



Mental Health
Coordinating Council



NCOSS

**Submission
Senate Community Affairs Committee
Inquiry into Mental Health Services in Australia
August 2007**



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**Senate Community Affairs Committee
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Introduction

This submission represents a joint response to the Terms of Reference of the Australian Senate Community Affairs Committee, *Inquiry into Mental Health Services in Australia* (2007), undertaken by two non-government peak bodies in NSW, the Mental Health Coordinating Council (MHCC) and the Council of Social Service of NSW (NCOSS).

MHCC is the state peak body for non-government organisations (NGOs) working for mental health throughout NSW and represents the views and interests of over 160 NGOs. Our member organisations specialise in the provision of services and support for people with a disability due to mental illness. MHCC provides leadership and representation to its membership and seeks to improve, promote and develop quality mental health services to the community. Facilitating effective linkages between government, non - government and private sectors, MHCC participate extensively in public policy development.

The organisation regularly consults with all sectors in order to respond to legislative reform and sits on numerous National, State (NSW) and State Government Department (NSW) committees and boards in order to effect systemic change. MHCC manages and conducts research projects and develops collaborative programs on behalf of the sector.

NCOSS is an independent non-government organisation and is the peak body for the non-government human services sector in NSW. NCOSS represents more than 7,000 community organisations, consumers and individuals and works with its members on behalf of disadvantaged people and communities towards achieving social justice in New South Wales. Affiliate members include local government councils, business organisations and Government agencies. NCOSS is part of a national network of Councils of Social Service.

MHCC and NCOSS thank the Senate Community Affairs Committee for inviting them to respond to the Inquiry into Mental Health Services in Australia. The joint submission is the product of extensive collaboration, consultation and meetings, held in order to maximise the level of community participation and share input from consumers, carers, other NSW peak bodies, key mental health organisations, service providers and interested stakeholders.

The Inquiry

MHCC and NCOSS were a little surprised to receive notification of another Inquiry following on from the Senate Inquiry in 2005, particularly since the *National Action Plan on Mental Health Plan 2006 – 2011* was only endorsed in July 2006. The roll out of many of the programs occurred during the last 6 – 12 months and some only got underway in July 2007. As a consequence, we suggest that it is rather difficult for us to comment meaningfully on the plan itself or the programs to which funds were allocated. Nevertheless, we have attempted to gather as much feedback as possible to pass on to the Committee.

The *National Action Plan on Mental Health Plan 2006-2011* appears to be a statement of commitment rather than an implementation plan, particularly since the Outcome and Progress Measures (p.7) fail to identify how data is to be collected, evaluated and measured. In most cases we do not have sufficient information as to which services are targeted and how they will be evaluated.

On the whole those consulted felt that the Inquiry was premature, the terms of reference broad and unclear as to what was being asked for, and that the terms of reference posed more questions than could be answered.

Nevertheless, MHCC and NCOSS acknowledge the Commonwealth Government's commitment to setting an agenda positioning effective responses to mental health problems as a national health priority and we welcome the opportunity to be consulted. We consider the *Council of Australian Governments* (COAG) arrangements for Commonwealth, States and Territories to work together to implement commitments in the most effective way, as a positive step towards governments working together to achieve better outcomes for people with mental illness.

Recommendations

1. That the Commonwealth, State and Territory Governments annually publish a report informing the sector as to which services/programs are targeted and where funding has been rolled out.
2. That the Commonwealth, State and Territory Governments publish a paper which identifies in detail the outcomes expected from the initiatives, and how outcomes will be evaluated and measured.
3. That an independently researched review funded through COAG is conducted by Commonwealth, State and Territory Governments to evaluate the outcome and progress measures to be used.
4. That the Commonwealth, State and Territory Governments collaborate with the NGO sector to promote the use of standardised data bases and outcome measurement to streamline reporting requirements for NGOs across programs.

The basis on which funds were allocated by the Commonwealth to go directly to NGOs as opposed to the State is unclear, and in some instances might prove problematic. However, the Commonwealth \$1.9 billion across two departments (Education and Training and the Department of Ageing and Disability) demonstrates a commitment to an across government approach.

In NSW, NGOs received no growth funding. In the State Budget (released 19 June 2007), the sector received State indexation of 3.3% to match the CPI and wage increases under the SACS award. There appears to be a mismatch between Commonwealth and State commitment to a whole of population approach to mental health care in the community.

Terms of Reference 1

The committee in considering this matter give consideration to:

Ongoing efforts towards improving mental health services in Australia, with reference to the National Action Plan on Mental Health agreed upon at the July 2006 meeting of the Council of Australian Governments, particularly examining the commitments and contributions of the different levels of government with regard to their respective roles and responsibilities.

NGOs did not participate in consultations informing the *National Mental Health Plan 2003-2008*, and *NSW: A New Direction for Mental Health*. These documents identified a population health approach to be reflected in access to community services at a local level, which we vigorously support. We understand that these documents were intended to underpin development of the COAG plans, a process in which NGOs were excluded.

We suggest that an absence of NGO involvement in consultations on COAG strategy and implementation plans is an unfortunate omission. We are now being asked to comment on plans that from our point of view do not necessarily represent a philosophical direction or funding necessary in order to meet priorities outlined in *The National Mental Health Plan 2003-2008*, and *NSW: A New Direction for Mental Health*.

Recommendation

5. That NGOs should be included in consultations to inform strategy and planning of future COAG implementation plans.

The COAG Process

Without a clear picture as to how coordination between governments is managed, there might be a potential for duplication between geographic distribution targeted by different Commonwealth and State programs. Some areas are thought to be receiving several services, whilst others none. Whilst the *National Action Plan on Mental Health (2006-2011)* is about coordination, fears have been expressed as to parallel processes that seem to be occurring between FACSIA, DOHA and NSW Health, which indicates a lack of overall coordination in planning and implementation.

Concern has been voiced with regard to absence of commitment to ongoing funding beyond 2011, and that short time frames to establish consortia and prepare applications for funding have been common. Commitment to some programs such as the Commonwealth funded Day to Day Living (\$46.0million, p.11) is only funded for 2 years. We ask what the plan is thereafter, and advocate that the positive outcomes of COAG funded programs inform future planning beyond this time.

- It is felt that insufficient thought and consultation had been applied to what services are to be funded, particularly since NGO peaks have not had the opportunity to make recommendations to COAG.

- At a MHCC consultation for member CEOs, senior executives commented that some programs were being micromanaged. The Senate Inquiry is seen as an opportunity for NGOs to inform governments about what data needs to be collected, evaluated and what the performance indicators are.
- Comment has been made that siloing of mental health and drug and alcohol agencies present some problems since the funding available prevents D & A agencies joining consortia.

The tender process designed by governments is thought to be a problem. Many organisations do not fit the tender specs, and they have to fit the model rather than make submissions based on how they are structured and function. Organisations should define and design the programs they operate, and evaluation should be an integral part of the design and taken into account in funding allocations.

The *National Action Plan on Mental Health (2006-2011)* offers a vision of coordinated services, which has not played out in reality. Area Health Services bear the responsibility for ensuring staff have knowledge of community services. A level of confusion was noted as to who is operating what service where. The establishment of a regional centralised intake process and networks across and between Area Health Services and NGOs is suggested.

Recommendation

6. That COAG investigate models that have been developed that accommodate regional base coordination through *Care- Link*, including the development of a regional centralised intake process with NGO peak bodies, and a centralised resource centre for mental health services to provide information and referral to Area Health Services, NGOs and the community.

7. That COAG resource research into how consumers and carers navigate the system.

8. That COAG resource a mechanism to coordinate with various programs offered by different governments and departments to enable the vision of coordinated services to be achieved.

