginal communities concerning the issue of both mental illness and "undiagnosed" mental illness due to inadequate resources in these communities. These are often people being treated for addictions, and fall under the dual diagnosis umbrella. Often these communities do not have basic drug and alcohol services. At one Probation and Parole District Office, there are over 30 offenders with significant drug and alcohol issues, but no counsellor. Even though every effort is made to fill the gap by bringing in the services from outside the communities, wherever possible, the responsibility falls to health services. It has been recommended that, given there is a dual diagnosis treatment trial under way, such trials should be extended to poorly resourced Aboriginal communities where the treatment is so urgently needed.[129]

16.75   The effect on Indigenous children and young people has not been fully counted in the equation of need, having been limited to addressing single issues such as the petrol sniffing epidemic:[130]

> Services for Aboriginal Australians continue to be acutely under funded, struggling to meet basic needs. Breakdown of traditional family structures and the loss of virtually entire generations due to substance abuse means parenting skills have been lost putting Aboriginal children in a situation of crisis. Community resources are reduced, leaving just the old struggling to care for the young as they handle their own ill health and poverty related

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127   Brideson and Kanowski, 'The Struggle for Systemic' adulthood' for Aboriginal Mental Health in the Mainstream: the Djirruwang Aboriginal and Torres Strait Islander Mental Health Program' in Jane Havleka, Charles Sturt University, *Submission 438*.

128   See for example, Ms Jane Havleka, Charles Sturt University, *Submission 438*, [np].

129   The Probation and Community Corrections Officers' Association Incorporated (PACCOA), *Submission 503*, p. 4.

130   Currently the subject of an inquiry by the Senate Community Affairs References Committee.

issues. Mental health programs need to be integrated and integral to the overall health, social and emotional wellbeing programs that need to be funded for Aboriginal people, implemented in a culturally appropriate and socially acceptable manner.[131]

Community-controlled services

16.76   Building self esteem and a sense of empowerment is an important element in recovery-based models for care of all people with mental illness, and is particularly important for Indigenous people. This fact was recognised in the National Aboriginal Health Strategy:

> The greater the degree of control a person has over their life and the greater the degree they feel they can participate in (influence) the way their social environment operates, the better their physical and mental health will be. [132]

16.77   It was cogently argued in the evidence that the best way to manage and ameliorate the levels of distress in Indigenous communities, and so to achieve progress with mental health and social outcomes, is to give these communities the power to determine the nature, scope and presentation of services to their own people:

> In certain areas Aboriginal mental health workers are placed in mainstream health services (or an Aboriginal staff member is designated that role), giving rise to problems of access and appropriateness when Aboriginal people won't utilise services for cultural and historical reasons. NCOSS strongly supports the placement of Aboriginal mental health workers in Aboriginal community-controlled organisations, from where they would work in conjunction with mainstream services to provide mental health services to the Aboriginal community. This would be consistent with the National Aboriginal Health Strategy, which has been agreed to by the NSW government and recognises that Aboriginal community controlled organisations are the best means for delivering health services to Aboriginal communities.[133]

16.78   The committee received a number of reports of community controlled models and partnerships which are achieving results:

> One such program is the Aboriginal Primary Health Care Access Program (APHCAP) which has considerable acceptance within the communities in regional SA and actively engages with Divisions of General Practice, is setting up Aboriginal controlled health centres on a "one stop" model. Workforce development for Aboriginal health workers in mental health is

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131   SA Division of General Practice, *Submission 88*, p. 8.

132   National Aboriginal Health Strategy Working Group, National Aboriginal Health Strategy, AGPS, Canberra, 1989, p. ix, quoted in HREOC, *Submission 368*, Attachment 1,pp. 9–10.

133   NCOSS —Council of Social Service of New South Wales, *Submission 274,* p. 8.

much needed, as well as these workers being able to easily access specialist support.[134]

16.79 However, there were very grave concerns that the funding needed for community controlled Indigenous health services, despite the rhetoric, is not ending up in Aboriginal hands. The experiences of the Central Aboriginal Congress are indicative:

> …in 1997 when Alice Springs began experiencing a major upsurge in the rate of youth suicides Congress called a meeting of all Aboriginal organisations in Alice Springs and established an Aboriginal youth committee to discuss the problem and help to develop potential solutions. In spite of this process Congress was unable to access any of the national youth suicide prevention funds to establish programs in accordance with community proposals because all of this money had been given to the states and territories.[135]

16.80 The Congress was later informed that all the youth suicide prevention money had been given to the Northern Territory Government for redistribution to community organisations, such as the Congress. The funds, however, were transferred to a non-Aboriginal mental health NGO. The Congress commented:

> …given that the principal need is in the Aboriginal community we do not think this is the best option. Aboriginal community controlled organisations have the best chance of providing such programs in a manner which will meet the needs of their communities and achieve health outcomes. Because of the difficulties that Aboriginal people are experiencing in accessing funding for social and emotional well being services and programs OATSIH are having to primarily use their PHC resources to fund the delivery of social and emotional well being services within Aboriginal community controlled PHC services. Such services should be funded with mainstream Mental Health specific funds.[136]

16.81 Congress maintains that Indigenous-controlled community services are best placed to build capacity to deliver targeted and culturally appropriate services to youth and remote communities.[137] Denial of direct funding to Indigenous organisations is contrary to the principles of community ownership and control espoused as Australian Government policy, not withstanding the insult to the Indigenous committee fora convened especially to consult over suicide prevention. The draining of dedicated OATSIH funds to support identified *national* mental health priorities, seems ill

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134 SA Division of General Practice, *Submission 88*, p. 8.

135 The Central Aboriginal Congress, Submission *486*, p. 7.

136 *Submission 486*, p. 7.

137 There are no services, for example, to support itinerant indigenous youth with social and emotional well being disorders in Alice Springs; there are no such services in existence. See *Submission* 486, p. 7.

considered given the high level of complex unmet need among Indigenous communities.[138]

16.82   Government evaluations have shown that only 38 per cent of Aboriginal Community-controlled organisations have a dedicated mental health or social and well being worker.[139] To foster genuine and effective local community-based mental health services around the country, submissions asked that the Government honour both the letter and the spirit of its commitments. Aboriginal Health and Medical Health Services advised that national leaders must:

- require all stakeholders to comply with existing Aboriginal health agreements, policies and processes at state, regional and local level;

- support those programs and providers currently providing services which the Aboriginal community value and utilise;

- enhance culturally appropriate services targeting Aboriginal children and adolescents, either directly or indirectly;

- support dedicated Aboriginal Health funding being directed to Aboriginal community health services to administer the development, implementation and evaluation of programs;

- secure effective implementation of state and local policy to Aboriginal Mental Health Workers in the public, private and Aboriginal community controlled health sectors; and

- promote effective coordination and support of local mental health services.[140]

16.83   To be effective, these core recommendations must be underpinned by a full commitment at federal level, in terms of recurrent funding, policy development and support for implementation of Indigenous emotional and wellbeing program. Submitters argued that this must be more than just rhetoric, backed up by the politics of mutual obligation. It must be based on genuine respect for what traditional cultures offer, and recognition that self determination of Indigenous people over conditions of life in all states and territories will be the foundation of real progress in Indigenous health.

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138   The committee notes in this regard Department of Health and Ageing advice that its Indigenous Mental Health program, comprising Social and Wellbeing Regional Centre, and the Bringing Them Home programs are not funded beyond annual allocations. Funding for some Social and Wellbeing programs are supplied annually 'subject to previous compliance'. The Link Up program, an integral response to the 'stolen generations', is now another program to be resourced by OATSIH Answers to Questions on Notice, *Submission* 476A, p. 5.

139   *Consultation Paper for the Development of the National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Well Being 2004-2009,* Canberra, 2003, p. 11.

140   Aboriginal Health and Medical Research Council of New South Wales, *Submission 406,* pp. 9–10.

Other groups: Gay, Lesbian, Bisexual and Transgender

16.84   The AIDS Council of NSW (ACON) told the committee that mental health problems are more common among gay, lesbian, bi-sexual and transgender (GLBT) people than among the population in general.[141] This relationship is related to society's response to homosexual and transgender people, many of whom experience discrimination and stigmatisation.[142]

16.85   Discrimination impacts not only on the mental wellbeing of GLBT people, but on their ability to access mental health services. Further, multiple discrimination, on the basis of both mental illness and sexuality, can seriously affect GLBT people's access to wider support services, such as housing, employment, law enforcement and general health services.[143] Training is required to ensure appropriate service delivery:

> It is important that all state and national strategies and policies recognize this and work to eliminate homophobia and discrimination on the basis of sexuality and gender identity.[144]

16.86   ACON suggested that community-based organisations are well positioned to provide culturally appropriate health services and support for GLBT, but note that funding is currently limited.[145]

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141   The Aids Council of NSW Inc (ACON), *Submission 531*, p. 3.

142   *Submission 531*, pp 3-4.

143   *Submission 531*, p. 6.

144   *Submission 531*, p. 5.

145   *Submission 531*, p. 6.

CHAPTER 17

RECOMMENDATIONS

17.1   This report has demonstrated that there is much work to do in the area of mental health. There needs to be more money, more effort and more care given to this neglected part of our health care system. There is not enough emphasis on prevention and early intervention. There are too many people ending up in acute care, and not enough is being done to manage their illness in the community. There are particular groups, and people with particular illnesses, who are receiving inadequate care. Many of these findings have been confirmed by other organisations and reports in recent years.

17.2   The tremendous interest in this inquiry indicates that there may now be a preparedness to fix the problems identified and that this inquiry is timely. The committee was inundated with submissions not only drawing attention to the system's failings, but offering constructive suggestions on how to fix them. As the inquiry was being conducted, widespread media attention to the issue was matched by regular policy announcements by governments.

17.3   Most recently this groundswell of interest has resulted in a commitment by the Council of Australian Governments (CoAG) to look at mental health reform. Translating community concern and the opportunity presented by this committee's extensive inquiry into policy action, CoAG is looking to negotiate the delivery of new and better services for people with mental illness.

17.4   The committee wholeheartedly endorses steps being taken by governments in this direction. Much of what the committee has investigated is relevant to CoAG's deliberations. The committee wanted to ensure that its findings could help shape proposals that CoAG would consider. As the Chair has outlined in the Foreword to this report, it decided to do this by delivering this first report in time for governments to effectively take account of its recommendations as they worked toward agreement on reform. This concluding chapter draws together a number of key recommendations, largely focussed on those things the committee believes should be drawn to CoAG's attention, and which could be relevant to its deliberations.

17.5   As the Foreword explains, further detailed recommendations will be included in the committee's second report to be released in coming weeks.

Seeking CoAG agreement on more community care

Recommendation 1

17.6   The committee recommends that <u>COAG</u> initiates:

- **A substantial overall increase in funding for mental health services over time, to more closely reflect the disease burden and to satisfy the very significant unmet need.**

  Note: evidence suggests that the mental health budget should, by 2012, reach between 9 and 12 percent of the total health budget and whilst significant investment is required in mental health in the short to medium term, it is anticipated that early intervention and community-based care would deliver savings in the long term.

- **From this additional funding, the establishment of a *Better Mental Health in the Community* initiative, comprising a large number of community-based mental health centres, the distribution primarily determined on the basis of populations and their needs. (Assuming populations of around 60 000, this would represent 300 to 400 community based mental health centres nationwide.) The *Better Mental Health in the Community* program should be rolled out over 4-5 years with governments contributing as follows:**

  - **States and territories to provide infrastructure for and ongoing management of mental health centres**

  - **Commonwealth to establish new direct Medicare recurrent funded arrangements for employed or contracted mental health staff in these centres – psychiatrists, psychologists, general practitioners (GPs), psychiatric nurses and social workers – with the expectation that services would be provided at times of greatest demand, including after hours and on weekends.**

- **The linking of resourcing for mental health to the two principles of rights to services, and responsiveness to needs of populations, including:**

  - **Establishment of defined mental health regions nationwide and commit to equitable mental health funding to each, basing this on Health Needs Index weightings.**

  - **Development of population-specific budgets, mental health plans and evidence based protocols for children, youth, aged, culturally and linguistically diverse (CALD) communities and Indigenous people.**

  - **Definition of benchmark ratios of mental health professionals to populations, based on analysing numbers needed to meet the population's mental health care needs now and in the medium and long term, recognising the range of health professions relevant to the sector.**

  - **Designation of an agreed number and distribution of community based mental health centres for youth 12 to 25 years of age, those with dual diagnoses and for specialist geriatric and Indigenous mental health, where appropriate.**

- **The Australian Government reform the Better Outcomes initiative to include a new set of Medicare mental health schedule fees and rebates for combinations of private consulting psychiatrists, GPs and psychologists who agree to work together or in conjunction with mental health centres under integrated, collaborative arrangements in the management of primary mental health services. Consideration should be given to the Divisions of General Practice managing the reformed Better Outcomes, perhaps restructured as Divisions of Primary Health.**

Developing mental health strategies

17.7 The above recommendation lies at the heart of the committee's vision of a mental health care system that is more accessible, more community centred and better resourced. However, more coordinated and effective planning should also pay big dividends for mental health, including reforms to the National Mental Health Strategy, as well as developing concrete plans in some specific areas of mental health.

Recommendation 2

17.8 The committee recommends that the <u>Australian Health Ministers</u> agree to:

- **Reform the National Mental Health Strategy (NMHS) to guarantee the right of people with mental illness to access services in the least restrictive environment, to be actively engaged in determining their treatment and to be assisted in social reintegration and underpin those rights with legislation.**

- **Include in the next NMHS Plan specific, measurable targets and consumer and/or health outcomes that are monitored and reported on annually.**

- **Agree to develop specific national mental health action plans for addressing child and adolescent, youth, aged, CALD communities and Indigenous Australians.**

- **Ensure that the objectives in the next NMHS Plan increase emphasis on delivery of community care, prevention and early intervention, providing a more appropriate balance between these services and acute and emergency care.**

- **Integrate the NMHS, National Drug Strategy, National Suicide Prevention Strategy and the National Alcohol Strategy and the delivery of services under these strategies.**

- **Agree that building public mental health services of high quality and high regard is a key to addressing mental health workforce issues.**

Recommendation 3

17.9 The committee recommends that the <u>Australian Health Ministers</u> agree to establish a timeline and implementation plan for the National Statement of Principles for Forensic Mental Health

Advocacy, monitoring and research

17.10   The committee heard extensive evidence of the need to strengthen consumer advocacy, improve mental health research, and create more rigorous monitoring of the implementation of mental health policy objectives. It is of the view that a range of organisations can contribute to achieving these goals. The following recommendation aims to spread a range of tasks across some existing, and some new, organisations that work on mental health and human rights.

Recommendation 4

17.11   The committee recommends that <u>Australian Health Ministers</u> agree to

- **Fund and empower the *Mental Health Council of Australia* to:**
  - **report annually on progress under the NMHS**
  - **conduct annual independent investigation, monitoring and reporting of services and Commonwealth/state expenditure**
  - **identify gaps in service provision, training and performance of the workforce, and**
  - **report on measurable targets such as suicide rates, homelessness, use of involuntary treatment orders, medication rates for high prevalence disorders, incarceration rates, and rates of engagement in education and the workforce.**

- **Establish and fund a *National Mental Health Advisory Committee* made up of consumers, carers and service providers to:**
  - **advise CoAG on consumer and carer issues**
  - **be an advocate for mental wellbeing, resilience and illness prevention**
  - **promote consumer involvement in service provision**
  - **promote the recovery model in mental health**
  - **promote community and school-based education and stigma reduction, and**
  - **promote and manage mental health first aid programs aiming for 6% of the population to be trained and accredited, targeting those with the greatest probability of coming in contact with mental health issues – teachers, police, welfare workers, and family carers.**

- **Establish and fund a joint *Commonwealth-State Mental Health Institute* to**
  - **develop a prioritised national framework for research and pilot programs**

- **review evidence-based research on health needs and cost effectiveness of treatments**
- **disseminate best practice service standards, and**
- **assist with establishing service targets and integration of services.**

- **Provide recurrent funding to the *Human Rights & Equal Opportunity Commission* (HREOC) to:**
  - **monitor human rights abuses and discrimination in employment, education and service provision of those with mental disability**
  - **liaise with state and federal ombudsmen to identify trends and systemic failures that give rise to complaints, and**
  - **investigate discrimination against people with mental illness in Supported Accommodation Assistance Program (SAAP), respite and private and public rental housing,**

17.12   The committee believes other measures should also be introduced that would strengthen leadership and consumer advocacy in mental health. Some of these will be outlined in the committee's second report, but others the committee believes should be considered immediately by governments

Recommendation 5

17.13   The committee recommends that <u>Australian Health Ministers</u> agree to recognise mental health as a designated ministerial responsibility in federal, state and territory departments of health

Recommendation 6

17.14   The committee recommends that <u>state and territory governments</u> agree to harmonise Mental Health Acts relating to involuntary treatment and admission 'sectioning', and establish inter-state arrangements for treatment where the strict application of state and territory responsibility can mean far longer distances must be travelled to access services than could be the case.

Recommendation 7

17.15   The committee recommends that <u>all governments</u> establish benchmarks for the employment of consumer and carer consultants in mental health services, including forensic mental health services, and that all service providers have formal mechanisms for consumer and carer participation.

17.16   Progress in mental health reform will rely on being able to assess the changing nature of mental health service provision, and on boosting the mental health research effort significantly. The committee believes that better information and research about mental health is something that could be a useful part of a CoAG package of reforms.

Recommendation 8

17.17   The committee recommends that the <u>Australian Institute of Health and Welfare</u> should collect comprehensive data on mental health service provision such as the number of people receiving treatment and the nature of that treatment, public and private, and on population wide indicators of mental health and wellbeing.

Recommendation 9

17.18   The Committee recommends that the <u>Australian Government</u> increase funding to the National Health and Medical Research Council (NHMRC), to enable an increase in research funding on mental health from $15 million,[1] at least doubling it to $30 million per year.

Other joint government initiatives

17.19   The committee heard about a host of other reforms and service delivery proposals that could deliver better mental health services. They have been discussed throughout the chapters of this report and some will also be addressed in the committee's second report. However the committee wanted to mention two that it believed would require cooperative action by governments and could be considered as part of the current CoAG process.

Recommendation 10

17.20   The committee recommends that <u>Australian Health Ministers</u> consider the creation of a national emergency 1800 telephone helpline, resourced to provide mental health crisis responses 24 hours a day, 7 days a week and staffed by personnel with expertise in mental health.

Recommendation 11

17.21   The committee recommends that <u>Australian Health Ministers</u> agree that funding for SAAP be increased overall, and that there be dedicated resources within that funding for clients with complex needs including dual diagnosis.

Recommendations for specific governments

In its second report, the committee will make a range of recommendations about specific issues and programs. Some of these will involve particular initiatives that look promising and warrant being expanded; others will involve practices and areas of neglect that need to be remedied. Given the current discussions going on in CoAG, however, the committee wanted to put some further recommendations forward that

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1   A. Jorm, K. Griffiths, H. Christensen and J. Medway, 'Research priorities in mental health, Part 1: an evaluation of the current research effort against the criteria of disease burden and health system costs', *Australian and New Zealand Journal of Psychiatry*, vol. 36, 2002, p. 325.

could be considered as all governments negotiate what the committee hopes will be a new deal for mental health.

Further recommendations for specific Australian Government action

Recommendation 12

17.22   The committee recommends that the <u>Australian Government</u>

- **Increase the number of funded places and financial incentives in accredited medical and allied health training courses to meet future mental health workforce demands.**

- **Substantially increase job support for people with mental illness, recognising its therapeutic value and provide tax incentives for businesses employing people with mental illness.**

- **Fund public education campaigns and programs for prevention and reduction in substance abuse.**

- **Consider tax incentives, wage replacement schemes and other financial support for employers to provide more flexible transitions into work, in hours worked, timing of work and workload and the provision of mental health services for those employees needing assistance in the workplace.**

Further recommendations for state and territory government action

Recommendation 13

17.23   The committee recommends that <u>state and territory governments</u>

- **Establish more respite and step up/step down accommodation options in conjunction with the federal government *Better Mental Health in the Community* program.**

- **Provide long-stay in-patient facilities with a focus on rehabilitation for patients with severe and chronic mental disability, co-located with general hospitals but set in spacious, home-like environments.**

- **Ensure safe environments for consumers in acute, long-stay and emergency settings, including gender and age group separation.**

- **Provide specialised mental health and dual diagnosis spaces or departments (as appropriate) within emergency departments in general hospitals.**

- **Establish more longer term supported, community-based housing for people with mental illnesses with links to community mental health centres for clinical support.**

- **Increase funding to establish more detoxification and rehabilitation services for people with drug and alcohol abuse disorders.**

- **That there be specialized inpatient facilities for people with dual diagnosis.**

- **Establish specialised programs within designated community mental health facilities to treat conditions such as eating disorders, perinatal depression and personality disorders.**

- **Transfer responsibility for mental health in general prisons to the department within each state or territory with portfolio responsibility for health.**

- **Increase levels of consumer involvement in mental health services, including consumer representation at all levels and provision of funding to consumer-run mental health services.**

17.24   The committee hopes this report will be a step forward in the process of improving mental health services in Australia. It looks forward to the adoption of the recommendations included here by CoAG and by all Australian governments.

Senator Lyn Allison
Chair

APPENDIX 1

DEFINITIONS OF MENTAL HEALTH AND MENTAL ILLNESS

Mental health

1.1 The National Mental Health Plan 2003-2008 (the Plan) declares that 'mental health is not simply the absence of mental illness' and defines mental health as:

[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'.[1]

1.2 The World Health Organisation (WHO) defines mental health as:

…a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.[2]

Mental illness

1.3 The Plan defines mental illness as:

…[a] mental illness is a clinically diagnosable disorder that significantly interferes with an individual's cognitive, emotional or social abilities.[3]

1.4 Diagnoses of mental illnesses conform to classifications listed in two professional publications: the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IVR); and the International Classification of Diseases, Tenth Edition (ICD-10).[4] The DSM-IVR covers mental illnesses and the ICD-10 covers mental and physical illnesses.

International Classification of Diseases

1.5 The ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States from 1994. It 'has become the international standard diagnostic classification for all general epidemiological and many health management purposes'.[5]

1.6 The ICD-10 'is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and hospital records. In addition to enabling the storage and retrieval of diagnostic information for

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1 Australian Health Ministers, *National Mental Health Plan 2003–2008*, 2003, p. 5.

2 http://www.who.int/mediacentre/factsheet/fs220/en/.htm, accessed 14/04/05.

3 Australian Health Ministers, *National Mental Health Plan 2003-2008*, 2003, p. 5.

4 Australian Health Ministers, *National Mental Health Plan 2003-2008*, 2003, p. 5.

5 World Health Organisation (WHO), International Classification of Diseases (ICD-10), http://www.who.int/classifications/icd/en/, (accessed 15 April 2005).

clinical and epidemiological purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO Member States'.[6]

1.7   The ICD-10 recognises the following mental illnesses:[7]

- Organic, including symptomatic, mental disorders
- Mental and behavioural disorders due to psychoactive substance use
- Schizophrenia, schizotypal and delusional disorders
- Mood [affective] disorders
- Neurotic, stress-related and somatoform disorders
- Behavioural syndromes associated with physiological disturbances and physical factors
- Disorders of adult personality and behaviour
- Mental retardation
- Disorders of psychological development
- Behavioural and emotional disorders with onset usually occurring in childhood and adolescence
- Unspecified mental disorder

The Diagnostic and Statistical Manual of Mental Disorders

1.8   The DSM-IVR uses a multiaxial or multidimensional approach to diagnosis because rarely do other factors in a person's life not impact their mental health. It describes five dimensions, or axes:[8]

Axis I: Clinical Syndromes

- This is what we typically think of as the diagnosis (e.g., depression, schizophrenia, social phobia)

Axis II: Developmental Disorders and Personality Disorders

- Developmental disorders include autism and mental retardation, disorders which are typically first evident in childhood.
- Personality disorders are clinical syndromes which have more long lasting symptoms and encompass the individual's way of interacting with the world. They include Paranoid, Antisocial, and Borderline Personality Disorders.

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6   WHO, ICD-10, http://www.who.int/classifications/icd/en/, (accessed 15 April 2005).

7   WHO, ICD-10, http://www.who.int/classifications/icd/en/, (accessed 15 April 2005).

8   AllPsych Online, DSM-IVR, http://allpsych.com/disorders/dsm.html, (accessed 15 April 2005).

Axis III: Physical Conditions which play a role in the development, continuance, or exacerbation of Axis I and II Disorders

- Physical conditions such as brain injury or HIV/AIDS that can result in symptoms of mental illness are included here.

Axis IV: Severity of Psychosocial Stressors

- Events in a person's life, such as death of a loved one, starting a new job, college, unemployment, and even marriage can impact the disorders listed in Axis I and II. These events are both listed and rated for this axis.

Axis V: Highest Level of Functioning

- On the final axis, the clinician rates the person's level of functioning both at the present time and the highest level within the previous year. This helps the clinician understand how the above four axes are affecting the person and what type of changes could be expected.

1.9   It is clear from the above that the DSM-IVR describes three main types of mental disorder, namely, clinical syndromes, development disorders and personality disorders. Other factors included in the axes, for example, physical conditions and psychosocial stressors, are not mental health disorders in themselves but are considered to have an important impact on the disorders described in Axis I and II.

1.10   The DSM-IVR describes the following disorders:[9]

- Adjustment Disorders
- Anxiety Disorders
- Dissociative Disorders
- Eating Disorders
- Impulse-Control Disorders
- Mood Disorders
- Sexual Disorders
- Sleep Disorders
- Psychotic Disorders
- Sexual Dysfunctions
- Somatoform Disorders
- Substance Disorders
- Personality Disorders

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9   The list and descriptions of mental disorders in the following paragraphs have been reproduced from *AllPsych ONLINE: The Virtual Psychology Classroom*, http://allpsych.com/disorders/disorders_alpha.html, (accessed 15 March 2006).

Adjustment Disorders

1.11   All of the disorders in this category relate to a significantly more difficult adjustment to a life situation than would normally be expected considering the circumstances. While it is common to need months, and perhaps even years, to feel normal again after the loss of a long-time spouse, for instance, when this adjustment causes significant problems for an abnormal length of time it may be considered an adjustment disorder.

Disorders in this Category

- Adjustment Disorder Unspecified

- Adjustment Disorder with Anxiety

- Adjustment Disorder with Depressed Mood

- Adjustment Disorder with Disturbance of Conduct

- Adjustment Disorder with Mixed Anxiety and Depressed Mood

- Adjustment Disorder with Mixed Disturbance of Emotions and Conduct

Anxiety Disorders

1.12   Anxiety Disorders categorise a large number of disorders where the primary feature is abnormal or inappropriate anxiety. Everybody has experienced anxiety. Chances are you experienced an increased heart rate, tensed muscles, and perhaps an acute sense of focus as you tried to determine the source of a noise. These are all symptoms of anxiety. They are also part of a normal process in our bodies called the 'flight or flight' phenomenon. These symptoms become a problem when they occur without any recognisable stimulus or when the stimulus does not warrant such a reaction.

Disorders in this Category

- Acute Stress Disorder

- Agoraphobia (with or without a history of Panic Disorder)

- Generalized Anxiety Disorder [GAD]

- Obsessive-Compulsive Disorder [OCD]

- Panic Disorder (with or without Agoraphobia)

- Phobias (including Social Phobia)

- Posttraumatic Stress Disorder [PTSD]

Dissociative Disorders

1.13   The main symptom cluster for dissociative disorders includes a disruption in consciousness, memory, identity, or perception. In other words, one of these areas is not working correctly and causing significant distress within the individual.

Disorders in this Category

- Dissociative Amnesia

- Dissociative Fugue

- Dissociative Identity (Multiple Personality) Disorder

- Depersonalization Disorder

Eating Disorders

1.14   Eating disorders are characterised by disturbances in eating behaviour. This can mean eating too much, not eating enough, or eating in an extremely unhealthy manner (such as binging or stuffing yourself over and over). Many people argue that simple overeating should be considered a disorder, but at this time it is not in this category.

Disorders in this Category

- Anorexia Nervosa

- Bulimia Nervosa

Impulse-Control Disorders

1.15   Disorders in this category include the failure or extreme difficulty in controlling impulses despite the negative consequences. This includes the failure to stop gambling even if you realise that losing would result in significant negative consequences. This failure to control impulses also refers to the impulse to engage in violent behaviour (e.g., road rage), sexual behaviour, fire starting, stealing, and self-abusive behaviours.

Disorders in this Category

- Intermittent Explosive Disorder

- Kleptomania

- Pathological Gambling

- Pyromania

- Trichotillomania

Mood Disorders

1.16   The disorders in this category include those where the primary symptom is a disturbance in mood. In other words, inappropriate, exaggerated, or a limited range of feelings. Everybody gets down sometimes, and everybody experiences a sense of excitement and emotional pleasure. To be diagnosed with a mood disorder, your feelings must be in the extreme. In other words, crying, and/or feeling depressed or suicidal frequently. Or having excessive energy where sleep is not needed for days at a time, and decision making processes are significantly hindered.

Disorders in this Category

- Bipolar Disorder

- Cyclothymic Disorder

- Dysthymic Disorder

- Major Depressive Disorder

Sexual Disorders

1.17   Paraphilias all have in common distressing and repetitive sexual fantasies, urges, or behaviours. These fantasies, urges, or behaviours must occur for a significant period of time and must interfere with either satisfactory sexual relations or everyday functioning if the diagnosis is to be made. There is also a sense of distress within these individuals. In other words, they typically recognise the symptoms as negatively impacting their life but feel as if they are unable to control them.

Disorders in this Category

- Exhibitionism
- Fetishism
- Frotteurism
- Paedophilia
- Sexual Masochism
- Sexual Sadism
- Transvestic Fetishism
- Voyeurism

Sleep Disorders

1.18   Primary sleep disorders are divided into two subcategories: Dyssomnias are those disorders relating to the amount, quality, and timing of sleep. Parasomnias relate to abnormal behaviour or physiological events that occur during the process of sleep or sleep-wake transitions. The term 'primary' is used to differentiate these sleep disorders from other sleep disorders that are caused by outside factors, such as another mental disorder, medical disorder, or substance use. The primary sleep disorders are listed below:

Disorders in this Category

- Dyssomnias
  - Primary Insomnia
  - Primary Hypersomnia
  - Narcolepsy
- Parasomnias
  - Nightmare Disorder
  - Sleep Terror Disorder
  - Sleepwalking Disorder

Psychotic Disorders

1.19   The major symptom of these disorders is psychosis, or delusions and hallucinations. Delusions are false beliefs that significantly hinder a person's ability to

function. For example, believing that people are trying to hurt you when there is no evidence of this, or believing that you are somebody else, such as Jesus Christ or Cleopatra. Hallucinations are false perceptions. They can be visual (seeing things that aren't there), auditory (hearing), olfactory (smell), tactile (feeling sensations on your skin that aren't really there, such as insects crawling on you), or taste.

Disorders in this Category

- Brief Psychotic Disorder
- Delusional Disorder
- Schizoaffective Disorder
- Schizophrenia
- Schizophreniform
- Shared Psychotic Disorder

Sexual Dysfunctions

1.20 The primary characteristic in this category is the impairment in normal sexual functioning. This can refer to an inability to perform or reach an orgasm, painful sexual intercourse, a strong repulsion of sexual activity, or an exaggerated sexual response cycle or sexual interest. A medical cause must be ruled out prior to making any sexual dysfunction diagnosis and the symptoms must be hindering the person's everyday functioning.

1.21 Gender Identity Disorder has also been placed in this category, although no outward dysfunction needs to be present for this disorder. Basically, it includes strong feelings of being the wrong gender, or feelings that your outward body is inconsistent with your internal sense of being either male or female.

Disorders in this Category

- Dyspareunia
- Female Orgasmic Disorder
- Female Sexual Arousal Disorder
- Gender Identity Disorder
- Hypoactive Sexual Desire Disorder
- Male Erectile Disorder
- Male Orgasmic Disorder
- Premature Ejaculation
- Sexual Aversion Disorder
- Vaginismus

Somatoform Disorders

1.22 Disorders in this category include those where the symptoms suggest a medical condition but where no medical condition can be found by a physician. In

other words, a person with a somatoform disorder might experience significant pain without a medical or biological cause, or they may constantly experience minor aches and pains without any reason for these pains to exist.

Disorders in this Category

- Body Dysmorphic Disorder
- Conversion Disorder
- Hypochondriasis Disorder
- Pain Disorder
- Somatisation Disorder

Substance Disorders

1.23   The two disorders in this category refer to either the abuse of, or dependence on, a substance. A substance can be anything that is ingested in order to produce a high, alter one's senses, or otherwise affect functioning. The most common substance used is alcohol although other drugs, such as cocaine, marijuana, heroin, ecstasy, special-K, and crack, are included. The most abused substances, caffeine and nicotine, are also included although these are rarely thought of in this manner by the layman.

Disorders in this Category

- Substance Abuse
- Substance Dependence

Personality Disorders

1.24   Personality Disorders are mental illnesses that share several unique qualities. They contain symptoms that are enduring and play a major role in most, if not all, aspects of the person's life. While many disorders vacillate in terms of symptom presence and intensity, personality disorders typically remain relatively constant.

1.25   To be diagnosed with a disorder in this category, a psychologist will look for the following criteria:

- Symptoms have been present for an extended period of time, are inflexible and pervasive, and are not a result of alcohol or drugs or another psychiatric disorder. The history of symptoms can be traced back to adolescence or at least early adulthood.

- The symptoms have caused and continue to cause significant distress or negative consequences in different aspects of the person's life.

- Symptoms are seen in at least two of the following areas:

    - *Thoughts* (ways of looking at the world, thinking about self or others, and interacting)

    - *Emotions* (appropriateness, intensity, and range of emotional functioning)

    - *Interpersonal Functioning* (relationships and interpersonal skills)

- *Impulse Control*

Disorders in this Category

- Antisocial Personality Disorder
- Borderline Personality Disorder
- Narcissistic Personality Disorder

APPENDIX 2

MENTAL HEALTH EXPENDITURE AND INITIATIVES

Preliminary

2.1   In any examination of the cost of service provision it is important to differentiate health funding and health expenditure. The Australian Institute of Health and Welfare (AIHW) defines health spending as follows:

> Health funding is reported on the basis of who provides funds that are used to pay for health expenditure. In the case of public hospital care, for example, although the states and territories incur the related expenditure, the Australian Government and the states and territories together provide over 90 per cent of the funding. Some other funding comes from private health insurers (for insured patients) and from individuals who choose to be treated as private patients and pay any fees charged.[1]

2.2   Health expenditure is defined:

> Health expenditure is reported in terms of who incurs the expenditure, rather than who ultimately pays for that expenditure. In our example of public hospital care, all the related expenditures (that is, expenditure on medical and surgical supplies, drugs, salaries of doctors and nurses, etc.) are incurred by the states and territories although a considerable proportion of those expenditures is funded by transfers from the Australian Government.[2]

2.3   Accordingly, an important distinction must be made when considering what the Australian Government provides, in terms of funding, and what the state and territory governments provide.

Government spending

2.4   As has been mentioned previously, the Australian government provides direct and indirect expenditure for mental health. Direct expenditure during 2001-02, relating to 'expenditure dedicated to the provision of specialised mental health services and related activates', totalled $1 145.8 million and included the following expenditure items:

- National Mental Health Strategy (NMHS)

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1   The Australian Institute of Health and Welfare (AIHW), *Australia's Health 2004*, Canberra, p. 228.

2   AIHW, *Australia's Health 2004*, Canberra, p. 228.

- Medicare Benefits Schedule
- Pharmaceutical Benefits Scheme
- Private health insurance rebates
- Department of Veteran's Affairs[3]

2.5   During 2001-02 the state and territory governments provided $1 797.6 million in direct expenditure on mental health. Direct and indirect expenditure by the Commonwealth, combined with direct expenditure by the states and territories, totalled $6 592.6 million.[4]

Australian government—direct expenditure

2.6   During the period 2001-02 the Australian government contributed $94.2 million to the National Mental Health Strategy (NMHS) . Under the National Mental Health Plan 2003-2008 the Australian government will spend, on current National Mental Health Strategy Initiatives: $6 million, annually recurrent, on the National Mental Health Program; $66 million, in total over the life of the plan, on Australian Health Care Agreements—Commonwealth Own Purpose Outlays; and, $331 million, in total over the life of the plan, on Australian Health Care Agreements—Mental Health to states and territories.[5] The Australian government advised that the funding of $331 million is specifically for states and territories to address public sector health reform, and the $66 million is for national reform activities. The $6 million recurrent funding is available for national strategic mental health projects.[6]

2.7   Given the implementation of the National Mental Health Plan 2003-2008 (the Plan) and the subsequent realignment of priorities under the new plan, it is difficult to compare and make comment upon the current expenditure on the NMHS to that for 2001-02, listed as $94.2 million.