Terms of Reference 2

The committee in considering this matter give consideration to:

(a) the extent to which the Action Plan assists in achieving the aims and objectives of the National Mental Health Strategy:

The terms of reference require comment and comparison on four different but interrelated documents. In response to this we have mapped the four documents in order to understand how they connect. The four documents in order of publication are: *The National Mental Health Plan, 2003 – 2008*; *A National Approach to Mental Health – from Crisis to Community (April 2006)*; *NSW: A New Direction for Mental Health (NSW Health - June 2006)*; and *the COAG National Action Plan on Mental Health (2006-2011)*.

Mapping Overview 2003 – 2011

National Mental Health Plan 2003-2008 (National Mental Health Strategy 2003)	A National Approach to Mental Health- from crisis to community (Select Committee April 2006 Recommendations)	NSW: A New Direction for Mental Health (NSW Health June 2006)	National Action Plan on Mental Health 2006-2011 (COAG July 2006)
§ Promoting mental health and preventing mental health problems and mental illness	§ Monitoring and research	§ Promotion, prevention and early intervention across the life span	§ Promotion, prevention and early intervention
§ Improving service responsiveness	§ Consumers rights and roles	§ Improving and integrating the care system	§ Integrating and improving the care system
§ Strengthening quality	§ Prevention and early intervention	§ Participation in the community and employment including accommodation	§ Participation in the community and employment, including accommodation
§ Fostering research, innovation and sustainability	§ Community treatment	§ Better workforce capacity	§ Coordinating care
	§ NGO's		§ Increasing workforce capacity
	§ Workforce and training		
	§ Crisis response		
	§ Housing		
	§ Employment and income support		
	§ Families and carers		
	§ Paying for mental health care		
	§ Criminal justice system		
	§ Dual diagnosis		
	§ Children and youth adults		
	§ Older people		
	§ CALD communities		
	§ Rural and remote		
	§ Indigenous people		
	§ Refugees		
	§ Adult Survivors of child abuse		

The *National Mental Health Plan 2003 - 2008* and the *National Action Plan on Mental Health 2006 - 2011*

National Mental Health Plan 2003-2008

The *National Mental Health Plan 2003-2008* has 4 priority themes:

1. Promoting mental health and preventing mental health problems and mental illness
2. Improving service responsiveness
3. Strengthening quality
4. Fostering research, innovation and sustainability

Under these themes 34 Outcomes detailed numerous key directions identified to meet the outcomes (p. 20-27). The *National Mental Health Plan 2003-2008* provided a framework for consolidating and building on the First and Second National Mental Health Plans. It emphasised the centrality of consumers, families and carers in reform, and focused on achieving gains through a population health framework, setting important priorities for the 5 years. Its aim was to improve the mental health and wellbeing of the Australian community, to improve the treatment, care and quality of life of people with mental health problems and mental illness across the lifespan.

The Plan also emphasised the importance of measurement and accountability. The previous plans were evaluated, with each evaluation containing a number of components that assessed their appropriateness and effectiveness. In both cases, these components included a mix of quantitative and qualitative data derived from consultations with key informants and commentary from international experts. The Plan stressed the need to continue public reporting of nationally aggregated data, and maintained a commitment to independent evaluation.

The document stressed that at the outset, evaluation of the Plan was an integral part of its implementation that should begin when the Plan commenced. The broad outcomes of the Plan were to be translated into a series of nationally consistent indicators, against which success (or lack thereof), could be measured. Development of the indicators would determine what data need to be collected. An overall evaluation was to be conducted as well as an evaluation of specific initiatives within the Plan, and subject to rigorous scrutiny.

National Action Plan on Mental Health 2006 - 2011

The *National Action Plan on Mental Health 2006-2011* is directed at achieving 4 outcomes:

Reducing the prevalence and severity of mental illness;

Reducing the prevalence of risk factors that contribute to the onset of mental illness and prevent long term recovery;

Increasing the proportion of people with an emerging or established mental illness who are able to access the right health care and other relevant community services at the right time with a particular focus on early intervention;

Increasing the ability of people with a mental illness to participate in the community, employment, education and training including through an increase in access to stable accommodation.

The 5 areas of action are:

Promotion, prevention and early intervention

Integrating and improving the care system

Participation in the community and employment including accommodation

Coordinating care

Increasing workforce capacity.

In the Plan, COAG committed to two initiatives to better integrate and connect services on the ground. These initiatives are outlined under section *Coordinating Care* (p.5).

“The first is joint action to coordinate the provision of health and community support services for people with severe mental illness and complex needs across Australia. The second is to establish institutional arrangements to ensure that new investment under this Plan, by each level of government is delivered in the most effective way within each State and Territory,” (p.1).

The Plan outlines where Commonwealth, State and Territory governments will expand and improve mental health services and access to them. It also outlines opportunities for improved connections between services provided by different governments and where collaboration and joint action will occur between governments, so that people with a mental illness are better supported to participate in the community.

Measuring the *National Action Plan on Mental Health 2006 - 2011* against the aims of the *National Mental Health Plan 2003 – 2008*

The general sentiment expressed during consultations was that whilst there are some positive initiatives outlined in the *National Action Plan 2006-2011*, the Plan fails to meet the outcomes stated in the *National Mental Health Plan 2003-2008*. The Plan states that in its two part structure “it describes overarching outcomes, areas for action with specific policy directions agreed between governments, and the implementation plans for each government,” (p.2).

However, the ‘overarching’ statements contain little real evidence as to how the initiatives are to be implemented and measured. At this early stage of roll-out, we are only in a position to comment in very general terms.

It is generally felt that the *National Action Plan on Mental Health 2006-2011* has a bio-medical approach to mental health. The language used such as “merging and established mental illness” does not fit a broader concept of mental health. Its aim is to reduce mental illness rather than promoting mental health or prevention of mental illness.

The *National Action Plan on Mental Health 2006-2011* does not take a population health approach to mental health and is directed at achieving 4 outcomes whose focus is primarily on mental illness. This is in stark contrast to the *National Mental Health Plan 2003 – 2008*, and the *NSW: A New Direction for Mental Health* (NSW Health – June, 2006) that set out a clear population health framework, with one of its aims being to promote mental health, recognising that mental health and mental illness are on a continuum. It identifies key directions to promote and improve mental health and to reduce prevalence of mental health problems and mental illness.

“Mental health promotion aims to protect, support and sustain the emotional and social wellbeing of the population, from the earliest years through adult life to old age. It should address people who are currently well, those at risk of developing a mental health problem, and those experiencing mental health problems or mental illness. A range of factors influences mental health. Public policies in sectors such as health, housing, welfare, education, employment, justice and corrections, art, sport and recreation, and the media impact on mental health. Supportive social, economic, educational, cultural and physical environments provide a basic framework for developing and maintaining mental health, particularly for children and adolescents whose early experiences shape their later mental health. Communities that recognise and accept diversity also contribute to social and emotional wellbeing. Communities in which people feel involved, included and empowered to influence decisions that affect them are supportive of mental health”.
(*The National Mental Health Plan 2003 -2008*, p.16).

The *National Action Plan on Mental Health 2006 - 2011* has 4 overarching outcomes it is directed to achieving, in contrast to the *National Action Plan on Mental Health 2003-2008* (p.20-27) which has 34 outcomes outlined in sub headings of key directions. Consultations identified the difficulty in evaluating where crossover between the desired outcomes exists in both documents. This is particularly problematic since the *National Action Plan on Mental Health 2006 - 2011* does not present detail explaining each stated commitment.

Recommendation

9. That a review of the 4 interrelated documents (The National Mental Health Plan, 2003 – 2008; A National Approach to Mental Health – from Crisis to Community (April 2006); NSW:A New Direction for Mental Health (NSW Health - June 2006); and the COAG National Action Plan on Mental Health (2006-2011) be referred to a COAG and key mental health NGO review panel to inform future strategy, planning and implementation and address inconsistencies between strategy and implementation.

10. That COAG future strategy and plans are balanced to incorporate more equitable funding for prevention, promotion and early intervention in addition to treating mental illness.