2.8   The Medicare Benefits Schedule, essentially Medicare, provides general benefits to all Australians through free treatment as a public patient at a public hospital, and with the Medicare rebate which covers 100 per cent of the schedule fee for a general practitioner and 85 per cent of the schedule fee for attendances by a consultant psychiatrist. The Schedule also provides specific benefits to persons suffering poor mental health in rural and remote locations, including:

- payment for clients located in rural and remote areas for consultations via telepsychiatry for assessment, diagnosis and treatment by consultant psychiatrist; and

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3   Australian Government, *Submission 476*, p. 14.

4   *Submission 476,* Attachment 2, p. 3.

5   *Submission 476*, p. 20.

6   *Submission 476*, p. 4.

- payments 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.[7]

2.9   The Australian government expenditure on the Medicare items attributable to mental health service delivery in 2001–02 was \$196.9 million to psychiatrists and \$167.3 to general practitioners.[8] During 2003-04 government expenditure had risen to \$201.3 million for consultant psychiatrists and \$175.6 million for general practitioners, however, the government did point out that due to MBS item structure developments since 2001-02 the data was not strictly comparable, but there was close correlation.[9]

2.10   The Pharmaceutical Benefits Scheme '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'.[10] During 2001-02 the Australian government contributed \$497.8 million to this scheme specifically for drugs relating to mental health, including antipsychotics, anxiolytics, hypnotics and sedatives, and antidepressants. This figure increased to \$591.472 million during 2003-04.[11]

2.11   In January 1999 the Australian government implemented legislation to provide for a rebate to private health insurance of some 30 per cent, replacing the private health insurance incentives scheme. The premise of this rebate was to encourage more people to obtain private health insurance and therefore assist in the private provision of health services including mental health services. Issues surrounding private health insurance are covered in more depth in chapter 12. Private health insurance rebates provided by the government during 2001-02 amounted to \$37.7 million.[12] More recent figures are not yet available for the committee.

2.12   Department of Veteran's Affairs expenditure, totalling \$133.8 million during 2001-02, included the provision of services to veterans as follows:

- Private hospitals
- Public hospitals
- Consultant psychiatrists
- Vietnam veteran's counselling services
- Pharmaceuticals

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7   Australian Government, *Submission 476*, p. 10.

8   Australian Government, *Submission 476*, p. 14.

9   Australian Government, *Submission 476*, p. 14.

10   Australian Government, *Submission 476*, p. 11.

11   Australian Government, *Submission 476*, p. 11 and *Attachment 2*, p. 3.

12   Australian Government, *Submission 476*, p. 14.

- Private practitioners

- Australian Centre for Post-traumatic Mental Health[13]

2.13   Other expenditure listed by the Australian government during 2001-02 on mental health service delivery included funding the establishment of the Divisions of General Practice, the OATSIH Emotional and Social Wellbeing Action Plan, Medical Specialists Outreach and Assistance program and the Rural Health Support, Education and Training Grants.

Australian government—indirect expenditure

2.14   The Australian government advised the committee, through their submission, of a range of areas where they provided funding in the area of mental health through a number of their departments. The government provided estimates of the cost burden through the provision of these services for mental health as a percentage of their overall cost burden. The primary figures provided by the government relate to the year 2001-02 as reported in the *National Mental Health Report 2004* and accordingly very little detail was obtained in regard to current levels of spending and the potential impact of current legislative change in the areas of welfare payments.

2.15   The National Suicide Prevention Strategy (NSPS) began in 1999 and aims to build upon the strengths of the previous National Youth Suicide Prevention Strategy (1995-1999) by increasing the focus across the lifespan.[14] 'The *Living Is For Everyone (LIFE) A Framework for Prevention of Suicide and Self-Harm in Australia*[15] was developed to guide action under the NSPS. The government advised that 'some 170 community-based suicide prevention programs have been funded in all states and territories and 25 national projects have also been developed' in line with the LIFE Framework.[16] During 2001-02 the government provided $9.8 million in funding to the NSPS.

2.16   Income support payments are indirect expenditure items provided through a number of Australian government departments including, DEWR, FaCS and the DVA. In determining the expenditure the Australian government estimated the mental health burden as a percentage of the overall expenditure burden.

2.17   During 2001-02 DEWR provided $1 693.6 million in income support to persons apparently affected with poor mental health amongst other disabilities through the following programs:

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13   Department of Health and Ageing (DoHA), *National Mental Health Report: Eighth Report—Summary of Changes in Australia's Mental Services under the National Mental Health Strategy 1993-2002,* Commonwealth of Australia, Canberra, 2003, p. 103.

14   Australian Government, *Submission 476*, p. 25.

15   *Submission 476*, p. 25.

16   *Submission 476*, p. 25.

- Disability Support Pension ($1 516.9 million, 23.7 per cent of total expenditure)

- Newstart Allowance ($143.1 million, 2.82 per cent of total expenditure)

- Sickness Allowance ($21.0 million, 22.4 per cent of total expenditure)

- Youth Allowance— Job Seekers ($6.5 million, 1.33 per cent of total expenditure)

- Mobility Allowance ($6.1 million, 9.0 per cent of total expenditure)[17]

2.18   During 2001-02 FaCS provided $179.7 million in income support to persons apparently affected with poor mental health amongst other disabilities through the following programs:

- Carer Payments ($98.3 million, 16.5 per cent of total expenditure)

- Carer Allowance ($81.4 million, 12.6 per cent of total expenditure)[18]

2.19   During 2001-02 DVA provided $95.0 million in income support to persons apparently affected by poor mental health, among other disabilities, through the invalidity service pension.[19]

2.20   Workforce participation program expenditure for persons with poor mental health, like the income support payment figures provided by the Australian government, relate to an estimate of expenditure based upon a proportion of total outlays. Indirect expenditure for workforce participation programs are provided by both DEWR and FaCS.

2.21   During 2001-02 DEWR provided $56.8 million in workforce participation programs in the following areas:

- Disability Open Employment providers ($29.4 million, 23.5 per cent of total expenditure)

- Vocational Support Programme ($27.5 million, 26.4 per cent of total expenditure)[20]

2.22   During 2001-02 FaCS provided $13.7 million in workforce participation programs in the following areas:

- Employment Services—Supported ($9.6 million, 9.09 per cent of total expenditure)

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17   Australian Government, *Submission 476,* Attachment 2, p. 9.

18   *Submission 476,* Attachment 2, p. 14.

19   *Submission 476,* Attachment 2, p. 19.

20   *Submission 476*, Attachment 2, p. 13.

- Employment Services—Open and Supported ($4.1 million, 19.84 per cent of total expenditure)[21]

2.23   The Australian Government estimates that during 2001-02 approximately $180.0 million of indirect government expenditure was provided to DVA disability compensation programs for people with accepted mental health conditions.[22]

2.24   The Department of Families, Community Services and Indigenous Affairs (FaCSIA) administers the housing and accommodation programs. During 2001-02 FaCSIA provided $108.9 million to persons with poor mental health through the following programs:

- Commonwealth-State Housing Agreements ($61.7 million, 6.0 per cent of total expenditure)

- Supported Accommodation Assistance Program (SAAP) ($47.1 million, 29 per cent of total expenditure)

- National Homelessness Strategy ($0.2 million, 23.0 per cent of total expenditure)[23]

2.25   Disability services are administered by FaCS and during 2001-02 FaCS provided approximately $42.6 million (8.5 per cent of total expenditure) under the Commonwealth State Territory Disability Agreement for mental health.[24]

2.26   DoHA provides resources for aged care residential and community services. During 2001-02 DoHA provided $1 258.5 million in indirect expenditure to person suffering poor mental health in the following areas:

- Aged Residential Care—High Level (Nursing Homes) ($1 217.2 million, 35.8 per cent of total expenditure)

- Aged Residential Care—Low Level (Hostels) ($37.2 million, 6.2 per cent of total expenditure)

- Aged Community Care, including the Dementia Education and Support Program, the Psychogeriatric Care Unit Program, the National Dementia Behaviour Advisory Service, and Dementia Support for Assessment ($4.1 million, 100 per cent of total expenditure)[25]

21   Australian Government, *Submission 476,* Attachment 2, p. 15.

22   *Submission 476*, Attachment 2, p. 19.

23   *Submission 476*, Attachment 2, p. 15.

24   *Submission 476*, Attachment 2, p. 17.

25   *Submission 476*, Attachment 2, p. 5.

2.27   DoHA also provided $10.0 million (1.62 per cent of total expenditure) in indirect expenditure on mental health through the Home and Community Care Program.[26]

State and territory government spending

2.28   The *National Mental Health Report 2005* provides a breakdown of each state and territory government's spending on mental health and the relative expenditure on different types of services across these jurisdictions.[27] Interested readers are referred to that report for a detailed review of state and territory spending. In addition, every state and territory government provided written submissions to the inquiry and details of their mental health programs and budget initiatives were generally included.

2.29   Recurrent expenditure on mental health services by state and territory governments totalled 1 975.8 million in 2002-03.[28] Just under half (49 per cent) of this expenditure went to hospitals and 51 per cent to community-based services,[29] including ambulatory services, residential services and NGOs.

2.30   At an aggregate level, state and territory government spending on mental health increased (in constant prices) from $75.49 per capita in 1992-93 to $100.02 in 2002-03.[30] Expenditure levels differ across the states and territories and over the 1993-2003 period the gap between the highest and lowest spending jurisdiction increased. The NMHR 2005 assessed that:

> While some variation between state and territory expenditure can be expected due to the different needs of their populations, the variation was too large for this to be the full explanation.[31]

2.31   In 2002-03, Western Australia had the highest per capita spending on mental health ($119.07) followed by Victoria ($106.57), the ACT ($103.06) and South Australia ($101.61). The Northern Territory ($85.76) had the lowest per capita

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26   *Submission 476*, Attachment 2, p. 7.

27   DoHA, *National Mental Health Report 2005: Summary of Ten Years of Reform in Australia's Mental Health Services under the National Mental Health Strategy 1993-2003*, Commonwealth of Australia, Canberra, 2005.

28   DoHA, *National Mental Health Report 2005,* Commonwealth of Australia, Canberra, 2005. p. 23.

29   DoHA, *National Mental Health Report 2005,* Commonwealth of Australia, Canberra, 2005. p. 5.

30   DoHA, *National Mental Health Report 2005*, Commonwealth of Australia, Canberra, 2005. p. 111.

31   DoHA, *National Mental Health Report 2005*, Commonwealth of Australia, Canberra, 2005, p. 3.

spending, followed by Queensland ($87.58), while Tasmania ($93.99) and New South Wales ($97.07) also had below national average spending.[32]

2.32   Over the ten years 1993 to 2003, the ACT's and Western Australia's per capita spending on mental health services increased the most (by 62 per cent and 58 per cent respectively). Queensland increased spending by 42 per cent, New South Wales by 35 per cent, Northern Territory by 32 per cent, South Australia by 28 per cent and Tasmania by 22 per cent. Victoria's expenditure increased the least (19 per cent), however Victoria had the highest per capita spending of all states and territories at the start of the period and remains the second highest.[33]

2.33   There are differences across the states and territories in the priority given to different forms of mental health care. In 2003, per capita spending on community based services was considerably higher in the ACT ($76) and Victoria ($70) than the other states and territories (ranging from $56 in both Western Australia and Tasmania, down to $37 in Queensland).[34]

2.34   Overall 6.2 per cent of state and territory mental health spending went to the NGO sector in 2003, an increase from 2 per cent in 1993. Victoria dedicated the highest proportion (11.5 per cent) of mental health spending to the NGO sector, followed by ACT (11.4 per cent). South Australia (2.1 per cent) followed by New South Wales (2.4 per cent) spent the lowest proportions on this sector.[35]

New initiatives

2.35   Reform to mental health services by the States and Territories continues. Recent initiatives of governments were outlined in Chapter 2, however the Committee also heard about new initiatives planned for future implementation.

2.36   The Victorian Government has committed over $180 million in the next four years to expanding mental health services and improving facilities.[36] This funding will deliver a range of initiatives:

- Dual diagnosis services for people with both a mental illness and a substance abuse disorder.[37]

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32   DoHA, *National Mental Health Report 2005,* Commonwealth of Australia, Canberra, 2005, p. 23.

33   DoHA, *National Mental Health Report 2005*, Commonwealth of Australia, Canberra, 2005, p. 24.

34   DoHA, *National Mental Health Report 2005,* Commonwealth of Australia, Canberra, 2005, p. 34.

35   DoHA, *National Mental Health Report 2005,* Commonwealth of Australia, Canberra 2005, p. 5.

36   Victorian Minister for Health – Victorian Government, *Submission 445,* p. 6.

37   *Submission 445,* p. 6.

- Sub-acute services to assist in the transition from in-patient assistance to home based care.[38]

- Intensive housing support services for people experiencing an acute mental health illness.[39]

- Enhanced management of mental health services to deliver quicker responses to crisis situations, more intensive service responses to ensure treatment is effective and improved follow-up to prevent relapse.[40]

2.37   The Queensland Government has committed funding to expand mental health services and facilities, including:

- 30 transitional accommodation places for people with mental illness.[41]

- Programs targeted at preventing suicide in high-risk groups[42] and an additional $175 000 funding to the Australian Institute for Suicide Research and Prevention to conduct related research.[43]

- $43.6 million over four years to provide integrated responses to people with dual diagnosis, and are homeless.[44]

- $6.9 million allocated to non-government organisations and some research institutions for providing mental health services to the community.[45]

2.38   The Western Australian Government has allocated an additional $173.4 million over the next three years to implement further reform, as identified in the Mental Health Strategy 2004-2007.[46] Funding will be used to expand mental health services and facilities, including:

- Additional specialist mental health professionals across emergency departments.[47]

- The Psychiatric Emergency Team will be expanded to increase coverage across the metropolitan area.[48]

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38   *Submission 445,* p. 6.

39   *Submission 445,* p. 6.

40   Victorian Minister for Health – Victorian Government, *Submission 445,* p. 6.

41   Queensland Government, *Submission 377A,* p. 7.

42   *Submission 377,* pp. 17; 35; 60.

43   *Submission 377,* p. 17

44   *Submission 377A,* p. 54.

45   *Submission 377,* p. 30.

46   Department of Health – Government of Western Australia, *Submission 376,* p. 9.

47   *Submission 376,* p. 19.

48   *Submission 376,* p. 19.

- 19 new mental health beds in four state hospitals.[49]

- 113 new adult inpatient beds and 420 supported community beds for people with severe mental illness.[50]

- Additional psychiatric cover in rural areas to ensure inpatient service is maintained.[51]

- 'Expansion of community mental health clinical services, through a case management approach'.[52]

- Establishment of adult day therapy services, delivering individual and group clinical programs.[53]

- Expansion of Post-Natal Depression services in areas of projected community growth, as well as developing services specific to the needs of Indigenous people and people from culturally or linguistically diverse (CALD) backgrounds.[54]

- Expansion of child and adolescent mental health services.[55]

- Implementation of a range of programs for attracting and retaining mental health professionals.[56]

- Funding to non-government organisations for mental health services.

2.39   The Northern Territory Government has allocated $12.7 million additional funding to mental health services over the period 2003-04 to 2005-06,[57] with the budget estimated in 2005-06 to be $28.8 million.[58] This will deliver enhanced clinical services and support to consumers and carers through a number of initiatives:

- $1.8 million to establish 24 hour 'sub-acute' residential beds in Darwin and Alice Springs.[59]

- An additional nine mental health positions created over the next three years to deliver further support to correctional centres.[60]

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49   *Submission 376,* p. 19.

50   *Submission 376,* pp. 19-20.

51   Department of Health – Government of Western Australia, *Submission 376,* p. 20.

52   *Submission 376,* p. 20.

53   *Submission 376,* p. 20.

54   *Submission 376,* p. 20.

55   *Submission 376,* p. 20.

56   *Submission 376,* p. 20.

57   Northern Territory Government, *Submission 393,* p. 2.

58   *Submission 393,* p. 30.

59   *Submission 393,* p. 20

60   *Submission 393,* p. 23.

- A significant increase in clinical and rehabilitation services available to prisoners.[61]

- Expansion of mental health services to rural and remote communities, including additional Aboriginal Mental Health Worker positions and commencement of visiting psychiatric services.[62]

- Establishment of child and adolescent psychiatric positions in regional centres and Consultation Liaison Nurse positions for acute assessment and after-hours services.[63]

- Expansion of training and education programs to enhance retention and the ongoing development of mental health professionals.[64]

- Funding to support the expansion of services provided through non-government organisations.[65]

2.40   The ACT Government continues to progress the implementation of a number of other initiatives to enhance mental health care services, including:

- Population-based modelling on current and future mental health needs in the ACT community.[66]

- Early intervention programs for specific areas of mental health treatment.[67]

- A new system to address the needs of people experiencing a mental illness and are in contact with the criminal justice system.[68]

- A 20 bed psycho-geriatric inpatient unit for Calvary Hospital.[69]

- $230 000 allocated to conduct a study on 'acute adult mental health, child and adolescent mental health services, crisis assessment and treatment services'.[70]

2.41   An additional $241 million has been allocated to mental health care in NSW over the period 2004-05 to 2007-08.[71] The NSW Government plans to deliver further reform through a range of initiatives:

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61   *Submission 393,* p. 32

62   Northern Territory Government, *Submission 393,* p. 30.

63   *Submission 393,* p. 30.

64   *Submission 393,* p. 31.

65   *Submission 393,* p. 31.

66   Minister for Health – ACT Government, *Submission 165,* p. 3.

67   *Submission 165,* p. 5.

68   *Submission 165A,* p. 13.

69   *Submission 165,* p. 6.

70   *Submission 165,* p. 6.

71   NSW Health – NSW Government, *Submission 470*, p. 5.

- Nine psychiatric emergency care centres across the state.[72]

- A further 300 beds are planned, in addition to the 300 already delivered since 2001.[73]

- Expansion of the Housing and Accommodation Support Initiative to provide further support to people residing in the community or in public housing that have a mental illness.[74]

- A rural emergency health care service, including a telephone help line and patient transportation service.[75]

- A three year pilot program of Integrated Services Project for Clients with Challenging Behaviour.[76]

- Mental Health Unique Patient Identifier system to increase information sharing between health care clinicians in an area.[77]

- The increased use of e-technology to better manage mental health in rural and remote areas.[78]

2.42   The South Australian Government has allocated $110 million to capital works spending in mental health, and the following projects are planned for development by the end of the decade:[79]

- New 20 bed aged acute mental health facilities at selected hospitals.

- An early intervention mental health service targeting children and young adults.