11. The COAG support NGOs in taking a lead role in developing how care coordination should be implemented.

The committee in considering this matter give consideration to:

(b) the overall contribution of the action plan to the development of a coordinated infrastructure to support community-based care;

The COAG Plan, through collaboration between Commonwealth, State and Territory has sought to provide a model of service delivery to support people with complex need, their carers and families to have access to a range of community services that assist them in managing their mental illness and participating as fully as possible in the community. This appears in the *National Action Plan 2006-2011* under *Coordinating Care* (p.5). We support this model of service delivery.

However, inconsistencies have become apparent between the States, who have different levels of engagement. In NSW, under the PHAMS program (a Commonwealth funded program which funds NGOs directly, p.10) the NSW Health, Mental Health and Drug and Alcohol Office (MHDAO) have interpreted Care Coordination as a method of referral via clinical services. As a consequence clients cannot be referred directly through a GP and must be processed through Area Health Services, who frequently lack capacity to handle the necessary referral processes. The concern is that centre based services will be flooded and that growth to staff numbers is directed at care coordination rather than the priority of case management.

Consultations identified that tender processes for Personal Helpers and Mentors (PHaMS) and Housing and Accommodation Initiative (HASI) favour larger organisations and exclude smaller NGOs. Smaller organisations need additional resources to provide appropriate services.

Some concern was expressed that PHAMS in some ways replicates HASI 2, and consumers reported that they need more centre based services to go to and that access is confusing.

Recommendation

12. That COAG review PHAMS referral processes to maintain community access rather than access via clinical services.

13. That COAG investigate inconsistencies between service delivery of PHAMS in States and Territories.

14. That the COAG tender process review smaller NGOs who may be appropriately placed to offer PHAMS services.

15. That the PHAMS program is developed to assist NGOs develop collaborative relationships with clinical teams provide support for NGOs.

Improved access through MBS

Improved access to psychologists and social workers through the Medical Benefits Schedule (MBS) has received widespread support. However, numerous concerns have been raised:

- The APS site for referral of accredited MBS psychologists lists key areas of expertise and identifies the clinician's therapeutic approach. However, GPs may be inadequately trained to understand the appropriateness of a modality, and match it to client needs. They may be more likely to refer according to location or to those personally known to them.
- A treatment plan may refer a client for 6 - 12 sessions (in exceptional circumstances 18). This can present a duty of care dilemma, since some clients may require therapy over longer periods.
- Many psychologists' fees exceed the MBS and many clients are unable to fund the balance. Out-of-pocket expenses will count towards both the original and the extended Medicare safety net which may not adequately cover high users of health services.
- The importance of the client / therapist relationship is central to successful outcomes. When a client is unable to develop a positive therapeutic alliance with a professional, and experiences little benefit over a number of sessions, they may be disinclined to seek further help. A query has been raised as to whether further sessions with an alternative psychologist are thereby limited by sessions already undertaken.
- The implementation of MBS access excludes practitioners other than psychologists and social workers as service providers. By excluding trained psychotherapists and counsellors who may be appropriately qualified to deal with a multitude of complex presentations and who are offering a broad range of therapeutic modalities, the process is underutilising a resource of skilled practitioners.
- This scheme may also be encouraging psychologists and social workers into private practice and away from mainstream and community services that already experience difficulty in finding suitably trained professionals.
- Some NGO counselling agencies whose waiting lists are already stretched, report that they receive referrals from psychologists who do not have expertise in some specialised fields, such as working with adult survivors of childhood abuse who present with a multitude of complex mental health problems. NGOs have not received enhanced funding for the services they deliver. However, it was reported that an ability to refer to psychologists presents an option for clients on waiting lists to access some help in the interim.
- Concerns that services would inevitably cause a shift from services for the seriously unwell to those better able to access to referrals, able to pay the gap, etc were expressed.

Recommendation

16. That COAG review the number of psychologist sessions available under the MBS scheme.

17. That COAG review the MBS fee structure so that clients unable to pay for ongoing sessions or the gap between MBS fee and actual charges will not be disadvantaged.

18. That COAG consult with and review proposals from professional bodies such as Psychotherapists and Counsellors Federation Australia (PACFA) to provide accreditation for suitably qualified counsellors and psychotherapists as a further resource to be included within the MBS scheme.

Mental Health Nurses

MHCC and NCOSS support the initiative for mental health nurses to assist people with serious mental illnesses to receive better coordinated care. Nevertheless, some concerns have been raised as to how this model might work in practice, particularly for small GP practices or private psychiatrists (e.g. where there is a lack of space in which to practice).

Consultations identified that since commencement of funding was to begin July 2007, that little information is available to comment on how the roll out of funds is to be delivered or how implementation arrangements are to be managed.

Recommendation

19. That COAG provide documentation on the implementation of coordinated treatment and care by mental health nurses including how consumer outcomes are to be measured.

Psychiatric Emergency Care Centres (PECC)

The nine PECC units which have been operating for some time are by all accounts running well. An evaluation report conducted by Dr Kevin Wolfenden which utilised surveys conducted by INFORMH has not been released. However, we were able to ascertain from anecdotal comment that staff, police, and ambulance drivers were supportive of the PECC units, which they believe have made their work easier to accomplish and improved service delivery.

Consumers and carers are generally pleased with services received although comment was made about the first four units established which operate in non-purpose built locations. The environment is less than ideal for those people using or working in them since windows are absent. More recently, units established in purpose built locations have met with general approval.

Some staffing problems were initially experienced, but latterly increased interest amongst mental health nurses, wanting to work in PECC has been noted, particularly since rotating staff between ED and PECC has afforded staff experience they are interested in acquiring.

We have been told that the evaluation has shown PECC units to be a valuable addition to service provision; are no more expensive to run than inpatient units; that time to care has improved; stays are shorter; and that consumers, carers and staff are much happier with the services provided.

Expansion of further units is to be evaluated shortly by the department who will subsequently report on its future policy regarding expansion across the State.

The committee in considering this matter give consideration to:

c) progress towards implementing the recommendations of the Select Committee on Mental Health, as outlined in its report *A National Approach to Mental Health - from crisis to community*;

In its final report, the *Select Committee on Mental Health* (2006), proposes 91 recommendations specific both in detailing particular initiatives and methods of implementation. This submission attempts to highlight recommendations that have been included or are absent in COAG commitments.

The *National Action Plan on Mental Health 2006-2011* contains plans for each government, which include some progress towards implementation of the recommendations of the Select Committee. In some cases roll out of funds has begun, in many cases the targets are unknown, recently commenced or due to commence. With some reservation expressed under separate headings in this submission, we express our support of many of the initiatives undertaken.

Recommendation

20. That COAG provide a report on uptake of services commenced since July 2006.

Participation in Community and Employment, including Accommodation

“The Plan aims to improve mental health and facilitate recovery from illness through a greater focus on promotion, prevention and early intervention; improved access to mental health services, including in Indigenous and rural communities; more stable accommodation and support; and meaningful participation in recreational, social, employment and other activities in the community. Improving the care system will involve a focus on better coordinated care and building workforce capacity”. (*The National Action Plan on Mental Health 2006 - 2011*, p.i).

We wholeheartedly support the specialist program to assist people with a mental illness obtaining and maintaining employment under the *Helping People with a Mental Illness enter and remain in Employment* (\$39.8million, p.10) program, implemented under the Commonwealth Plan which commenced in July 2006. Since the ‘Welfare to Work’ legislation, emphasis has shifted away from providing specialist disability employment support to channelling people with disability into the mainstream Job Network System.

There is ample evidence that people with mental illness need access to a specialised approach to ensure positive long-term employment outcomes. It is really important that people unable to use generic services have access to appropriate services that acknowledge ‘one size fits all’ does not apply.

Recommendation

21. That COAG review and report on outcomes for users of the Helping People with a Mental Illness enter and remain in Employment program.

Increasing Workforce Capacity

A number of Commonwealth programs totalling \$129.9 million and from NSW totalling \$23.2 million, address gaps in workforce capacity and go some way to meeting the recommendations of the *Select Committee on Mental Health* (2006, Rec 30.3.21; 31. 3.22; 32.3.23; 33.3.24).

Both the Commonwealth and NSW provide funding through a range of training programs, curricula development and scholarships to enhance the mental health workforce. However, there is no reference in the *National Action Plan on Mental Health* (2006 - 2011) to stand alone specialist degrees for mental health nurses, which we believe is a priority.

Of grave concern are levels of uptake for workforce training particularly in areas of need such as rural and remote, Indigenous and CALD communities. Without greater availability of scholarships, many potential candidates will be excluded by their inability to fund the fees, and the problems mainstream services experience across Australia in finding adequate numbers of mental health workers to undertake the roles necessary, are even more marked in isolated locations servicing culturally diverse communities.

The State allocated \$12.2million to an Aboriginal Mental Health Workforce Program. This initiative aimed to place local Aboriginal mental health trainees in mainstream community mental health teams to address the high and complex needs of Aboriginal people, and for Aboriginal people to engage better with mental health services. This programme was expanded following a pilot in the Greater Western Area Health Service, which won the Premier's Public Service Award in 2005. Commencement was in July 2006. We are unable to confirm whether these programs have been implemented, and where.

The number of nurses required in the mental health system can be mitigated by better understanding the role and function of nurses in the mental health system. Nurses are providing interventions and support which could be more appropriately provided by non-clinical workers. In other words, as referred to elsewhere in this submission, COAG should be providing infrastructure resources, workforce education and training through and for the NGO sector.

Recommendation

22. That COAG target support to NGO services to provide programs and workforce training in identified areas of need.

23. That COAG report on implementation and evaluate expansion of the Aboriginal Mental Health Workforce Program.

Mental Health and Drug and Alcohol Services

Programs supported under the Commonwealth implementation plan have been received with a measure of scepticism. Whilst we support the program in principle, *Alerting the Community to Links between Illicit Drugs and Mental Illness* (\$21.6million, p.9) was referred to by those working in the sector during consultations as a politically motivated, fear based initiative that is part of a drive to be tough on drugs.

The Commonwealth initiative, *Improved Services for People with Drug and Alcohol Problems and Mental Illness* (\$73.9million, p.10) is considered a poor strategy. The NGO peaks submitted a proposal for community recovery, rehabilitation and counselling programs that enhance capacity and workforce development, proposing that the peaks were best placed to construct the framework and strategy for service delivery. This was rejected, and the process did not meaningfully engage with those who would be delivering services. Subsequently, the tender process required organisations to compete for resources.

The State program *Better Integration of Mental Health Services with Drug and Alcohol Services* (\$17.6million, p.13) is reportedly going well, but we have yet to see a report and evaluation of the impact of the graduates placed within drug and alcohol and mental health services, which commenced July 2006.

Recommendation

24. That the Commonwealth review the tendering process for delivery of best practice models for intervention for people with drug and alcohol problems and mental illness delivered by the NGO sector.

25. That the Commonwealth support a model that enables the NGO peaks to lead the direction of model development, capacity building and workforce development.

Criminal Justice System

A number of *Senate Inquiry into Mental Health* (2006) recommendations are under way, including significant expansion of diversionary programs and housing and employment programs to reduce cycles of offending behaviour and assist with recovery (Rec 57. 3.48).

However, there is no evidence that state and territory governments have taken into account the need to substantially increase provision of step-down supported accommodation and skill based programs to facilitate reintegration into the community, and prevent homelessness following release from incarceration and forensic facilities (Rec 65.3.56).

According to the Auditor General it costs approximately \$63,000 per annum to keep a person in corrective services, compared to an estimated \$34,000-52,000 to appropriately house a homeless and mentally ill person, and \$4,000 to supervise someone in the community (2006). The NSW allocation of \$2.7 million per annum to fund community based organisations that provide post release services such as supported housing, employment assistance, living skills and counselling is totally inadequate.

Butler and Allnutt (2003) found that when a broad definition of 'any psychiatric disorder' was used, 74% of the NSW inmate population was affected. According to recent data collection, the fastest growing group in NSW prisons is Aboriginal women (Baldry, E. 2006). Evidence shows that overall women are the growth group in the criminal justice system. Female prisoners have a higher prevalence of psychiatric disorder than male prisoners (90% were affected in the preceding 12 months before incarceration).

Our understanding is that there is only one post release service dedicated to supporting men with mental illness funded under the Community Funding Program, New Horizons Enterprises, which offer beds for three men at a time.

Recommendation

26. That COAG urgently review the need for: supported accommodation and employment; living skills; ongoing support and community engagement programs following release from gaol or forensic facilities.

27. That COAG target funding at pre and post release programs developed by the NGO sector to support released prisoners or forensic patients from re-offending and/or becoming homeless.

28. That COAG urgently assess the particular needs (mental illness / co-morbidity) for female inmates and female forensic patients with particular prior to and post release to halt the cycle of re-entry into the criminal justice system.

29. That COAG consult with PIAC who have recently conducted a report on the issue of pre and post release programs which they will be releasing in the near future.

In NSW and WA, responsibility for the release of forensic patients ultimately falls to Ministerial (Executive) Discretion. In other states it is within the jurisdiction of mental health courts or mental health tribunals. The *Senate Inquiry on Mental Health (2006)* recommended uniformity within all states and territories (Rec 58. 3.49). The forensic provisions of the NSW Mental Health Act 1990 are currently under review. If Executive Discretion is abolished in NSW, this is likely to have impact on the numbers of people requiring support in the community post release.

The *Senate Inquiry on Mental Health (2006)* proposed that state and territory governments aim as far as possible for the treatment of all people with mental illness in the justice system to take place in forensic facilities that are physically and operationally separate from prisons, and incorporate this aim into infrastructure planning (Rec 59. 3.50). This work is underway with the new forensic hospital at Malabar, outside the confines of Long Bay Goal, under construction.

The *Senate Inquiry on Mental Health (2006)* also proposed that the Australian, State and Territory governments review funding for prescription medicines and medical care to examine anomalies and differences in quality of care between community primary care and care currently provided in prisons (Rec 60.3. 51). Our understanding is that Justice Health (JH) has quality management systems in place to monitor and review all aspects of service delivery with the objective of providing care commensurate to that received in the community. The Drugs and Therapeutic Committee (JH) ensure compliance with PBS requirements and the relevant State Act.

During consultations, concerns were raised in relation to the recommendation that governments establish protocols for mental health assessments of prisoners on entry into the criminal justice system (Rec 61.3.52). This was discussed in reference to the Scott Simpson case.

However, we do not know whether an agreement was reached on protocols for mental health assessments under the Expansion of Community Forensic Mental Health Services (\$6.5million) and/or Supporting People with Mental Illness in the Prison System (\$5million) which seem to provide two possible funding streams for prisoners with a mental illness. Since both programs commenced in July 2006, it would be useful to have access to evaluation reports on impact and of these initiatives from Area Health Services and the Department of Corrective Services.

Recommendation

30. That COAG report on the impact of two NSW initiatives: Expansion of Community Forensic Mental Health Services; and Supporting People with Mental Illness in the Prison System on people in the criminal justice system, their carers and the workforce.

Review of National Standards

We understand that a review of National Standards for mental health services, service providers performance and of performance indicators for mental health inpatient and dual diagnosis services and follow up in the community is underway, as recommended in the *Senate Inquiry on Mental Health* (2006, Rec 14, p. 13).

Community Rehabilitation Services

We support the NSW initiative to introduce Vocational Education Training and Employment (VETE) clinicians to provide: individual assessments, intervention, preparation and support of VETE plans; linkages and advice on mental health issues as required to Vocational Rehabilitation providers; employment services and educational providers; and the development of local service networks to facilitate referral and management options. However, despite commencement in July 2006, we have been unable to ascertain as to what services have been provided, where they are available, what impact they have had outside of Area Health Services; and whether positive outcomes have been noted for consumers.

It is proposed that these positions should engage with NGO employment services, and increase the capacity of organisations to work with people with mental illness.