- A 35 bed adult acute mental health facility at the Noarlunga Hospital.

- 45 new adult acute beds at the Lyell McEwin health Service.

- A 40 bed secure forensic mental health facility to replace the existing facility, plus a new 30 bed secure rehabilitation facility.

- Expansion of the mental health facility at Modbury Public Hospital to include 24 new beds.

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72   Premier Morris Iemma, 'Meeting on Mental Health is Overdue', *Daily Telegraph,* 11 January 2006, p. 27.

73   Premier Morris Iemma, 'Meeting on Mental Health is Overdue', *Daily Telegraph,* 11 January 2006, p. 27.

74   NSW Health – NSW Government, *Submission 470*, p. 6.

75   Premier Morris Iemma, 'Meeting on Mental Health is Overdue', *Daily Telegraph,* 11 January 2006, p.27.

76   *Submission 470*, p. 6.

77   *Submission 470*, p.25.

78   *Submission 470*, p.56-57.

79   Department of Health – South Australia Government, *Submission 506,* p. 24.

- An upgrade of Woodleigh House at Modbury Public Hospital to provide better standards of care.

- $300,000 to upgrade mental health facilities in Port Pirie, Port Lincoln, Gawler and Berri.

- With assistance from the Australian Government, three 20-bed Community Rehabilitation Centres will be constructed in the Northern, Central and Southern parts of Adelaide.

2.43   In Tasmania, the government is implementing initiatives across health care services, such as improving services for children and adolescents and adult aged care, and forensic mental health. This is being achieved through injection of more resources and legislative amendments, and very importantly, 'cultural and social service reform'.[80]   Through the 'Bridging The Gap' program launched by the Tasmanian Government in January 2005, $47 million over four years has been allocated to improving mental health services.

2.44   These initiatives included, as set out in Chapter 2;[81]

- 62 packages of care to support clients to live in the community.

- A 12 bed high support community facility in Launceston.

- 12 bed cluster houses for supported accommodation in the South and the North West Coast.

- A total of 48 new clinical positions across a range of mental health care settings.

- $3.78m to drive quality and safety improvements, assist with the application of the Mental Health Act and develop a mother and baby service.

- $4.52m to upgrade existing mental health and non-government organisations' facilities and services.

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80   Tasmanian Government, *Submission 502*, p. 3.

81   Tasmanian Government, *Submission 502*, p. 7.

APPENDIX 3

REPORT OF MENTAL HEALTH SERVICES OBSERVED IN TRIESTE, ITALY

January 2006

Senator Lyn Allison,

Chair, Senate Select Committee on Mental Health

3.1   While Australia's demographics and the development of its health system is different from that of Italy there are some lessons to be learned from the mental health services in Trieste region – a system that is world renowned. Some of these are:

- Early, easily accessible, community-based intervention is successful in reducing serious episodes of illness that require acute care and therefore cost

- Mental health teams must have a comprehensive range of clinical and psycho social skills and that the sole focus on mental health by these professionals leads to high levels of expertise and effective treatment

- Mental health services must provide or be closely linked with housing, employment and social reintegration provision for minimising psychiatric disability

- It is possible to treat the vast majority of people with mental illness in an environment free of physical or chemical restraint if their human rights and their experiences are respected and services readily accessible

- That families and carers can be relieved of the most onerous caring tasks if they are engaged with and informed by service providers in the care provided.

A brief history

3.2   Mental health reform commenced in Italy in the early 1970s when institutions were unlocked, patients free to come and go and, over time, retrained staff and services were transferred into the community. The Trieste asylum once housed 1,200 patients but now 94% of mental health budget is spent on expert, community-based centres. These centres – of which there are four in Trieste serving a population of 250,000 – provide full clinical and psychosocial support and the service costs half that of the former institutional arrangements of usually permanent institutionalisation.

3.3   Health and social services are well integrated, employment rates are high, demand for acute care is low and functioning levels of those affected by mental illness are high. Medication has been significantly reduced and few with mental illness are caught up in the criminal justice system.

3.4   Italy is divided into 20 regions and the Trieste region – Region Friuli-Venezia Giulia – is one of four regional governments that have autonomy over their health and other expenditure.

Community-based mental health services, Trieste style

3.5   A significant difference between the Italian and Australian systems is that mental health services provided to people with mental illnesses are delivered by multi-disciplinary teams of mental health workers at each of the community-based mental health centres (MHC). Clinical support is available 24 hours a day, 7 days a week. Staff morale and commitment is high.

3.6   Staffing levels are set at around 1 per 1 000 residents and the Trieste region has 237 mental health workers – 28 psychiatrists, 7 psychologists, 180 psychiatric nurses, 10 social workers and 6 psychosocial rehabilitation workers.

3.7   MHCs have an open door policy, are in airy, well designed buildings with ample multi-purpose indoor and outdoor spaces. They are abuzz with activity, provide accommodation for up to 8 'guests' overnight or longer, as necessary, and three meals a day are served to many more. No one is turned away, yet it is unusual for all beds to be occupied.

3.8   An unwell person is assessed by a mental health worker very soon after they present at the centre. Two psychiatric nurses are on duty overnight.

3.9   MHCs are drop in centres and provide lots of formal and informal engagement between staff and people with mental illness and their families and, importantly, with the outside world.

3.10   Eight beds in the psychiatric ward of the general hospital are used principally by those with a mental illness that also require treatment for a physical illness and are rarely fully utilised.

3.11   The commitment to deinstitutionalisation, re-engagement with community. civic rights, integration, innovation and evidence-based practice drives service delivery.

3.12   A separate consumer/advocacy sector has not evolved as it has in Australia, because services are there for people who need them and social cooperatives and work give people with mental illness a meaningful voice.

The Trieste region's achievements include:

- An average of only 7 per 100,000 residents are subject to involuntary treatment (and none in 2004/5 in one of the 4 areas) compared with 30 per 100,000 Italy-wide.
- ECT is no longer used
- No one with mental illness is homeless in the region

- Only 1 mentally ill person is in a forensic hospital

- Suicide rates have been reduced by 30% over the last 8 years

- 400 people with mental illness are employed on award wages in social cooperatives operating business ranging from restaurants, horticulture, gardening, the arts, museums, hotels, etc and 30% of these people are affected by psychosis. A further 200 people are employed in private firms.

Some philosophies and rationale underpinning Trieste's mental health system

- That people must have the opportunity to be not just patients but people who are individuals with complex lives and needs

- That the social capital of relational resources of individuals, measured by trust, reciprocity, the use of the power of negotiation, political awareness and civic participation, are positively correlated with health conditions.

- That participation in society is an important indication that the person is emerging from isolation. The terms 'recovery' and 'emancipation' are used to emphasise the lack-of-freedom, the loss of rights, the denial of access to resources and the effort which must be made in order to "come back".

- That belonging to a place, or a group, can provide a sense of communality with other people's experiences.

- That the citizenship rights (political, legal, social) of an individual and the acquisition of material resources (housing, jobs, goods, services), training (living and work related) and information (psycho-education, social awareness) are all necessary for recovery.

- That people have a right to be treated with respect and dignity and to be partners with health professionals in the progress of their recovery

- That an individual's strengths and experiences must be built upon and a sense of ownership of and responsibility for their actions accepted

- That the community must openly take responsibility its own mental health problems

- Work is not so much a goal as an instrument for recovery and emancipation and for defeating stigmatisation and a very important way out of the psychiatric 'circuit'.

Psychosocial support provided in the Trieste region

- Family and user associations, clubs and recovery homes.

- 12 group homes with a total of 72 beds, staffed at a range of levels according to need

- 2 day centres including training programs and workshops

- Individual projects, developed for each person engaged in MHCs, including objectives and time frames

- An open door policy

- A focus on familial relations and engagement of the family

- The engagement of clients in regular paid employment through training and ongoing support and a close working relationship with 13 accredited social cooperatives and private employers

- Services that include inpatient, outpatient and home care, individual and group therapy, psycho social rehabilitation, a GP 'health tutor' and facilitation of membership of associations and social enterprise activities

- A prison consultancy service

- Basic and professional training activities

National Government initiatives in mental health

3.13   Legislation in 1978 required the closure of psychiatric institutions which was carried out over a period of some years during which time staff in those institutions were retrained in community-based clinical services and supports and patients transferred to community care once services were in place.

3.14   Overall health budgets are provided by the National government on a per capita basis with weightings for disadvantage. The percentage of that budget to be spent on mental health is not prescribed and ranges from 5% in the Trieste -province to 2% in others.

3.15   By law, general hospitals can have no more than 16 psychiatric beds and there must be no more than 1 acute care bed for 10,000 inhabitants.

3.16   Where in 1971 there were more than 100,000 patients in 75 to 80 mental health institutions, Italy with 57 million inhabitants, now has just 3,500 public psychiatric beds (with roughly the same number in private psychiatric clinics although these are largely for high prevalence disorders). A further 17,000 people with mental illness are accommodated in group homes of up to 20.

Mental health and the criminal justice system

3.17   The National Minister of Justice sets progressive goals to reduce the number of people in forensic hospitals, currently down to 2 per 100,000 residents – a total of 1,100 for all Italy.

3.18   The Trieste region currently has only one forensic patient and every effort is taken to keep people with mental illness out of the criminal justice system.

3.19   The police play a useful role in the mental health system but always in partnership with mental health teams. For consumers who are delusional, the police presence is often seen as an assurance that their rights are being protected. Police receive no special training in dealing with people with mental illness but their close working relationship with the MHC teams has ensured their responses are appropriate.

3.20   Police are often called to attend incidents but are accompanied by a mental health worker once it is established that the person concerned may be mentally ill and he or she is usually taken to the MHC in an ordinary vehicle (not a divvy van). If the person arrives at the general hospital, a worker from the MHC will attend within a very short time to assess and usually transfer the person to the MHC for accommodation and treatment, even if he or she has been charged with an offence. This avoids the need for people requiring care to be in remand if their health in that environment would further deteriorate.

3.21   The MHC team is involved at every stage, providing assessments and briefs for police and legal representatives, physically taking responsibility for the person concerned and providing treatment until they are well enough to face the charges, arranging legal representation, providing expert opinion in court and ongoing care in prison if a custodial sentence is the outcome. These situations are effectively co-managed by the legal and mental health teams

3.22   The courts consider pleas of diminished responsibility, after a psychiatric assessment is provided, and are encouraged to do so because of the presence of appropriate services in the community. These services have transformed the perception once held that a person diagnosed with mental illness is both incapacitated and dangerous, to one whereby the community is confident that services and care are in place to deal with the illness and to prevent violent incidents

3.23   According to the 1978 law, the city mayor (as the main health authority for citizens) signs treatment orders at the request of two doctors. Urban police are present, alongside mental health workers, during the administration of medication.

Social cooperatives and other employment initiatives

3.24   The genesis of Trieste's social cooperatives was in 1973 when patients, supported by health professionals, won the right to turn their "work therapy" cleaning tasks into a maintenance contract that applied union rules and salaries under a cooperative. The administration resisted this move but capitulated after a strike supported by the union. These 'inmates' became workers with jobs, salaries and rights.

3.25   Social cooperatives now operate hotels, successfully tender for front office and call centre services for public agencies and museum staff, are involved in agricultural production, gardening and craft, carpentry, photo and video production and run a radio station. They also provide IT services, publishing and serigraphics.

3.26   Every year there are 120-150 trainees in social cooperatives and open employment, of which 30 became employees.

3.27   The indicators of rehabilitation through work include improved socialisation, self-care, family relationships, lower admission rates and less medication.

3.28   The theory is that work settings should be capable of promoting and widening other fields of interest, develop worker/employer partnerships, job attachment and a sense of identity and belonging. The challenge is to overcome the passive status of being 'assisted' and to involve people as 'subjects' with their own abilities.

APPENDIX 4

SUBMISSIONS, RESPONSES TO ADVERSE COMMENT AND ANSWERS TO QUESTIONS ON NOTICE

This appendix provides a list of submissions and responses received to adverse comment made in evidence.

It also lists answers provided to questions taken on notice by witnesses at the committee's public hearings. The majority of answers have been accepted and numbered as additional submissions. Additional information accompanying a number of answers is listed separately below.

Submissions

1	Associate Professor Brian Boettcher
2	insane australia
2A	insane australia
3	Dr Simon Byrne
4	Dr Julie Johnstone
5	Consumers and Carers from the NSW Far South Coast
5A	Consumers and Carers from the NSW Far South Coast
6	Victorian Deaf Society
7	Mr Mark Lacey
8	Mr Michael Williams
9	Name withheld
10	Name withheld
11	Name withheld
12	Name withheld
13	Name withheld
14	ARC Group

15	Name withheld
16	Name withheld
17	Mr David Heckendorf LLB BA
18	Confidential
19	Name withheld
20	Name withheld
21	Name withheld
22	Name withheld
23	ARAFMI National Council Inc
24	West Australian Child and Adolescent Mental Health Services Advisory Committee
25	Dr Yun Hee Jeon
26	Name withheld
27	Name withheld
28	Name withheld
29	Confidential
30	Professional Psychotherapy Centre
31	Name withheld
32	Professor Margot Prior
33	Confidential
34	Name withheld
34A	Confidential
35	Miss Margaret Burton
36	Ms Lorna Cleave
37	Name withheld
38	Name withheld

39	M Mandeno
40	Ms Anne Matheson and Dr Anthony Marinac
41	Homeless Persons' Legal Clinic
42	Name withheld
43	OZcare
44	Ms Nicci Wall
45	Confidential
46	Associate Professor David Straton
47	Professor Anthony Jorm and Ms Betty Kitchener
48	Name withheld
48A	Name withheld
49	Name withheld
50	The Australian Psychological Society Ltd
50A	The Australian Psychological Society Ltd
51	Newtown WDVCAS: Marrickville Legal Centre
52	Dr Andrew Gunn MBBS BA MAPhil FRACGP
53	Name withheld
54	Name withheld
55	Name withheld
56	Name withheld
57	Name withheld
58	Dr Donald Scott-Orr
59	Name withheld
60	The Northern Beaches Mental Health Consumer Network
60A	The Northern Beaches Mental Health Consumer Network
61	Name withheld

62	Name withheld
63	Name withheld
64	Confidential
65	Mental Health Resource Service
66	Name withheld
67	Micah Projects Inc
68	Australian Rotary Health Research Fund
69	Confidential
70	Name withheld
71	Ms Christine Couzens
72	Mill Park Family Support Group
73	Name withheld
74	Name withheld
75	Name withheld
76	Name withheld
77	Name withheld
78	Name withheld
79	Mr David Gould
80	Name withheld
81	Confidential
82	Healthscope Ltd
82A	Healthscope Ltd
82B	Healthscope Ltd
83	Australian Infant, Child, Adolescent and Family Mental Health Association
83A	Confidential (DVD)
84	Ms Sharon Ponder

85   School of Nursing & Midwifery – University of South Australia

86   Name withheld

87   Confidential

88   SA Division of General Practice Inc

89   Name withheld

89A   Confidential

90   Name withheld

91   White Wreath Association Inc

92   Autism Aspergers Advocacy Australia

93   Ms Jenine Bailey

94   Name withheld

95   Name withheld

96   Mildura Mental Health Services

97   Brotherhood of St Laurence

98   ORYGEN Research Centre

99   Department of Psychological Medicine – Children's Hospital at Westmead, and The Tamworth Child and Adolescent Mental Health Services (CAMHS), Hunter New England Area Health

100   Name withheld

101   Western Australia Section of the College of Clinical Psychologists

102   Name withheld

103   Canberra Schizophrenia Fellowship

104   Mr Kieran Wicks

105   Origins Vic Inc

106   Health Consumers of Rural and Remote Australia – (HCRRA)

107   Boystown

108   Comprehensive Area Service Psychiatrists Special Interest Group

108A   Comprehensive Area Service Psychiatrists Special Interest Group

109   National Drug and Alcohol Research Centre

110   Mental Health Research Institute

111   Strategic Planning Group for Private Psychiatric Services

112   Mental Health Foundation ACT Inc

113   Ms Sheelah Egan

114   Mr Brian Haisman

115   Mr Neil Alcorn

116   Mental Illness Fellowship NQ

116A   Mental Illness Fellowship NQ

117   Confidential

118   Name withheld

119   Mr Keith Sayers

120   Australian Principals Associations Professional Development Council

120A   Australian Principals Associations Professional Development Council

121   Name withheld

122   Name withheld

123   Name withheld

124   Name withheld

125   Name withheld

126   Ms Geraldine Spencer

127   Confidential

128   Name withheld

129   Name withheld

130   Name withheld

131   Name withheld

132	Name withheld
133	SANE Australia
134	Name withheld
135	Confidential
136	Confidential
136A	Confidential
137	Name withheld
138	Mr Shane Jones
139	Confidential
140	Mrs I Thomas
141	Confidential
142	Ms Paola Mason
143	Australian Private Hospitals Association
143A	Australian Private Hospitals Association
144	Name withheld
145	R Wilson
146	A N Brooks
147	Ms Pearl Bruhn
148	Confidential
149	Ms Karen Trenfield
150	East Gippsland Consumer & Carer Group
151	Anxiety & Depression Support Group – Albury Wodonga
152	Mr Ross O'Donovan
153	blue National Postnatal Depression Program
154	SANE form letter
155	Dr Alice H Caseleyr