Recommendation

31. That COAG review and report on VETE services that commenced in 2006, and require VETE services to engage with local NGO employment services.

Resource and Recovery

Although not clearly identifiable in the *National Action Plan on Mental Health* (2006 - 2011), the Recovery and Resource Services Program is a component of the Mental Health - Community Rehabilitation Program, which in turn is part of the Mental Health Community Enhancement Program detailed in the NSW: A new direction in Mental Health (p.14).

The NSW State budget (June 2007) announced funding of \$3million to this program designed to increase the capacity of NGOs in providing support and access to community inclusive social, leisure and recreational opportunities and vocational services, based on best available evidence and practices. The Recovery and Resource Services Program sits within the broader NSW Health Mental Health Program.

This program has been identified as having a focus on establishing services in identified areas of need, particularly areas with a limited range of community based mental health services. Whilst we see that this program is an important State effort towards resourcing the sector, we suggest that this allocation will not adequately meet the needs identified.

Recommendation

32. That COAG re-evaluate the Resource and Recovery Programs and the funding allocated to this aspect of community rehabilitation.

Community based services for Indigenous and CALD families

Under the *National Action Plan (2006 – 2011)*, the Commonwealth has sought to fund programs through the NGO sector which are targeted at programs to support families, children and young people affected by mental illness. Programs focus on prevention and early intervention particularly for Indigenous and CALD families. Commencement date was July 2006, but we are unable to ascertain which services are running the programs.

Recommendation

33. That COAG identify services that are to be the recipients of the initiative and evaluate those services that have commenced a program.

Suicide Prevention

We fully support the expansion of national and community based projects under the National Suicide Prevention Strategy under the Commonwealth implementation plan (\$62.4million, p. 9). We understand that rates of suicide have fallen since the 1990's. However, an evaluation of the *Life is for Living* suite of resources for the prevention of suicide in Australia is yet to be approved by the Department of Health and Ageing and we are unable to comment until we are able to assess the research data and evidence presented.

Day to Day Living

The Commonwealth initiative *Day to Day Living* (\$46million, p.11) commenced July 2007. We are unable to ascertain which NGO services were targeted to receive support for addition places in structured programs for people with severe mental illness.

Recommendation

34. That COAG provide the sector with information as to who are to be recipients of enhanced funding under the Day to Day Living programs.

Family and Carers

The sector is very supportive of the Commonwealth initiative *Families and Carers* (\$224.7million, p.11). However, two reservations were voiced during consultations with regard to these programs. Firstly, that they are targeted primarily at the elderly with little or no focus on young carers who often struggle to access resources. Secondly, it is suggested that emphasis is put on respite for carers of a person with an intellectual disability rather than a mental illness, and that the focus should be more equitable.

Recommendation

38. That COAG report on the uptake of services and evaluate service delivery criteria to encompass many carers excluded from the service.

We understand that the NSW State *Family and Carers Mental Health Programme* (\$13.5million enhancement, p.14) has been running well since it commenced in July 2006. However, views expressed are that: it is too early to measure outcomes; that the evaluation process should have been designed together with the service delivery framework; and that funding for data collection and evaluation needed to be costed into the tender process. The issue of recruitment particularly in rural and regional areas still presents a major problem, but overall service users and workers are happy with the service.

The committee in considering this matter give consideration to:

(d) identifying any possible remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness.

Commitment to between Government Arrangements

The success of the Plan requires continuing effort by all governments. The COAG plan does not make clear how the new arrangements for the Commonwealth and States and Territories to work together to implement commitments in the most effective way will be implemented. It is also unclear as to the rationale behind the particular decisions for either Commonwealth or State implementation.

In order that initiatives do not cause fragmentation, the Plan needs to clarify how it will define opportunities where better connections can be made between services provided by different governments, and where greater collaboration and joint action will occur between governments, so that people with a mental illness are better supported to participate in the community.

Recommendation

36. That COAG review and report on plans to implement commitments between Commonwealth and State Governments to work together to support people in the community with mental health problems.

Research

Standards and monitoring, key directions and outcomes 27 to 29 of the *National Mental Health Plan 2003 – 2008*, are not clearly defined in the *National Action Plan 2006 -2011* (p.6 - 7) which talks about measuring progress of outcomes over the life of the plan and beyond. It states that a series of measures have been identified and that an independent evaluation would be undertaken after 5 years. Since the Plan fails to elaborate, we ask what the parameters for these measures are; when will they be implemented; and what research has been initiated to provide the data and indicators? Without such information we are unable to comment in any meaningful way.

The following points were raised in response to this discussion as to what information the sector would like to have in order to respond to comments sought.

How would the following be measured?

- Commitment to partnerships between Commonwealth and State;
- Matching philosophy to implementation plans;
- Measuring whether plans are working;
- Measuring the uptake of service;
- Measuring impact – reduction of mental illness;
- Capacity of infrastructure to support community access;
- Measuring workforce capacity to meet needs of expanded services;
- Measuring carer pathways;
- Measuring outcomes of emotional and social wellbeing.

Recommendation

37. That COAG present extensive detail on:-

- § The growth in services and increased service quality and to meet specified quality criteria in both private and public sectors;
- § Comprehensive implementation and further development of routine outcome measures;
- § Monitoring of performance of mental health services regarding emotional and social wellbeing for consumers and carers through collection and sharing of information and data.

The *National Mental Health Plan 2003 – 2008* (p.27-30) outlines its commitment to fostering research, innovation and sustainability and a strategic mental health research agenda to underpin policy and practice that is not clearly evident in the *National Action Plan 2006 - 2011*. However, the NSW implementation plan supports university research into depression, anxiety disorders and schizophrenia, and to the Brain and Mind Research Institute to conduct research and clinical outreach services, but nothing is identified that investigates a population health perspective of mental health.

Recommendation

38. That COAG review the agenda for research to include a broad spectrum of mental health issues that relate to population health rather than limiting this to a biomedical model.

Human Rights

The *Senate Inquiry into Mental Health* (2006) made a recommendation (Rec 18. 3.9) requesting that the Human Rights and Equal Opportunity Commission (HREOC) complete its work on advance directives and protocols that would recognise the rights of consumers to, for example: identify substitute decision-makers; appropriate treatments and other financial; medical and personal decisions; particularly for the care of children. HREOC did not agree with the Committee that further work by them would be the best means for advancing provision for recognition of advance directives, rather than work through bodies with more authority and direct involvement in the area i.e. guardianship authorities in each jurisdiction. Subsequently, the NSW Mental Health Act 2007 assented in Parliament on 19 June 2007, now includes Clause 72, which enables a consumer to make an advanced directive by nomination of a primary carer or exclusion of any person to notice and information. We assume that policy and protocols are now being developed within government departments.

Recommendation

39. That COAG report on the status of policy development regarding advanced directives.

The *Senate Inquiry into Mental Health* (2006) also recommended (Rec 64. 3.55) that HREOC undertake a national review of the treatment of women with mental health problems within the criminal justice and prison systems. HREOC informed us that they did submit a proposal for funding but were unsuccessful.

Justice Health (NSW) has reported 90% of the female population present at reception with a broad spectrum of mental disorders (Halpin et al., 2004). Evidence has also shown that high numbers of female inmates are victims of childhood sexual and physical abuse. We suggest that the Senate Inquiry recommendation for an independent research review remains a pressing priority.

Recommendation

40. That COAG review the need for a research review into women in the criminal justice system, and investigate the most appropriate body to conduct such a study.

Rural and Remote

This submission notes that the Commonwealth initiative: Mental Health Services in Rural and Remote Areas (\$51.7million), provides greater access to mental health services in rural and remote areas through funding by appropriately trained allied mental health professionals. However, concerns have been raised as to the capacity to source and train staff in these locations, and whether incentives have been provided to promote rural and remote employment as suggested in the Senate Recommendations (Rec 86. 3.77), not evident in the *National Action Plan on Mental Health 2006 - 2011*.