156   Name withheld

157   Confidential

158   Professor Graeme Smith

159   Ms Marian A Forster

160   Mr Dilip Balu

161   Name Withheld – Parts A & B

161   Confidential – Part C

162   Name withheld

163   Name withheld

164   Name withheld

165   Mr Simon Corbell MLA – Minister for Health, ACT Health

165A Mr Simon Corbell MLA –Minister for Health, ACT Health

165AA Mr Simon Corbell MLA – Minister for Health, ACT Health

165B Mr Simon Corbell MLA – Minister for Health, ACT Health

166   Australian Institute of Criminology

167   Australian Medical Association

167A Australian Medical Association

168   Australian Polish Community Services

169   Australian Healthcare Association

170   Black Dog Institute

171   Western Australian Network of Alcohol and Other Drug Agencies

172   Office of the Public Advocate, Victoria

173   MHCC – Mental Health Co-ordinating Council

174   Justice Action

175   Magistrates Court of South Australia - Magistrates Court Diversion Program
      (mental impairment)

176   Professor Gavin Andrews

176A   Professor Gavin Andrews

177   Mr Jon Chesterson

178   Professor Anthony Jorm

179   Name withheld

180   Ms Lina Eve

181   National Rural Health Alliance Inc

181A   National Rural Health Alliance Inc

182   Ms Dawn Joyce

183   Break the Psycle

184   Ms Diane Williams

185   Mr Peter Hutten

186   Centre for Mental Health Research

187   Australian Health Promotion Association

188   Name withheld

189   National Network of Private Psychiatric Sector Consumers and their Carers

189A   National Network of Private Psychiatric Sector Consumers and their Carers

190   B Eldershaw

191   Southern Suburbs Taskforce

192   Name withheld

193   Mr Vincent Marmont

194   Name withheld

195   Name withheld

196   Name withheld

197   Brisbane Obsessive Compulsive Disorder Support Group   (BOCD Support Group)

198	Ms Lily Arthur
199	Mission Australia
200	Multicultural Mental Health Australia
200A	Multicultural Mental Health Australia
201	Confidential
202	Learning & Attentional Disorders Society of WA Inc (LADS)
203	National Association of Practising Psychiatrists
204	The Cairnmillar Institute
205	Confidential
206	Mental Healthcare Chaplaincy Under the Auspices of Healthcare Chaplaincy Council of Victoria Inc
207	Ms Merinda Epstein
208	Name withheld
209	Ms Loma Pincham
210	Ms Janine Anderson
211	YSAS – Youth Substance Abuse Service
212	Public Health Association of Australia Inc
213	Confidential
214	Mental Health Community Coalition of the ACT Consumer and Carer Caucus
214A	Mental Health Community Coalition of the ACT Consumer and Carer Caucus
215	Ms Maureen Melville
216	Victorian Transcultural Psychiatry Unit
217	Centre for Psychiatric Nursing Research and Practice - CPNRP
218	St Vincent de Paul Society Victoria Inc
219	New South Wales Branch of the Faculty of Psychiatry of Old Age within the Royal Australian and New Zealand College of Psychiatrists
220	Doctors Reform Society

221   The Epilepsy Foundation of Victoria Incorporated

222   Drug Action Information Exchange

223   Health Services Union

223A Health Services Union

224   GROW

224A Confidential

225   The National Council of Women of Queensland

226   Professor Christopher Puplick AM

227   The Network for Carers of people with a mental illness

228   Centre of Full Employment and Equity (CofFEE)

229   Mr Simon Schooneveldt

230   Mental Health Association NSW Inc

231   ARAFMI HUNTER

232   Combined Community Legal Centres Group (NSW)

233   Ms Roslyn Robertson

234   The Richmond Fellowships of Australia

235   Dr Simone Fullagar

236   Jewish Family Centre

237   Name withheld

238   Name withheld

239   Name withheld

240   Mr & Mrs Neumann

241   envision Support Services

242   Mr Wayne Rudall

243   Fairfield Local Government Area

244   Name withheld

244   Confidential – Attachments 245   The South Australian Country Women's Association Incorporated

246   Action on Disability within Ethnic Communities Inc

247   Confidential

248   Confidential

249   Name withheld

250   Friends of Callan Park

250A Friends of Callan Park

251   Name withheld

252   Name withheld

253   Mr Geoff Waghorn and Mr Chris Lloyd

254   Police Federation of Australia (PFA)

255   Dr Georgina Phillips

255A Dr Georgina Phillips

256   Welfare Rights Centre, Sydney

257   Name withheld

258   Confidential

259   blueVoices

260   Psychology Private Australia Inc

260A Psychology Private Australia Inc

261   Dr Roger Cribb

262   Mental Health Council of Australia

262A Mental Health Council of Australia

263   Dr Teresa Flower and Dr Robert Adler

264   Name withheld

265   Dr Gil Anaf

266   Richmond Fellowship of New South Wales

267   Confidential – 13 May 2005-10 February 2006

267   Victorian Mental Illness Awareness Council – 10 February 2006

267A   Victorian Mental Illness Awareness Council

268   Public Advocate, South Australia

269   Ms Barbara Maison

270   Ms Samantha Battams

271   Name withheld

272   Name withheld

273   Name withheld

274   NCOSS – Council of Social Service of New South Wales

275   Mr Ivan D Carnegy

275A   Mr Ivan D Carnegy

275B   Mr Ivan D Carnegy

276   Catholic Health Australia

276A   Catholic Health Australia

277   The Australasian Society for Psychiatric Research

278   Australian Federal Police

279   UnitingCare NSW, ACT

280   ORYGEN Youth Health

281   Australian Injecting & Illicit Drug Users League

281A   Australian Injecting & Illicit Drug Users League

282   Ms Nene Henry

283   Sisters Inside Inc

283A   Sisters Inside Inc

284   ORYGEN Research Centre

284A ORYGEN Research Centre

284B ORYGEN Research Centre

285   Youth Mental Health Coalition

285A Youth Mental Health Coalition

285B Confidential

286   Mental Carers Network Inc

287   Mr Carl Armstrong

288   The Queensland Alliance

289   Office of the Protective Commissioner

290   The Queensland Council for Civil Liberties (QCCL)

291   UnitingCare Australia

292   Australian Health Insurance Association Ltd

292A Australian Health Insurance Association Ltd

293   Schizophrenia Fellowship of Queensland Inc

294   Australian Medical Council

295   Pharmacy Guild of Australia

296   NISAD – Schizophrenia Research

297   Carers WA

298   Hume City Council

298A Hume City Council

299   Mr Stanley Catts

299A Mr Stanley Catts

300   Centre for Social Justice

301   NIFTeY Australia and The Australian Association for Infant Mental Health

302   Catholic Welfare Australia

302A Catholic Welfare Australia

321A The Association for Australian Rural Nurses, Australian and New Zealand College of Mental Health Nurses and Royal College of Nursing, Australia

322 Australian Mental Health Consumer Network

323 The Royal Australian and New Zealand College of Psychiatrists (RANZCP)

323A The Royal Australian and New Zealand College of Psychiatrists (RANZCP)

324 St. Vincent's Mental Health Service

325 Victoria Legal Aid

326 City of Port Phillip

327 Australian Federation of Deaf Societies (AFDS)

328 Name withheld

329 Lifeline Australia

330 Legal Aid Commission of New South Wales (Legal Aid NSW)

331 Ms Gloria Arentz

332 Dr Jennifer Torr – Centre for Developmental Disability Health Victoria

333 Disability Council of NSW

334 Drug-Free Attention Deficit Support Inc

334A Drug-Free Attention Deficit Support Inc

335 ACROD

336 Dr Ron Spielman

337 Dr Jillian Horton-Hausknecht

338 Waverley Council

339 Mr Wayne Chamley

340 Broken Rites (Australia) Collective Inc

341 The New South Wales Council for Intellectual Disability

341A The New South Wales Council for Intellectual Disability

342 West Heidelberg Community Legal Service

343   Youth Affairs Council of Victoria Inc

344   Youth Affairs Council of Victoria Inc – Youth Reference Group

345   St Luke's Anglicare Limited

346   General Practice Divisions Victoria

347   VICSERV (Psychiatric Disability Services of Victoria)

348   Northern Territory Legal Aid Commission and the Northern Territory Community Visitor Program

349   Mr Michael Witkowycz

350   Name withheld

351   intenionally left blank

352   Office of the Public Advocate - WA

353   Blue Care

354   Mental Illness Education ACT

355   Confidential

355A   Confidential

356   Australian Doctors' Fund

357   Confidential

358   The Ignatius Centre for social policy and research

359   Confidential

360   Confidential

361   Mr Malcolm Campbell

362   The Dual Disability Programme (DDP)

363   beyondblue

364   Health Consumers' Council

365   Confidential

366   Jurgen Hemmerling

367   Name withheld

367A   Name withheld

368   Human Rights and Equal Opportunity Commission

369   ParaQuad Victoria

370   Form letter – Care Leavers' submissions

371   Intentionally left blank

372   Royal Australian and New Zealand College of Psychiatrists (Faculty of Psychiatry of Old Age)

373   Public Interest Advocacy Centre

374   Eastern Hume Dual Diagnosis Services

374A   Eastern Hume Dual Diagnosis Services

375   Name withheld

376   Department of Health – Government of Western Australia

377   Queensland Government

377A   Queensland Government

378   Bio-Balance Health Association Inc

378A   Bio-Balance Health Association Inc

378B   Bio-Balance Health Association Inc

379   Mr Graham Brereton

380   Ms Kath O'Brien

381   Catholic Social Services Victoria

382   Intentionally left blank

383   The Psychotherapy and Counselling Federation of Australia (PACFA)

384   Name withheld

385   Name withheld

386   Ms Vicki Cowling OAM and Dr Adrian Falkov

387   Mr David Walshe

387A   Confidential

388   Mental Illness Fellowship Victoria

389   Medicines Australia

390   St Vincents & Mater Health

391   New South Wales Nurses' Association

392   Intenionally left blank

393   Northern Territory Government

393A   Northern Territory Government

394   Eastern and Central Africa Communities of Victoria Inc

395   Ms Gladys Berejiklian MP

396   Dr Tracy Schrader

397   Forum of Australian Services for Survivors of Torture and Trauma

397A   Forum of Australian Services for Survivors of Torture and Trauma

397B   Forum of Australian Services for Survivors of Torture and Trauma

398   Professor Henry Brodaty

399   NSW Commission for Children and Young People

400   Care Leavers of Australian Network (CLAN)

401   Mr Raymond Rudd and Professor Henry Jackson

402   Mental Illness Fellowship of Australian Inc

403   Hanover Welfare Services

404   Ms Janine Rod

405   Confidential

406   Aboriginal Health & Medical Research Council

407   Christian Science Committee on Publication

408   Australian Mental Health Suicide Consumer – Alliance Inc. Club Speranza

408A   Australian Mental Health Suicide Consumer – Alliance Inc. Club Speranza

409   NT Mental Health Coalition, NTCOSS

409   Confidential – Attachments

410   NSW Farmers Association

411   Australian College of Psychological Medicine

412   Mr Sharn Hunkin

413   Australian Guidance and Counselling Association

414   Dr R W Lyndon

415   Name withheld

416   Mr Ken Payne

417   Name withheld

418   Name withheld

419   CASA – Cancer, Advocacy, Diversity and Social Support

420   Origins Incorporated Supporting People Separated by Adoption

420A   Ms Jan Brunsdon-Benson-Kashin for Origins Inc

421   People with Disability Australia

422   Institute of Psychiatric Evaluation

423   Ms Debbie Har

424   The Law Society of South Australia

425   Suicide Prevention Australia

426   Queensland Nurses Union

427   Name withheld

428   The Royal Australian and New Zealand College of Psychiatrists Aboriginal and Torres Strait Islander Mental Health Committee

429   Mr Peter Birleson

430   The Gold Coast Institute of Mental Health

430A   The Gold Coast Institute of Mental Health

431   Name withheld

432   Older People's Mental Health Committee - North Coast Area Health Service in New South Wales

433   Ms Sherry Joynt

434   Mental Health Foundation of Australia

435   National Council of Women of Australia Inc Ltd

436   Mr Peter D Rodgers (This submission not on line)

437   Mr Robert Golding

438   Ms Jane Havelka. Charles Sturt University, Faculty of Health Studies – School of Clinical Sciences

439   Confidential

440   Mr Stephen Corry

440A   Mr Stephen Corry

441   Auseinet

442   Ms Pam Perrott

443   Name withheld

444   Name withheld

445   Victorian Minister for Health – Victorian Government,

445A   Victoria – Department of Human Services

446   Name withheld

447   Ms Theresa Richards

448   P Mason

449   Name withheld

450   La Trobe University, Australian Research Centre in Sex, Health and Society

451   Name withheld

452   Association for Counselling Psychology

453	Dr Barbara Tooth
454	Mr Philip Robertson
455	The Mental Health Council of Tasmania Inc (ARAFMI – Hobart)
456	Name withheld
457	Australian Council of Social Service – ACOSS
458	Mr Ian W Webster
459	Name withheld
460	Name withheld
461	Ms Dianne Barr
461	Confidential – Attachments
462	Confidential
463	Queensland Centre for Intellectual & Developmental Disability (QCIDD) Mater Hospital
464	Anglicare Tasmania
465	Confidential
466	The Royal Women's Hospital
467	Intentionally left blank
468	Australian Red Cross
469	Name withheld
470	NSW Health – NSW Government
470A	NSW Health Department – NSW Response
471	Name withheld
472	Mental Health Law Centre WA
473	Mr David Yan Han
474	Confidential
475	depressionNet

476   Australian Government

476A   Australian Government – Health & Ageing

476B   Australian Government: Employment and Workplace Relations

476C   Australian Government: Child Support Agency

476D   Australian Government: Immigration and Multicultural and Indigenous Affairs

477   Mr Glen Patrick Minahan

477A   Mr Glen Patrick Minahan

478   St Vincent de Paul Society

479   Australian Psychological Society Ltd. College of Clinical Psychologists. Victorian Section

480   Name withheld

481   Confidential

482   Mr David Copolov

483   S A V E – Australia Inc

484   Mr Graeme Bond

485   Dr Greg Malcher

486   Central Australian Aboriginal Congress

487   Confidential

488   Mr Bruce Hamilton

489   Confidential

490   Ms Jan Telfer

491   Inspire Foundation

492   Mr Peter K

493   Confidential

493A   Confidential

493B   Confidential

494	Citizens Commission on Human Rights (NSW)
495	Name withheld
496	Ms Jolan Tobias
497	Confidential
498	Ms Allison Ewens
499	Name withheld
500	Dr Simon Bridge
501	Western Australian Department of Education and Training
502	Tasmanian Government
503	Probation and Community Corrections Officers' Association Incorporated
503	Attachment 6 published as – Name withheld
503	Confidential – Attachments 2 & 3, 5 & 11
503A	Probation and Community Corrections Officers' Association Incorporated
504	Ms Sherry Watson
505	Queensland Public Tenants Association Inc
506	Department of Health – South Australia Government
506A	Department of Health – South Australia Government
507	Shopfront Youth Legal Centre
508	Ms Christine Hill
509	Australian Council on Healthcare Standards
510	Confidential
511	Name withheld
511A	Confidential
512	Name withheld
513	Name withheld
514	Ms Meaghan Nixon

515   Name withheld

516   Name withheld

517   Name withheld

518   Name withheld

518A   Name withheld

519   Name withheld

520   Name withheld

521   Mr Kevin Kidd

522   Confidential

523   Mr Noel Trevaskis

524   Confidential

525   Confidential

526   Dr Robert Di Nicolantonio

526A   Dr Robert Di Nicolantonio

527   Orignis Inc – Supporting Inquiry into Mental Health

528   Confidential

529   Wirrika Maya Health Service

530   Citizens Commission on Human Rights (in Victoria Citizens Committee on Human Rights Inc.)

531   AIDS Council of NSW

532   Dr J R Clayer

533   Intentionally left blank

534   Ms Fay Jackson – Open Minds Consultancy

535   Mr Edward and Mrs Colleen Kosowicz

536   ARAFMI Victoria

537   Ms Jan Kealton

538	Ms Sue Koningen
539	Ms Juliet Gibson
539A	Ms Juliet Gibson
540	Name withheld
541	Ms Anne Hayres
542	Name withheld
543	Name withheld
544	PANDA – Post and Antenatel Depression Association Inc
545	Name withheld
546	Name withheld
547	Mr David McKinnon
548	Advocates for Survivors of Child Abuse
549	Confidential
550	R Darryl Maybery & Dr Andrea Reupert
551	Ms Bonnie Trevanion
552	Name withheld
553	Gold Coast Drug Council Inc
553A	Gold Coast Drug Council Inc
554	The Gender Identity Awareness Association
554	Confidential – Attachments 4 and 5
555	Centre Against Sexual Assault – Loddon Campaspe Region
555A	Centre Against Sexual Assault – Loddon Campaspe Region
556	SOMA Health
557	Royal Children's Hospital, Melbourne
558	Eastern Health Mental Health Program

Proforma letters

Submissions from care leavers (Submission 370)

The committee received many submissions from people who spent time in institutional and foster care during childhood. Most of these submissions were in the form of a standard letter, to which people added details of the place or places where they were in care. These submissions were each accepted, but listed only once as Submission 370. Where a person also sent a personal submission different to the standard letter, that submission is listed separately.

Submissions regarding mental health funding and the justice system (Submission 154)

Many submitters sent in a standard letter concerning lack of funding for mental health issues, and over-representation of people with mental illness in the criminal justice system. These submissions were each accepted but listed only once, as Submission 154.

Responses to adverse comment

Under Senate resolutions persons who may have been commented upon adversely in evidence are provided the right of reply.

Listed below are responses received to adverse comments made in evidence.

1   Dr Ruth Vine, Director Mental Health, Victorian Department of Human Services. Response to Submission 195, dated 21 July 2005

2   Ms Robyn Kruk, Director General, NSW Health. Response to Submission 195, dated 5 August 2005

3   Dr Ruth Vine, Director Mental Health, Victorian Department of Human Services. Response to Submission 484, dated 30 August 2005

4   Mr Neil Whittaker, A/g Director General, Queensland Department of Corrective Services. Response to Submission 283, dated 7 September 2006

5   Mr Neil Whittaker, Deputy Director-General, Queensland Department of Corrective Services. Response to Submission 283A, dated 22 September 2005

6   Ms Linda Sorrell, Chief Executive, Southern Health. Response to Submission 554, dated 10 March 2006

7   Mr David McGrath, A/Director, Centre for Mental Health, NSW Health. Response to Submission 535, dated 22 March 2006

Additional information received with answers to questions on notice

Additional information accompanying answers to questions on notice is listed below.

sane Australia

- Dare to care! SANE Mental Health Report 2004

- Psychosocial Rehabilitation blueprint

- Employment and Psychiatric Disability blueprint

- Carer Education and Training blueprint

- Care of Older People with a Psychiatric Disability blueprint

- Planned Respite Care blueprint

- Supported Accommodation

- Recreation and Psychiatric Disability

Psychiatric Disability Services of Victoria (VICSERV) Inc

- VICSERV Membership

- VICSERV Training

- VICSERV Being a Keyworker 1 – *Establishing the Relationship* Participant Guide

- VICSERV Being a Keyworker III – Goal Setting Participant Course Material

- Day 2 Session Outline

- Setting a Rehabilitation Goal

- Being A Keyworker IV Assessing Client Strengths and Needs Participant Guide

- VICSERV Being a Keyworker IV Assessing Client Strengths and Needs Tools and Strategies

- VICSERV Being a Keyworker IV Assessing Client Strengths and Needs Information Sheets

Families and Friends for Drug Law Reform

- National Families & Community Conference on Drugs "Voices to be Heard"

NSW Farmers Association

- Clinical Psychology in Rural General Practice: *A Pilot of a collaborative model of mental health service delivery* Vines, R.F., Hurley, B.M. and Thomson, D.M. – Autumn 2002.