Recommendation

41. That COAG provide ongoing incentives to mental health professionals to promote employment in rural and remote areas.

Some of the programs under the COAG plan, particularly the Better Access through Medicare Benefits Schedule depend on the ability to refer patients to psychologists and social workers. In rural and remote locations this will inevitably pose a problem of access to services due to distance; availability; inadequate numbers of practitioners; transport; and cost.

It has been suggested that COAG investigate transport funding under programs such as Health Related Transport and Isolated Patients Transport Accommodation Assistance Scheme in NSW.

Recommendation

42. That COAG review rural and remote access to services i.e. under the MBS Scheme.

43. That COAG address the associated problems of i.e. practitioner numbers; transport; cost etc.

44. That COAG review funding allocation to infrastructure, resources and training for community based services to conduct appropriate alternative programs.

Capital Funding

Most NGO contracts include operational guidelines excluding them from the capital funding they require in order to take up the meaningful position proposed in the three documents that informed the COAG implementation Plan. In NSW, the sector received \$4 million for infrastructure over 2 years. This in no way meets the commitment to community access stated in The *National Action Plan 2006 - 2011* or as recommended in the Senate Select Committee on Mental Health (Recommendation 28) of *A National Approach to Mental Health – from Crisis to Community* (April 2006, p.15).

Recommendation

45. That COAG urgently review policy around capital funding for NGOs.

Community Counselling Services

MHCC and NCOSS are very supportive of a number of programs such as the 1800 crisis helpline and web-based support program initiatives under both Commonwealth and State implementation plans.

However, we do not see this as a substitute for face to face counselling. We see community counselling as an effective method of reducing the burden on mainstream services.

It has been suggested that increased utilisation of telephone help-lines is a reflection of the failure of the system to provide appropriate services, and some concern has been raised by consumers with regards to the religious affiliations of telephone counselling services.

Recommendation

46. That COAG review the concept of funding allocations for 'face to face' counselling available through community organisations via GPs and self-referral.

Child and Maternal Mental Health Services

The *Senate Inquiry into Mental Health* (2006) suggested that better links be created between child/ maternal health and mental health services to assist families identified through these services to be at risk of/ or having mental health problems, and that funding be provided for collaborative programs (Rec 5, 3. 42, p.19). We can find no reference to any initiatives either Commonwealth or State that address these concerns.

Recommendation

47. That COAG assess the needs of children and mothers at risk of mental health problems and review the evidence that prompted Recommendation 51(p.19).

Culturally appropriate services for Refugees and CALD Young Adults

The only programs that target CALD recipients identified in the *National Action Plan 2006 - 2011* are through Commonwealth community based programs for families (p.9) mentioned earlier. Frequently, CALD clients from refugee backgrounds have a significant history of trauma and have special and complex needs that mainstream mental health services may be ill-equipped to provide.

Similarly, mainstream adult mental health services are often unable to provide appropriate interventions for younger adults, especially those from marginalised and culturally diverse backgrounds. Youth health services that cater to young people up to 24 years may be unable to offer culturally appropriate mental health services. The shortage of such options presents a significant barrier to access.

The *Senate Inquiry into Mental Health* (2006) made three recommendations (Rec 78, 79 & 80) that refer to increasing the capacity of primary care providers to detect and manage symptoms of/and mental illness in CALD consumers; that culturally specific services be developed at all levels of government; and the dissemination of information to CALD communities on mental health problems through the community. Recommendations 77 and 81 also referred to provision of culturally appropriate services to refugee communities and a review of policies and health care delivery in Australian detention facilities that recognised the complex needs of asylum seekers.

We can find no reference to any other mainstream or community based services in the *National Action Plan 2006 - 2011*, either Commonwealth or State (other than already mentioned) that refer to CALD communities. Of particular concern is the absence of service provision to refugee victims of torture and trauma, either through enhanced funding to STARTTS or through NGO community based organisations.

Recommendation

48. That COAG review allocation of funds to support both mainstream and community based services to provide culturally appropriate mental health services to CALD and refugee consumers and their families.

Victims of Childhood Sexual and Physical Abuse

Sexual, physical and emotional abuse and neglect have significant mental health repercussions. Research studies consistently demonstrate that adult survivors of all forms of childhood abuse and neglect manifest high rates of mental illness: depressive and anxiety symptoms, substance abuse disorders, eating disorders, post-traumatic stress disorders, suicidality as well as poor physical health. Extensive research suggests that Complex Post Traumatic Stress Disorder looms large amongst the variety of negative mental health effects that survivors experience. Abusive behaviours and assault, whether physical, sexual or psychological can also create long-term interpersonal difficulties, distorted thinking patterns and emotional distress. The complex needs of adult survivors often overwhelm the capacity of mainstream services.

In a National report published by the Kids First Foundation (2003) into the cost of child abuse and neglect in Australia, it was estimated that the cost to Australian taxpayers was approximately \$5 billion per annum. The long term human cost and cost of public intervention was estimated at three quarters of the annual cost, and the long – term human and social cost at \$2 billion per annum.

Child abuse and neglect are the root cause of many of Australia's social ills – substance abuse, welfare dependency, homelessness, crime, relationship and family breakdown, chronic physical and mental illness. If not effectively targeted, the life-long impact of child abuse will continue unabated, putting increased pressure upon already stretched government health and social services.

The *Senate Inquiry into Mental Health* (2006) suggested that access to effective non-pharmacological treatment options be improved across the mental health system through better access to 'talking therapies' provided by psychologists, psychotherapists and counsellors for people with histories of child abuse and neglect (Rec 35, 3.27, p. 17).

As previously discussed in this submission, the access to psychologists and social workers through the MBS scheme is not in most cases appropriate to the long-term psychotherapeutic needs of this client group. We advocate as a matter of priority that funding be allocated to this long neglected client group for research of alternative treatments as suggested in Recommendation 36. Our primary concern however, is that funds be allocated firstly to provision of long-term counselling through the MBS scheme, and secondly that community based services are funded to provide individual counselling and group programs.

Group therapy interventions designed to promote a reduction in symptomatology, encourage long-term stability, and provide strategies for improving quality of life, breaking the cycle of re-admission into hospital, social exclusion, homelessness and unemployment, and provide an opportunity to enhance social skills, connection, adopt new strategies and model favourable behaviours.

Adult survivors remain some of the most marginalised people with mental health problems in the community across all cultural contexts. Services available for adults who have childhood related trauma are seriously limited and often, they are triaged out of the system due to assessments that focus on, for example, a substance abuse issue. To gain access they have to pay in the private sector. For most, self funding is not an option.

Recommendation

49. That COAG urgently review the plethora of evidence supporting service provision in the community of non-pharmacological therapies for adult survivors of childhood abuse.

50. That both Commonwealth and State Governments urgently address the gap in service provision to adult survivors of childhood abuse and neglect in both mainstream and community based services as a matter of urgency.

Medicare Provider Numbers

The *Senate Inquiry into Mental Health* (2006) proposed that greater flexibility in the allocation of Medicare provider numbers for mental health service provision (for instance psychiatric nurse practitioners and counsellors), is exercised in rural and remote areas in recognition of the shortage of psychiatrists and psychologists in these locations (Rec 84, 3.75, p.24). Our understanding is that such flexibility has not been progressed.

Recommendation

51. That the Commonwealth initiate a review of the MBS scheme for psychological services, and the provision of provider numbers to a variety of allied professionals with appropriate qualifications to be used as a resource across all communities both city, regional, rural and remote.

Indigenous Communities

Some Commonwealth funding directed at supporting Indigenous families through community based programs and improving capacity of health workers was identified, although we are unsure where initiatives have been implemented since commencement July 2006. However, there is little that we could identify in the State Plan other than a small Aboriginal Mental Health Workforce Program (p.15), which proposes that the initiative will take place in mainstream services. The *Senate Inquiry into Mental Health (2006)* had proposed that governments direct recurrent funding to Indigenous community controlled health services to administer the development, implementation and evaluation of appropriate mental health programs (Rec 91, 3.82, p.25). We endorse a community controlled model as recommended by the Inquiry.