- What happens when children with attention deficit/hyperactivity disorder grow up? *Journal of the Royal Society of medicine*, volume 97, November 2004.

- Attention ADHD Costs Americans $77 Billion in Lost Income.

Dr Whiting

- NSW Public Health Bulletin Supplement, volume 15, Number S – 3, August, 2004. Trends in the prescribing of stimulant medication for the treatment of Attention Deficit Hyperactivity Disorder in adults in NSW.

Australian Mental Health Consumer Network Inc

- Partnership or Pretence. A handbook of empowerment and self advocacy for consumers of psychiatric services and those who provide or plan those services. A personal contribution to the development of the psychiatric consumer movement in Australia by Janet Meagher AM.

Department of Health – Government of Western Australia

- Protocol between the Western Australia Police Service and the Mental Health Division of the Health Department of Western Australia.

- Report on the investigation into mental health and DSPD services for prisoners in England by the Attorney General, Jim McGinty, MLA; Minister for Health and Electoral Affairs 1–11 July 2005.

Australian Principals Associations Professional Development Council

- Community Matters. Working with diversity for wellbeing. Mind Matters.

The Royal Australian College of General Practice

- RACGP representation on the various Government and other committees related to mental health.

- The Royal Australian College of General Practitioners Submission to the Productivity Commission – Review of the Health Workforce in Australia, August 2005.

- Mental Health Curriculum Statement 4.

- The Royal Australian College of General Practitioners. The Review of the Curriculum for Australian General Practice 2005/06.

APPENDIX 5

WITNESSES WHO APPEARED BEFORE THE COMMITTEE AT PUBLIC HEARINGS

Thursday, 19 May 2005, Canberra

BOND, Professor Gary, Guest Speaker for Schizophrenia Awareness Week; Visiting International Speaker, Mental Illness Fellowship of Australia

BURGESS, Mr Mark Anthony, Chief Executive Officer, Police Federation of Australia

GOONREY, Ms Christine, Project Officer, Mental Health Council of Australia

GRIFFITHS, Dr Kathleen, Senior Fellow and Director, Depression and Anxiety Consumer Research Unit, Centre for Mental Health Research, Australian National University

HICKIE, Professor Ian, Board Member and Clinical Adviser, Mental Health Council of Australia

KNOWLES, the Hon. Rob, Executive and Board Member, Mental Health Council of Australia

MENDOZA, Mr John, Chief Executive Officer, Mental Health Council of Australia

NOTHLING, Dr Martin, Federal Councillor, Australian Medical Association

OZDOWSKI, Dr Sev, OAM, Human Rights Commissioner and Acting Disability Discrimination Commissioner, Human Rights and Equal Opportunity Commission

PRING, Dr Bill, Representative, Australian Medical Association

SMITH, Ms Dawn, Deputy Chair, Mental Health Council of Australia

WAGHORN, Mr Geoffrey, Research Scientist, Queensland Centre for Mental Health Research and Mental Illness Fellowship of Australia

WILDMAN, Mr Neil Thomas, Deputy Chief Executive Officer, Mental Health Council of Australia

WILSON, the Hon. Keith, Chair, Mental Health Council of Australia

Monday, 4 July 2005, Canberra

ARMSTRONG, Ms Wendy Elizabeth, Executive Director, Association for Australian Rural Nurses Inc.

CARNELL, Ms Kate, Chief Executive Officer, Australian Divisions of General Practice

FOLEY, Ms Elizabeth Ruth, Director, Policy, Royal College of Nursing, Australia

GEE, Ms Christine Alexia, Vice-President, Australian Private Hospitals Association; Chair, Psychiatry Committee, Australian Private Hospitals Association

GREGORY, Mr Gordon, Executive Director, National Rural Health Alliance

HARRIGAN, Ms Rachel Mary, Policy Officer, Catholic Welfare Australia

HODGSON, Ms Donna, Member, Royal College of Nursing, Australia; Member, Australian and New Zealand College of Mental Health Nurses Inc.

JACOBS, Mr Brian, General Manager, Mental Health ACT, ACT Health

JOHNSON, Mr Richard James, General Manager, Lifeline Bundaberg

KONG, Mr Fred, Vice President, Richmond Fellowship of Australia

LIPSCOMBE, Ms Joan Margaret, Consultant, National Rural Health Alliance

MACKEY, Mr Paul Francis, Director, Policy and Research, Australian Private Hospitals Association

MAY, Dr Jennifer, Secretary, National Rural Health Alliance Council

OSBORNE, Mr Brian, Chair, Mental Health Committee, Australian Health Insurance Association

PHILLIPS, Ms Anita, Manager, Communications and Policy, National Rural Health Alliance

QUINLAN, Mr Francis Gerard, Executive Director, Catholic Welfare Australia

RATH, Mr Wilfred James, President, Richmond Fellowship Australia

RYAN, Ms Kim, Executive Officer, Australian and New Zealand College of Mental Health Nurses Inc.

SCHNEIDER, Mr Russell John, Chief Executive Officer, Australian Health Insurance Association

SHERBON, Dr Tony, Chief Executive, ACT Health

SMITH, Mrs Dawn, Chief Executive Officer, Lifeline Australia

SULLIVAN, Mr Francis John, Chief Executive Officer, Catholic Health Australia

TROMPF, Mrs Linda, Director, Mental Health Policy, ACT Health

WALTERS, Dr Robert, Chairman, Australian Divisions of General Practice

WELLS, Mrs Leanne, Manager, Policy and Development, Australian Divisions of General Practice

Tuesday, 5 July 2005, Melbourne

ARISTOTLE, Mr Paris, Executive Member, Forum of Australian Services for Survivors of Torture and Trauma and Director, Victorian Foundation for Survivors of Torture

AROCHE, Mr Jorge, Executive Member, Forum of Australian Services for Survivors of Torture and Trauma and Executive Director, Service for the Treatment and Rehabilitation of Torture and Trauma Survivors

CLARKE, Mr Dave, Chief Executive Officer, Psychiatric Disability Services of Victoria (VICSERV) Inc

COGLIN, Dr Michael, Chief Medical Officer, Healthscope Ltd

COLLINS, Ms Isabell, Director, Victorian Mental Illness Awareness Council

CROWTHER, Ms Elizabeth, Chief Executive, Mental Illness Fellowship Victoria

EPSTEIN, Ms Merinda Jane, private capacity

HOCKING, Ms Barbara, Executive Director, SANE Australia

JACKSON, Mr Mark, Policy Officer, Psychiatric Disability Services of Victoria (VICSERV) Inc

KAPLAN, Dr Ida, Manager, Direct Services, Victorian Foundation for Survivors of Torture and Member, Forum of Australian Services for Survivors of Torture and Trauma

KENNETT, Hon. Jeffrey, AC, Chairman, beyondblue: the national depression initiative

PETHICK, Ms Leanne Therese, Founder and Chief Executive Officer, depressioNet

REED, Mr Gerard Michael, Communications Manager, Mental Illness Fellowship Victoria

ROPER, Ms Catherine Elizabeth, Member, insane australia

WEBB, Mr David Robert, Chair, Victorian Mental Illness Awareness Council

WEBB, Mr David Robert, Member, insane australia

WILLIAMS, Ms Susan Malena, National Manager, Psychiatry, Healthscope Ltd

WISSMANN, Ms Denise, Manager, Training Development and Delivery, Psychiatric Disability Services of Victoria (VICSERV) Inc

YOUNG, Ms Leonie, Chief Executive Officer, beyondblue: the national depression initiative

Wednesday, 6 July 2005, Melbourne

BURROWS, Professor Graham Dene, AO, KCSJ, Chairman, Mental Health Foundation of Australia

BURT, Mr Michael John Gavin, Chief Executive Officer, Victorian Institute of Forensic Mental Health

CROTON, Mr Gary James, Clinical Nurse Consultant, Eastern Hume Dual Diagnosis Service, Northeast Health Wangaratta

EPSTEIN, Ms Merinda Jane, Policy Officer, Mental Health Legal Centre Inc.

FREIDIN, Dr Julian, President, Royal Australian and New Zealand College of Psychiatrists

HAPPELL, Dr Brenda, Director, Centre for Psychiatric Nursing Research and Practice

INCERTI, Mrs Kate, Housing Information and Support Officer, City of Port Phillip

JACKSON, Mr Brian, Executive Member and Senior Nurse Adviser, Centre for Psychiatric Nursing Research and Practice

JACKSON, Professor Henry James, Private capacity

LAMMERSMA, Dr Johanna, Honorary Secretary, Royal Australian and New Zealand College of Psychiatrists

LOVELOCK, Mr Harry, Director of Policy, Royal Australian and New Zealand College of Psychiatrists

MAHONY, Ms Nicole Helen, Director, City Communities, Hume City Council

McQUEENIE, Ms Megan Ann, Executive Director, Mental Health Foundation of Australia

MULLEN, Professor Paul Edward, Clinical Director, Victorian Institute of Forensic Mental Health

PHILLIPS, Dr Georgina Ann, Private capacity

ROLFE, Dr Timothy John, Consultant Psychiatrist, Eastern Dual Diagnosis Service, Victoria and Clinical Director/Consultant Psychiatrist, Southern Dual Diagnosis Service, Victoria

ROPER, Ms Cath, Consumer Academic, Centre for Psychiatric Nursing Research and Practice

RUDD, Mr Raymond Peter, Private capacity

SALTMARSH, Mr Keir Justin, Chairperson, Committee of Management, Mental Health Legal Centre Inc.

SGRO, Ms Silvana, Policy Analyst, Centre for Psychiatric Nursing Research and Practice

SHEARER, Ms Denise Maureen, Manager, Social Development, Hume City Council

TOPP, Ms Vivienne Margaret, Lawyer and Policy Worker, Mental Health Legal Centre Inc.

Thursday, 7 July 2005, Melbourne

ALBISTON, Ms Dianne, Clinical Program Manager, ORYGEN Youth Health

BROWN, Mr Eric Kahotea, Platform Team Member, ORYGEN Youth Health

CHANEN, Dr Andrew, Consultant Psychiatrist and Senior Lecturer, ORYGEN Youth Health and ORYGEN Research Centre

DIXON, Mr Christopher, Platform Team Member, ORYGEN Youth Health

FRIEDEL, Miss Emily Jane, Platform Team Member, ORYGEN Youth Health

GELMI, Miss Fran, Platform Team Member, ORYGEN Youth Health

LUBMAN, Dr Dan, Consultant Psychiatrist and Senior Lecturer, ORYGEN Youth Health and ORYGEN Research Centre

MARTIN, Mr Christopher Edward, Platform Team Member, ORYGEN Youth Health

McGORRY, Professor Patrick, Director, ORYGEN Youth Health and ORYGEN Research Centre

TOBIAS, Ms Jolan Lara, Platform Team Member, ORYGEN Youth Health

VINE, Dr Ruth Geraldine, Director, Mental Health, Department of Human Services, Victoria

YUNG, Associate Professor Alison Ruth, Consultant Psychiatrist and Principal Research Fellow, ORYGEN Research Centre

Wednesday, 27 July 2005, Canberra

BUSH, Mr William, Member, Families and Friends for Drug Law Reform (Australian Capital Territory) Inc.

GERRAND, Ms Valerie, Former Convenor and Current Member, Mental Health Special Interest Group, Public Health Association of Australia

GORDON, Ms Amanda, President, Australian Psychological Society

GREEN, Ms Deborah, President, Australian Healthcare Association

HUMPHRIES, Ms Susan Margaret, Interim Convenor, Mental Health Special Interest Group, Public Health Association of Australia

JOHNSTON, Mr Brian, Associate Member, Australian Healthcare Association; and Chief Executive Officer, Australian Council on Healthcare Standards

LAUT, Ms Pieta-Rae, Executive Director, Public Health Association of Australia

LEAHY, Mr Denis, Alternate National Councillor (NSW), Pharmacy Guild of Australia

LITTLEFIELD, Professor Lyndel Kay, Executive Director, Australian Psychological Society

MAHAR, Mr Keith, President, Mental Illness Education Australian Capital Territory

MAY, Ms Khin Win, Policy Officer, National Secretariat, Pharmacy Guild of Australia

McCONNELL, Mr Brian Peter, President, Families and Friends for Drug Law Reform (Australian Capital Territory) Inc.

OLSEN, Mr John Lloyd, Mental Health Consumer Advocate, Greater Southern Area Health Service

POWER, Ms Prue, Executive Director, Australian Healthcare Association

SIMMONS, Mr Paul, National Councillor (SA), Pharmacy Guild of Australia

SKELTON, Mr John James, Convenor, Sapphire Coast Group, Association of Relatives and Friends of the Mentally Ill

STEEPER, Mrs Elizabeth, Committee Member and Project Officer, Mental Illness Education Australian Capital Territory

STOKES, Mr David Lewis, Manager, Professional Issues, Australian Psychological Society

WILLOW, Ms Winsome, President, Mental Health Community Coalition; and Manager, Inanna Inc.

WYLDE-BROWNE, Ms Margy, Executive Officer, Mental Illness Education Australian Capital Territory

Tuesday, 2 August 2005, Sydney

ALSHAMS, Mr Maqsood, Spokesperson, Specialist Assignment Volunteers Enterprise Australia Inc.

BATH, Ms Nicola Jayne, Manager, Treatment Program and Policy, Australian Injecting and Illicit Drug Users League

BRODATY, Professor Henry, Private capacity

BROWN, Mr Alan, Board Member and Chair, Rural Affairs Committee, New South Wales Farmers Association

CASEY, Ms Brianna, Senior Policy Manager, Rural Affairs, New South Wales Farmers Association

CASSANITI, Ms Maria, Consortium Member, Multicultural Mental Health Australia

CHAMLEY, Dr Wayne Alfred, Treasurer, Broken Rites Australia

COLLINS, Mr Brett Anthony, Spokesperson, Justice Action

GRIFFITHS, Ms Meg, National Program Manager, Multicultural Mental Health Australia

JOHNSON, Mr Andrew, Director, Australian Council of Social Service

JORDAN, Ms Amanda, Consumer Representative, Centre for Eating and Dieting Disorders New South Wales

KOHN, Dr Michael, Medical Director, Eating Disorder Program, Children's Hospital at Westmead; and Medical Director, Meridian Clinic

LEAHY, Miss Judith Louise, Adviser, Centre for Eating and Dieting Disorders New South Wales

MACFIE, Mr Gregor, Policy Officer, Australian Council of Social Service

MAGUIRE, Ms Sarah Louise, Eating Disorder Service Development Officer for New South Wales, Centre for Eating and Dieting Disorders New South Wales

McKAY, Dr Roderick, Chair, New South Wales Branch of the Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists

OWEN, Mr Alan, Health Policy Adviser, Australian Council of Social Service

PENGLASE, Dr Joanna, President, Care Leavers of Australia Network

PROCTER, Associate Professor Nicholas, Adviser, Multicultural Mental Health Australia

PUPLICK, Professor Christopher, Private capacity

RUSSELL, Associate Professor Janice, Director, Eating Disorder Program, Centre for Eating and Dieting Disorders New South Wales

SHEEDY, Ms Leonie Mary, Office Manager, Care Leavers of Australia Network

STRUTT, Mr Michael, Researcher and Spokesperson on Forensic and Criminological Issues, Justice Action

Wednesday, 3 August 2005, Sydney

ANDREWS, Professor John Gavin, Director, World Health Organisation Collaborating Centre, University of New South Wales at St Vincent's Hospital, Sydney

BASSON, Dr John, Statewide Director, Forensic Mental Health, Justice Health, NSW Health

BRERETON, Mr Graham John, Private capacity

CAMPBELL, Ms Helen, Representative, Combined Community Legal Centres Group, New South Wales

CASEY, Ms Desley, Consumer Coordinator, Northern Beaches Mental Health Consumer Network

CORRY, Mr Stephen Mannix, Private capacity

FORBES, Ms Linda Athalie, Casework Coordinator, Welfare Rights Centre

GOLLEDGE, Ms Emma Jane, Coordinator, Homeless Persons Legal Service, Public Interest Advocacy Centre

GURR, Dr Roger, Chair, Policy Committee, Comprehensive Area Service Psychiatrists Network

KELLY, Mr Jack, Chairperson, Management Committee, Association of Relatives and Friends of the Mentally Ill, Hunter

MARSH, Mrs Susan, Network Administration Worker and Fundraising Officer, Northern Beaches Mental Health Consumer Network

McGARRELL, Mr Eugene, Acting Director, Centre for Mental Health, NSW Health

McMAHON, Mr Mark, Co-Consumer Coordinator, Northern Beaches Mental Health Consumer Network, and Chairperson, Northern Sydney Mental Health Consumer Network

MORAN, Mr Simon James, Principal Solicitor, Public Interest Advocacy Centre

MURRAY, Ms Robyn, Manager, Clinical Partnerships, Centre for Mental Health, NSW Health

PONDER, Mrs Sharon Eileen, Private capacity

ROSEN, Professor Alan, Secretary, Comprehensive Area Service Psychiatrists Network

SKILLEN, Miss Lindsey, Member, Association of Relatives and Friends of the Mentally Ill, Hunter

Thursday, 4 August 2005, Brisbane

ARTHUR, Mrs Lily, National Secretary, Origins Incorporated, SPSA Queensland Branch

BEDWELL, Mr Kingsley Jon, President, Queensland Alliance of Mental Illness and Psychiatric Disability Groups Inc.

BOARDMAN, Mr Ian, Public Advocate, Office of the Public Advocate Queensland

BRYANT, Ms Linda May, Queensland Coordinator, Origins Incorporated, SPSA Queensland Branch

CHEVERTON, Mr Jeffery Stephen, Executive Director, Queensland Alliance of Mental Illness and Psychiatric Disability Groups Inc.

CONNOR, Ms Helen, Chair, Australian Mental Health Consumer Network

DOYLE, Mrs Jacqueline, Department Manager, Envision Support Services, Auspice Family Support Group Australia

FULLER, Mr Brian, Private capacity

IRONS, Mr Lindsay, Senior Research Officer, Office of the Public Advocate Queensland

KILROY, Ms Debbie, OAM, Director, Sisters Inside

KILROY, Ms Debbie, OAM, Director, Sisters Inside, Queensland Alliance of Mental Illness and Psychiatric Disability Groups Inc.