It was also proposed that governments fund the *Commonwealth-State Mental Health Institute* in collaboration with the National Aboriginal Community Controlled Health Organisation to research the most effective means of addressing Indigenous mental health needs, including the development of appropriate diagnostic tools for assessment of mental illness among the Indigenous population, collection of data and provision of information (Rec 90, 3.81, p.25). This recommendation was absent from both Commonwealth and State Plans.

Recommendation

52. That COAG review the initiative to place Aboriginal mental health workers in mainstream services to help Aboriginal people engage better with mental health services, and give preference to supporting Indigenous specific mental health services in the communities where they are most needed as suggested by the *Senate Inquiry into Mental Health (2006)*.

53. That COAG initiate research to identify evidence based practice to address Indigenous mental health needs and the development of appropriate diagnostic tools for assessment of mental illness among the Indigenous population, collection of data and provision of information.

Special Mental Health Services for Older People.

A NSW initiative (\$37.3million, p.13) to provide enhanced assessment services is welcomed. However, we are unable to ascertain where expansion had occurred since commencement in July 2006, or whether service provision improvements had been evaluated.

The NSW initiative for older people (\$10.8million, p.13) proposes to reconfigure seven units across the State as short-medium assessment facilities. It is unclear from the scant information provided as to what this reconfiguration is proposed to achieve.

Some concern has been voiced that this might result in a downgrading of services to older people with challenging behaviours and dementia related mental health problems.

Recommendation

54. That COAG evaluate improvement to assessment and service delivery as a result of implementation of two NSW initiatives for mental services and assessment for older people that commenced in July 2006.

Community Mental Health Emergency Care

In NSW, under the COAG Implementation Plan, funding has been allocated to enhancing community emergency mental health care, by funding 65 additional specially trained professionals to respond to out of hours emergency and acute emergency responses across the State, which was universally supported at consultations.

Recommendation 35 of the Select Committee (2006, p.16) suggested that mobile intensive teams or crisis assessment teams be adequately resourced to provide mental health crisis responses 24 hours a day, minimising the need for police and ambulance attendance, and avoiding patient admission.

However, consultations identified that the sector were unclear as to whether this commitment Enhancing Community Mental Health Emergency Care (\$51.4million, implementation July 2006), through the NSW Implementation Plan referred to crisis teams. The sector report several specific areas where 'crisis teams are in crisis.' Reports of difficulties in maintaining staff levels due to burnout are common.

Concerns were raised as to where the professionals would be found to undertake training, and whether this might result in staff shortages elsewhere. Further detail is needed on the expansion of crisis teams, particularly in rural and remote locations.

In rural and remote locations, the problem was expressed as having to have a "crisis by appointment." It was generally felt that the *National Action Plan 2006 - 2011*, does not adequately provide for people who are not 'sufficiently in crisis' unless they identify as having a substance abuse issue. The pressure on acute beds is such that quite unwell people may be turned away or discharged precipitately.

Recommendation

55. That COAG report on implementation and impact of the initiative of enhancing mental health emergency care.

56. That COAG identify measures used to evaluate emergency and acute responses.

57. That COAG report on process of implementation for crisis teams in rural and remote areas.

58. That COAG report on access and equity to crisis intervention measures for ATSI and CALD communities.

59. That COAG investigate and report on non-admission and discharge statistics for people presenting in crisis in emergency and inpatient services.

Early Intervention Children and Young People

We are pleased that COAG have sought to meet *Senate Inquiry into Mental Health (2006)* recommendations at both a Commonwealth and State level (Rec 72, 73). However, concerns were raised that focus is primarily on diagnosis, early intervention and first episode psychosis with too little contribution to promoting resilience or ways of enabling people.

Youth health services and other generalist counselling services characteristically pick up young people excluded by mental health services, without having the appropriate facilities or resources to support them. The consequences are extensive waiting lists and decreased early intervention opportunities.

There is also a shortage of accommodation services that accept young people with dual diagnosis. Frequently the exclusion criteria are so regimented that they do not enable high-risk clients to access appropriate accommodation (if available). Youth services report the frustration of seeing clients caught in a cycle of referral because services do not work with co-morbidity.

Many youth health services offer primary care in mental health; however, referral networks have diminished over the last fifteen years and the referral pathways for young people with mental health issues are complex. Given the difficulties of engaging marginalised young people in health services, complex referral pathways create barriers to access, increasing the likelihood that clients will be lost through the referral process in which the onus is on clients to engage with services, even when a clear need for active intervention exists.

Recommendation

60. That COAG target funding for youth programs that provide improved integration between mental health and drug and alcohol programs and supported accommodation.

Consumer and Carer Participation in the Workforce

In the principles, aims and objectives of the *National Mental Health Plan 2003 – 2008*, the Plan set out to meet the aspirations of the mental health sector. It sought to develop a model of consumer and carer participation that represents a true partnership between mental health services, consumers and carers, in a process of collaboration to achieve improved long-term outcomes for consumers and the community.

An essential component of the development of improved service delivery is through increased consumer and carer input in the system in its broadest sense. The *National Action Plan 2006 - 2011* does not provide any support from either the Commonwealth or State to fund education for consumer / carer workforce development, or to facilitate peer support for students or practising consumer or carer advocates. This is a serious omission to implementation plans, since part of the recovery and empowerment process for many consumers and carers is to meaningfully engage in education that will lead ultimately to employment.

Recommendation

61. That COAG review funding initiatives for building workforce capacity and participation in the community and employment by funding scholarship programs to assist consumers and carers to engage in mental health advocacy and policy development training, undergraduate and post-graduate degrees.

62. That COAG fund consumer / peer support services to support consumers through education and as peer support for those engaged in employment.

Terms of Reference 3

3. That the committee have access to, and have power to make use of, the evidence and records of the Select Committee on Mental Health.

MHCC and NCOSS consultations identified that the question asked was unclear. We assume that this refers to issues of confidentiality, particularly information presented to the committee in camera. We suggest that submissions provided to the committee unless otherwise requested can be freely made use of, provided they do not contain names of individuals whose permission has not been sought for publication. Any information received by the committee in camera, or in written form should be de-identified unless otherwise approved.

Recommendation

63. That Commonwealth, State and Territory governments make issues of confidentiality and privacy clear when requesting submissions i.e. that a form granting or denying permission to quote, reference or publish on a government website be attached to any submission document.

Conclusion

MHCC and NCOSS would like to acknowledge the extent to which the Commonwealth has supported the community so that they may develop ways of meeting the needs of their constituencies.

The *Not for Service* Report (Mental Health Council of Australia and the Brain and Mind Research Institute in association with the Human Rights and Equal Opportunity Commission) told us that the absence of community services was the primary cause for people with serious mental illnesses being unable to access the help that they need and are entitled to (2005). The process of de-institutionalisation was not accompanied by corresponding supports for mentally ill people to live in the community. This left Governments with the massive task of translating the outcomes and key directions of the National Mental Health Strategy into a mental health care system that delivers 'the highest attainable standard' of health care.

The report proposed that there was a lamentable absence of community based programs to support people with mental illness in the community and the Commonwealth has sought to redress the balance by a determined effort to develop a better community based option. Whilst acknowledging the positive increase in programs from the Commonwealth that deliver new or enhanced services to people with a mental illness, we wish to stress the need for clear pathways and improved referral systems and a nationally coordinated approach.

Despite the evidence, NSW spends less than the national average, and a tiny percentage of the mental health budget on community based services.

We thank the Senate Committee for the opportunity to respond to this inquiry, and look forward to the outcome of its deliberations. If there is any assistance we can offer the Senate Standing Committee on Community Affairs during this Inquiry, we are most happy to be of assistance.