KLINTBERG, Mr Neville Stuart, Co-facilitator and Member, Brisbane Obsessive Compulsive Disorder Support Group

KOLAITIS, Ms Elizabeth Rodothea, Queensland Branch Program Coordinator, GROW

LAING, Mrs Joan Margaret, Member, Brisbane Obsessive Compulsive Disorder Support Group

LUCAS, Ms Mary Anne, National Executive Officer, GROW

MEAGHER, Ms Janet, Patron, Australian Mental Health Consumer Network

MINNAAR, Mrs Patricia Ann Theresa, Coordinator, Brisbane Obsessive Compulsive Disorder Support Group

PATE, Ms Kim, Executive Director, Canadian Association of Elizabeth Fry Societies and Consultant, Sisters Inside

REID, Ms Wendy Kathleen, General Manager, Kids Help Line, BoysTown

TANIN, Ms Michelle, Private capacity

WALSH, Ms Karyn Joan, Coordinator, Micah Projects Inc.

WARNER, The Hon. Anne, President, Management Committee, Sisters Inside

WONG, Ms Christina Hoi Yan, Private capacity

Friday, 5 August 2005, Cairns

BAILEY, Ms Jenine, Indigenous Researcher, Rural Health Research Unit, James Cook University

BRIDGE, Dr Simon, Private capacity

ELLIS, Ms Gaynor Anne, Coordinator, Mental Health Resource Service, Centacare Cairns

HARRIS, Ms Philippa Joan, Coordinator, Mental Illness Fellowship North Queensland Inc.

JOHNSTONE, Dr Julie, Private capacity

KNOWLES, Ms Leanne, Manager, Social Health Unit, Wuchopperen Health Service, Cairns

LINK, Mr Johnathan Roy, Community Liaison and Development Officer, Royal Flying Doctor Service

MILLARD, Mr Mark William, Service Development Coordinator, Cairns Integrated Mental Health Service

O'DONOVAN, Mr Ross James, Chairperson, Cairns Consumer and Carer Advisory Group

O'TOOLE, Ms Catherine, Manager, Advance Employment Inc.

TYSON, Ms Lynette, President, Mental Illness Fellowship North Queensland Inc.

WILLIAMS, Mr Craig Anthony, Chief Executive Officer, Far North Queensland Consortium for Social and Emotional Health and Wellbeing Ltd

Tuesday, 30 August 2005, Darwin

AH CHEE, Ms Donna, Deputy Director, Central Australian Aboriginal Congress

BOFFA, Dr John, Public Health Medical Officer, Central Australian Aboriginal Congress

BROWN, Ms Dawn Patricia, Member, Northern Territory Mental Health Coalition

CARTER, Ms Kirsty Jean, Spokesperson, Northern Territory Mental Health Coalition

CLISBY, Ms Judy, Manager, Community Visitor Program

DEVLIN, Ms Jennifer, Solicitor, Northern Territory Legal Aid Commission

GREEN, Mrs Joy Ann, Member, Northern Territory Mental Health Coalition

GRIEW, Mr Robert, Chief Executive Officer, Department of Health and Community Services, Northern Territory

HENDRY, Ms Bronwyn, Director, Mental Health, Department of Health and Community Services, Northern Territory

JAMES, Mrs Julie Ann, Member, Northern Territory Mental Health Coalition

McCONACHY, Ms Sandy, Mental Health Program Manager, Top End Division of General Practice

PARKER, Dr Robert Michaelis, Acting Director of Psychiatry, Top End Mental Health Services, Department of Health and Community Services, Northern Territory

PARKER, Dr Robert Michaelis, Chair, Aboriginal and Torres Strait Islander Mental Health Committee, Royal Australian and New Zealand College of Psychiatrists

RHODES, Ms Rose, Assistant Secretary Community Services, Department of Health and Community Services, Northern Territory

SAMBONO, Mr Henry, Senior Adviser to Aboriginal Mental Health Program, Top End Division of General Practice

Thursday, 1 September 2005, Perth

BADCOCK, Dr Johanna, Committee member and Western Australian representative, Australasian Society for Psychiatric Research

BYRNE, Dr Simon, Private capacity

DRAKE, Ms Maxine Elizabeth, Advocate, Health Consumers Council

FRANCES, Miss Katherine, Private capacity

GROVES, Dr Aaron, Director, Office of Mental Health, Department of Health

HORTON, Dr Jillian, Private capacity

JABLENSKY, Professor Assen, Member, Australasian Society for Psychiatric Research

JONES, Ms Margaret Lynn, Consultant Clinical Psychologist representing North Metropolitan Area Health Service, Child and Adolescent Health Services on the Child and Adolescent Mental Health Services Advisory Committee

MARWICK, Mr Patrick John, Chairperson, Child and Adolescent Mental Health Services Advisory Committee

MAYCOCK, Associate Professor Bruce, Associate Director, Western Australian Centre for Health Promotion Research

MORGAN, Ms Vera, President, Australasian Society for Psychiatric Research

NOTTAGE, Dr Cathy, Member, Attention Deficit Hyperactivity Disorder Team, Bentley Family Clinic

SCOTT, Ms Michelle, Public Advocate, Office of the Public Advocate

SPENCER-FAWELL, Mrs Elizabeth Anne, Executive Officer and Consultant Accredited Practising Dietitian, Learning and Attentional Disorders Society of Western Australia

TONER, Mrs Michele Eva, President, Management Committee and Media and Government Spokesperson, Learning and Attentional Disorders Society of Western Australia

TOWLER, Dr Simon, Executive Director, Health Policy and Clinical Reform, Department of Health

WHITELY, Mr Martin Paul, MLA, Chairperson, Drug Free Attention Deficit Support Inc.

WHITING, Dr Kenneth Rowland, Chairman, Professional Advisory Committee, Learning and Attentional Disorders Society of Western Australia

WYNN OWEN, Dr Peter, Acting Director, Office of Mental Health, Department of Health

Tuesday, 27 September 2005, Adelaide

ANAF, Dr Gil, Immediate Past President, National Association of Practising Psychiatrists

BICKNELL, Mr Peter Ernest, Chief Executive Officer, UnitingCare Wesley Port Adelaide; and Representative, UnitingCare Australia

BOUCHER, Ms Susan Pamela, Chief Executive Officer, Australian Principals Associations Professional Development Council Inc

BRAYLEY, Dr John Quinton, Director, Mental Health, Department of Health, South Australia

BROWN, Ms Elizabeth Mary, President, Australian Guidance and Counselling Association, South Australia

CARSON, Mrs Ruth Mary, Carer Representative, Strategic Planning Group for Private Psychiatric Services, National Network of Private Psychiatric Sector Consumers and Carers

DURRINGTON, Ms Learne, Executive Director, Mental Health, Central Northern Adelaide Health Service, Department of Health, South Australia

FARR, Ms Margaret, Assistant Public Advocate, Office of the Public Advocate, South Australia

FEAR, Mr Graeme, Coordinator, New South Wales State Council, Advisory Committee for the Care of People with Mental Illness, St Vincent de Paul Society

FUDGE, Ms Elizabeth, Project Manager, Children of Parents with a Mental Illness, Australian Infant, Child, Adolescent and Family Mental Health Association Ltd

GARVIN, Ms Susan, Company Secretary, Australian Infant, Child, Adolescent and Family Mental Health Association Ltd

GLOVER, Anne, AO, State President, South Australian Branch, National Investment for the Early Years

HARLEY, Mr John Maxwell, Public Advocate, Office of the Public Advocate, South Australia

HARRIS, Sister Myree, President, New South Wales State Council Advisory Committee for the Care of People with Mental Illness, St Vincent de Paul Society

HATFIELD DODDS, Ms Lin, National Director, UnitingCare Australia

HERBERT, Mr Royce Lincoln, President, Australian Guidance and Counselling Association, South Australia

MASON, Ms Paola, Co-Founder, Children of Mentally Ill Consumers; and Member, Australian Infant, Child, Adolescent and Family Mental Health Association Ltd

McMAHON, Ms Janne Christine, Independent Chair, National Network of Private Psychiatric Sector Consumers and Carers

O'HANLON, Ms Anne, Project Coordinator, Research and Evaluation, Auseinet

PARHAM, Ms Jennie Ann, Project Manager, Auseinet

RICKWOOD, Associate Professor Debra, Consultant, Auseinet

ROBINSON, Mr Philip, PSM, Chair, Board of Directors, Australian Infant, Child, Adolescent and Family Mental Health Association Ltd

WATERS, Mr Mark, Manager, Employment Access, UnitingCare Wesley Port Adelaide; and Representative, UnitingCare Australia

WATSON, Ms Sally, Executive Member, South Australian Branch, Australian Association for Infant Mental Health

ZOELLNER, Mr Don, Chair, MindMatters National Reference Committee

Friday, 7 October 2005, Canberra

ADDISON, Ms Linda, Assistant Secretary, Private Health Insurance Branch, Department of Health and Ageing

BOZIC, Ms Suzanne, Director, Carers Policy and Program Section, Disability and Care Branch, Department of Family and Community Services

BUCKINGHAM, Mr William James, Consultant, Health Priorities and Suicide Prevention Branch, Department of Health and Ageing

CASEY, Mr Dermot, Assistant Secretary, Detention Health Services Strategy Branch, Department of Immigration and Multicultural and Indigenous Affairs

DAVIES, Mr Philip, Acting Secretary, Department of Health and Ageing

DRAYTON, Ms Moya, National Manager, Disabilities Services Branch, Centrelink

HOGG, Ms Carolyn, Deputy Chief Executive Officer, Centrelink

HORVATH, Professor John, Chief Medical Officer, Department of Health and Ageing

HORVATH, Professor John, Chief Medical Officer, Department of Health and Ageing

LEARMONTH, Mr David, First Assistant Secretary, Primary Care Division, Department of Health and Ageing

LEARMONTH, Mr David, First Assistant Secretary, Primary Care Division, Department of Health and Ageing

LYONS, Ms Margaret, First Assistant Secretary, Health Services Improvement Division, Department of Health and Ageing

McALPINE, Ms Patricia, National Manager ProfessionalPractice, CRS Australia

McGLEW, Mr Paul John, Acting Assistant Secretary, General Practice Programs Branch, Primary Care Division, Department of Health and Ageing

MOULD, Dr Janet, General Manager, Program Review Division, Medicare Australia

O'CONNELL, Ms Lyn, First Assistant Secretary, Detention Services Division, Department of Immigration and Multicultural and Indigenous Affairs

PRIMROSE, Dr John, Medical Adviser, Pharmaceutical Benefits Branch, Department of Health and Ageing

PRIMROSE, Dr John, Medical Adviser, Pharmaceutical Benefits Branch, Department of Health and Ageing

ROBERTSON, Ms Samantha, Acting First Assistant Secretary, Medicare Benefits Branch, Department of Health and Ageing

ROBERTSON, Ms Samantha, Acting First Assistant Secretary, Medicare Benefits Branch, Department of Health and Ageing   1

SANDISON, Mr Barry, Acting Group Manager, Working Age Policy, Department of Employment and Workplace Relations

SAVAGE, Mr Nathan, Assistant Secretary, Health Priorities and Suicide Prevention Branch, Department of Health and Ageing

SAVAGE, Ms Joy, Assistant Secretary, Health Strategies, Office for Aboriginal and Torres Strait Islander Health, Department of Health and Ageing

SPERLING, Ms Perry, First Assistant Secretary, Service Delivery Policy and Strategy, Department of Human Services

STEVENSON, Ms Cheryl, Branch Head, Service Quality and Support Group, Child Support Agency

WESTON, Ms Michelle, Section Manager, Disability Policy, Department of Family and Community Services

WHITEFORD, Professor Harvey Alick, Mental Health Clinical Adviser, Department of Health and Ageing

WOOD, Ms Ellen, Section Manager, Homelessness Policy and Assistance, Housing Support Branch, Department of Family and Community Services

Friday, 28 October 2005, Canberra

BRENT, Mr Ronald Ian, Deputy Commonwealth Ombudsman, Commonwealth Ombudsman

CASTLES, Dr Carole, President, Australian College of Psychological Medicine

GRAINGER, Mr David L, Chair, Health Policy Development Strategic Committee, Medicines Australia

HICKIE, Professor Ian, Clinical Adviser, Mental Health Council of Australia

KIFT, Ms Dale Monica, Rank and File Member, Probation and Community Corrections Officers' Association Inc.

MASRI, Mr George Michael, Director, Immigration Investigations Team, Commonwealth Ombudsman

McIVER, Mr Douglas Lindsay, Private capacity

McIVER, Mrs Janice Marin, Private capacity

McMILLAN, Professor John Denison, Commonwealth Ombudsman, Commonwealth Ombudsman

MENDOZA, Mr John, Chief Executive Officer, Mental Health Council of Australia

NORMAN, Mr Brian Bently, Foundation President, Immediate Past President and Spokesperson, Probation and Community Corrections Officers' Association Inc.

OZOLS, Mrs Ingrid, Executive Member, Mental Health Council of Australia

POWLAY, Mr John Frederick, Private Health Insurance Ombudsman

ROSENBERG, Mr Sebastian, Deputy Chief Executive Officer, Mental Health Council of Australia

ROWE, Dr Leanne, Councillor, Royal Australian College of General Practitioners

SHAW, Dr Brendan Antony, Senior Manager, Policy and Research, Medicines Australia

WILSON, the Hon. Keith, Chair, Mental Health Council of Australia

Wednesday, 1 February 2006, Hobart

BERKERY, Ms Priscilla, Consumer Representative, Mental Health Council of Tasmania

BEVAN, Ms Georgia Anne, Coordinator/Support Worker, Mental Health Council of Tasmania

BLANCO, Mr Antonio (Tony), Member, Victorian Branch, Health and Community Services Union

BURKE, Mr Gerald Ian, Executive Director, Tasmanian Division, Australian Red Cross

DAVIS, Dr Maryanne, Member, Tasmanian Branch, Health and Community Services Union

FLANAGAN, Ms Josephine Cecilia, Manager, Social Action and Research Centre, Anglicare Tasmania

GRAHAM, Associate Professor Des, State Manager, Mental Health Services, Tasmanian Department of Health and Human Services

GUPPY, Ms Denise, Assistant State Secretary, Victorian Branch, Health and Community Services Union

JORM, Professor Anthony Francis, Private capacity

KLEYN, Mr Thomas, Senior Industrial Officer, Tasmanian Branch, Health and Community Services Union

LAMB, Mr Daryl Graham, State Manager, Community Services, Anglicare Tasmania

LANGFORD, Ms Lorette, State Coordinator, Mental Health Programs, Australian Red Cross

MACGREGOR, Mr Roderick Peter, Executive Officer, Mental Health Council of Tasmania

MUSKETT, Mrs Coral, State Director of Nursing, Mental Health Services, Tasmanian Department of Health and Human Services

THOMSON, Mr Craig, National Secretary, Health Services Union

TICKNER, Mr Robert, Chief Executive Officer, Australian Red Cross

Thursday, 2 February 2006, Gold Coast

ALCORN, Ms Mary, Executive Director, Gold Coast Drug Council Inc.

COMPTON, Mr Andrew Bruce, Department Head, Mental Health Association Queensland Inc.

COUSINS, Mr Sean, President, Gold Coast Drug Council Inc.

KEALTON, Mrs Lesley Janet, Private capacity

KONINGEN, Ms Susan Peta, Private capacity

MORRIS, Dr Philip Leo Patrick, Executive Director, Gold Coast Institute of Mental Health

NICOL, Mrs Judith Frances, Vice-President, Bio-Balance Health Association Inc.

RANSLEY, Dr Janet, Senior Lecturer, School of Criminology and Criminal Justice, Griffith University

SKELTON, Mr John James, Vice-President, Bio-Balance Health Association Inc.

STEPHENSON, Ms Susan Ann, Executive Director, Mental Health Association Queensland Inc.

STEWART, Associate Professor Anna, School of Criminology and Criminal Justice, Griffith University

STUCKEY, Dr Richard Hill, Member, Bio-Balance Health Association Inc.

THOMPSON, Mrs Helen Patricia, Private capacity

APPENDIX 6

ADDITIONAL INFORMATION AUTHORISED FOR PUBLICATION BY THE COMMITTEE

1   Professor Patrick McGorry – Beattie Smith Lecture 2004

2   Associate Professor Alan Rosen: Australian Psychiatry: From disparate state services to 2005

3   Associate Professor Alan Rosen: The Australian Experience of Deinstitutionalization: Interaction of Australian Culture with the Development and Reform of its Mental Health Service

4   SAVE – Australia Inc, Forum on Mental Health and Human Rights in Australia, 31 March 2005

5   Professor Ian Hickie, Grace Groom and Tracey Davenport: Investing in Australia's Future: Summary, December 2004

6   Professor Ian Hickie, Grace Groom and Tracey Davenport

7   Auditor-General Victoria: Mental Health services for people in crisis, October 2002

8   Auditor-General's Report Performance Audit: Emergency Mental Health Services, NSW Department of Health, May 2005

9   Ms Merinda Epstein: Spectrum Conference – Getting some action at a National level – the lament of a tired campaigner

10   Ms Merinda Epstein: Evolution or Revolution – 3rd Australian Conference on Safety and Quality of Health Care – Adelaide, 11th-13th July 2005

11   A. Rosen, P. McGorry, G. Groom, I. Hickie, R. Gurr, B. Hocking, M. Leggatt, A. Deveson, K. Wilson, D. Holmes, V. Miller, L. Dunbar, F. Stanley: Australia needs a mental health commission

12   Cairns District Health Service. Cairns Integrated Mental Health Residential Rehabilitation Service 2005

13   Cairns District Health Service. Moowooga Street Fact Sheet 2005

14   The Winston Churchill Memorial Trust of Australia Report by Myree Harris RSJ – 2002 Churchill Fellow

15   Submission of the Rau Family to the Inquiry into the Detention of Cornelia Rau: Public Version, Released 30 May 2005

16   Unfenced road ahead: a review of rural and remote mental health service delivery and policy – Ann Kreger and Ernest Hunter

17   Commonwealth's National Mental Health Report, 2004

18   Regional Aboriginal Integrated Social & Emotional Wellbeing Program (RAISE): A case study in Aboriginal primary mental health care linkages

19   Evidence for Using Atypical Antipsychotics in Mood and Anxiety Disorders. Larry Culpepper, M.D., M.P.H.

20   Department of Health 2005 – Government of Western Australia: Stimulant Prescribing and Usage Patterns for the Treatment of ADHD in Western Australia 1 August 2003 – 31 December 2004

21   Mental Health – Law and Human Rights (New Zealand). No-Force Advocacy by Users and Survivors of Psychiatry

22   David Adair. Peer Support Programs Within Prisons - December 2005. Graduate Diploma in Criminology and Corrections, School of Sociology and Social Work, University of Tasmania

APPENDIX 7

LIST OF TABLED DOCUMENTS

19 May 2005, Canberra

Mental Health Council of Australia

- The Medical Journal of Australia, 18 April 2005, Volume 182, Number 8, *Australian mental health reform: time for real outcomes* - Ian B Hickie, Grace L Groom, Patrick D McGorry, Tracey A Davenport, Georgina M Luscombe

- *Investing in Australia's future: the personal, social and economic benefits of good mental health*, December 2004 - Professor Ian Hickie, Brain & Mind Research Institute, University of Sydney, NSW. Dr Grace Groom, Mental Health Council of Australia, ACT. Ms Tracey Davenport, Brain & Mind Research Institute, University of Sydney, NSW.