**The Mental Health Coordinating Council (MHCC)
NSW Council for Social Services (NCOSS)
August 2007**

Summary of Recommendations

1. That the Commonwealth, State and Territory Governments annually publish a report informing the sector as to which services/programs are targeted and where funding has been rolled out.
2. That the Commonwealth, State and Territory Governments publish a paper which identifies in detail the outcomes expected from the initiatives, and how outcomes will be evaluated and measured.
3. That an independently researched review funded through COAG is conducted by Commonwealth, State and Territory Governments to evaluate the outcome and progress measures to be used.
4. That the Commonwealth, State and Territory Governments collaborate with the NGO sector to promote the use of standardised data bases and outcome measurement to streamline reporting requirements for NGOs across programs.
5. That NGOs should be included in consultations to inform strategy and planning of future COAG implementation plans.
6. That COAG discuss models have been developed that accommodate regional base coordination through *Care- Link*, including the development of a regional centralised intake process with NGO peak bodies, and a centralised resource centre for mental health services to provide information and referral to Area Health Services, NGOs and the community.

7. That COAG resource research into how consumers and carers navigate the system.
8. That COAG resource a mechanism to coordinate with various programs offered by different governments and departments to enable the vision of coordinated services to be achieved.
9. That a review of the 4 interrelated documents (The National Mental Health Plan, 2003 – 2008; A National Approach to Mental Health – from Crisis to Community (April 2006); NSW: A New Direction for Mental Health (NSW Health - June 2006); and the COAG National Action Plan on Mental Health (2006-2011) be referred to a COAG and key mental health NGO review panel to inform future strategy, planning and implementation and address inconsistencies between strategy and implementation.
10. That COAG future strategy and plans are balanced to incorporate more equitable funding for prevention, promotion and early intervention in addition to treating mental illness.
11. The COAG support NGOs in taking a lead role in developing how care coordination should be implemented.
12. That COAG review PHAMS referral processes to maintain community access rather than access via clinical services.
13. That COAG investigate inconsistencies between service delivery of PHAMS in States and Territories.
14. That the COAG tender process review smaller NGOs who may be appropriately placed to offer PHAMS services.
15. That the PHAMS program is developed to assist NGOs develop collaborative relationships with clinical teams provide support for NGOs.
16. That COAG review the number of psychologist sessions available under the MBS scheme.
17. That COAG review the MBS fee structure so that clients unable to pay for ongoing sessions or the gap between MBS fee and actual charges will not be disadvantaged.
18. That COAG consult with and review proposals from professional bodies such as PACFA to provide accreditation for suitably qualified counsellors and psychotherapists as a further resource to be included within the MBS scheme.
19. That COAG provide documentation on the implementation of coordinated treatment and care by mental health nurses including how consumer outcomes are to be measured.
20. That COAG provide a report on uptake of services commenced since July 2006.
21. That COAG review and report on outcomes for users of the Helping People with a Mental Illness enter and remain in Employment program.

22. That COAG target support to NGO services to provide programs and workforce training in identified areas of need.
23. That COAG report on implementation and evaluate expansion of the Aboriginal Mental Health Workforce Program.
24. That the Commonwealth review the tendering process for delivery of best practice models for intervention for people with drug and alcohol problems and mental illness delivered by the NGO sector.
25. That the Commonwealth support a model that enables the NGO peaks to lead the direction of model development, capacity building and workforce development.
26. That COAG urgently review the need for supported accommodation and employment; living skills; ongoing support and community engagement programs following release from gaol or forensic facilities.
27. That COAG target funding at pre and post release programs developed by the NGO sector to support released prisoners or forensic patients from re-offending and/or becoming homeless.
28. That COAG urgently assess the particular needs (mental illness / co-morbidity) for female inmates and female forensic patients with particular prior to and post release to halt the cycle of re-entry into the criminal justice system.
29. That COAG consult with PIAC who have recently conducted a report on the issue of pre and post release programs which they will be releasing in the near future.
30. That COAG report on the impact of two NSW initiatives: Expansion of Community Forensic Mental Health Services; and Supporting People with Mental Illness in the Prison System on people in the criminal justice system, their carers and the workforce.
31. That COAG review and report on VETE services that commenced in 2006.
32. That COAG re-evaluate the Resource and Recovery Programs and the funding allocated to this aspect of community rehabilitation.
33. That COAG identify services that are to be the recipients of the initiative and evaluate those services that have commenced a program.
34. That COAG provide the sector with information as to who are to be recipients of enhanced funding under the Day to Day Living programs.
35. That COAG report on the uptake of services and evaluate service delivery to encompass many carers excluded from the service.

- 36.** That COAG review and report on plans to implement commitments between Commonwealth and State Governments to work together to support people in the community with mental health problems.
- 37.** That COAG present extensive detail on:-
- § The growth in services and increased service quality and to meet specified quality criteria in both private and public sectors;
 - § Comprehensive implementation and further development of routine outcome measures;
 - § Monitoring of performance of mental health services regarding emotional and social wellbeing for consumers and carers through collection and sharing of information and data.
- 38.** That COAG review the agenda for research to include a broad spectrum of mental health issues that relate to population health rather than a biomedical model.
- 39.** That COAG report on the status of policy development regarding advanced directives.
- 40.** That COAG review the need for a research review into women in the criminal justice system, and investigate the most appropriate body to conduct such a study.
- 41.** That COAG provide ongoing incentives to mental health professionals to promote employment in rural and remote areas.
- 42.** That COAG review rural and remote access to services i.e. under the MBS Scheme.
- 43.** That COAG address the associated problems of i.e. practitioner numbers; transport; cost etc.
- 44.** That COAG review funding allocation to infrastructure, resources and training for community based services to conduct appropriate alternative programs.
- 45.** That COAG urgently review policy around capital funding for NGOs.
- 46.** That COAG review the concept of funding allocations for 'face to face' counselling available through community organisations via GPs and self-referral.
- 47.** That COAG assess the needs of children and mothers at risk of mental health problems and review the evidence that prompted Recommendation 51(p.19).
- 48.** That COAG review allocation of funds to support both mainstream and community based services to provide culturally appropriate mental health services to CALD and refugee consumers and their families.
- 49.** That COAG urgently review the plethora of evidence supporting service provision in the community of non-pharmacological therapies for adult survivors of childhood abuse.

50. That both Commonwealth and State Governments urgently address the gap in service provision to adult survivors of childhood abuse and neglect in both mainstream and community based services as a matter of urgency.
51. That the Commonwealth initiate a total review of the MBS scheme, and review the provision of provider numbers to a variety of allied professionals with appropriate qualifications to be used as a resource across all communities both city, regional, rural and remote.
52. That COAG review the initiative to place Aboriginal mental health workers in mainstream services to help Aboriginal people engage better with mental health services, and give preference to supporting Indigenous specific mental health services in the communities where they are most needed as suggested by the *Senate Inquiry into Mental Health* (2006).
53. That COAG initiate research to identify evidence based practice to address Indigenous mental health needs and the development of appropriate diagnostic tools for assessment of mental illness among the Indigenous population, collection of data and provision of information.
54. That COAG evaluate improvement to assessment and service delivery as a result of implementation of two NSW initiatives for mental services and assessment for older people that commenced in July 2006.
55. That COAG report on implementation and impact of the initiative of enhancing mental health emergency care.
56. That COAG identify measures used to evaluate emergency and acute responses.
57. That COAG report on process of implementation for crisis teams in rural and remote areas.
58. That COAG report on access and equity to crisis intervention measures for ATSI and CALD communities.
59. That COAG investigate and report on non-admission and discharge statistics across emergency and inpatient services.
60. That COAG target funding for youth programs that provide improved integration between mental health and drug and alcohol programs and supported accommodation.
61. That COAG review funding initiatives for building workforce capacity and participation in the community and employment by funding scholarship programs to assist consumers and carers to engage in mental health advocacy and policy development training, undergraduate and post-graduate degrees.
62. That COAG fund consumer / peer support services to support consumers through education and as peer support for those engaged in employment.

63. That Commonwealth, State and Territory governments make issues of confidentiality and privacy clear when requesting submissions i.e. that a form granting or denying permission to quote, reference or publish on a government website be attached to any submission document.