4 July 2005, Canberra

The Richmond Fellowship ACT

- The Australian Mental Health Services Reference Guide – Answers That Matter

Australian Private Hospitals Association (AHIA)

- *Enshrining Portability of Private Health Insurance*. Final Report by Access Economics Pty Limited for Australian Private Hospitals Association. June 2005

5 July 2005, Melbourne

beyondblue

- The *beyondblue* National Postnatal Depression Program & beyondbabyblues: the consumer voice and lived experience of PND. Emotional Health During Pregnancy & Early Parenthood. Information Booklet Victoria.

- beyondblue: the national depression initiative

- beyondblue's blueVoices virtual network

- About Depression

- A guide to the *beyondblue* website www.beyondblue.org.au

- *beyondblue*: The Way Forward 2005-2010

- Antenatal and Postnatal Depression. A Guide to Management

- Open your eyes to what depression is costing your organisation

- The *beyondblue* National Depression in the Workplace Program

- Postcard – know Y someone's really feeling down?

- A guide to the Ybblue website www.ybblue.com.au

- Fact Sheet 1 – Depression: isn't it just a tough time?

- Fact Sheet 3 – The stats and facts about anxiety

- Fact Sheet 4 – The help is out there, Fact Sheet 14 – Getting by

- Fact Sheet 5 – How can I help?

- The Medical Journal of Australia, 7 October 2002, Volume 177, Supplement – Preventing Depression

- The Medical Journal of Australia, Supplement, 4 October 2004, Volume 181 Number 7 – Depression: reducing the burden

- beyondblue Annual Report 2003-2004

- beyondblue Annual Report 2002-2003

insane australia

- An invitation. Confidential Forum for Former In-Patients of Psychiatric Hospitals in New Zealand before the end of 1992

- The National Mental Health Consumers' Self-Help Clearinghouse. Directory of Consumer-Driven Services ((1) ds)

- The National Mental Health Consumers' Self-Help Clearinghouse. Directory of Consumer ((2) 3p)

- World Network of Users and Survivors of Psychiatry WNUSP – Advocacy Note: Forced Interventions Meet International Definition of Torture Standards

- World Network of Users and Survivors of Psychiatry WNUSP – "Advocacy Note on Legal Capacity"

- 'Psychiatric services users: the WHO perspective' Benedetto Saraceno

- document dated July 4, 2005 – United Nations Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities

Ms Merinda Epstein

- Article, *Cut it out, please*
  http://society.guardian.co.uk/mentalhealth/comment/0,8146,1274966,00.html

SANE Australia

- SANE Helpline 2005. A report on SANE Australia's national mental illness helpline

6 July 2005, Melbourne

Eastern Hume Dual Diagnosis Services

- Disc Gary Croton – Audio overview supporting Power Point presentation

- Australian treatment system's recognition of / response to co-occurring mental health & substance use disorders

- Substance Abuse Treatment For Persons With Co-Occurring Disorders. A Treatment Improvement Protocol TIP 42. US Department of Health and Human Services. Substance Abuse and Mental Health Services Administration Centre for Substance Abuse Treatment

Mental Health Legal Centre

- The Mental Health Legal Centre Leaflet – Legal information legal advice legal referral legal advocacy law reform

- United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care

- Newspaper article: The Australian – Monday July 4 2005, *Bed crisis forces doctors to certify mental patients* Clara Pirani Medical reporter

- Mental Health Legal Centre Inc Handout, October 2003, A0013662S, *The Law Gives All Patients These Rights*

- *Patients' Rights* A self-help guide to the Victorian mental Health Act. Mental Health Legal Centre Inc., 6th edition, June 2005

- Mental Health Legal Centre Annual Report 2003/04: *Your Rights Patients' Rights* A self-help guide to the Victorian Mental Health Act

Ms Merinda Epstein

- On Gratitude

Victorian Institute of Forensic Mental Health

- Victorian Institute of Forensic Mental Health Annual Report 2003/2004

Mental Health Foundation of Australia

- Leaflet – *Mental Health Foundation Australia* CAN 005 895 992

- Leaflet – *What Is Mental Health?* Six ways to keep mentally healthy

- Leaflet – *Dealing with Borderline Personality Disorder*

- Leaflet – *Dealing with Negative Emotions*

- Leaflet – *The Anxiety Disorders*

- Leaflet – *Depression*

- *Adolescent Health and Wellbeing: A Guide to Effective Coping* Barry J. Evans, Neil Coventry, and Graham D. Burrows AO, KSJ (Editors)

- *Understanding Depression* Barry J. Evans, Graham D. Burrows AO, KSJ, and Trevor R. Norman

- *Your guide to RESPONSIBLE GAMBLING* Greg J. Coman Phd and Graham D. Burrows AO, KCSJ, MD

- *Your guide to Understanding and Managing Stress* (Revised Edition) Barry J. Evans PhD, Greg J. Coman MSc, Graham D. Burrows AO, KSJ, MD

Centre for Psychiatric Nursing Research & Practice

Ms Cath Roper – Consumer Academic

- *Force in Mental Health Services: International User/Survivor Perspectives* Mary O'Hagan. (Adapted from a paper given at the Paradox of Rights Seminar Auckland 29 August 2002)

- *Learning together – Education and Training Partnerships in Mental Health* prepared by Deakin Human Services Australia

Mr Raymond Rudd – Clinical Psychologist

- Copy letter to The Hon Simon Crean MHR Hotham dated 10.09.04 signed by Raymond Rudd MAPS MCCP

- *National Commission for children and young people* Labor Discussion Paper 003, The Hon Simon Crean MP Leader of the Opposition, Nicola Roxon MP Shadow Minister for Children and Youth

- *Growing Up – Investing in the Early Years* Simon Crean, MP Leader of the Opposition, Nicola Roxon, MP, Shadow Minister for Children and Youth January 2003 – DP 012

Professor Henry Jackson - Clinical Psychologist

- The University of Melbourne 2005 Postgraduate Handbook – School of Behavioural Science Faculty of Medicine, Dentistry and Health Sciences

7 July 2005, Melbourne

ORYGEN

- ORYGEN Clinical Services – ORYGEN Youth Health

27 July 2005, Melbourne

Australian Healthcare Association

- Australian Council on Healthcare Standards Submission

Australian Psychological Society

- Australian Psychological Society Presentation July 2005

Public Health Association of Australia

- Mental Health Disorders; Effective Treatment and Community Support

- A National Service Framework for Mental Health

- Suicide Prevention Policy 2003

- Appendix 1. National Institute for Clinical Excellence Guideline – Schizophrenia (NICE, 2002)

- Family Intervention Studies: Relapse Rates at 6-12 months

Pharmacy Guild of Australia

- Unit Dose 7 Webstersystem … plus example of blister pack

2 August 2005, Sydney

SAVE – Australia Inc

- *Refuge Australia* Australia's Humanitarian Record, Klaus Neumann

NSW Farmers Association

- A NSW Farmers Blueprint for Maintaining the Mental Health and Wellbeing of the People on NSW Farms

Australian Injecting & Illicit Drug Users League

- Department of Health and Ageing. *Barriers and Incentives to Treatment for Illicit Drug Users*. Monograph Series No.53. *National Drug Strategy*

Multicultural Mental Health Australia

- Leaflet *Multicultural Mental Health Australia*

- *REALITY CHECK culturally diverse mental health consumers speak out*

- *In Their Own Right. Assessing the needs of Carers in Diverse Communities*

3 August 2005, Sydney

Mr Stephen Corry

- Newspaper article (no reference) Article *Rehab centre to stay* by Raylene Bliss together with a picture of the 4491 Centre at Leichhardt

Comprehensive Area Service Psychiatrists Special Interest Group

Professor Alan Rosen

- Article from Dr John Hoult dated 8 March 2004 for Sydney Morning Herald

- Involuntary Admissions 1991 – 2004

- The M·H·S Conference. The MHS Connect 5 Issues of concern about Australian Mental Health Services

- Involuntary Admissions, Magistrate Inquiries and CCO/CTOs

- Newspaper article. The Weekend Australian July 30-31 -21. *Balancing act for mind care* Alan Rosen

- Clinical perspectives. Evidence based community alternatives to institutional psychiatric care

- Mental Health Needs within the General Hospital and the central role of Consultation-Psychiatric Services

NSW Health Department

- New South Wales Interagency Action Plan for Better Mental Health

4 August 2005, Brisbane

Origins Inc. Supporting People Separated by Adoption Queensland Branch

- Submission

Australian Mental Health Consumer Network – Ms Helen Connor

- Consumer Operated Services Discussion Paper developed for the National Mental Health Working Group, March 2005

- Consumer Operated Services, Discussion Paper. Appendix B. Sommers, D, Campbell, J., and Rittenhouse, T. (1999). Annotated Bibliography on Consumer-Operated Services. Missouri Institute of Mental Health Program in Consumer Studies and Training: St Louis, MO. Supported through a subcontract with the Center for Mental Health Policy and Services Research, University of Pennsylvania: Philadelphia

- The state of knowledge of the effectiveness of consumer provided services

Brisbane Obsessive Compulsive Disorder Support Group

- Leaflet. Brisbane Obsessive Compulsive Disorder Support Group

- Brisbane OCD Newsletter. December 2004

envision Support Services

- envision Support Services. Patch Model

5 August 2005, Cairns

Mental Illness Fellowship – NQ

- History of Major Government Funding and Service Provision 1991 until 2005 Schizophrenia/Mental Illness Fellowship NQ Inc

Wauchopperen – Aboriginal Medical Services

- Learners' Permits for Parents. Program Evaluation. Toni Mehigan BA (Psych) Dip. Ed. Grad Dip App APsych. MACA (Clinical) MAPS

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- Letter on behalf of Brodrick Osborne. Team Leader (Allied Health) Mental Health – Cairns Base date 2 August 2005

- Issues for presentation at Senate Select Committee on Mental Health – Cairns Public Meeting – 29-7-05. By RFDS – Cairns Base

Dr Simon Bridge

- Leaflet. Toughin' it out. Survival skills for dealing with suicidal thoughts

Cairns Consumer Advisory Group

- Consumer and Carer Participation Policy, a framework for the mental health sector

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Northern Territory Department of Health

- Aboriginal Health and Families. A Five Year Framework for Action

- Building Healthier Communities. A Framework for Health and Community Services

1 September 2005, Perth

The Australasian Society for Psychiatric Research

- Statement of Proposed Minimum Short-Term Outcomes

Drug-Free Attention Deficit Support Inc

Professor Bruce Maycock

- Issues for consideration relating to the illicit diversion and use of dexamphetamine Maycock B, Burns S., Brown G., Smith J. 2005. West Australian Centre for Health Promotion Research. Curtin University

Mr Martin Whitely

- 3 keys to understanding the ADHD debate

Learning and Attentional Disorders Society of WA Inc (LADS)

- Global consensus on ADHD/HKD

27 September 2005, Adelaide

Australian Guidance and Counselling Association

- Australian Journal of Guidance and Counselling. Volume 15 Number 1 July 2005

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Folder enclosing

- MindMatters – promoting wellbeing for secondary students. April 2005
- MindMatters – World Health Organisation model for school mental health promotion
- Poster – every teacher is a teacher for wellbeing
- Staff matters – staff matters web-based resources
- MindMatters Plus

UnitingCare Australia

- Presentation: Lin Hatfield Dodds, National Director, UnitingCare Australia. Peter Bicknell, CEO, Uniting Care Wesley Port Adelaide (UCWPA)Mark Walters, Manager, Employment Access, UCWPA Adelaide, September 2005

St Vincent de Paul Society

- The Winston Churchill Memorial Trust of Australia. Report by MYREE Harris RSJ 2002/2 Churchill Fellow

Ausinet

Folder containing:

- Living is for everyone – A framework for prevention of suicide and self-harm in Australia. Areas for action;

- Living is for everyone – A framework for prevention of suicide and self-harm in Australia. Learnings about suicide

- Living is for everyone – A framework for prevention of suicide and self-harm in Australia. Building partnerships

- Mental Health in Australia Working together for: •promotion •prevention •early intervention •suicide prevention

- Mental Health Promotion. Case Studies from Countries. A Joint Publication of the World Federation for Mental Health and the World Health Organization

- National Action Plan for Promotion, Prevention and Early Intervention for Mental Health 2000. A Joint Commonwealth, State and Territory Initiative under the Second National Mental Health Plan. National Mental health strategy

- Pathways of Recovery: Preventing Relapse. A discussion paper on the role of relapse prevention in the recovery process for people who have been seriously affected by mental illness. Prepared for the National Mental Health Promotion and Prevention Working Party by Debra Rickwood. June 2004

- Promoting Mental Health. Concepts ▪ Emerging Evidence ▪ Practice. Summary Report. A Report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and The University of Melbourne

- Promotion, Prevention and Early Intervention for Mental Health. A Monograph 2000. national mental health strategy

- Prevention of Mental Disorders. Effective Interventions and Policy Options. Summary Report. World Health Organization. Geneva

NIFTeY Australia and The Australian Association for Infant Mental Health

- The Case for Prevention Early Years Intervention. *"Focus on the Growing Efficacy of Prevention Programs"*

- Folder containing:

  - AICAFMHA Actively promoting positive mental health for infants, children, young people and their families/carers.

- Leaflet. AICAFMHA Promoting Mental Health for Young Australian

- Position Paper. Improving the mental health of infants, children and adolescents in Australia. Prepared by AICAFMHA

- Flyer. IACAPAP 10-14 September 2006 Melbourne. 17th International Association for Child and Adolescent Psychiatry and Allied Professions Congress

- Information sheet: AICAFMHA: promoting mental health for young Australians

- Leaflet – Children of Parents with a Mental Illness: A National Initiative

- The Best For Me and My Baby. Managing Mental Health during Pregnancy and Early Parenthood. Health professionals and parents working together

- Family Talk. Tips and information for families where a parent has a mental health problem or disorder

- Principles and Actions for Services and People Working with Children of Parents with a Mental Illness. April 2004. national mental health strategy

7 October 2005, Canberra

Department of Health and Ageing

- Key Performance Indicators for Australian Public Mental Health Services. National mental health strategy. Information Strategy Committee Discussion Paper No. 5

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- 'Baxter Plan' – Stage 1 Existing External Elevation
- Discussion Paper. Mental Health Strategy – Palmer Recommendations

28 October 2005, Canberra

Royal Australian College of General Practitioners

- clockwork: time for young people. making general practice work for young people. Dr Leanne Rowe

- The Royal Australian College of General Practitioners. Annual Report 2004-2005

- QA&CPD Quality Assurance and Continuing Professional Development. Program Handbook 2005-2007 Triennium. For general practitioners

- National Aboriginal Community Controlled Health Organisation NACCHO. National guide to a preventive health assessment in Aboriginal and Torres Strait Islander peoples. The Royal College of General Practitioners. Enclosed in the publication are two posters, one for Adult Preventive Health Life Cycle Summary and another for Child Preventive Health Life Cycle Summary.

- RACGP 3 Standards for general practices 3rd edition. Our standards Our general practice

- afp Vol 34 No 10 October 2005. Health inequalities

- Leaflet. RACGP. GP learning Information Booklet

Mental Health Council of Australia

- Mental Health. Creating a Supportive Workplace. An easy to understand guide on the most commonly occurring mental illnesses and what you can do. Telstra Care

- Mental Health Council of Australia. Promoting Supportive Workplaces for People with Mental Illness Employer Forums. Report to the Department of Employment and Workplace Relations. 4 August 2005

- Is real reform of the MBS for psychiatrists economically, socially or professionally desirable? Ian B Hickie MD FRANZCP., Tracey A Davenport BA (Hons), GCM., Georgina M Luscombe BSc(Hons), Elizabeth M Scott MBBS, BSc(Hons, FRANZCP., Elizabeth Mackenzie MBBS, FRANZCP., Hugh Morgan MBBS, FRANZCP., Andrew Wilson MM, FRANZCP., David A Barton MBBS, FRANZCP, MRACMA., Elaine Barrett BA (Hons).

- Investing in Australia's future: the personal, social and economic benefits of good mental health. Summary December 2004

- The Medical Journal of Australia 16 July 2001 Volume 175 Supplement. SPHERE: A National Depression Project

- MJA Supplement Vol 176 20 May 2002. Treating depression: the *beyondblue* guidelines for treating depression in primary care. "Not so much what you do but that you keep doing it"

- Papers BMJ Volume 326 10 May 2003. Association between antidepressant prescribing and suicide in Australia, 1991-2000: trend analysis. Wayne D Hall, Andrea Mant, Philip B Mitchell, Valerie A Rendle, Ian B Hickie and Peter McManus

- Supplement MJA Volume 181 Number 7 4 October 2004. General practitioners' response to depression and anxiety in the Australian community: a preliminary analysis. Ian B Hickie, Jane E Pirkis, Grant A Blashki, Grace L Groom and Tracey A Davenport

- Victoria Auditor General. Follow-up of selected performance audits tabled in 2002 and 2003. PP No. 171 Session 2003-05

Mr Douglas McIver and Mrs Janice McIver

- A Personal Experience of Intervention. Strategies for Schizophrenia.

- Miscellaneous documents

1 February 2006, Hobart

Professor Anthony Jorm

- Mental Health First Aid Manual

Australian Red Cross – Mr Robert Tickner

Folder consisting of:

- Letter signed by Mr R Tickner

- External Evaluations

- The Australian Red Cross Society "MATES" Program: An Initial Evaluation. Iain Montgomery and Jim Young Department of Psychology University of Tasmania

- University of Tasmania. School of Sociology & Social Work. Evaluation Report of Red Cross MATES Program, November 2000

- Australian Red Cross MATES Program Evaluation Report December 2002

- M.A.T.E.S. Program. MATES Information Sheet and Conditions

- M.A.T.E.S.   Confidentiality Agreement

- Australian Red Cross Volunteer Policy and Procedure

- M.A.T.E.S. Program

- Testimony: Thoughts on MATES

2 February 2006, Gold Coast

Ms Sue Koningen

- The Empowering Families Program

Dr Richard Stuckey

- Statement: Mrs Helen Thompson